Provider Suits Over Medicaid Rates: How We Got to Where We Are Today and the Shapes of Things to Come

By Mark H. Gallant

So Long Supremacy Clause

On March 31, 2015, the Supreme Court issued its much anticipated (some would say dreaded) decision in Armstrong v. Exceptional Child Center, Inc. A 5-4 majority (Justice Scalia, joined by Chief Justice Roberts and Justices Alito, Thomas and Breyer) concluded that health care providers have no right to sue States under the Supremacy Clause for prospective relief against Medicaid rate cuts alleged to violate Section 1902(a)(30)(A) of the Social Security Act (Section 30(A)). This article explores where we are now, how we got here, and what the future portends for the rights of providers (and Medicaid beneficiaries) to contest inadequate payment rates under what currently is the largest single insurance program in the United States.

I. Section 30(A)

The so-called “equal access” clause found in Section 30(A) relevantly provides that a Medicaid State plan must:

provide such methods and procedures relating to . . . payment for [ ] care and services available under the plan . . . that 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 are and services are available to the general population in the geographic area . . .

With the repeal in 1997 of the similarly worded Boren Amendment,3 Section 30(A) became the one remaining provision of Title XIX of the Social Security Act (other than those regarding supplemental payments for “disproportionate share” hospitals) that speaks to the payment of sufficient rates for Medicaid providers. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), “Medicaid is a major source of revenues for safety net hospitals” and “Section 1902(a)(30)(A) of the Act is now the foundational statutory provision that governs federal review of state pay-

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ment methodologies for all services covered by Medicaid.\textsuperscript{4}

\section*{II. The Armstrong Decision}

Armstrong involved payments under Idaho’s Medicaid program for residential habilitation services for individuals with development disabilities. The rates were frozen by the state legislature at 2006 levels by a 2009 appropriations bill, despite language in the State medical assistance plan that presumed coverage of costs (subject to inflation). The rate freeze was entirely budget-driven: there was no pretense that the legislature or the state Medicaid agency had considered the Section 30(A) factors or assessed the impact on patient access prior to freezing the payments (which evidence in the litigation indicated would reduce provider participation). Based on its prior Section 30(A) precedents, the Ninth Circuit concluded that the Idaho law imposing the rate freeze was preempted because it was promulgated without regard for whether the resulting rates bore a reasonable relation to the costs of providing the services at issue or would impair the quality of care.\textsuperscript{5} The Supreme Court granted review to decide whether a claim challenging the State’s failure to comply with Section 30(A) – which the Court presumed was not enforceable through an implied statutory private right of action\textsuperscript{6}—could be brought directly under the Supremacy Clause—an issue the Court had ducked in 2012 in Douglas v. Independent Living Center (ILC).\textsuperscript{7}

\textsuperscript{4} MACPAC Report to Congress (March 2011) at 155, 159.

\textsuperscript{5} In Orthopedic Hosp. v. Belshe, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998), the Ninth Circuit had concluded in a suit brought under 42 U.S.C. § 1983 that Section 30(A) requires payments that are determined in advance to bear a reasonable relation to the costs of providing services of suitable quality to Medicaid beneficiaries. The Ninth Circuit subsequently decided in Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005), that providers lacked the right to enforce Section 30(A) under the more stringent § 1983 standing requirements embraced by the Supreme Court in Gonzaga Univ. v. Doe, 536 U.S. 273 (2002). In Armstrong the Ninth Circuit struck the budgetary act’s limitation on habilitation service fees based on preemption principles. Prior to Armstrong, a plaintiff needed only to assert an injury in fact to satisfy standing requirements for a claim brought under the Supremacy Clause rather than satisfy the more stringent standing requirements of § 1983.

\textsuperscript{6} The plaintiffs in Armstrong did not assert that an express or implied private right of action existed under Section 30(A) itself. The majority accordingly presumed there was none for purposes of its Supremacy Clause analysis.

