

ENFORCING A CRITICAL ENTITLEMENT: PREEMPTION CLAIMS AS AN ALTERNATIVE WAY TO PROTECT MEDICAID RECIPIENTS' ACCESS TO HEALTHCARE

Abstract: When faced with shrinking budgets and swelling Medicaid rolls, states frequently try to reduce Medicaid spending by slashing provider reimbursement rates. Reimbursement rates, however, significantly impact provider participation and consumer access to healthcare services. Therefore, such cutbacks to Medicaid's already low rates often undermine the program's promise of "mainstream" medical access for the poor and disabled. Medicaid beneficiaries and providers long used the court system to combat these rate cuts by suing under 42 U.S.C. § 1983 and arguing that inadequate reimbursement rates violate the "equal access provision" of the federal Medicaid Act. But in 2002, the U.S. Supreme Court foreclosed this avenue of relief and seemed to leave doctors and patients without standing to challenge even the most draconian rate cuts. A recent series of decisions by the U.S. Court of Appeals for the Ninth Circuit, however, suggests that the Supremacy Clause presents an alternative means of enforcing the equal access provision. This Note explores both the promise and pitfalls of an equal access preemption claim and argues that Medicaid providers and beneficiaries should be able to enjoin significant rate cutbacks and protect healthcare access by challenging state changes to reimbursement rates as preempted by the Medicaid Act.

INTRODUCTION

In 2007, in suburban Maryland, twelve-year-old Deamonte Driver died of complications arising from a tooth abscess.¹ He died, in part because his mother, Alyce, could not find a dentist who accepted Medicaid patients and was willing to treat him.² Alyce had been struggling for months to find a dentist to treat Deamonte and his younger brother, DaShawn, who constantly complained of toothaches.³ Even with the help of an attorney, however, it took many weeks and more than two dozen phone calls to the Drivers' Medicaid provider for the family to

¹ Mary Otto, *For Want of a Dentist*, WASH. POST, Mar. 2, 2007, at B01.

² *Id.* In 2007, less than one-fifth of Maryland's dentists accepted Medicaid patients. *Id.*

³ *Id.*

locate a willing dentist.⁴ During this time, Deamonte's abscess went untreated and bacteria spread from his mouth to his brain, causing the brain infection that ultimately killed him.⁵

States have long regarded spending on Medicaid—the joint federal-state health insurance program for the “deserving poor”⁶—as a major financial pressure and, therefore, frequently target it for budget cuts.⁷ Common cost-control strategies include restricting eligibility, trimming benefits, raising copayments, and reducing provider reimbursement rates.⁸ Lowering reimbursement rates is often the preferred strategy because the political and financial ramifications are often less immediately apparent than those provoked by direct cuts in eligibility or benefits for the needy people who depend on Medicaid for health insurance.⁹ When the needy are ineligible for Medicaid, or their healthcare benefits are reduced, their health needs immediately either go unmet or are shifted onto local hospitals, clinics, and other state-financed programs.¹⁰ When providers' rates are reduced, however, although physicians and hospitals are unhappy, the immediate consequences for Medicaid recipients do not appear to be as grave.¹¹ Thus, in many states Medicaid reimbursement rates have traditionally been far lower than those of Medicare¹² or private insurers—so low, in fact,

⁴ *Id.*

⁵ *Id.*

⁶ Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 419 (2008) (explaining that only certain categories of the poor, such as children, pregnant women, and the aged, blind, or permanently disabled, must be eligible for Medicaid); see 42 U.S.C. § 1396a(a)(10)(A) (2006) (listing the groups for which a state must provide Medicaid in order to receive federal funding).

⁷ VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., REPORT NO. 7815, 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, at 8, 14 (2008), available at <http://www.kff.org/medicaid/upload/7815.pdf> (noting that, on average, Medicaid spending accounts for an impressive seventeen percent of state spending).

⁸ See *The Medicaid Dilemma: Shrinking Budgets, Difficult Choices*, TRENDWATCH (Am. Hosp. Ass'n, Washington, D.C.), June 2003, at 4, available at <http://www.aha.org/aha/trendwatch/2003/tw2003vol5no2pt1.pdf>; see also Abigail R. Moncrieff, Comment, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 673 (2006).

⁹ See Moncrieff, *supra* note 8, at 673–74; *The Medicaid Dilemma*, *supra* note 8, at 5–6.

¹⁰ See *The Medicaid Dilemma*, *supra* note 8, at 6. See generally Anna Tavis, Note, *Healthcare for All: Ensuring States Comply with the Equal Protection Rights of Legal Immigrants*, 51 B.C. L. REV. 1627 (2010) (exploring the consequences of Massachusetts and New Jersey making legal immigrants ineligible for Commonwealth Care and FamilyCare, respectively).

¹¹ See Moncrieff, *supra* note 8, at 673–74.

¹² Medicare is a federal health insurance program that offers coverage to people aged sixty-five and over, and people with permanent disabilities. See 42 U.S.C. § 1395 (2006);

that many healthcare providers lose money when they treat Medicaid patients.¹³ Because of these paltry reimbursement rates, healthcare providers commonly refuse to treat Medicaid patients.¹⁴

As the Driver family's tragedy illustrates, low provider reimbursement rates can ultimately mean that Medicaid recipients encounter significant delays in accessing non-emergency treatment¹⁵ and are limited in their choice of qualified providers.¹⁶ This fundamentally undermines Medicaid's core goal of providing "mainstream" medical access to the poor and disabled.¹⁷

Due to the current recession, the financial outlook for Medicaid is especially grim.¹⁸ Thousands more people than expected have been added to states' Medicaid rolls since the economic downturn began in 2007.¹⁹ At the same time, enormous budget shortfalls have led many

THE HENRY J. KAISER FAMILY FOUND., REPORT NO. 1066-12, MEDICARE FACT SHEET: MEDICARE AT A GLANCE (2010), *available at* <http://www.kff.org/medicare/upload/1066-12.pdf>.

¹³ See Robert Lowes, *Will Healthcare Reform Increase Medicaid Pay as Well as Enrollment?*, MEDSCAPE MED. NEWS, Mar. 23, 2010, <http://www.medscape.com/viewarticle/718673>. In 2008, Medicaid reimbursement rates, on average, were only 72% of Medicare rates; reimbursement rates for primary care services were even lower, at around 66% of Medicare rates. *Id.* During the same period, Medicare itself paid 12% less than private insurers. *Id.* In March 2010, however, as part of national healthcare reform, Congress mandated that in 2013–2014 federal funding will be used to raise Medicaid reimbursement rates to 100% of Medicare rates for primary care services provided by pediatricians, family physicians, and general internists. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1202, 124 Stat. 1029, 1052–53; see THE HENRY J. KAISER FAMILY FOUND., REPORT NO. 8023-R, SUMMARY OF COVERAGE PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AND THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (2010), *available at* <http://www.kff.org/healthreform/upload/8023-R.pdf>. Although this is a positive step, Medicare rates themselves are often inadequate, and this reform applies only to primary care providers. See Lowes, *supra*.

¹⁴ Sean Jessee, Comment, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 797 (2009).

¹⁵ *Id.* at 798.

¹⁶ See BARRY FURROW ET AL., HEALTH LAW 23 (2d ed. 2000).

¹⁷ See *Medicare and Medicaid, Hearings Before the S. Comm. on Fin.*, 91st Cong. 57 (1970) (statement of Hon. John G. Veneman, Under Secretary, Department of Health, Education, and Welfare) (testifying that "[t]he whole purpose of the 1965 act" was to provide "mainstream medical care" for all the people of this country"); see also Moncrieff, *supra* note 8, at 675.

¹⁸ VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., REPORT NO. 7985, 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, at 7 (2009), *available at* <http://www.kff.org/medicaid/upload/7985.pdf>.

¹⁹ Pauline Vu, *Medicaid Programs Feel Weight of Recession*, STATELINE, Feb. 6, 2009, <http://www.stateline.org/live/details/story?contentId=374699>. For example, in 2009, Kentucky added three thousand people per month to its Medicaid rolls, three times as many as anti-

states to cut Medicaid spending—often by reducing provider reimbursement rates.²⁰ These pressures will eventually be compounded by the Patient Protection and Affordable Care Act's (PPACA) expansion of Medicaid to millions of poor Americans who were not previously eligible.²¹ Although the federal government will initially finance this expansion, states will have to shoulder some of the costs after 2016.²² In light of the ongoing recession and the swelling of Medicaid rolls, it is critical for Medicaid beneficiaries and providers to be able to demand powerfully that states stop targeting reimbursement rates as a way to balance budgets.²³ This Note contends that bringing suit under the federal Supremacy Clause is a viable way for these groups to protect reimbursement rates and, thereby, protect healthcare access for Medicaid beneficiaries.²⁴

Throughout the 1990s, Medicaid beneficiaries and providers sought to ensure adequate reimbursement rates by bringing civil suits against state Medicaid officials under 42 U.S.C. § 1983.²⁵ Courts were

pated; Florida added two hundred thousand to its Medicaid rolls in 2008, twelve percent more than in 2007. *Id.*

²⁰ See SMITH ET AL., *supra* note 18, at 30. The American Recovery and Reinvestment Act of 2009 (ARRA) helped to offset the current economic strain on state Medicaid programs by temporarily increasing the share of Medicaid costs paid by the federal government (known as "FMAP"). American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 5001, 123 Stat. 115, 496-502; see VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., REPORT NO. 8105, HOPING FOR ECONOMIC RECOVERY, PREPARING FOR HEALTH REFORM: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2010 AND 2011, at 5 (2010), <http://www.kff.org/medicaid/upload/8105.pdf>. This enhanced funding, however, is due to expire in June 2011; the ensuing drop in federal funding will likely force states to make additional cutbacks in Medicaid spending in order to keep their budgets balanced. See SMITH ET AL., *supra*, at 5.

²¹ See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271-79; THE HENRY J. KAISER FAMILY FOUND., *supra* note 13. All individuals under the age of sixty-five with incomes at or below 133% of the federal poverty level will be eligible for Medicaid. § 2001, 124 Stat. at 271.

²² See THE HENRY J. KAISER FAMILY FOUND., *supra* note 13. The federal government will pay all the costs of covering those who are "newly eligible" for Medicaid in 2014-2016. *Id.* From 2017 onwards, however, it will provide slightly less federal funding each year. *Id.*

²³ See SMITH ET AL., *supra* note 18, at 30; Vu, *supra* note 19.

²⁴ See U.S. CONST. art. VI; *infra* notes 231-303 and accompanying text.

²⁵ 42 U.S.C. § 1983 (2006); see, e.g., Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen, 93 F.3d 997, 999 (1st Cir. 1996); Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026, 1029 (7th Cir. 1996); Ark. Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 528 (8th Cir. 1993). Although outside the scope of this Note, it should be noted that Medicaid beneficiaries and providers also tried, with some success, to combat low reimbursement rates by using § 1983 to bring suits under some other provisions of the Medicaid Act, including 42 U.S.C. § 1396a(a)(8) (2006), the "reasonable promptness" clause. See Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 336 F. Supp. 2d 1050, 1109 (N.D. Okla. 2005) (concluding that "reasonably prompt assis-

generally receptive to claims brought under § 1983 to enforce various provisions of the Medicaid Act, including 42 U.S.C. § 1396a(a)(30)(A)²⁶ (the “equal access provision”).²⁷ This provision requires state Medicaid programs to provide “methods and procedures” for payment rates that are consistent with quality care and adequate to enlist enough providers so that healthcare services are available to Medicaid beneficiaries “at least to the extent” they are available to the “general population” in the same area.²⁸ Some plaintiffs prevailed in arguing that state Medicaid officials violated § 30(A) by inadequately providing for the reimbursement of Medicaid providers.²⁹ In the wake of the U.S. Supreme Court’s recent clarification of the requirements for stating a cause of action in a § 1983 suit,³⁰ however, there is a clear trend in the U.S. courts of appeals away from allowing private individuals to challenge Medicaid reimbursement rates under § 1983.³¹

Recently, the U.S. Court of Appeals for the Ninth Circuit suggested that an alternative way of enforcing the equal access provision is possi-

“tance” is denied where Medicaid’s reimbursement rates are insufficient to attract an adequate number of healthcare providers), *rev’d* 472 F.3d 1208 (10th Cir. 2007); *see also* Jesse, *supra* note 14, at 815.

²⁶ 42 U.S.C. § 1396a(a)(30)(A) (2006). The provision requires a state plan for medical assistance 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

Id.

²⁷ *See, e.g., Bullen*, 93 F.3d at 1005; *Sullivan*, 91 F.3d at 1028–29; *Reynolds*, 6 F.3d at 522 (holding that the equal access provision “require[s] states to ensure that Medicaid recipients have access to medical care that is at least equal to that of the general population”).

²⁸ 42 U.S.C. § 1396a(a)(30)(A); *see Bullen*, 93 F.3d at 999; *Sullivan*, 91 F.3d at 1028–29; *Reynolds*, 6 F.3d at 522.

²⁹ *See Reynolds*, 6 F.3d at 531 (concluding that a reimbursement rate reduction by Arkansas’s Medicaid program violated § 30(A)). *But see Sullivan*, 91 F.3d at 1029–30 (deciding that plaintiffs failed to show reimbursement rates set by Indiana’s Medicaid program violated the equal access provision); *cf. Bullen*, 93 F.3d at 999, 1011 (remanding for further proceedings on plaintiff’s substantive claims).

³⁰ *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002); *infra* notes 113–117 and accompanying text (discussing new standard announced by *Gonzaga*).

³¹ *See, e.g., Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1060 (9th Cir. 2005); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004).

ble.³² In 2008, in *Independent Living Center of Southern California, Inc. v. Shewry*, the Ninth Circuit upheld a preliminary injunction enjoining the enforcement of a California law that cut reimbursements for Medicaid providers by ten percent.³³ The court concluded that Medicaid recipients and providers, who brought the suit on the theory that the state's rate cut was preempted by the federal Medicaid Act's equal access provision, had a proper cause of action under the U.S. Constitution's Supremacy Clause.³⁴ This holding and subsequent opinions issued by the court reveal that the Ninth Circuit—although it has held that the equal access provision is not enforceable via § 1983³⁵—will allow the enforcement of the equal access provision via the Supremacy Clause.³⁶ Thus, preemption seems to present a promising (and, as yet, relatively unexplored) method of enforcing the equal access provision in order to protect provider reimbursement rates and thereby protect access to healthcare for Medicaid recipients.³⁷

This Note argues that Medicaid recipients and providers should be able to enforce the equal access provision by challenging state changes to reimbursement rates as preempted by the Medicaid Act.³⁸ If they cannot, Medicaid risks becoming a worthless safety net because provider shortages will leave many recipients unable to access even basic healthcare.³⁹ Although litigation in *Independent Living Center* is ongoing, this Note suggests that preemption is a viable way to meaningfully enforce the equal access provision.⁴⁰ Therefore, preemption should no longer

³² See *Indep. Living Ctr. of S. Cal., Inc. v. Shewry (Independent Living I)*, 543 F.3d 1047, 1048–49 (9th Cir.), *opinion issued by (Independent Living II)*, 543 F.3d 1050 (9th Cir. 2008), *cert. denied*, 129 S. Ct. 2828 (2009), and *on remand to No. CV 08-3315*, 2008 WL 3891211 (C.D. Cal. Aug. 18, 2008), *aff'd sub nom. Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly (Independent Living III)*, 572 F.3d 644 (9th Cir. 2009), *motion to vacate denied*, 590 F.3d 725 (9th Cir. 2009), and *petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958).