The Supremacy Clause issue decided by Armstrong had been the subject of certiorari in Douglas v. Independent Living Ctr. of S. Cal., 132 S.Ct. 1204 (2012). ILC involved a series of across-the-board MediCal program rate reductions that had been enjoined as conflicting with Section 30(A), as previously construed by the Ninth Circuit. In that case, the Solicitor General, whose views were solicited by the Court, initially opposed certiorari on the basis that the availability of Supremacy Clause relief was not seriously in question. After certiorari was granted, however, the federal government did an about face, and the SG argued against the recognition of private enforcement actions in the brief on the merits, revealing what may have been a tension between the positions of the Departments of Health and Human Services (HHS) and Justice on provider enforcement of Title XIX. In ILC, the Supreme Court vacated the Ninth Circuit’s judgment and remanded the case for reconsideration because the Centers for Medicare & Medicaid Ser-

During oral argument, Chief Justice Roberts signaled concerns that recognizing a Supremacy Clause action by providers would “open the floodgates” to lawsuits and enmesh the federal courts in sticky State budgeting issues. The majority opinion, delivered by Justice Scalia, flowed from that theme. Adopting the position advocated by the States and the Solicitor General (SG) on behalf of the Obama Administration, the Armstrong Court rejected claims by healthcare providers for prospective relief under the Supremacy Clause against a State law alleged to facially conflict with Section 30(A). The Court essentially concluded that the Supremacy Clause is not a proper vehicle for private parties to enforce Spending Clause enactments for which no express or implied statutory right of action is independently available. Four Justices (the majority, minus Justice Breyer) also separately concluded that Section 30(A) lacks the clear “rights-conferring” language needed to make that provision privately enforceable through the Civil Rights Act.\textsuperscript{8}

In squelching Supremacy Clause-based reimbursement suits by providers against States, the Armstrong majority rested on two broad assumptions: First, that Congress did not intend for providers to privately enforce Section 30(A) because the Medicaid Act contains an “express” enforcement mechanism—the “nuclear” option of the Secretary of Health and Human Services (HHS) to withhold all federal funding if a State fails to comply with Title XIX—which Congress wanted to be “exclusive.”\textsuperscript{9} Second, that the text of Section 30(A) was “judgment laden,” and that the phrase “consistent with efficiency, economy and quality of care” was too vague to be “judicially administrable” and should properly be left to the “Secretary alone” to divine and enforce due to its “sheer complexity.”\textsuperscript{10}

Part IV of the opinion additionally presumed that Section 30(A) is not enforceable through an action for prospective declaratory and injunctive relief brought under the Civil Rights Act, 42 U.S.C. § 1983—a question that was not part of the Court’s grant of certiorari, but a point that nevertheless was prominently argued by the SG. In this regard, Justices Scalia, Roberts, Alito, and Thomas concluded in Part IV of the decision that “Section 30(A) lacks the sort of right-creating language needed to imply a private right of action” (standard) or to assert standing to sue under § 1983.\textsuperscript{11} Justice Breyer did not join in Part IV of the decision.

\textsuperscript{8} 42 U.S.C. § 1983 (§ 1983). Section 1983 authorizes private suits for injunctive relief and monetary damages for violations of the Constitution or federal laws under color of state law. Due to Eleventh Amendment constraints, § 1983 claims that will impact a State Treasury are limited strictly to prospective (i.e., declaratory and injunctive) relief under the Ex Parte Young doctrine. A Supremacy Clause claim requires a state law—such as a budget bill—or regulation that conflicts with a federal statute. Claims under § 1983 predicated on violations of federal laws can extend more broadly to challenges to substantive or sub-regulatory state actions, such as suits challenging offending Medicaid State plan amendments.

\textsuperscript{9} Armstrong, slip. op. at 6-7.

\textsuperscript{10} Armstrong, slip. op. at 7.