³³ *Id.*

³⁴ *Id.*

³⁵ See *Sanchez*, 416 F.3d at 1060, 1062 (holding that neither Medicaid recipients nor providers can enforce the equal access provision under § 1983 because the provision does not create the sort of individual right *Gonzaga* requires for § 1983 suits).

³⁶ See *Independent Living I*, 543 F.3d at 1048–49; *infra* notes 211–215, 222 and accompanying text (discussing the Ninth Circuit's related rulings).

³⁷ See Rochelle Bobroff, *Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes*, 10 LOY. J. PUB. INT. L. 27, 73–74 (2008).

³⁸ See *infra* notes 46–79, 231–303 and accompanying text.

³⁹ See *infra* notes 46–79, 231–303 and accompanying text.

⁴⁰ See *infra* notes 231–303 and accompanying text. A prototypical § 30(A) preemption claim, aimed at enjoining Medicaid cutbacks, would allege that a state law regulating Medicaid reimbursement rates conflicts with the federal Medicaid Act's equal access provision. See *infra* notes 137–158, 258–270 and accompanying text (explaining that the Su-

be overlooked or dismissed—as it generally was prior to *Independent Living Center*—as an alternative to § 1983 enforcement of the equal access provision.⁴¹ In Parts I and II, this Note provides a brief history of Medicaid and the equal access provision.⁴² Part III explains the rise and fall of enforcement of the equal access provision under § 1983.⁴³ Part IV dissects *Independent Living Center* in terms of its presentation of a federal preemption claim as a viable way for Medicaid providers and beneficiaries to enjoin the implementation of significant cutbacks to reimbursement rates by state Medicaid programs.⁴⁴ Finally, Part V explores both the promise and the pitfalls of preemption and the equal access provision as a means to achieve and protect adequate access to healthcare for Medicaid beneficiaries—and thus as a means to prevent other families from suffering a tragedy like that of the Drivers.⁴⁵

premay Clause allows such suits). The plaintiff would be careful to name as defendants only state officers who “have some connection with the enforcement of the act” so as to fall within the exception to Eleventh Amendment immunity recognized by *Ex parte Young*. See 209 U.S. 123, 157 (1908). The plaintiff would request, as a remedy, prospective injunctive relief. See *infra* notes 271–279 and accompanying text (outlining available remedies). If the court finds that the plaintiff has standing to proceed, the plaintiff would seek a preliminary injunction so as to enjoin the state’s rate-reducing legislation during the litigation. See *infra* notes 165–221 and accompanying text (tracing *Independent Living Center*’s slow journey through the court system). At all stages of the suit, the plaintiff would be careful to argue under the controlling interpretation of the equal access clause in the particular jurisdiction. See *infra* notes 239–251 and accompanying text (comparing competing interpretations of § 30(A)).

⁴¹ See Bobroff, *supra* note 37, at 72–73; Huberfeld, *supra* note 6, at 437–38 n.126; Jessee, *supra* note 14, at 821–23.

In a 2008 article, Rochelle Bobroff (who later represented the *Independent Living Center* plaintiffs) analyzed the application of preemption and § 1983 to the enforcement of federal safety net statutes. See Bobroff, *supra* note 37, at 30. But Bobroff only briefly touched on what this means for the equal access provision. See *id.* at 72–73.

In a 2008 article, Nicole Huberfeld addressed the narrowed ability of those trying to enforce Medicaid entitlements via § 1983 and suggested legislative responses; but preemption is relegated to a footnote. See Huberfeld, *supra* note 6, at 413–14, 437–38 n.126.

In a 2009 comment, Sean Jessee briefly acknowledged that preemption may be an alternative way to challenge low reimbursement rates. See Jessee, *supra* note 14, at 821–23, 826. But Jessee argued that because (1) the 2008 decision did not touch on the merits of the preemption claim and (2) the Supreme Court has suggested that without a “persuasive” reason, preemption is not favored, preemption is not yet a viable alternative to § 1983 in the Medicaid rate context. See *id.* Since Jessee’s comment was published, however, the Ninth Circuit has issued additional opinions in *Independent Living Center* and lower courts have analyzed and applied the case’s reasoning. See *infra* notes 211–230 and accompanying text.

⁴² See *infra* notes 46–88 and accompanying text.

⁴³ See *infra* notes 89–128 and accompanying text.

⁴⁴ See *infra* notes 129–230 and accompanying text.

⁴⁵ See *infra* notes 231–303 and accompanying text.

I. THE MEDICAID PROGRAM

A. *Origins, Purpose, and Scope of the Program*

Until the Medicaid Act was enacted in 1965,⁴⁶ healthcare in America was a two-tiered system: wealthy Americans were cared for by private providers, but poor Americans generally were cared for—if at all—in emergency rooms and charitable clinics.⁴⁷ Medicaid was intended to eliminate the lower tier by providing at least some of the nation's poor with “mainstream” healthcare: access to good hospitals and private physicians.⁴⁸ The program has four general categories of eligibility: children and their caretakers, pregnant women, people with disabilities, and the elderly.⁴⁹

Medicaid is a joint federal-state welfare program, in which the federal government shares costs with states that choose to participate in the program.⁵⁰ It is structured as one of the federal grant-in-aid programs, which are enacted under Congress's Spending Clause powers, and which condition states' receipt of federal funds on compliance with specific requirements—in this case, those laid out in the Medicaid Act.⁵¹ To participate, a state must submit to the Secretary of Health and Human Services a “plan for medical assistance”⁵² that describes the scope and nature of the state's Medicaid program and complies with the requirements of the Medicaid Act.⁵³ If the Secretary approves the plan, the state

⁴⁶ Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (2006)).

⁴⁷ See Moncrieff, *supra* note 8, at 675.

⁴⁸ See Jessee, *supra* note 14, at 794; Moncrieff, *supra* note 8, at 675.

⁴⁹ See 42 U.S.C. § 1396a(a)(10)(A) (describing the groups of individuals for whom a state must provide Medicaid in order to receive federal funding). Income, immigration, and residency restrictions must also be met. *See id.*

⁵⁰ See Jessee, *supra* note 14, at 794.

⁵¹ See Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 10 (2006).

⁵² 42 U.S.C. § 1396a(a). The Act defines “medical assistance” as “payment” for the cost of certain medical services, rather than the actual provision of medical services. *See id.* § 1396d(a) (2006); Julia Gilmore Gaughan, Comment, *Institutionalization as Discrimination: How Medicaid Waivers, the ADA, and § 1983 Fail*, 56 U. KAN. L. REV. 405, 409 (2008).

Because every state creates and maintains its own Medicaid program and because the Medicaid Act is so broadly worded and flexible, variation among the states in terms of eligibility, coverage, delivery, and reimbursement “is the rule rather than the exception.” ELICIA J. HERZ, CONG. RESEARCH SERV., RL33202, MEDICAID: A PRIMER, summary (2008). The Medicaid Act even allows states to experiment beyond the parameters of its broad regulations via a waiver program. *See* Moncrieff, *supra* note 8, at 676.

⁵³ 42 U.S.C. § 1396a (listing the requirements for state Medicaid plans to receive federal funding). Historically, the Medicaid Act required states to provide seven services. *See* 42

can submit quarterly expense reports and will be reimbursed for a portion of the costs it incurs by administering the program and paying healthcare providers for their services.⁵⁴ If a state fails to comply with the Act's requirements, including those related to provider reimbursement rates, the Secretary is authorized to revoke federal funding.⁵⁵

Today, Medicaid is a major player in the country's healthcare system.⁵⁶ Within state budgets, spending on Medicaid programs is second only to spending on education.⁵⁷ Nationally, Medicaid provides health insurance coverage to sixty million people and accounts for roughly 17% of all healthcare spending and 7% of the total federal budget.⁵⁸

B. *An Ever-Growing Reimbursement Crisis*

State Medicaid programs have a great deal of freedom, even within the bounds of the equal access provision, to establish their own reimbursement rates for providers and their own system of setting and paying those rates.⁵⁹ As a result, the process of setting Medicaid reim-

U.S.C. §§ 1396a(a)(10), 1396d(a)(1)–(5), (17), (21) (listing services including inpatient hospital; outpatient hospital; other laboratory and x-ray; nursing facility; early and periodic screening, diagnostic, and treatment; physician; nurse-midwife; and nurse-practitioner). Each state, however, could choose to provide additional services as part of its Medicaid program, such as dental services or prescription drug coverage. *See* 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(10), (12). In 2005, however, Congress passed the Deficit Reduction Act (the "DRA"), which allows states to provide only "benchmark" coverage for certain groups instead of the traditional Medicaid benefits package. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended in scattered sections of 20 and 42 U.S.C.); *see* KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., REPORT NO. 7465, DEFICIT REDUCTION ACT OF 2005: IMPLICATIONS FOR MEDICAID 2–3 (2006), *available at* <http://www.kff.org/medicaid/upload/7465.pdf>. Under the DRA, states can choose to model Medicaid benefits on certain "benchmarks," such as the biggest commercial HMO in the state, a plan offered to state or federal employees, and any proposal approved by the Secretary. *Id.* at 3.

⁵⁴ APRIL GRADY, CONG. RESEARCH SERV., RS22849, MEDICAID FINANCING 1 (2008). The federal share for administrative costs does not vary by state (states are generally reimbursed for 50% of the cost of administering their Medicaid program). *Id.* at 1–2. The federal share for provider reimbursement, however, varies according to a state's federal medical assistance percentage ("FMAP") and can range from 50% to 83%, depending in part on states' per capita income. *Id.*

⁵⁵ 42 U.S.C. § 1396c (2006) (describing when the Secretary may refuse to make payments to a state's Medicaid program).

⁵⁶ *See* SMITH ET AL., *supra* note 18, at 9.

⁵⁷ *Id.* at 14.

⁵⁸ GRADY, *supra* note 54, at 3; SMITH ET AL., *supra* note 18, at 9.

⁵⁹ *See* HERZ, *supra* note 52, at 10; Moncrieff, *supra* note 8, at 676 (noting that state Medicaid programs can either reimburse providers via private managed care organizations or by acting as a third-party payer on behalf of Medicaid beneficiaries).

bursement rates varies from state to state.⁶⁰ Frequently, the state agency that administers Medicaid prescribes reimbursement rates as part of its budget proposal to the state legislature and submits its reimbursement methodology to the Secretary (who reviews it for consistency with § 30(A)) for approval as part of the state plan.⁶¹ Sometimes, however, a state statute dictates a particular methodology for rate setting or a specific rate for a certain medical service.⁶²

Despite this variation in procedure, Medicaid reimbursement rates have traditionally⁶³ been significantly lower than those of both Medicare and private insurers.⁶⁴ This is problematic primarily because reimbursement rates are “an important determinant of provider participation and access to services for Medicaid beneficiaries.”⁶⁵ Not surprisingly, nationwide physician surveys show that although most physicians accept Medicaid patients, fewer accept new Medicaid patients than new patients with other types of insurance.⁶⁶ Furthermore, more physicians accept new Medicaid patients in states that have higher Medicaid reimbursement rates than in states with lower rates.⁶⁷ Physicians frequently cite low Medicaid reimbursement rates as their principal reason for re-

⁶⁰ See MARK MERLIS, CONG. RESEARCH SERV., RL32644, MEDICAID REIMBURSEMENT POLICY 1 (2004).

⁶¹ See, e.g., ANNE DUNKELBERG, KAISER COMM’N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND STATE BUDGETS: A CASE STUDY OF TEXAS 2–4, 18 (2002) (describing how Texas sets its Medicaid budget); ELEANOR KINNEY, KAISER COMM’N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND STATE BUDGETS: A CASE STUDY OF INDIANA 1–6, 10 (2002) (describing how Indiana sets its Medicaid budget); CARSON STREGE-FLORE & ALLYSON HAUCK, KAISER COMM’N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID AND STATE BUDGETS: A CASE STUDY OF IDAHO 2–3 (2002) (describing how Idaho sets its Medicaid budget).

⁶² See, e.g., *Minn. Pharmacists Ass’n v. Pawlenty*, 690 F. Supp. 2d 809, 812 (D. Minn. 2010) (describing how a Minnesota statute limits the maximum reimbursement rate for prescription drugs); DUNKELBERG, *supra* note 61, at 18 (noting that although generally HMOs participating in Texas’s Medicaid program negotiate their own reimbursement rates, a Texas statute requires fee increases for some services be passed on to providers).

⁶³ In March 2010, Congress eliminated the historical disparity between Medicaid and Medicare rates for a few types of healthcare providers. See Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1202, 124 Stat. 1029, 1052–53 (to be codified at 42 U.S.C. §§ 1396a, 1396u-2, 1396d); see also *supra* note 13.

⁶⁴ See SMITH ET AL., *supra* note 7, at 30; *supra* notes 12–13 and accompanying text.

⁶⁵ SMITH ET AL., *supra* note 7, at 30. Some researchers, however, have disputed the link between higher fees and higher physician participation in Medicaid. Stephen Zuckerman et al., *Trends in Medicaid Physician Fees, 2003–2008*, HEALTH AFF., w517 (Apr. 28, 2009), <http://content.healthaffairs.org/cgi/reprint/28/3/w510>.

⁶⁶ Stephen Zuckerman et al., *Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation*, HEALTH AFF., W4-381 (June 23, 2004), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1>; see also SMITH ET AL., *supra* note 7, at 30.

⁶⁷ See Zuckerman et al., *supra* note 66, at W4–381.

fusing to accept Medicaid patients.⁶⁸ Thus, low reimbursement rates can negatively impact the ability of Medicaid beneficiaries to access health-care—particularly primary, specialty, and dental care—outside of an emergency room.⁶⁹

During the last economic downturn, from 2001 to 2004, *every* state froze or reduced physician reimbursement rates in order to contain Medicaid spending.⁷⁰ The cutbacks exposed the vulnerabilities of Medicaid reimbursement, and Deamonte Driver's death in 2007 brought the issue into the national spotlight.⁷¹ As the economy improved, many states began to focus on increasing reimbursement rates in an effort to make up for the years of reduced or frozen rates.⁷²

A 2008 survey of Medicaid program directors by the Kaiser Commission on Medicaid and the Uninsured found that, specifically because of such increases, patient access had improved in some states from 2007.⁷³ The survey reported that, although access to primary care physicians was "generally regarded as favorable," most states still "reported some or significant problems accessing" specialized care and dental care.⁷⁴

Due to the current economic recession, states are once again slashing reimbursement rates as a way to balance their budgets.⁷⁵ At the start of fiscal year 2010, three out of every four states expected budget short-

⁶⁸ SMITH ET AL., *supra* note 7, at 30.

⁶⁹ *See id.* at 54.