III. Armstrong’s Implications

The implications of the Armstrong decision are sweeping, both generally and for Medicaid providers in particular. In reversing the Ninth Circuit’s judgment, Armstrong severely curtailed direct Supremacy Clause actions and largely limited private parties to invoking the Supreme Court as a defense against the affirmative exercise of State police powers in conflict with federal law. Most immediately, Armstrong closed the door to federal suits by Medicaid providers (and perhaps beneficiaries) against States for cutting or freezing Medicaid rates without engaging in methods and procedures satisfactory for “assuring” the Secretary that the rates and payments will be “sufficient” to enlist enough providers to afford Medicaid recipients access to covered services comparable to that available to non-Medicaid patients in the same geographic area.

In closing the floodgates to judicial actions, Armstrong may have left Medicaid providers drowning in red ink. Medicaid typically reimburses health care providers well below what even Medicare pays. The correlation between payment levels and provider participation was sharply drawn by Congress when it amended Section 30(A) in 1989. The House Report observed:

There is no doubt that Medicaid reimbursement rates have not kept pace with average community rates . . . The Committee believes that without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program . . . [T]he Committee bill would require that Medicaid payments for all practitioners be sufficient to enlist enough providers . . . .

The Medicaid program has been plagued by insufficient provider participation and long wait times for patients to see specialists—something opponents of Medicaid expansion under “Obamacare” have repeatedly cited as evidence of a failed and “broken” program, unworthy of being expanded. Congress also has correlated sufficient payments with access to medical services in going through the annual exercise of waiving the Medicare sustainable growth rate (SGR) limits on physician payments, and in setting floors for Medicaid rates for OB/GYN services. A temporary two-year (2013 and 2014) “bump” of Medicaid payments for primary care physician services to no less than what Medicare would pay was mandated by the Affordable Care Act (ACA). The PCP bump was found by a recent ten-state study to have increased access to primary care appointments for Medicaid patients by 8%, despite hitches and delays in the implementation of that provision.

Given the administrative hassles and low fees, many non-hospital providers elect not to participate in Medicaid at all. Many that do choose to participate elect to see only limited numbers of Medicaid patients. This is permitted under federal law, which contains no prohibition against economic discrimination (i.e., limiting the numbers of Medicaid patients accepted, or closing “panels” to new Medicaid patients based on financial considerations). Meanwhile, “Medicaid expansion” under the ACA has added 11 million individuals to the Medicaid and CHIP program rolls since 2014 as of February 2015, exacerbating an existing national shortage of primary care practitioners (PCPs). Pandits have raised concerns that the sunsetting of the PCP payment bump, combined with SCOTUS’ rejection of provider suits to compel States to pay minimally adequate rates, will further shrink access to care for Medicaid enrollees – just as Medicaid and CHIP program participation has crested to 70 million (or about 20 percent of the population).

IV. What Precedents?

Close readers of the Court’s prior decisions in Wilder v. Virginia Hosp. Ass’n (Wilder), even Gonzaga Univ. v. Doe (Gonzaga), may be left wondering whether stare decisis has lapsed into rigor mortis given Armstrong’s paradigm shifts from prior judicial pronouncements. In 1990, a 5-4 Supreme Court decided in Wilder that hospitals and nursing homes were entitled to sue States under § 1983 to challenge rates that did not comply with the Boren Amendment. A professed concern of the Armstrong majority was that Section 30(A) was simply too generalized and diffuse to be judicially enforceable. The Boren Amendment’s language, however, was very similar to that of Section 30(A). It required that a State plan for medical assistance provide payments for facility services which the State “finds, and makes assurances to the Secretary are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities . . . to provide care in conformity with . . . quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . [to services] of adequate quality.”

The 1990 version of SCOTUS professed “little doubt that health care providers are the intended beneficiaries of the Boren Amendment” and concluded that the Boren Amendment’s mandate of “reasonable and adequate” payment for “efficiently and economically operated” facilities was not so vague as to be “beyond the competency of the judiciary to enforce.” Enforcement under § 1983 was deemed available as to both the Boren Amendment’s procedural requirements (i.e., taking the requisite steps to support “assurances” to the Secretary) and substantive requirements (i.e., paying rates that actually satisfy the “reasonableness and adequacy” and “access” requirements). It is arguable that Section 30(A)—which by its literal terms requires “payment . . . sufficient to enlist enough providers” so that covered services of adequate quality “are available” for