⁷⁰ *See* SMITH ET AL., *supra* note 18, at 6. Medicaid is always strained during economic downturns because increases in unemployment cause Medicaid enrollment (and therefore state spending on Medicaid) to soar while also causing tax revenues (used by states to pay for Medicaid) to decline. *See* SMITH ET AL., *supra* note 7, at 7; *see also* SMITH ET AL., *supra* note 20, at 6 ("More than any other area, provider rates are linked to economic conditions. Under budget pressure, states turn to rate cuts to have an immediate budget impact").

⁷¹ *See* SMITH ET AL., *supra* note 7, at 54.

⁷² *Id.* at 25, 30.

⁷³ *Id.* at 10.

⁷⁴ *Id.* Roughly 17% of states reported problems with access to primary care for Medicaid beneficiaries; 36% reported problems with access to specialty care; and 39% percent reported problems with access to dental care. *Id.* at 55 fig.29.

⁷⁵ *See* VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., REPORT NO. 8049, MEDICAID'S CONTINUING CRUNCH IN A RECESSION: A MID-YEAR UPDATE FOR STATE FY 2010 AND PREVIEW FOR FY 2011, at 5 (2010), *available at* <http://www.kff.org/medicaid/upload/8049.pdf>. For example, on January 1, 2010, Kansas's Medicaid program cut provider reimbursement rates by ten percent. Kevin Sack & Robert Pear, *States Consider Medicaid Cuts as Use Grows*, N.Y. TIMES, Feb. 19, 2010, at A1. Georgia's commissioner of community health warned that the state may have to cut Medicaid reimbursement rates for providers by over sixteen percent. *See id.*

falls in their Medicaid budgets.⁷⁶ A major reason for this was that enrollment in state Medicaid programs was projected to increase by an average of 6.6% in fiscal year 2010 (after increasing 5.4% in fiscal year 2009), primarily due to increased unemployment during the recession.⁷⁷ Budget pressure led thirty-three states to cut or freeze reimbursement rates in fiscal year 2009; thirty-nine states did so in fiscal year 2010, and thirty-seven states are planning reimbursement rate restrictions for fiscal year 2011.⁷⁸ One state Medicaid official recently suggested that further cuts to reimbursement rates “could affect access,” but admitted “we’re at the point where that may be a secondary consideration.”⁷⁹

II. THE EQUAL ACCESS PROVISION

The inclusion of an equal access provision in the Medicaid Act suggests that Congress foresaw the temptation states would face to set low reimbursement rates for healthcare providers, particularly when state budgets were tight.⁸⁰ The equal access provision, § 30(A), requires state Medicaid programs to ensure that Medicaid payment rates are both “consistent with efficiency, economy, and quality of care” and “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.”⁸¹

Because the equal access provision is included among the requirements a state’s Medicaid plan must meet to qualify for federal funding, the Secretary of Health and Human Services can withhold funding from a state if its Medicaid program fails to comply.⁸² For example, if a state sets reimbursement rates so low that they are inconsistent with provision of quality care or insufficient to enlist enough providers to treat

⁷⁶ See SMITH ET AL., *supra* note 18, at 26. The federal fiscal year runs from October 1 of a given year to September 30 of the next calendar year (which is the year by which the fiscal year is identified); for example, fiscal year 2010 began on October 1, 2009 and ended on September 30, 2010. See BILL HENIFF, JR., CONG. RESEARCH SERV., 98–325, THE FEDERAL FISCAL YEAR 1 (2003).

⁷⁷ See SMITH ET AL., *supra* note 18, at 6.

⁷⁸ See SMITH ET AL., *supra* note 20, at 6.

⁷⁹ Kevin Sack, *Rate of Enrollment in Medicaid Rose Rapidly, Report Says*, N.Y. TIMES, Oct. 1, 2009, at A1 (quoting Charles Duarte, administrator of Nevada’s Division of Health Care Financing and Policy).

⁸⁰ See Moncrieff, *supra* note 8, at 674.

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

⁸² 42 U.S.C. §§ 1396a(a), 1396c (describing when the Secretary may refuse to make payments to a state’s Medicaid program).

Medicaid beneficiaries, the Secretary can theoretically withhold federal Medicaid funding from that state.⁸³ This remedy, however, has failed to provide a significant check on cutbacks to reimbursement rates.⁸⁴ Medicaid recipients are unlikely to pursue this enforcement avenue because their access to healthcare would be dramatically reduced by the Secretary's withholding of federal funds from an already cash-strapped state.⁸⁵ The revocation of federal funding is therefore unappealing from the perspective of the Secretary and Medicaid beneficiaries alike because it would likely result in even lower reimbursement rates and thousands of Medicaid recipients either losing some of the services they currently receive or losing their coverage altogether.⁸⁶

Because the remedy provided by the Medicaid Act has proven inadequate and the Act does not include a private right of action whereby individuals can enforce its provisions,⁸⁷ Medicaid recipients and providers long turned to § 1983 to enforce the requirements of the Medicaid Act's equal access provision.⁸⁸

⁸³ See 42 U.S.C. §§ 1396a(a)(30)(A), 1396c.

⁸⁴ See Huberfeld, *supra* note 6, at 462 (observing that the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicaid on the Secretary's behalf, "is notoriously uninterested in enforcing the terms of State plans against the states; instead it seeks cooperation, when it makes demands at all"); Jon Donenberg, Note, *Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements*, 117 YALE L.J. 1498, 1501-02 (2008) (explaining that withholding by the Secretary is an ineffective compliance mechanism because (1) enforcement is a low priority for a federal grant-in-aid agency, like CMS, because its primary role is to help and support participating states with their programs; (2) cutting off federal funds is likely to destroy a state's Medicaid program; (3) the withholding procedure is long and tedious; and (4) the Secretary and other federal administrators, because they are not accountable to the public, are likely to regard maintaining positive relationships with state authorities as more important than responding to the problems of Medicaid providers and beneficiaries).

⁸⁵ See Jessee, *supra* note 14, at 826.

⁸⁶ See *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 52 (1981) (White, J., dissenting). Justice White stressed, in the context of the Developmentally Disabled Assistance and Bill of Rights Act (which, like the Medicaid Act, provides for withholding funds from non-compliant programs), that "a funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act." *Id.* The same is true in the context of the Medicaid Act. See Huberfeld, *supra* note 6, at 462; Jessee, *supra* note 14, at 825.

⁸⁷ See H.R. REP. NO. 105-149, at 591 (1997) (stating that the Committee's intent in repealing the Boren Amendment, discussed *infra* notes 104-108 and accompanying text, was that no provision of 42 U.S.C. § 1396a "will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive").

⁸⁸ See, e.g., *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 924 (5th Cir. 2000); *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1005 (1st Cir. 1996); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993).

III. THE RISE AND FALL OF § 1983 ENFORCEMENT OF THE EQUAL ACCESS PROVISION

This Part explains why, although 42 U.S.C. § 1983 once presented a workable way of enforcing the equal access provision, in the wake of the U.S. Supreme Court's recent clarification of the requirements for stating a cause of action under § 1983, it is no longer a viable method by which to protect provider reimbursement rates.⁸⁹ Section A introduces § 1983 and its significance for plaintiffs.⁹⁰ Section B explains that throughout the late 1990s and early 2000s, Medicaid beneficiaries and providers used § 1983 suits to enforce the equal access provision.⁹¹ Section C discusses how, in 2002, in *Gonzaga University v. Doe* the Supreme Court articulated a narrowed standard for asserting a cause of action under § 1983.⁹² Finally, Section D argues that this narrowed standard sounded the death knell for the enforcement of the equal access provision under § 1983.⁹³

A. Section 1983 and Statutory Rights

Section 1983 permits citizens to bring civil suits against state officials in order to redress violations of federal rights.⁹⁴ In 1980, in *Maine v. Thiboutot*, the U.S. Supreme Court recognized that § 1983 protects federal statutory rights in addition to rights conferred by the Constitution.⁹⁵ Thus, plaintiffs can use § 1983 to enforce a right conferred by a federal statute that does not, itself, include a private right of action—as is true of the Medicaid Act.⁹⁶

After creating some confusion as to whether *Thiboutot* applied to legislation enacted under Congress's Spending Clause power,⁹⁷ in *Blessing v. Freestone*, in 1997, the Court clarified the test for determining when a federal law confers a right enforceable through § 1983.⁹⁸ Under *Bless-*

⁸⁹ See *infra* notes 94–128 and accompanying text.

⁹⁰ See *infra* notes 94–102 and accompanying text.

⁹¹ See *infra* notes 103–112 and accompanying text.

⁹² See *infra* notes 113–117 and accompanying text.

⁹³ See *infra* notes 118–128 and accompanying text.

⁹⁴ 42 U.S.C. § 1983 (2006); see *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980).

⁹⁵ See 448 U.S. at 4.

⁹⁶ See *id.* at 5; Donenberg, *supra* note 84, at 1516.

⁹⁷ See *Suter v. Artist M.*, 503 U.S. 347, 355–56 (1992) (holding that the Adoption Assistance and Child Welfare Act of 1980 does not confer rights to individuals enforceable under § 1983); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981) (rejecting plaintiff's claim that the Developmentally Disabled Assistance and Bill of Rights Act of 1975 conferred rights enforceable via § 1983).

⁹⁸ 520 U.S. 329, 340–41 (1997).

ing, to successfully enforce a right conferred by a federal statute, a plaintiff need only show that: (1) Congress intended for the statutory provision at issue to benefit the plaintiff; (2) the right allegedly conferred by the statute is not so “vague and amorphous” that judicial competence would be strained by its enforcement; and (3) the statute “unambiguously impose[s] a binding obligation on the States.”⁹⁹ If a plaintiff meets this test, it is presumed that the statutory right can be enforced under § 1983.¹⁰⁰ This presumption can be rebutted, however, by a showing that Congress foreclosed a remedy under § 1983.¹⁰¹ Congress can do so explicitly, by statutorily forbidding resort to § 1983, or impliedly, by enacting an enforcement scheme that is irreconcilable with § 1983.¹⁰²

B. Pre-2002 Success for Medicaid Act Enforcement

The U.S. Supreme Court held for the first time in *Wilder v. Virginia Hospital Ass’n* in 1990 that a provision of the Medicaid Act created a federal right enforceable under § 1983.¹⁰³ The case was brought by healthcare providers who argued that Virginia’s Medicaid reimbursement rates were not reasonable, as required by the now-repealed Boren Amendment¹⁰⁴ to the Medicaid Act.¹⁰⁵ *Wilder* announced that the Boren Amendment gave healthcare providers a substantive right to “reasonable and adequate” reimbursement rates, which they could enforce under § 1983.¹⁰⁶ It reasoned that the amendment conferred an enforceable federal right because: (1) providers were clearly the intended beneficiaries of the amendment; (2) the amendment was cast in

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 341.

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ 496 U.S. 498, 509–10 (1990).

¹⁰⁴ 42 U.S.C. § 1396a(a)(13)(A) (1994) (repealed 1997). The Boren Amendment required states to set provider reimbursement rates that were “reasonable and adequate” to meet the costs incurred by “efficiently and economically operated facilities.” *Id.* Its language was similar to that of the equal access provision, but its requirements were slightly less flexible. See *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly (Independent Living III)*, 572 F.3d 644, 654–55 (9th Cir.), *motion to vacate denied*, 590 F.3d 725 (9th Cir. 2009), and *petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958); *Ark. Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519, 525 (8th Cir. 1993) (“[T]he equal access provision is very analogous to the Boren Amendment examined in *Wilder*; they are similar not only in function but also in the specific language employed.”). Congress repealed the Boren Amendment in 1997 with the express intention of reversing *Wilder* and, additionally, preventing further provider challenges to Medicaid reimbursement rates. See H.R. REP. NO. 105-149, at 591 (1997).

¹⁰⁵ *Wilder*, 496 U.S. at 503–04.

¹⁰⁶ *Id.* at 509–10.

“mandatory rather than precatory terms”;¹⁰⁷ and (3) federal funding was explicitly conditioned on compliance with its requirements.¹⁰⁸

In the wake of *Wilder*, federal circuit courts across the nation ruled that Medicaid beneficiaries and providers had a private right of action under § 1983 to enforce various provisions of the Medicaid Act, including the equal access provision.¹⁰⁹ Equal access suits brought under § 1983 had some success in preventing state Medicaid programs from making cutbacks to reimbursement rates.¹¹⁰ Despite the loose § 1983 standard articulated in *Blessing*, however, the case law grew increasingly fractured after 1997 because of Congress’s repeal of the Boren Amendment.¹¹¹ Legislative history suggests that Congress specifically intended the Amendment’s repeal to prevent Medicaid providers from bringing reimbursement rate suits under § 1983 and to thereby increase the flexibility of state Medicaid programs in setting reimbursement rates.¹¹²

¹⁰⁷ *Id.* at 512.

¹⁰⁸ *See id.* at 510, 512.

¹⁰⁹ *See, e.g.,* Visiting Nurse Ass’n of N. Shore, Inc. v. Bullen, 93 F.3d 997, 1005 (1st Cir. 1996) (concluding that Medicaid providers have standing to sue under § 1983 to enforce § 30(A)); Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026, 1029 (7th Cir. 1996) (deciding that Medicaid providers have a private right of action, under § 1983, to enforce § 30(A)); Miller v. Whitburn, 10 F.3d 1315, 1319–20 (7th Cir. 1993) (holding that Medicaid recipients can enforce Medicaid’s early periodic screening, diagnostic, and treatment services (“EPSDT”) provisions under § 1983); Reynolds, 6 F.3d at 527–28 (holding that Medicaid beneficiaries and providers can enforce § 30(A) under § 1983).

¹¹⁰ *See Reynolds*, 6 F.3d at 521 (concluding that a reimbursement rate reduction by Arkansas’s Medicaid program violated § 30(A) because the impact of the rate reduction on access, economy, efficiency, and quality of care had not been considered). *But see Sullivan*, 91 F.3d at 1029 (deciding that plaintiffs failed to show reimbursement rates set by Indiana’s Medicaid program violated § 30(A)); *cf. Bullen*, 93 F.3d at 1011 (remanding for further proceeding on plaintiff’s substantive claims).

¹¹¹ *See, e.g.,* Pa. Pharmacists Ass’n v. Houstoun, 283 F.3d 531, 541–42 (3d Cir. 2002) (concluding that pharmacists, as providers, cannot bring a § 1983 claim to enforce § 30(A)); Evergreen Presbyterian Ministries Inc. v. Hood, 235 F.3d 908, 927–29 (5th Cir. 2000) (holding that Medicaid beneficiaries, but not providers, can enforce § 30(A) under § 1983) (abrogation by *Gonzaga* recognized in *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007) (noting that *Gonzaga* “abrogated *Evergreen* in respect to such suits by recipients while confirming it insofar as it disallows § 1983 actions by providers under the Equal Access provision”).

¹¹² *See* H.R. REP. NO. 105-149, at 591 (1997) (“It is the Committee’s intention that, following enactment of this Act, neither this nor any other provision of [42 U.S.C. § 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.”); *see also* Long Term Care Pharmacy Alliance v. Ferguson, 362 F.3d 50, 58 (1st Cir. 2004).