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16 See Appointment Availability After Increases in Medicaid Payments for Primary Care, The New England Journal of Medicine (Jan. 15, 2015). The ACA required rates for primary care services at least equivalent to Medicare rates for the same services for a two-year period and provided for full federal funding of the increase. Upon the sunsetting of this provision in 2015, states widely abandoned Medicare rate parity and reverted to payment for the PCP services at pre-ACA levels.
20 The Court observed that: “It would make little sense for Congress to require a state to make findings without requiring those findings to be correct.” 496 U.S. at 510.
Medicaid enrollees “at least to the extent” that they are available for non-Medicaid patients in the same geographic area—includes a more precise and measurable benchmark for judicial oversight than the Boren Amendment standards. As the House Report put it, the issue is whether Medicaid rates are sufficient to attract enough providers and to keep “pace with average community rates.”

In his concurrence, Justice Breyer appeared deeply troubled—despite the express reference, not once but twice, in Section 30(A) to “payments” for providers—by the Ninth Circuit’s conclusion that Section 30(A) substantively requires the States to have a basis for assuring that Medicaid rates bear a reasonable relation to providers’ costs. The majority believed that only the Secretary was capable of deciding whether Section 30(A) requires rates that are sufficient to cover provider costs. These concerns may be something of a red herring. To avoid becoming embroiled in complex and judgment-laden policy decisions, judicial intervention easily can be limited to enjoining the implementation of facially non-compliant or entirely budgetary rate reductions adopted without regard of the equal access requirements—as occurred in Idaho. Cases in which States slash or freeze rates based purely or substantially on budgetary concerns can of course be remanded to permit the State Medicaid agency to utilize “procedures and methods” to ensure that the resulting payments will be “consistent with . . . quality of care” and capable of assuming adequate provider participation.

Indeed, when it initially opposed certiorari in ILC—the precursor to Armstrong that was remanded without resolving the Supremacy Clause issue—the Justice Department disagreed with the Ninth Circuit’s view that Section 30(A) requires States to conduct a cost coverage study prior to cutting or freezing Medicaid rates, but nonetheless heartily endorsed judicial review focused on whether (i) the rate reduction “was based solely on budgetary concerns,” (ii) “the State failed to study the effect of the rate reduction in a meaningful way,” or (iii) the result of the rate change would impair quality by forcing “at least some providers to stop treating [Medicaid] beneficiaries.”

My what difference a day makes (actually, the eight months between the SG’s opposition to certiorari in ILC and the filing of his brief on the merits in that case).

An approach comparable to that suggested by the Justice Department in its opposition to certiorari in ILC, was recently taken by the Third Circuit in

Christ the King Manor, Inc. v. Sebelius.

In that case, CMS had approved a Pennsylvania State plan amendment (SPA) that reduced nursing home rates through the crude application of a “budget adjustment factor” without considering whether the resulting payments complied with Section 30(A). The court found with little apparent difficulty that Pennsylvania (whose SPA proposal had been rubber-stamped by CMS) had adopted the rates for purely budgetary reasons without any consideration of the factors prescribed by Congress. The Third Circuit remanded the case to the Secretary for further review and consideration based on the factors enunciated in Section 30(A). The Third Circuit also seemed to have had little problem reviewing the legality of Pennsylvania’s compliance with Section 30(A), which it sustained in

Rite Aid of Pennsylvania, Inc. v. Houston

before the Third Circuit later concluded that providers lacked § 1983 standing to challenge the State’s pharmacy fees in

Pennsylvania Pharmacists Ass’n v. Houston.

In Rite Aid, the appeals court rejected the providers’ argument that Section 30(A) could only be satisfied by a cost coverage study or some particular “procedural methodology,” while concluding that States must use some objective process capable of reasonably supporting an “assurance” to the Secretary of the sufficiency of the rates. Pennsylvania was found in Rite Aid to have acted in a manner that was not arbitrary or capricious because it compared the revised prescription rates to those paid by commercial third-party payers and by Medicaid programs in neighboring states, and had not “entirely failed to consider an important aspect of the problem” or “each of the section 30(A) factors.”

The Seventh Circuit has taken a similar approach. Whether or not the Ninth Circuit got it right in concluding that a prior cost coverage analysis is essential, courts seem to have had little difficulty in interpreting and applying Section 30(A).

The U-turns taken in Armstrong did not end there. While recognizing that civil rights actions affirmatively authorized by § 1983 may be precluded by a robust and comprehensive statutory enforcement scheme evidencing congressional intent “to foreclose private enforcement of the statute pursuant to § 1983,” the Wilder Court had found “little merit” to the suggestion that the Secretary’s statutory option of cutting off all Medicaid funding to a rogue State was “sufficient to displace the remedy provided in 1983.” SCOTUS so ruled in Wilder because Title XIX contained no comprehensive remedial scheme, and the never used Secretarial option of cutting off all federal funding—odd relief for remedying a State’s failure to pay providers enough—coupled with “the Secretary’s limited oversight,” could not effectively displace private legal actions. As the dissenters observed, Armstrong turned the formulation applied in Wilder and other prior SCOTUS precedents on its head in concluding that any statutory governmental enforcement mechanism is sufficient evidence of congressional intent to deny an implied right of action (including under § 1983) to private parties.

The Armstrong majority also pronounced that Congress could not have anticipated implied actions by providers to enforce the payment provisions of Section 30(A) because the Court had not granted certiorari in Wilder until after the current version of Section 30(A) had already been enacted. That conclusion, however, seems to disregard the Wilder Court’s stated understanding that congressional expectations that participating providers could sue States to ensure adequate Medicaid rates were traceable to legislative history dating back to the 1970’s (a position also underscored by the Amicus Brief filed in Armstrong by Democratic members of Congress). The Wilder Court thus found it “clear that prior to the passage of the Boren Amend-

21 Brief for the United States as Amicus Curiae regarding certiorari in ILC at page 10 (Dec. 2010).
22 730 F.3d 291 (3d Cir. 2013).
23 171 F.3d 842 (3d Cir. 1999).
25 171 F.3d 842, 853.
26 See Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026, 1030 (7th Cir. 1996)
27 496 U.S. 498, 520.
ment, Congress intended that health care providers be able to sue in federal court for injunctive relief to ensure that they were reimbursed reasonable rates.”

Wilder also observed that provider suits were commonplace during the 1970’s and that “Congress amended the Act in 1975 to require States to waive any Eleventh Amendment immunity from suits for violation of the [Medicaid] Act,” but, in so doing, was not “contravening or constraining the rights of the providers” of Medicaid services “to seek prospective, injunctive relief” against unlawful Medicaid rates.

Finally, the Armstrong decision even appears to have suggested further restricting the already rigid standing principles enunciated in Gonzaga v. Doe. In Gonzaga, the Court limited standing under § 1983 to enforce federal statutes to particular parties on whom the underlying statutory language “conferred rights,” while overlooking § 1983 suits by a broader class of “incidental beneficiaries” injured in fact by a violation of the underlying federal law. A majority in Gonzaga (which included the four Wilder dissenters) found no right on the part of a student to sue a university under § 1983 for releasing academic records in violation of the Family Educational Rights Privacy Act of 1974 (FERPA) due to the absence of rights-conferring language. Yet the Gonzalez Court distinguished the Boren amendment from FERPA, describing the former as containing language under which “Congress left no doubt of its intent for private enforcement,” and contrasted FERPA’s generalized non-disclosure provisions as a “far cry from the sort of individualized, concrete monetary entitlement found enforceable in... Wilder.” In contrast with those more contemporaneous plaudits for Wilder, four Justices proclaimed in Part IV of Armstrong that “our later opinions plainly repudiate the ready implication of a § 1983 action that Wilder exemplified,” suggesting that today, even Wilder would be considered dead letter.