C. Gonzaga Articulates a New Standard

Enforcement of the equal access provision via § 1983 was further complicated when the U.S. Supreme Court refined the *Blessing* test in *Gonzaga University v. Doe* in 2002.¹¹³ In *Gonzaga*, the Court concluded that a student could not sue a private university under § 1983 in order to enforce the Family Educational Rights and Privacy Act of 1974 because the Act does not create the sort of personal right that is enforceable under § 1983.¹¹⁴ Emphasizing that only “rights,” and not vague “benefits” or “interests,” are enforceable under § 1983, the Court held that in order for *Blessing*’s first prong (congressional intent that the statutory provision benefit the plaintiff) to be satisfied, the statute must “unambiguously” confer a federal right.¹¹⁵ Thus, in order to be enforceable under § 1983, a statute must contain “rights-creating terms”¹¹⁶ and be focused on benefiting an individual plaintiff, rather than on institutional policies or practices in the aggregate.¹¹⁷

D. Post-Gonzaga Downfall

The Court in *Gonzaga* explicitly distinguished *Wilder* and did not profess to abrogate its holding that Medicaid providers could use § 1983 to enforce the Boren Amendment.¹¹⁸ Nonetheless, in light of *Gonzaga*’s holding that a federal statutory right must be “unambiguously” conferred in order to support a cause of action under § 1983,¹¹⁹ federal circuit courts have tended to accept § 1983 enforcement of Medicaid provisions that reference “individuals” or “families”¹²⁰ but reject the enforceability of those with broader, more general language.¹²¹

¹¹³ *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282–83 (2002) (reaffirming the *Blessing* test and refining the first of its three prongs).

¹¹⁴ *See id.* at 276.

¹¹⁵ *See id.* at 282–83.

¹¹⁶ *Id.* at 284 (listing Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972 as examples of statutes that contain such “rights-creating” language because they are “phrased in terms of the persons benefited”).

¹¹⁷ *See id.* at 288.

¹¹⁸ *See id.* at 280–81.

¹¹⁹ *See Gonzaga*, 536 U.S. at 283.

¹²⁰ *See Bobroff*, *supra* note 37, at 62–64. For example, circuit courts have repeatedly held that 42 U.S.C. § 1396a(a)(10) is still enforceable via § 1983 because, unlike the equal access provision, § 1396a(a)(10) clearly conveys an individual right. *See, e.g., Watson v. Weeks*, 436 F.3d 1152, 1159–60 (9th Cir. 2006) (holding that § 1396a(a)(10) “creates a right enforceable by section 1983”); *S.D. ex. rel. Dickson v. Hood*, 391 F.3d 581, 603 (5th Cir. 2004) (holding that § 1396a(a)(10) contains “precisely the sort of ‘rights-creating’ language identified in *Gonzaga* as critical to demonstrating a congressional intent to establish a new right”); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 183 (3d Cir. 2004) (hold-

With only one exception, every circuit court that has considered the equal access provision after *Gonzaga* has held that the provision is not enforceable under § 1983.¹²² For example, in 2004 in *Long Term Care Pharmacy Alliance v. Ferguson*, the U.S. Court of Appeals for the First Circuit held that pharmaceutical providers could not use § 1983 to challenge reimbursement rates as violating the equal access provision because the provision does not create “explicit rights” for providers.¹²³ In so doing, the court reversed its own earlier holding that the equal access provision is enforceable via § 1983.¹²⁴ It reasoned that, under *Gonzaga*, clear statutory language is required for the creation of private rights enforceable via § 1983 and the equal access provision lacks such language.¹²⁵

In light of the growing number of circuit courts holding that § 1983 cannot be used to enforce the equal access provision and thereby assure adequate reimbursement rates for Medicaid providers, there is reason to worry that “Medicaid is metamorphosing into a right without a remedy.”¹²⁶ The timing of this development is particularly troubling because, due to tight state budgets produced by the recession and the dramatic swelling of state Medicaid rolls brought about both by the recession and national healthcare reform, protecting provider reimbursement rates is a

ing that § 1396a(a)(10) “unambiguously confer[s]” a right “vindicable under § 1983”). The relevant portion of this section of the Medicaid Act requires that a state plan for medical assistance “provide . . . for making medical assistance available . . . to all [eligible] individuals.” 42 U.S.C. § 1396a(a)(10)(A) (2006) (emphasis added).

¹²¹ See, e.g., *Hawkins*, 509 F.3d at 703 (concluding, in light of *Gonzaga*, that § 30(A) is not enforceable under § 1983 because it does not unambiguously confer individual private rights); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006) (holding that, based upon a *Gonzaga* analysis, § 30(A) “does not create a federal right enforceable under § 1983”); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542–43 (6th Cir. 2006) (determining that § 30(A) “has an aggregate focus rather than an individual focus” and its “broad and nonspecific” language is “ill-suited to judicial remedy”); *Sanchez v. Johnson*, 416 F.3d 1051, 1060 (9th Cir. 2005) (holding that because the “text and structure of § 30(A) simply do not focus on an individual recipient’s or provider’s right to benefits” as required by *Gonzaga*, neither Medicaid recipients nor providers can enforce the provision under § 1983); *Ferguson*, 362 F.3d at 58–59 (concluding that, under *Gonzaga*, § 30(A) does not confer a private right of action to providers such as pharmacies). But see *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005, 1015–16 (8th Cir. 2006) (adhering, in spite of *Gonzaga*, to the court’s prior precedent that § 30(A) creates a right enforceable under § 1983 for Medicaid beneficiaries and providers), *vacated on other grounds sub nom.* *Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142, 1142 (2007).

¹²² Compare cases cited *supra* note 121, with *Pediatric Specialty Care*, 443 F.3d at 1015–16.

¹²³ 362 F.3d at 58.

¹²⁴ *Id.* at 58–59 (recognizing that *Gonzaga* overruled *Bullen*, 93 F.3d 997).

¹²⁵ *Id.*

¹²⁶ Huberfeld, *supra* note 6, at 417.

more critical concern than ever before.¹²⁷ Therefore, a recent holding by the Ninth Circuit, suggesting that the Constitution's Supremacy Clause may provide an alternative way for Medicaid providers and beneficiaries to enforce the equal access provision, merits thorough examination.¹²⁸

IV. THE RISE OF ENFORCEMENT VIA THE SUPREMACY CLAUSE?

In 2008, in *Independent Living Center of Southern California, Inc. v. Shewry*, the U.S. Court of Appeals for the Ninth Circuit became the first federal circuit court to suggest that an implied cause of action under the Supremacy Clause could provide an alternative way to enforce Medicaid's equal access provision.¹²⁹ Although the Ninth Circuit was the first circuit court to reach this conclusion in the context of § 30(A), its holding has a solid basis in decades of U.S. Supreme Court decisions on the issue of federal preemption, generally,¹³⁰ and is supported by other circuit court decisions in cases involving preemption of state law by other provisions of the Medicaid Act.¹³¹

This Part explains how a federal preemption claim is an alternative way for Medicaid providers and beneficiaries to enjoin the implementation of significant cutbacks to reimbursement rates by state Medicaid programs.¹³² Section A presents a brief overview of the federal preemption doctrine.¹³³ Section B explains that the Supreme Court has repeatedly assumed that the Supremacy Clause creates an implied cause of action for plaintiffs asserting a federal preemption claim.¹³⁴ Section C explores how federal circuit courts have received preemption claims

¹²⁷ See Sack, *supra* note 79; *supra* notes 75–79 and accompanying text.

¹²⁸ See *Indep. Living Ctr. of S. Cal., Inc. v. Shewry* (*Independent Living I*), 543 F.3d 1047, 1048–49 (9th Cir.), *opinion issued by* (*Independent Living II*), 543 F.3d 1050 (9th Cir. 2008), *cert. denied*, 129 S. Ct. 2828 (2009), *and on remand to* No. CV 08-3315, 2008 WL 3891211 (C.D. Cal. Aug. 18, 2008), *aff'd sub nom.* *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly* (*Independent Living III*), 572 F.3d 644 (9th Cir. 2009), *motion to vacate denied*, 590 F.3d 725 (9th Cir. 2009), *and petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958).

¹²⁹ See *Indep. Living Ctr. of S. Cal., Inc. v. Shewry* (*Independent Living I*), 543 F.3d 1047, 1048–49 (9th Cir.), *opinion issued by* (*Independent Living II*), 543 F.3d 1050 (9th Cir. 2008), *cert. denied*, 129 S. Ct. 2828 (2009), *and on remand to* No. CV 08-3315, 2008 WL 3891211 (C.D. Cal. Aug. 18, 2008), *aff'd sub nom.* *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly* (*Independent Living III*), 572 F.3d 644 (9th Cir. 2009), *motion to vacate denied*, 590 F.3d 725 (9th Cir. 2009), *and petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958).

¹³⁰ See *infra* notes 140–158 and accompanying text.

¹³¹ See *infra* notes 159–164 and accompanying text.

¹³² See *infra* notes 137–230 and accompanying text.

¹³³ See *infra* notes 137–139 and accompanying text.

¹³⁴ See *infra* notes 140–158 and accompanying text.

asserting that state laws conflict with the Medicaid Act.¹³⁵ And Section D dissects *Independent Living Center* and surveys its impact within the Ninth Circuit and across the nation.¹³⁶

A. The Supremacy Clause

Under the Supremacy Clause, from which the preemption doctrine is derived, state laws are invalid if they are contrary to or interfere with federal law.¹³⁷ There are two basic types of preemption: explicit and implied.¹³⁸ If an allegedly preemptive federal statute does not contain explicitly preemptive language, implied preemption may still be found either in the case of (1) field preemption, where the federal regulatory scheme is so pervasive that no room is left for supplemental state regulation in that area, or (2) conflict preemption, where it is impossible to comply with both the state and federal regulations or the state law presents “an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”¹³⁹

B. Preemption and the Supreme Court

Although the U.S. Supreme Court has never said so explicitly, it has repeatedly assumed that the Supremacy Clause creates an implied cause of action for plaintiffs alleging that a state law is preempted by a conflicting federal law.¹⁴⁰ For example, in 1983, in *Shaw v. Delta Airlines, Inc.*, the Court unanimously held that federal courts have jurisdiction under the federal question statute, 28 U.S.C. § 1331, to resolve cases in which a plaintiff seeks prospective injunctive relief from a state statute by alleging that it conflicts with—and is therefore preempted by—a federal law.¹⁴¹ The plaintiffs in *Shaw* were employers who claimed New York laws forbidding discrimination on the basis of pregnancy and requiring employers to pay sick leave benefits to women who were unable to work due to pregnancy were invalid because they were preempted by the federal Employee Retirement Income Security Act of 1974 (ER-

¹³⁵ See *infra* notes 159–164 and accompanying text.

¹³⁶ See *infra* notes 165–222 and accompanying text.

¹³⁷ See U.S. CONST. art. VI; *Gade v. Nat'l Solid Waste Mgmt. Ass'n*, 505 U.S. 88, 108 (1992).

¹³⁸ See *Gade*, 505 U.S. at 98.

¹³⁹ *Id.* (quoting *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)); see David Sloss, *Constitutional Remedies for Statutory Violations*, 89 IOWA L. REV. 355, 390–91 (2004).

¹⁴⁰ See *infra* notes 141–158 and accompanying text; see also Bobroff, *supra* note 37, at 29; Sloss, *supra* note 139, at 390–91.

¹⁴¹ 463 U.S. 85, 96 n.14 (1983).

ISA).¹⁴² In deciding the case, the Court dealt only summarily with plaintiffs' right to bring the suit in federal court.¹⁴³ Without considering whether ERISA gave the plaintiffs a private cause of action, the Court matter-of-factly observed in a footnote that "[i]t is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights. . . . This Court, of course, frequently has resolved pre-emption disputes in a similar jurisdictional posture."¹⁴⁴ Thus, the Court implicitly held that plaintiffs can obtain injunctive relief, via the Supremacy Clause, from a state law that conflicts with a federal statute even if the federal statute does not contain a private cause of action or confer a right enforceable under § 1983.¹⁴⁵

In 2002, during the same term it decided *Gonzaga University v. Doe*, the Court reaffirmed its lenient approach to federal preemption suits.¹⁴⁶ In *Verizon Maryland, Inc. v. Public Service Commission*, a telecommunications company sued officials of Maryland's Public Service Commission, asserting that the Commission's decision on compensation rights conflicted with, and was therefore preempted by, federal law.¹⁴⁷ Citing *Shaw*, the Court held that it had jurisdiction under § 1331 to resolve the federal preemption claim.¹⁴⁸ But the Court found that it was not necessary to decide whether the allegedly preemptive federal statute contains a private cause of action in order to reach the merits of the case.¹⁴⁹ As long as a valid cause of action is arguable (because the allegedly conflicting federal law does not indicate an intent to withdraw federal jurisdiction under § 1331) and the claim of preemption is not "wholly insubstantial or frivolous," federal courts have jurisdiction to decide whether a state action is preempted by federal law.¹⁵⁰ In so holding, the Court implicitly decided that whether the allegedly preemptive statute contains a private cause of action is immaterial to the reviewability of a federal preemption claim.¹⁵¹

¹⁴² *Id.* at 88.

¹⁴³ *See id.* at 96 n.14.

¹⁴⁴ *Id.*; *see* Sloss, *supra* note 139, at 377–78.

¹⁴⁵ *See Shaw*, 463 U.S. at 96 n.14.

¹⁴⁶ *Verizon Md., Inc. v. Pub. Serv. Comm'n*, 535 U.S. 635, 642 (2002).

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *See id.* (noting that "[w]e need express no opinion" on the Commission's argument that the Court did not have jurisdiction to resolve the case because the allegedly preemptive federal act did not contain a private cause of action to challenge the Commission's order).

¹⁵⁰ *Id.* at 643 (quoting *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 89 (1998)).

¹⁵¹ *See id.*; *see also* Bobroff, *supra* note 37, at 29.

Since 2002, the Court has decided two cases involving preemption and the Medicaid Act.¹⁵² In both, as in *Verizon* and *Shaw*, the Court's majority opinion reached the merits of the case without deciding whether the allegedly preemptive federal statute created a private cause of action.¹⁵³ In 2003, in *Pharmaceutical Research & Manufacturers of America v. Walsh*, an association of drug manufacturers challenged Maine's prescription drug rebate program as preempted by the federal Medicaid Act.¹⁵⁴ A majority of the Court, without any discussion of the source of the plaintiffs' cause of action, held that the drug manufacturers had not sufficiently shown that Maine's rebate program conflicted with the Medicaid Act.¹⁵⁵ In 2006, in *Arkansas Department of Health & Human Services v. Ahlborn*, a Medicaid recipient argued that the federal Medicaid Act preempted Arkansas Department of Health and Human Services' ("ADHS") assertion of a claim against proceeds she received from the settlement of a personal injury lawsuit.¹⁵⁶ The Supreme Court made no mention of the source of the plaintiff's cause of action or the Court's jurisdiction, but concluded that ADHS's claim was preempted because it conflicted with the Medicaid Act.¹⁵⁷

Although the Court did not explain in either of these cases whether the plaintiff's cause of action came from the Medicaid Act or the Constitution, and the Court has yet to explicitly hold that the Supremacy Clause creates an implied right of action for preemption cases, these cases strongly indicate that the Court is more receptive to suits brought under the preemption doctrine than under § 1983.¹⁵⁸

¹⁵² Ark. Dep't of Health & Human Servs. v. Ahlborn, 547 U.S. 268, 274, 292 (2006); Pharm. Research & Mfrs. of Am. v. Walsh, 538 U.S. 644, 650, 667–68 (2003).