V. Agency Enforcement of Section 30(A)

In the absence of a legislative correction, the cloud Armstrong has cast over the rights of Medicaid providers and patients might be dissipated going forward by a combination of vigorous agency enforcement of Section 30(A) and meaningful judicial review of the Secretary’s approval of Medicaid waivers or State plan amendments authorizing rate freezes or reductions. Indeed, Justice Breyer suggested in his majority opinion in ILC that the availability or not of Supremacy Clause relief might be much ado about nothing, since the right of providers to advance challenges to the Secretary’s approvals of offending State plan amendments or waivers under the Administrative Procedure Act (APA) was noncontroversial. How this all will unfold remains to be seen, and there is cause for trepidation.

(i) CMS Action and Inaction in Regard to Section 30(A)

In arguing against private enforcement in Armstrong, the SG contended that the Court properly should depend upon the Secretary and not providers to ride herd over noncompliant States—an assumption embraced by both Justice Scalia’s decision and Justice Breyer’s concurrence. Arguing against the need for private enforcement, the SG contended that enforcement of Section 30(A) should be handled through the “expert judgment of the State and CMS.” In support, the SG repeatedly cited to (although did not describe in any detail) the Secretary’s publication of a Proposed Section 30(A) Rule said to evidence that HHS “is committed to ensuring that state programs afford beneficiaries meaningful access to covered care and services.” In another trusting homage, the SG also stated that “[i]t is essential that States carefully consider what impact payment rates may have on the availability of [sufficient] providers.”

In contrast with this rosy picture, an Amicus Brief filed in Armstrong by former HHS and CMS officials strongly supported private enforcement and disputed that CMS had either the will or the staffing to meaningfully ensure State compliance with Section 30(A). Bruce Vladeck, a former CMS Administrator, co-authored a New York Times Op-Ed article that similarly observed that “[t]he department doesn’t have the resources to oversee compliance with the equal access provision.”

As Justice Anthony M. Kennedy acknowledged during the oral argument in ILC “only 500 [CMS] employees supervise nearly $400 billion in expenditures,” and staffing of State plan reviews competes with other priorities in a shrinking budget—such as the National Institutes of Health, Food and Drug Administration and Centers for Disease Control and Prevention.

Even a cursory review of the case law reveals instances where the Secretary has readily approved Medicaid waivers or State plan amendments embodying rate cuts without so much as considering the requirements of Section 30(A) or related provisions of Title XIX. Contrary to the convenient assumptions of the Armstrong majority, the Secretary’s reviews of State Medicaid blueprints have tended to focus not on the adequacy or sufficiency of payments to providers, but rather on whether or not the State has employed finan-

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28 496 U.S. 498, 516.
29 Id.
30 536 U.S. 273, 279.
31 Armstrong, slip. op. at 9 fn. * It is noteworthy that in rejecting provider standing to enforce Section 30(A) under the Civil Rights Act in Pa. Pharmacists Ass’n, then Judge Alito, writing for a unanimous Third Circuit, observed that “[i]t is... apparent from the statutory language that the intended beneficiaries of Section 30(A) are [Medicaid] recipients...”) 283 F.3d at 538 (emphasis added). Relying on then Judge Alito’s en banc opinion in Pennsylvania Pharmacists, Fla. Pediatric Soc’y v. Dade, S.D. Fla., No. 1:05-cv-23037 (Dec. 30, 2014) recently concluded that beneficiaries possess standing to enforce Section 30(A) under § 1983. It remains to be seen whether Justice Alito still agrees with Judge Alito in light of Part IV of Arm-
32 See concurring Opinion of Breyer, J., slip. op. at 4.
34 See, e.g., Beno v. Shalala, 30 F.3d 1057 (9th Cir. 1994) (approval of § 1115 waiver plan for failure by CMS to apply statutory standards in adopting managed care plan motivated by cost savings); Christ the King Manor v. Sebelius, 730 F.3d 291 (approval of rate reductions based solely on budgetary constraints and without any consideration of Section 30(A) standards); The Arc of Calif. v. Douglas, 757 F.3d 975 (9th Cir. 2014) (illustrating failure of CMS to consider Section 30(A) compliance in approving a Medicaid waiver under which the obligations to comply with Section 30(A) had never been “waived”).
cial tricks (in the form of questionable intergovernmental transfers or provider taxes) to improperly “shift” the State’s share of Medicaid funding to the federal government. The agency’s light touch on scrutinizing the adequacy of provider rates also may betray a material conflict of interest: when a State reduces Medicaid payments to providers—rightly or wrongly—the federal government, which pays the majority share through federal financial participation, reaps an even greater savings than the State does.