¹⁵³ See *Ahlborn*, 547 U.S. at 274, 292; *Walsh*, 538 U.S. at 650, 667–68.

¹⁵⁴ See 538 U.S. at 650.

¹⁵⁵ See *id.* at 667–68. In separate concurring opinions, however, Justices Scalia and Thomas both argued that private individuals cannot sue under the Supremacy Clause to enjoin state laws that violate provisions of the Medicaid Act. See *id.* at 675 (Scalia, J., concurring); *id.* at 682 (Thomas, J., concurring).

¹⁵⁶ See 547 U.S. at 274.

¹⁵⁷ See *id.* at 292.

¹⁵⁸ See *id.*; *Walsh*, 538 U.S. at 667–68; see also Sloss, *supra* note 139, at 390–91 (“[T]he Court is willing to grant relief in *Shaw* preemption cases even if the plaintiff lacks a private right of action under the preemptive federal statute, and without regard to whether the statute creates individual rights that are enforceable pursuant to § 1983.”).

C. Preemption and the Circuit Courts

Federal circuit courts have been similarly receptive to preemption suits.¹⁵⁹ In the wake of *Gonzaga* and *Verizon*, several circuit courts have concluded that plaintiffs can challenge, under the Supremacy Clause, state laws that conflict with federal statutes even when the plaintiffs would not be able to do so under § 1983.¹⁶⁰

Furthermore, in 2006 in *Lankford v. Sherman*, the U.S. Court of Appeals for the Eighth Circuit clearly indicated that it is receptive to cases alleging that a state law is preempted by a provision of the Medicaid Act, even though it cannot be enforced under § 1983.¹⁶¹ In *Lankford*, a case in which disabled adult Medicaid recipients alleged that a state regulation was preempted, the Eighth Circuit held that although the Medicaid Act's reasonable standards provision, 42 U.S.C. § 1396a(a)(17), does not create a right enforceable under § 1983, it likely preempted a state regulation restricting the availability of durable medical equipment.¹⁶²

The Ninth Circuit, however, was the first to suggest that the Supremacy Clause could provide an alternative way to enforce Medicaid's equal access provision.¹⁶³ Its decisions in *Independent Living Center* and related cases, which will be explored in the next Section, leave no doubt as to the Ninth Circuit's full support for the proposition that plaintiffs can successfully sue under the Supremacy Clause to challenge Medicaid reimbursement rates as preempted by § 30(A).¹⁶⁴

¹⁵⁹ See, e.g., *Lankford v. Sherman*, 451 F.3d 496, 509, 513 (8th Cir. 2006) (holding that “[p]reemption claims are analyzed under a different test than section 1983 claims” and concluding that plaintiffs, disabled adult Medicaid recipients, had demonstrated that a state regulation restricting the availability of durable medical equipment was likely preempted by Medicaid's reasonable standards provision, 42 U.S.C. § 1396a(a)(17) (2006)); *Planned Parenthood of Hous. & Se. Tex. v. Sanchez*, 403 F.3d 324, 333–35 (5th Cir. 2005) (holding “the rule that there is an implied right of action to enjoin state or local regulation that is preempted by a federal statutory or constitutional provision—and that such an action falls within the federal question jurisdiction—is well-established” and finding that rule unchanged by *Gonzaga*); *Qwest Corp. v. City of Santa Fe*, 380 F.3d 1258, 1266–67 (10th Cir. 2004) (holding that although the plaintiff, a telecommunications provider, could not challenge a state ordinance under § 1983 because the federal Telecommunications Act does not confer any private right upon individuals, the plaintiff could challenge the ordinance, under the Supremacy Clause, as preempted by the Telecommunications Act).

¹⁶⁰ See, e.g., *Lankford*, 451 F.3d at 509, 513; *Sanchez*, 403 F.3d at 333–35; *Qwest*, 380 F.3d at 1266–67; see also *supra* note 159 (summarizing the holdings of these cases).

¹⁶¹ See 451 F.3d at 513.

¹⁶² See *id.*

¹⁶³ *Independent Living II*, 543 F.3d at 1052.

¹⁶⁴ See *infra* notes 165–230 and accompanying text.

D. Independent Living Center: *Preemption and § 30(A)*

In April 2008, in *Independent Living Center*, California healthcare advocates, pharmacies, and Medicaid recipients and providers (collectively, “ILC”) sued the Director of California’s Department of Health Care Services (“the Director”), Sandra Shewry, seeking to enjoin implementation of California Assembly Bill 5 (“AB 5”).¹⁶⁵ The bill, which was scheduled to take effect on July 1, 2008, cut by ten percent payments to healthcare providers by California’s Medicaid program (Medi-Cal).¹⁶⁶ ILC sued under the Supremacy Clause, arguing that AB 5 is invalid because its mandated rate cut conflicts with the federal Medicaid Act’s equal access provision.¹⁶⁷ Although ILC brought the action in state court, the Director quickly removed it to federal court under federal question jurisdiction.¹⁶⁸

ILC advanced two arguments in support of its conflict preemption claim.¹⁶⁹ First, ILC argued that the rate cut would lead so few providers to enlist in the Medi-Cal program that Medi-Cal recipients would have dramatically less access to medical care and services than is available to California’s general population, a clear breach of the Medicaid Act’s equal access provision.¹⁷⁰ Payments by Medi-Cal were so low, even before AB 5, that 45% of primary care physicians, 50% of specialists, and 90% of dentists in California refused to accept Medi-Cal patients or participate in the Medi-Cal program.¹⁷¹ Implementation of AB 5’s rate cut, ILC contended, would lead even more providers to reduce services to Medi-Cal recipients or stop participating in Medi-Cal entirely.¹⁷²

Second, ILC argued that AB 5 was preempted by § 30(A) because the legislature had not complied with procedural requirements that the Ninth Circuit had previously construed § 30(A) to mandate.¹⁷³ In an earlier case involving § 1983 and § 30(A), the Ninth Circuit held that a

¹⁶⁵ *Independent Living II*, 543 F.3d at 1052; see CAL. WELF. & INST. CODE § 14105.19(b)(1) (West 2008).

¹⁶⁶ *Independent Living II*, 543 F.3d at 1053. Specifically, AB 5 reduces payments to healthcare providers participating in Medi-Cal’s fee-for-service plan (including physicians, dentists, and pharmacies) by 10%; payments to managed care plans by the actuarial equivalent of a 10% reduction; and payments to non-contract acute care hospitals by 10%. *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ See *id.* at 1053–54.

¹⁶⁹ See *id.* at 1053.

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² See *Independent Living II*, 543 F.3d at 1053.

¹⁷³ See *id.*

state Medicaid program must rely on “responsible cost studies” when setting Medicaid reimbursement rates and generally must set rates that have a “reasonable relationship” to the cost of quality healthcare.¹⁷⁴ ILC contended that, in violation of this interpretation of § 30(A), the state had failed to consider whether the ten percent reduction would be consistent with quality care and neglected to examine cost studies.¹⁷⁵ The state’s only apparent consideration, ILC contended, was addressing “the fiscal emergency declared by the Governor” and “implement[ing] cost containment measures affecting health services, at the earliest possible time.”¹⁷⁶

1. District Court Denies Injunction

The U.S. District Court for the Central District of California, despite noting that it was “acutely cognizant of the potential adverse consequences of the ten percent rate reduction,” denied ILC’s motion for a preliminary injunction in June 2008.¹⁷⁷ The court explained that ILC’s case would likely fail on the merits, in the wake of *Gonzaga*, because ILC has no “federal rights under § 30(A).”¹⁷⁸

The district court rejected ILC’s contention that it had an implied right of action arising out of the Supremacy Clause.¹⁷⁹ Only three categories of *Shaw* preemption claims have been allowed, the district court stated: (1) where a plaintiff alleges that a state law requires him to violate a federal law; (2) where a plaintiff claims that a state law, which is preempted by a federal law, will restrict his conduct; and (3) where a plaintiff contends that “federally created rights” are interfered with by a state law.¹⁸⁰ Because ILC’s preemption claims did not fit into any of these *Shaw* categories, the district court reasoned that ILC’s claims had very little chance of succeeding on the merits.¹⁸¹

¹⁷⁴ *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997).

¹⁷⁵ See *Independent Living II*, 543 F.3d at 1053.

¹⁷⁶ *Id.* (internal citations omitted).

¹⁷⁷ *Independent Living Center*, 2008 WL 4298223, at *5. A plaintiff obtains injunctive relief by establishing “that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” *Independent Living III*, 572 F.3d at 651 (quoting *Winter v. Natural Res. Def. Council*, 129 S. Ct. 365, 374 (2008)).

¹⁷⁸ *Independent Living Center*, 2008 WL 4298223, at *5.

¹⁷⁹ See *id.* at *4–5.

¹⁸⁰ *Id.* at *4. Although the district court cited cases representing each of these three “categories,” it gave no hint as to where it had discovered or derived the rule that these were the only situations in which *Shaw* applied. See *id.*

¹⁸¹ See *id.* at *4–5.

Strangely, rather than relying on *Shaw* and its progeny, the bulk of the district court's analysis drew primarily on Ninth Circuit decisions involving the equal access provision and § 1983, even though ILC sued under the Supremacy Clause.¹⁸² Thus, the seemingly confused district court applied *Gonzaga*'s narrowed test for § 1983 claims to ILC's preemption claim and concluded that ILC failed to sufficiently state a claim for relief.¹⁸³

2. Ninth Circuit Remands for Consideration on the Merits

ILC successfully appealed to the Ninth Circuit for emergency relief from this decision.¹⁸⁴ On July 11, 2008, a three-judge panel of the Ninth Circuit heard argument and issued an order vacating the district court's ruling and remanding the case for consideration of the merits.¹⁸⁵ In its order, the Ninth Circuit explicitly held that a plaintiff could bring a preemption claim like ILC's without an express right of action.¹⁸⁶ It is well-established, the Ninth Circuit explained, that a plaintiff can sue under the Supremacy Clause to enjoin the implementation of a state law that conflicts with a federal law "regardless of whether the federal statute at issue confers an express 'right' or cause of action on the plaintiff."¹⁸⁷ The district court's decision was vacated because it was entirely based on the "legal error" that ILC could not seek injunctive relief under the Supremacy Clause without having an individual right arising from the Medicaid Act.¹⁸⁸

In a longer opinion, issued in September 2008, the Ninth Circuit elaborated on its July order.¹⁸⁹ In addition to more fully explaining

¹⁸² See *id.* at *3–4 (discussing *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005) (holding that neither Medicaid recipients nor providers could enforce § 30(A) via § 1983 because § 30(A) does not create an "individual right" as required by *Gonzaga*)).

¹⁸³ See *id.* at *5.

¹⁸⁴ *Independent Living I*, 543 F.3d at 1048–49.

¹⁸⁵ *Id.* at 1049.

¹⁸⁶ *Id.* at 1048–49.

¹⁸⁷ *Id.* (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983); *Lankford*, 451 F.3d at 509–10; *Sanchez*, 403 F.3d at 331–35; *Local Union No. 12004, United Steelworkers v. Massachusetts*, 377 F.3d 64, 75 (1st Cir. 2004); *Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 819 n.3 (D.C. Cir. 2004); *Ill. Ass'n of Mortgage Brokers v. Office of Banks & Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002); *Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 73 (1st Cir. 2001), *aff'd sub nom.* *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003); *St. Thomas–St. John Hotel & Tourism Ass'n v. Virgin Islands*, 218 F.3d 232, 241 (3d Cir. 2000); *Village of Westfield v. Welch's*, 170 F.3d 116, 124 n.4 (2d Cir. 1999); *Burgio & Campofelice, Inc. v. N.Y. Dep't of Labor*, 107 F.3d 1000, 1005–07 (2d Cir. 1997); *Bud Antle, Inc. v. Barbosa*, 45 F.3d 1261, 1269 (9th Cir. 1994)).

¹⁸⁸ *Id.* at 1049.

¹⁸⁹ See *Indep. Living II*, 543 F.3d at 1055.

what is required for a plaintiff to state a preemption claim, the Ninth Circuit dismissed the district court's analytical framework and rejected arguments advanced by the Director.¹⁹⁰ In this opinion, however, the Ninth Circuit continued to decline to weigh in on the merits of ILC's preemption claim.¹⁹¹

In the longer opinion, the Ninth Circuit elaborated upon its earlier holding that a private individual may seek injunctive relief under the Supremacy Clause and 28 U.S.C. § 1331.¹⁹² To bring a preemption suit, the court explained, a plaintiff need only (1) allege that a state law is preempted by federal law and (2) satisfy the traditional standing requirements.¹⁹³ This conclusion, the court explained, was supported by decades of U.S. Supreme Court precedent, such as *Shaw*, which the Ninth Circuit interpreted as standing for the general principle that "the Supremacy Clause provides a cause of action to enjoin implementation of allegedly unlawful state legislation."¹⁹⁴ Thus, the court held that because (1) ILC contended that the rate cuts violate § 30(A) and are thus unlawful and (2) the rate cuts are causing injury to at least one of the plaintiffs and the other Article III standing requirements are met, the suit can go forward.¹⁹⁵

The Ninth Circuit rejected the district court's suggestion that ILC's claim for injunctive relief, brought under the Supremacy Clause, must meet the same standards as a suit brought under § 1983.¹⁹⁶ The Ninth Circuit explained that a plaintiff suing under the Supremacy Clause for prospective injunctive relief does not need to assert a federal right in the same way that *Gonzaga* holds a plaintiff must assert an "unambiguously conferred right" to bring a suit under § 1983.¹⁹⁷ Observing that "the well-established rule in both this court and in other circuits is precisely

¹⁹⁰ See *id.* at 1055, 1057, 1061–62.

¹⁹¹ See *id.* at 1066.

¹⁹² See *id.* at 1056–57, 1065–66. The Ninth Circuit stressed that "*Shaw* did not give rise to some unique line of 'Shaw preemption' cases, but merely reaffirmed the traditional rule that injunctive relief is presumptively available in federal court to enjoin state officers from implementing a law allegedly preempted under the Supremacy Clause." *Id.* at 1057.

¹⁹³ See *id.* at 1058 ("[A] plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption . . . need only satisfy traditional standing requirements.").

¹⁹⁴ *Id.* at 1056.

¹⁹⁵ *Independent Living II*, 543 F.3d at 1065–66.

¹⁹⁶ See *id.* at 1055 ("The Supreme Court has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under § 1983 be met, and without intimating that such claims must fit into one of three categories or 'circumstances' in order to be cognizable.").

¹⁹⁷ See *id.* at 1058, 1062.

the opposite,”¹⁹⁸ the Ninth Circuit reasoned that to hold otherwise would require it to apply the test used to determine whether a plaintiff can seek relief via § 1983 to preemption suits.¹⁹⁹ This would clearly be improper, because although the U.S. Supreme Court has recently made the test for bringing a damages action under § 1983 stricter, it has continued to reaffirm the availability of a suit for injunctive relief under the Supremacy Clause where a federal law preempts a state one.²⁰⁰

Moreover, the Ninth Circuit rejected the district court’s suggestion that *Shaw* preemption cases are limited to three “categories.”²⁰¹ Noting that it was unaware of any precedent for so limiting *Shaw* and observing that the Director had failed to suggest any, the Ninth Circuit dismissed the argument entirely.²⁰²

The Director’s contention that a preemption claim brought under a federal Spending Clause statute, like the Medicaid Act, should be treated differently from non-Spending Clause legislation was also rejected by the Ninth Circuit.²⁰³ In reaching this conclusion, the Ninth Circuit relied on the U.S. Supreme Court’s 2003 decision in *Walsh*, which reached the merits of the pharmaceutical manufacturers’ claim that a Maine statute was preempted by the federal Medicaid Act.²⁰⁴ The Ninth Circuit interpreted this result as suggesting that federal laws have

¹⁹⁸ *Id.* at 1058–59. For support, the court cited cases from the First, Second, Third, Seventh, Eighth, and Tenth Circuits holding that, regardless of whether the allegedly preemptive federal statute creates a “right,” private parties may bring preemption suits seeking injunctive relief. *See id.* (citing *Qwest*, 280 F.3d at 1266; *Local Union No. 12004*, 377 F.3d at 75; *Ill. Ass’n of Mortgage Brokers*, 308 F.3d at 765; *St. Thomas–St. John Hotel & Tourism Ass’n*, 218 F.3d at 241; *Welch’s*, 170 F.3d at 124 n.4; *Burgio & Campofelice, Inc.*, 107 F.3d at 1005–07; *First Nat’l Bank of E. Ark. v. Taylor*, 907 F.2d 775, 776 n.3 (8th Cir. 1990)).

¹⁹⁹ *See id.* at 1062 (“[B]oth the Supreme Court and the courts of appeal have consistently rejected attempts to extend this analysis to claims for purely prospective injunctive relief under the Supremacy Clause, rendering the ‘rights’ requirement inapplicable to ILC’s claims in this case.”). For support, the court cited recent cases from the Fifth and Eighth Circuits. *See id.* at 1062–63 (citing *Lankford*, 451 F.3d at 509; *Sanchez*, 403 F.3d at 335).

²⁰⁰ *See id.* at 1062.

²⁰¹ *See Independent Living II*, 543 F.3d at 1057. The three categories identified by the district court were (1) where a plaintiff alleges that a state law requires him to violate a federal law; (2) where a plaintiff claims that a state law that is preempted by a federal law will restrict his conduct; and (3) where a plaintiff contends that “federally created rights” are interfered with by a state law. *See id.*; *supra* note 180 and accompanying text.

²⁰² *See Independent Living II*, 543 F.3d at 1055.

²⁰³ *See id.* at 1061–62.

²⁰⁴ *See id.* at 1059–60 (discussing *Walsh*, 538 U.S. 644).

preemptive power, regardless of the authority under which they were enacted by Congress.²⁰⁵

3. District Court Grants Preliminary Injunction

On remand, the district court faced the problem of interpreting the equal access provision in order to determine whether ILC had shown sufficient likelihood of success to merit a preliminary injunction.²⁰⁶ The district court decided that although the Ninth Circuit had determined, in the wake of *Gonzaga*, that § 30(A) could no longer be enforced via § 1983, the Ninth Circuit's interpretation of § 30(A), announced in 1997 in *Orthopaedic Hospital v. Belshe*, a § 1983 case, still controlled.²⁰⁷ Thus, the district court proceeded with its analysis of ILC's likelihood of success on the merits under *Belshe*, which held that § 30(A) requires (1) provider reimbursements to be "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers to provide access to Medicaid recipients" and (2) the state Medicaid program to use "responsible cost studies" containing "reliable data" when setting those rates.²⁰⁸

Based on this interpretation of § 30(A), the district court concluded that ILC had demonstrated that its preemption claim had a likelihood of success on the merits because (1) reports, declarations, and studies submitted by ILC established a risk of irreparable injury to healthcare access and (2) the Director could not show that the Department had considered the impact of the payment cut on healthcare quality or access.²⁰⁹ Thus, the district court granted a preliminary injunction, enjoining implementation of the rate reduction.²¹⁰

²⁰⁵ See *id.* at 1061. The court acknowledged in a footnote, however, that Justices Scalia and Thomas had expressed skepticism of preemption suits brought under Spending Clause statutes like the Medicaid Act in concurring opinions in *Walsh*. See *id.* at 1060 n.12.

²⁰⁶ See *Independent Living Center*, 2008 WL 3891211, at *2–4.

²⁰⁷ See *id.* at *4 (citing *Belshe*, 103 F.3d at 1496).

²⁰⁸ *Id.* at *3–4 (quoting *Belshe*, 103 F.3d at 1496).

²⁰⁹ See *id.* at *4, *9, *11.

²¹⁰ *Id.* at *11. The preliminary injunction was granted with respect to the reduction in payments for Medi-Cal's fee-for-service program, but denied with respect to the managed care plans and non-acute care hospitals because no risk of irreparable injury to those services was shown. See *id.* The district court subsequently, in response to a motion filed by the Director arguing that the original order violated the Eleventh Amendment, amended the preliminary injunction so that it granted only prospective relief. See *Independent Living III*, 572 F.3d at 648, 650.

4. Ninth Circuit Upholds Preliminary Injunction

When the Director appealed this order, the Ninth Circuit refused to rehear the case en banc, reaffirmed its earlier holding that ILC had stated a cognizable claim under the Supremacy Clause, and upheld the preliminary injunction granted by the district court.²¹¹

Significantly, the Ninth Circuit noted that the *Belshe* court's interpretation of § 30(A) is just as persuasive in preemption cases as it had been in § 1983 cases.²¹² The court reasoned that *Belshe* "clearly controls" in both cases because determining the underlying purpose of the allegedly preemptive federal law is the first step in a conflict preemption analysis as well as the central focus of *Belshe's* interpretation of § 30(A).²¹³

Ultimately, the Ninth Circuit held that the district court had not abused its discretion in finding that ILC had demonstrated a sufficient likelihood of success on the merits to be granted a preliminary injunction.²¹⁴ Applying *Belshe's* interpretation of § 30(A) to the facts, the Ninth Circuit concluded that "the Director violated § 30(A) when he implemented the rate reductions mandated by AB 5" because he failed to rely on *any* cost studies in setting Medicaid rates.²¹⁵

5. The U.S. Supreme Court and Other Plaintiffs Take Note

The U.S. Supreme Court, in June 2009, denied the Director's petition for writ of certiorari on the issue of whether Medicaid providers and recipients state a valid cause of action under the Supremacy Clause by alleging that a state law reducing provider reimbursement rates conflicts with § 30(A).²¹⁶ A subsequent petition for certiorari is currently pending before the Court, however.²¹⁷ In this petition, the Director asked the Court to decide the same issue presented in the 2009 petition

²¹¹ See *Independent Living III*, 572 F.3d at 648, 650–51.

²¹² See *id.* at 652–53.

²¹³ See *id.* at 653 ("In both cases, the central question is the purpose underlying § 30(A), and as to that question, [*Belshe*] clearly controls.").

²¹⁴ See *id.* at 657.

²¹⁵ *Id.* at 652. The Ninth Circuit departs from some other circuits in interpreting § 30(A) to include the procedural requirement that the state Medicaid Director conduct cost studies before setting Medicaid rates. *Id.*; see *infra* notes 239–251 and accompanying text. The court noted in this opinion, however, that "[e]ven if we were to interpret § 30(A) to mandate a substantive rather than procedural result, the ten percent rate reduction might still conflict with the quality of care and access provisions of § 30(A), as the cuts have apparently forced at least some providers to stop treating Medi-Cal beneficiaries." *Independent Living III*, 572 F.3d at 657.

²¹⁶ See *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal.*, 129 S. Ct. at 2828.

²¹⁷ *Maxwell-Jolly*, 130 S. Ct. 3349, 3349 (2010) (mem.).

and, additionally, to consider the validity of the Ninth Circuit's interpretation of § 30(A).²¹⁸ The Supreme Court has invited the Solicitor General to file a brief in response to the petition.²¹⁹ This invitation prompted the National Association of State Medicaid Directors ("NASMD") to send a letter to then-Solicitor General Elena Kagan, urging her to request that certiorari be granted.²²⁰ NASMD warned that if *Independent Living Center* is not overturned, "it could open the floodgates of litigation against the states on virtually any number of hundreds of Medicaid provisions for which Congress did not intend to confer judicially enforceable rights."²²¹

Even as the Director continues to challenge *Independent Living Center*, plaintiffs in the Ninth Circuit have lost no time in using the case to support challenges to similar rate or service reductions in Medicaid and other state welfare programs.²²²

Plaintiffs beyond the Ninth Circuit are also beginning to challenge Medicaid rate cuts on the same theory, with varying success.²²³ For example, in February 2010 in *Minnesota Pharmacists Ass'n v. Pawlenty*, the U.S. District Court for the District of Minnesota allowed pharmacies and Medicaid recipients to proceed with discovery on the issue of whether

²¹⁸ See Petition for Writ of Certiorari at ii, *Maxwell-Jolly*, No.09-508 (U.S. filed Feb. 16, 2010).

²¹⁹ *Maxwell-Jolly*, 130 S. Ct. at 3349.

²²⁰ Letter from Carol H. Steckel, Chairperson, Nat'l Ass'n of State Medicaid Dirs., to Elena Kagan, U.S. Solicitor Gen. (Jun. 18, 2010), available at http://www.nasmd.org/home/doc/NASMD_LETTER_TO_Kagan.pdf.

²²¹ *Id.*

²²² See, e.g., *Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 849, 853 (9th Cir. 2009) (granting motion to stay AB 1183 (which cut Medi-Cal reimbursement rates for certain healthcare services) as to hospitals in a case alleging that AB 1183 is preempted by § 30(A)); *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1109, 1118, 1123 (N.D. Cal. 2009) (relying in part on *Independent Living Center* in granting a preliminary injunction enjoining a California law (which reduces or terminates in-home assistance for thousands of Californians) when plaintiffs challenged the law as preempted by various federal statutes, including § 1396a(a)(17) of the Medicaid Act); *Managed Pharmacy Care v. Maxwell-Jolly*, 603 F. Supp. 2d 1230, 1234–35, 1242 (C.D. Cal. 2009) (citing *Independent Living Center* in granting a preliminary injunction enjoining enforcement of AB 1183 in a suit brought by pharmacists on the theory that AB 1183 is preempted by § 30(A)), *aff'd* *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, No. 09-55692, 2010 WL 737650 (9th Cir. Mar. 3, 2010), *petition for cert. filed*, 78 U.S.L.W. 3581 (U.S. Mar. 24, 2010) (No. 09-1158).

²²³ See, e.g., *Conn. Ass'n of Health Care Facilities, Inc. v. Rell*, No. 10-2237-CV, 2010 WL 2232693, at *31 (D. Conn. Jun. 3, 2010), *aff'd* No. 10-2237-CV, 2010 WL 3894794 (2d Cir. Oct. 6, 2010); *Springfield Hosp. v. Hoffman*, No. 09-CV-00254-CR, 2010 WL 3322716, at *38–40 (D. Vt. Apr. 9, 2010); *Minn. Pharmacists Ass'n v. Pawlenty*, 690 F. Supp. 2d 809, 824–26, 828–29 (D. Minn. 2010) (allowing plaintiffs challenging a Medicaid rate cut as preempted by § 30(A) to conduct further discovery into the Secretary's approval of the rate cut).

reductions in the rates set by Minnesota's Medicaid program for brand-name drugs were preempted by § 30(A).²²⁴ Similarly, the U.S. District Court for the District of Connecticut, in its October 2010 decision in *Connecticut Ass'n of Health Care Facilities, Inc. v. Rell*, refused to dismiss an association of nursing facilities' claim that a Connecticut budget provision, which froze some Medicaid reimbursement rates, was preempted by § 30(A).²²⁵ Although the court also refused to grant a preliminary injunction in the case, it reasoned that "if Plaintiff could prove that [the budget provision] stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress, it would be preempted."²²⁶ However, in April 2010 in *Springfield Hospital v. Hoffman*, the U.S. District Court for the District of Vermont dismissed, for failure to state a claim, a case in which a hospital contended that adjustments to the disproportionate share hospital payments it receives through Vermont's Medicaid program are preempted by § 30(A).²²⁷ Because the hospital argued that state officials' actions—rather than state legislation—conflicted with § 30(A), the court explained, the claim did "not arise under the *Supremacy Clause* which requires, as a condition precedent to its application, a state-federal law conflict."²²⁸

These district court cases, as well as the Ninth Circuit's decisions in *Independent Living Center* and related cases, are instructive in anticipating some of the problems plaintiffs are likely to encounter in using § 30(A) preemption suits to combat state cuts to Medicaid reimbursement rates.²²⁹ Potential problems and limitations are considered in the next Part.²³⁰

V. PREEMPTION AS A WORKABLE ALTERNATIVE?

In the wake of the U.S. Court of Appeals for the Ninth Circuit's 2008 decision in *Independent Living Center of Southern California, Inc. v. Shewry*, preemption is a promising method of enforcing the equal ac-

²²⁴ 690 F. Supp. 2d at 828–29.

²²⁵ 2010 WL 2232693, at *6–9.

²²⁶ *Id.* at *31 (internal quotation marks and citation omitted). The Second Circuit affirmed the district court's denial of a preliminary injunction in a summary order issued in October 2010; the order suggests that the Second Circuit may be receptive to § 30(A) preemption claims because the preliminary injunction was affirmed not because the plaintiff's claim was invalid, but simply because plaintiff had failed to show that the rate freeze would cause irreparable harm. *See* 2010 WL 3894794, at *1–2.

²²⁷ 2010 WL 3322716, at *2, *38–40.

²²⁸ *Id.* at *39.

²²⁹ *See infra* notes 239–303 and accompanying text.

²³⁰ *See infra* notes 239–303 and accompanying text.

cess provision in order to protect providers' Medicaid reimbursement rates.²³¹ Nevertheless, although the court in *Independent Living Center* makes a persuasive case for preemption's promise as an alternative to § 1983, there are a number of significant pitfalls that could pose a threat to efficacy of preemption claims in the context of the equal access provision.²³² First, it may be harder to challenge a state law as conflicting with § 30(A) in jurisdictions that interpret the vaguely-worded provision differently than the Ninth Circuit.²³³ Second, if the Secretary approves a state's Medicaid reimbursement rates, plaintiffs may find insurmountable the deference that some courts accord the Secretary's approval.²³⁴ Third, if a state tries to avoid preemption problems by cutting Medicaid reimbursement rates in a less direct manner than California did with AB 5, plaintiffs may be unable to fit their claim under the Supreme Court's "preemption" analysis rather than its "violation" analysis.²³⁵ Fourth, because the relief available in preemption cases is different from that available in § 1983 cases, preemption claims may be less appealing for plaintiffs.²³⁶ Fifth, if arguments that have been advanced by Justices Scalia and Thomas, in opposition to preemption suits, persuade either lower courts or a majority of the U.S. Supreme Court, it could become impossible to use any provision of the Medicaid Act to bring a preemption claim.²³⁷ And, sixth, Congress might try to remove this avenue of challenging reimbursement rates.²³⁸ Each of these issues is explored, in turn, below.

A. *Interpreting the Equal Access Provision*

The chances of successfully establishing that a state has lowered Medicaid reimbursement rates in a way that conflicts with § 30(A) will

²³¹ See *See* *Indep. Living Ctr. of S. Cal., Inc. v. Shewry (Independent Living I)*, 543 F.3d 1047, 1048–49 (9th Cir.), *opinion issued by (Independent Living II)*, 543 F.3d 1050 (9th Cir. 2008), *cert. denied*, 129 S. Ct. 2828 (2009), and *on remand to* No. CV 08-3315, 2008 WL 3891211 (C.D. Cal. Aug. 18, 2008), *aff'd sub nom.* *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly (Independent Living III)*, 572 F.3d 644 (9th Cir. 2009), *motion to vacate denied*, 590 F.3d 725 (9th Cir. 2009), and *petition for cert. filed*, 78 U.S.L.W. 3500 (U.S. Feb. 16, 2010) (No. 09-958); *supra* notes 222–228 and accompanying text.

²³² See *infra* notes 233–238 and accompanying text.

²³³ See *infra* notes 239–251 and accompanying text.

²³⁴ See *infra* notes 252–257 and accompanying text.

²³⁵ See *infra* notes 258–270 and accompanying text.

²³⁶ See *infra* notes 271–279 and accompanying text.

²³⁷ See *infra* notes 280–293 and accompanying text.

²³⁸ See *infra* notes 294–303 and accompanying text.

likely depend on what the particular court deems to be the controlling interpretation of the equal access provision.²³⁹

Both the Eighth and Ninth Circuits have interpreted § 30(A) to include a procedural as well as a substantive requirement: these courts understand § 30(A) to require both that a substantive result of equal access be achieved and that certain factors be considered in the process of setting Medicaid reimbursement rates.²⁴⁰ Although the Ninth Circuit does not interpret § 30(A) to oblige state Medicaid programs to adhere to a rigid formula for determining reimbursement rates,²⁴¹ the court understands § 30(A) to require states to “(1) rely on responsible cost studies . . . that provide reliable data as a basis for its rate setting, *and* (2) study the impact of the contemplated rate change(s) on the statutory factors *prior to* setting rates, or in a manner that allows those studies to have a meaningful impact on rates”²⁴² Similarly, the Eighth Circuit has interpreted § 30(A) to mean that a state Medicaid program is “obliged to consider” the factors listed in § 30(A)—access, economy, efficiency, and quality of care—in setting reimbursement rates.²⁴³

The Third and Seventh Circuits, however, in decisions analyzing § 30(A), interpreted it to include a substantive requirement, but not a procedural one.²⁴⁴ The Seventh Circuit holds that § 30(A) requires

²³⁹ Compare *Independent Living III*, 572 F.3d at 652 (interpreting the equal access clause as including a procedural as well as a substantive requirement and holding that “it is clear that the Director violated § 30(A) when he implemented the rate reductions mandated by AB 5”), with *Conn. Ass’n of Health Care Facilities, Inc. v. Rell*, No. 10-2237-CV, 2010 WL 2232693, at *25–26, *38 (D. Conn. Jun. 3, 2010) (interpreting the equal access clause as solely a substantive requirement and holding that the plaintiff failed to show a likelihood of success on the merits as to its § 30(A) preemption claim), *aff’d* No. 10-2237-CV, 2010 WL 3894794 (2d Cir. Oct. 6, 2010).

²⁴⁰ See *Independent Living III*, 572 F.3d at 651, 653–54; *Ark. Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993).

²⁴¹ *Independent Living III*, 572 F.3d at 653 (explaining that a Medicaid program is not required to “follow a rigid formula of payments equal to an efficiently and economically operated hospital’s costs regardless of other factors”) (quoting *Orthopaedic Hosp. v. Bel-she*, 103 F.3d 1491, 1498 (9th Cir. 1997)).

²⁴² *Cal. Pharmacists Ass’n v. Maxwell-Jolly*, 596 F.3d 1098, 1115 (9th Cir. 2010) (internal quotation marks and citations omitted), *petition for cert. filed*, 78 U.S.L.W. 3581 (U.S. Mar. 24, 2010) (No. 09-1158).

²⁴³ *Reynolds*, 6 F.3d at 530; see also *Minn. HomeCare Ass’n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (concluding that § 30(A) “mandates consideration of the equal access factors of efficiency, economy, quality of care and access to services in the process of setting or changing payment rates,” but “does not require the State to utilize any prescribed method of analyzing and considering said factors”). To date, however, the Eighth Circuit has only interpreted § 30(A) in the context of a § 1983 suit. See *Reynolds*, 6 F.3d at 530; *Gomez*, 108 F.3d at 918.

²⁴⁴ See *Rite Aid v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999); *Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); see also *Independent Living III*, 572 F.3d at 655 (dis-

state Medicaid programs “to produce a *result*,” but not to use a particular methodology to achieve that result.²⁴⁵ Similarly, the Third Circuit holds that § 30(A) requires a state Medicaid program “to achieve a certain result,” but does not require that a particular process be used to accomplish that result.²⁴⁶ Thus failure to consider the effect of a rate cut or to perform cost studies in reducing reimbursement rates would not be enough for the rate cut to be preempted by § 30(A) in these circuits.²⁴⁷ Nevertheless, the circuits that generally reject the notion that § 30(A) imposes particular procedural requirements on the rate-setting process still tend to consider the motivations behind the rate cuts and apply a sort of arbitrary and capricious review to state rate-setting.²⁴⁸

The vagueness of the equal access provision poses a problem for actions brought under the Supremacy Clause similar to the one it posed for suits brought under § 1983.²⁴⁹ Because of a lack of data, it may be more challenging to establish a rate reduction’s substantive effect on access (particularly before the rate reduction is implemented) than to establish whether the requisite procedural steps were taken in setting the reduced rate.²⁵⁰ Thus, preemption suits will likely prove less successful in jurisdictions, like the Third and Seventh Circuits, which

cussing the approach of the Third and Seventh Circuits). The Third and Seventh Circuits have only interpreted § 30(A) in the context of a § 1983 suit—not a preemption suit. *See Rite Aid*, 171 F.3d at 851; *Sullivan*, 91 F.3d at 1030. But recently the Second Circuit, in an unpublished summary order, indicated its agreement with the Third and Seventh Circuits by affirming the denial of a preliminary injunction in a § 30(A) preemption suit in part “[b]ecause there is no procedural requirement under the ‘equal access provision.’” *Reli*, 2010 WL 3894794, at *1.

²⁴⁵ *Sullivan*, 91 F.3d at 1030.

²⁴⁶ *Rite Aid*, 171 F.3d at 851 (“[S]ection 30(A) requires the state to achieve a certain result but does not impose any particular method or process for getting *to* that result.”).

²⁴⁷ *See id.*; *Sullivan*, 91 F.3d at 1030.

²⁴⁸ *See Rite Aid*, 171 F.3d at 853, 856 (noting that “budgetary considerations may not be the sole basis for a rate revision” and holding that in setting payment rates for pharmacists, the state Medicaid agency’s “decision-making” must be “reasonable and sound”); *Reynolds*, 6 F.3d at 529 (applying “arbitrary and capricious” review to a state Medicaid agency’s reduction of reimbursement rates to determine if the agency violated § 30(A)); *see also Independent Living III*, 572 F.3d at 656 (discussing this tendency).

²⁴⁹ *See Independent Living III*, 572 F.3d at 652 (holding that *Belshé*’s interpretation of § 30(A) is just as persuasive in preemption cases as it had been in § 1983 cases); *see also* *Visiting Nurse Ass’n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1008, 1010 (1st Cir. 1996) (declining to rule that Massachusetts’s new method of setting Medicaid reimbursement rates was prohibited by § 30(A)’s procedural requirements); *Sullivan*, 91 F.3d at 1029 (deciding that plaintiffs failed to show that reimbursement rates set by Indiana’s Medicaid program violated the equal access provision).

²⁵⁰ *See Independent Living III*, 572 F.3d at 652 (relying heavily on the legislature’s procedural failures in evaluating whether a preliminary injunction was merited).

do not interpret § 30(A) to include a procedural requirement as well as a substantive one.²⁵¹

B. *Dealing with Deference*

Where the Secretary approves a state plan that includes the challenged reimbursement rates, courts may find that the Secretary's conclusion that the reimbursement rates comply with § 30(A) should be entitled to substantial deference.²⁵²

For example, in 2004, in *Pharmaceutical Research & Manufacturers of America v. Thompson*, the U.S. Court of Appeals for the District of Columbia Circuit held that the Secretary's interpretation of the Medicaid Act has the force of law and is therefore reviewed only according to the deferential framework established in the Supreme Court's 1984 decision in *Chevron U.S.A. v. Natural Resources Defense Council*.²⁵³ This is because the Medicaid Act expressly delegates authority to the Secretary to evaluate and approve state Medicaid plans.²⁵⁴ Thus, the D.C. Circuit reasoned, under *Chevron* the Secretary's interpretations of the Medicaid Act are controlling unless they are arbitrary and capricious.²⁵⁵

When the Secretary's approval of state Medicaid plans is only subject to "arbitrary and capricious" review, plaintiffs alleging that § 30(A) preempts a Medicaid rate cut will encounter a heavy—but not impossible—burden of proof if the Secretary approves a state plan incorporating the cut.²⁵⁶ In addition to showing that the rate cut violates § 30(A),

²⁵¹ See *Reil*, 2010 WL 2232693, at *25–26, *38 (finding § 30(A) not to contain a procedural requirement and denying plaintiff a preliminary injunction in a § 30(A) preemption case); see also *Rite Aid*, 171 F.3d at 851; *Sullivan*, 91 F.3d at 1030.

²⁵² See *Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 822 (D.C. Cir. 2004) (holding that the Secretary's interpretation of the Medicaid Act is "entitled to *Chevron* deference"); *Minn. Pharmacists Ass'n v. Pawlenty*, 690 F. Supp. 2d 809, 825–26 (D. Minn. 2010) (allowing plaintiffs to proceed with discovery in a § 30(A) preemption case, but holding that "[t]he Secretary's decisions interpreting the Medicaid statute are entitled to *Chevron* deference 'because they carry the force of law'").

²⁵³ *Thompson*, 362 F.3d at 822; see *Chevron U.S.A., Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842–44 (1984). In *Chevron*, the Court held that where "Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation" and any resultant "regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." 467 U.S. at 843–44.

²⁵⁴ *Thompson*, 362 F.3d at 821–22.

²⁵⁵ *Id.* at 822.

²⁵⁶ See *Pawlenty*, 690 F. Supp. 2d at 825–26 (concluding, where plaintiffs challenged a Medicaid rate cut approved by the Secretary as preempted by § 30(A), that although the Secretary's approval is entitled to *Chevron* deference, "this Court's review of that decision—even under a deferential arbitrary and capricious standard—cannot proceed without a

as interpreted by that jurisdiction, such plaintiffs will likely have to show that the Secretary's approval of the rate cut was arbitrary and capricious.²⁵⁷

C. Preemption Versus Violation

The U.S. Supreme Court consistently reaches the merits of cases in which a plaintiff asserts that a state law is preempted by a federal law, without considering the source of the plaintiff's cause of action.²⁵⁸ The Court has been unwilling, however, to reach the merits of cases in which a plaintiff alleges that an unwritten state policy or practice violates a federal law unless the plaintiff can show a clear statutory right of action either under § 1983 or the challenged statute itself.²⁵⁹ Some worry that preemption will therefore have a significantly narrower scope of coverage than § 1983 and that this distinction could incentivize states to de-codify laws in order to avoid preemption challenges.²⁶⁰ It remains to be seen whether these issues will meaningfully limit the usefulness of preemption as a way to challenge Medicaid reimbursement rates.²⁶¹

Preemption's usefulness as a way of enforcing § 30(A) hinges on how states go about reducing Medicaid reimbursement rates.²⁶² If rates are reduced via a state law or regulation, plaintiffs challenging the reduction as preempted by § 30(A) would most likely be found to have an

more substantial record of the Secretary's decision-making process" and allowing further discovery on this issue).

²⁵⁷ See *id.*

²⁵⁸ See, e.g., *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 274, 292 (2006); *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 650, 667–68 (2003); *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 366 (2000) (granting plaintiffs injunctive relief, without addressing the source of their cause of action, where plaintiffs alleged that a Massachusetts law prohibiting state procurement from companies doing business with Burma was preempted by a federal statute governing trade with Burma); see also *supra* notes 140–158 and accompanying text (discussing the Supreme Court's tendency to assume that the Supremacy Clause creates an implied cause of action for plaintiffs asserting a federal preemption claim).

²⁵⁹ See *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001) (holding that plaintiffs lacked a private right of action to enforce Title VI of the Civil Rights Act of 1964 where they claimed that the Alabama Department of Public Safety's policy of administering driver's license exams only in English violated Title VI); see also *Bobroff*, *supra* note 37, at 74; *Sloss*, *supra* note 139, at 357–58, 369.

²⁶⁰ See *Bobroff*, *supra* note 37, at 74 (“[I]t remains an open question whether the scope of coverage under preemption will be as broad as under § 1983, particularly with regard to unwritten policies and practices not sanctioned by state laws.”); *Sloss*, *supra* note 139, at 360 (noting that the differing treatment of “violation” and “preemption” cases “creates perverse incentives for states to de-codify laws”).

²⁶¹ See *infra* notes 262–270 and accompanying text.

²⁶² See *Bobroff*, *supra* note 37, at 74; *Sloss*, *supra* note 139, at 357–58, 369.

implied cause of action under the Supremacy Clause.²⁶³ This would be true in the case of regulations as well as statutes because the U.S. Supreme Court has expanded the principle it announced in 1983 in *Shaw v. Delta Airlines, Inc.*²⁶⁴—that federal courts have jurisdiction over suits alleging that a state statute is preempted by a federal statute—to include state regulations as well.²⁶⁵ Rate cuts, however, may not always be the product of a law explicitly cutting Medicaid reimbursement rates by ten percent, like the California act challenged in *Independent Living Center*.²⁶⁶ If a state reduces Medicaid reimbursement rates without either passing a law or promulgating a regulation, and does so instead via unwritten policies or practices that are not sanctioned by state law, a court might find that plaintiffs challenging the cuts do not have a valid cause of action under the Supremacy Clause.²⁶⁷

States with tight budgets will clearly wish to avoid preemption challenges when they target Medicaid reimbursement rates for cutbacks.²⁶⁸ Nevertheless, although there is a great diversity in how states set rates, it is unlikely that states could reduce many rates via unsanctioned, unwritten policies, given that reimbursement rates are ultimately factored into state budgets.²⁶⁹ Thus, it seems unlikely that the Court's "violation" jurisprudence will become a stumbling block for careful plaintiffs challenging rate reductions as preempted by the equal access provision.²⁷⁰

²⁶³ See Bobroff, *supra* note 37, at 74; Sloss, *supra* note 139, at 357–58, 369.

²⁶⁴ See *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96 n.14 (1983).

²⁶⁵ See *United States v. Locke*, 529 U.S. 89, 94 (2000) (holding that some regulations promulgated by Maine's Office of Marine Safety were preempted by federal laws); see also Sloss, *supra* note 139, at 380–81; Chang Derek Liu, Note, *The Blank Page Before You: Should the Preemption Doctrine Apply to Unwritten Practices?*, 109 COLUM. L. REV. 350, 364 (2009).

²⁶⁶ See 543 F.3d at 1053.

²⁶⁷ See *Springfield Hosp. v. Hoffman*, No. 09-CV-00254-CR, 2010 WL 3322716, at *39–40 (D. Vt. Apr. 9, 2010) (holding that plaintiff hospital failed to state a claim in a § 30(A) preemption case where "Hospital asserts that it is not state *legislation* but state officials' actions in implementing the new [disproportionate share hospital] methodology that fail to comply with federal law"); see also *Shaw*, 463 U.S. at 96 n.14; Bobroff *supra* note 37, at 74; Sloss, *supra* note 139, at 357–58, 369.

²⁶⁸ See Sack, *supra* note 79; *supra* notes 75–79 and accompanying text (discussing the various ways in which states go about setting Medicaid rates).

²⁶⁹ See HERZ, *supra* note 52, at 10 (observing that there is a great deal of variation among the states in terms of establishing, setting, and paying reimbursement rates); see also *supra* note 61 and accompanying text.

²⁷⁰ See Bobroff *supra* note 37, at 74; Sloss, *supra* note 139, at 357–58, 369.

D. *Relief Available*

Irrespective of these issues, equal access challenges brought under the Supremacy Clause offer somewhat limited relief to plaintiffs.²⁷¹ Although plaintiffs can seek prospective injunctive and declaratory relief, money damages are unavailable in a federal preemption suit brought under the Supremacy Clause.²⁷² Thus, there is no way for plaintiffs to use such a suit to obtain relief for past violations.²⁷³

For this reason, the Supremacy Clause and § 1983 serve somewhat different functions: the Supremacy Clause, which can be used to achieve injunctive relief, is useful for addressing systematic violations while § 1983, which can be used to obtain money damages as well as injunctive relief, is more useful for remedying ad hoc violations.²⁷⁴ Therefore, a preemption challenge involving § 30(A) is clearly an effective way to address rate *cuts*, but is unlikely to be as effective a way as § 1983 to remedy past effects of low reimbursement rates.²⁷⁵

The limited relief available to plaintiffs suing under the Supremacy Clause may also make it more difficult—and less appealing—for plaintiffs to sue at all.²⁷⁶ Because attorneys' fees may be awarded in a § 1983 suit, even resource-poor plaintiffs were typically able to hire attorneys on a contingency-fee basis to represent them in equal access actions brought under § 1983.²⁷⁷ Attorneys cannot be enlisted on the same sort of contingency-fee basis for Supremacy Clause actions because attorney fees are not available.²⁷⁸ As a result, it will likely be harder for resource-poor plaintiffs to afford legal representation for even the strongest § 30(A) Supremacy Clause complaint.²⁷⁹

E. *Minority Views on the U.S. Supreme Court*

Preemption could be rendered an entirely ineffectual way of enforcing the equal access provision if either lower courts or a majority of the U.S. Supreme Court justices are persuaded by arguments that have

²⁷¹ See Bobroff *supra* note 37, at 74; Sloss, *supra* note 139, at 389.

²⁷² See Sloss, *supra* note 139, at 389; see also *Independent Living II*, 543 F.3d at 1063–64.

²⁷³ See Sloss, *supra* note 139, at 389.

²⁷⁴ *Id.* at 414.

²⁷⁵ See *id.*

²⁷⁶ See SARA ROSENBAUM, CAL. HEALTHCARE FOUND., MEDICAID PAYMENT RATE LAWSUITS: EVOLVING COURT VIEWS MEAN UNCERTAIN FUTURE FOR MEDI-CAL 2, 11 (2009).

²⁷⁷ See *id.*

²⁷⁸ *Id.*

²⁷⁹ *Id.*

been advanced by Justices Scalia and Thomas.²⁸⁰ These justices have argued that a preemption claim brought under the Medicaid Act—or any other law enacted under Congress’s Spending Clause power—should be rejected.²⁸¹

Justices Scalia and Thomas have both suggested that beneficiaries of Spending Clause legislation generally lack a cause of action to enforce such legislation because of its contractual nature.²⁸² Their general argument seems to be that legislation enacted by Congress under its Spending Clause power “is much in the nature of a contract,” because such legislation usually involves an offer (the state’s submission of a plan to the federal government) and an acceptance (approval of the state plan by the federal government).²⁸³ As a result, private beneficiaries of Spending Clause legislation (like Medicaid recipients) are effectively third-party beneficiaries of a contract between the federal and state governments.²⁸⁴ Thus, because the common law restricts third party beneficiaries’ right to enforce a contract,²⁸⁵ Scalia and Thomas argue that third parties cannot sue—either under the Supremacy Clause or § 1983—to enforce Spending Clause legislation unless they are granted an explicit statutory right of action.²⁸⁶

Additionally, in separate concurrences in the Court’s 2003 decision in *Pharmaceutical Research & Manufacturers of America v. Walsh*, both Scalia and Thomas suggested that, in the context of the Medicaid Act

²⁸⁰ See *Walsh*, 538 U.S. at 675 (Scalia, J., concurring); *id.* at 682 (Thomas, J., concurring); *Blessing v. Freestone*, 520 U.S. 329, 349–50 (1997) (Scalia, J., concurring).

²⁸¹ See *Walsh*, 538 U.S. at 675 (Scalia, J., concurring); *id.* at 682 (Thomas, J., concurring); *Blessing*, 520 U.S. at 349–50 (Scalia, J., concurring).

²⁸² See *Walsh*, 538 U.S. at 675 (Scalia, J., concurring); *id.* at 682 (Thomas, J., concurring); *Blessing*, 520 U.S. at 349–50 (Scalia, J., concurring).

²⁸³ *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); see *Walsh*, 538 U.S. at 682 (Thomas, J., concurring) (noting that Spending Clause legislation “is much in the nature of a contract” (quoting *Pennhurst*, 451 U.S. at 17)); *Blessing*, 520 U.S. at 349–50 (Scalia, J., concurring) (observing that a federal-state funding and spending agreement is “in the nature of a contract” (quoting *Pennhurst*, 451 U.S. at 17)); see also Sloss, *supra* note 139, at 422–23.

²⁸⁴ See *Walsh*, 538 U.S. at 683 (Thomas, J., concurring); *Blessing*, 520 U.S. at 349–50 (Scalia, J., concurring); see also Sloss, *supra* note 139, at 422–23.

²⁸⁵ See *Walsh*, 538 U.S. at 683 (Thomas, J., concurring) (stating that a third-party beneficiary of a contract “may only sue for breach if he is the ‘intended beneficiary’ of the contract”); *Blessing*, 520 U.S. at 349–50 (Scalia, J., concurring) (explaining that historically, third-party beneficiaries were never permitted to sue to enforce a contract); see also Sloss, *supra* note 139, at 422–23.

²⁸⁶ See *Walsh*, 538 U.S. at 683 (Thomas, J., concurring) (“I would give careful consideration to whether Spending Clause legislation can be enforced by third parties in the absence of a private right of action.”); *Blessing*, 520 U.S. at 349–50 (Scalia, J., concurring); see also Sloss, *supra* note 139, at 423–24.

specifically, private individuals cannot sue under the Supremacy Clause to enjoin state laws that violate provisions of the Medicaid Act because termination of federal funding is the only remedy available when a state plan violates the Act.²⁸⁷ Thomas placed great emphasis on Congress's delegation of "a type of pre-emptive authority" (the power to revoke federal funding from state plans that do not comply with the Medicaid Act's requirements) to the Secretary via the Medicaid Act.²⁸⁸ He interpreted this grant of authority to the Secretary to mean that noncompliant state plans should be de-funded, but "are not void under the Supremacy Clause," explaining: "States are free to deviate from the Medicaid Act's requirements, subject only to sanctions by the Secretary."²⁸⁹ Scalia echoed this argument in his concurrence.²⁹⁰

These arguments seem not to have persuaded a majority of the Court because in *Walsh*, and subsequently in 2006 in *Arkansas Department of Health & Human Services v. Ahlborn*, the Court implicitly held that a private individual, without asserting any separate statutory cause of action, can properly challenge a state law as preempted by the Medicaid Act by suing for injunctive relief under the Supremacy Clause.²⁹¹ Furthermore, circuit courts have interpreted *Walsh* to suggest that plaintiffs can allege, under the Supremacy Clause, that a state law is preempted by federal spending clause legislation, just as with any other type of federal law.²⁹² If the Court shifted to embrace such arguments or lower courts began to find this logic persuasive, however, suing under the Supremacy Clause may not be an effective way for individuals to enforce the equal access provision.²⁹³

²⁸⁷ See *Walsh*, 538 U.S. at 675 (Scalia, J., concurring) ("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.") (internal citations omitted); *id.* at 680 n.3 (Thomas, J., concurring) ("States are free to deviate from the Medicaid Act's requirements, subject only to sanctions by the Secretary.").

²⁸⁸ See *id.* at 679–80 (Thomas, J., concurring).

²⁸⁹ *Id.* at 680 n.3.

²⁹⁰ See *id.* at 675 (Scalia, J., concurring).

²⁹¹ See *Ahlborn*, 547 U.S. at 274, 292; *Walsh*, 538 U.S. at 667–68. In *Walsh*, the Court was split six to three; in *Ahlborn* the decision was unanimous. *Ahlborn*, 547 U.S. at 274, 292; *Walsh*, 538 U.S. at 667–68.

²⁹² See, e.g., *Independent Living II*, 543 F.3d at 1061–62; *Planned Parenthood of Hous. & Se. Tex. v. Sanchez*, 403 F.3d 324, 332 (5th Cir. 2005) (describing *Walsh* as "implicitly reject[ing] the contention that asserting the preemptive force of federal Spending Clause legislation is itself no claim"); *Thompson*, 362 F.3d at 819 n.3.

²⁹³ See *supra* notes 280–292 and accompanying text.

F. Congress's Power

The final significant issue facing preemption in the context of the equal access provision is that Congress ultimately controls federal courts' jurisdiction to decide cases.²⁹⁴ The U.S. Supreme Court has suggested that there is a presumption in favor of federal jurisdiction in cases in which a private individual sues under the Supremacy Clause to enjoin enforcement of a state law that allegedly conflicts with a federal law.²⁹⁵ A defendant in a preemption case can rebut this presumption, however, by establishing that Congress intended to prevent federal courts from having jurisdiction over claims arising out of a particular federal statute.²⁹⁶ This constraint is not unique to preemption claims; in fact, the Court has established a similar limitation on suits brought under § 1983.²⁹⁷

Congress's power over federal jurisdiction does mean that the ability of federal courts to consider preemption claims is ultimately subject to Congress's whim.²⁹⁸ If Congress perceives that states are being dramatically constrained by an inability to make necessary cutbacks to Medicaid reimbursement rates during a major economic recession, it could amend the Medicaid Act to specifically bar federal jurisdiction.²⁹⁹

Theoretically, however, Congress could just as easily decide to augment, rather than undercut, federal courts' ability to consider equal access provision challenges.³⁰⁰ Congress could do so in a number of ways.³⁰¹ For example, Congress could write an explicit private cause of action into the equal access provision of the Medicaid Act.³⁰² Alternatively, Congress could breathe new life into § 1983, circumventing the Court's newly conservative interpretation of the statute, by rewriting

²⁹⁴ See *Seminole Tribe v. Florida*, 517 U.S. 44, 74 (1996) ("[W]here Congress has prescribed a detailed remedial scheme for the enforcement against a State of a statutorily created right, a court should hesitate before casting aside those limitations and permitting an action against a state officer based upon *Ex parte Young*."); see also Sloss, *supra* note 139, at 389–90.

²⁹⁵ See *Shaw*, 463 U.S. at 96 n.14; see also Sloss, *supra* note 139, at 389–90.

²⁹⁶ See *Shaw*, 463 U.S. at 96 n.14; see also Sloss, *supra* note 139, at 389–90.

²⁹⁷ See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 284–85, 284 n.4 (2002).

²⁹⁸ See *Shaw*, 463 U.S. at 96 n.14; see also Sloss, *supra* note 139, at 389–90.

²⁹⁹ See *supra* note 104 and accompanying text. In 1997, Congress repealed the Boren Amendment, which had been widely interpreted as providing plaintiffs with a cause of action to challenge Medicaid reimbursement rates. See 42 U.S.C. § 1396a(a)(13)(A) (1994) (repealed 1997). In doing so, it bowed to pressure from the states, which had argued that the Boren Amendment was too restrictive. See Moncrieff, *supra* note 8, at 679 n.30.

³⁰⁰ See Bobroff, *supra* note 37, at 85.

³⁰¹ See *id.*

³⁰² See *id.*

§ 1983 so that it clearly allows courts to consider suits brought by beneficiaries of safety net statutes—like the Medicaid Act—to enforce the benefits such statutes confer.³⁰³

CONCLUSION

Despite its issues, preemption is a promising alternative method of enforcing the equal access provision. The U.S. Supreme Court, by reaching the merits of cases with no other apparent cause of action, has repeatedly implied that the Supremacy Clause creates a cause of action for plaintiffs alleging preemption of a state law by a conflicting federal law. In addition, the Supreme Court has indicated that it is more receptive to suits brought under the preemption doctrine than under § 1983. And although the Ninth Circuit is as yet the only circuit court to fully embrace the enforceability of § 30(A) under the Supremacy Clause, several circuit courts have recently held that plaintiffs can challenge state laws that conflict with federal statutes (even when the plaintiffs would not be able to do so under § 1983). Furthermore, several lower courts, outside of the Ninth Circuit, have accepted the reasoning of that court's 2008 decision, *Independent Living Center of Southern California, Inc. v. Shewry*, with regard to the basic validity of § 30(A) preemption suits.

Currently—due to states' shrinking budgets and expanding Medicaid rolls—the ability of both Medicaid recipients and providers to enforce the equal access provision is particularly critical. Plaintiffs and courts should embrace § 30(A) preemption suits in order to protect access to healthcare for Medicaid recipients, from the elderly poor to needy children like Deamonte Driver.

ROSEMARY B. GULTINAN

³⁰³ See *id.*