(ii) The Secretary’s Pending Section 30(A) Rule

The notion that HHS (or the States) can be depended upon to fill the void created by Armstrong also is highly suspect given the agency’s proposed rulemaking efforts. In promoting exclusive federal enforcement, the SG’s Amicus Brief in Armstrong (similar to his merits brief in ILC) repeatedly referenced the Secretary’s intent to enact a Section 30(A) regulation that would render provider legal actions superfluous. This assertion, however, contrasts markedly with the terms and structure of the Secretary’s proposed 30(A) implementing regulation. Under the Proposed 30(A) Rule, which drew over 200 comments and which has been languishing since its May 6, 2011 publication, the Secretary indicated that CMS intends to rely “upon State assurances” that the access standards have been satisfied, and that CMS review “will generally be limited to issues of whether the State collected relevant data.” 76 Fed. Reg. 26342, 26349 (col. 1 and 3) (May 6, 2011). CMS took this decidedly hands-off approach despite having recognized that “only a few States indicated that they relied on actual data” about the projected impacts of rate cuts on access to quality care before proposing to reduce rates. Id. at 26361-62.

The Proposed Section 30(A) Rule does require the States to compare revised rates to one of three objective benchmarks, including Medicare payment levels. But, like the proverbial toothless tiger, the Proposed Rule does not require any assurance that Medicaid rates actually are based on one of the benchmarks, let alone compare with average community rates. Finally, the Proposed Rule relies on the States themselves to monitor and self-report access problems following payment reductions, and to develop their own corrective action plans to address the problems they elect to self-report. This approach may give new meaning to the adage about putting the fox in charge of the henhouse.

And then there is the strange path HHS followed in connection with the Proposed Section 30(A) Rule. While the SG repeatedly, if obliquely, reminded SCOTUS in ILC and Armstrong that a regulation governing section 30(A) compliance was in the making, the Proposed Rule has been sitting in an unpublished state for nearly four years. The Secretary recently withdrew another proposed regulation (dealing with repaying and reporting government program overpayments) that had languished for three years without a final regulation, citing an obligation under the Social Security Act to withdraw proposed rules that have not been finalized within three years. That has not been done with respect to the proposed 30(A) rule. Cynical observers may wonder whether the proposed 30(A) rule has been left on the books throughout the pendency of the Armstrong appeal to buttress the SG’s repeated reliance on the forthcoming Section 30(A) rule to assure concerns about curtailing suits by Medicaid providers. Cynics also might wonder whether the proposed rule was not finalized in advance of the Armstrong decision to avoid calling attention to the Secretary’s curious approach of letting budget-challenged State governments police themselves, or giving lie to the government’s insistence that the Secretary could be trusted to exercise close oversight on access without the need for interference by litigious providers.

(iii) APA Review of State Plan Amendment and Medicaid Waiver Approvals

Two critical issues are likely to be litigated in the near future: (i) does the Secretary’s application of Section 30(A)—which, if it adheres to the proposed rule, will set no standards that actually depend upon the sufficiency or adequacy of “payments”—conflict with its text, and (ii) what degree of judicial deference is CMS due when it is sued under the APA for approving a Section 1115 waiver or State plan amendment embodying rate reductions said to violate Section 30(A)? Although direct provider suits against states under federal law are now history, the Supreme Court acknowledged in both Armstrong and ILC that providers do have a cause of action under the APA to challenge the Secretary’s approvals of rate reductions under the APA. As epitomized by Motor Vehicles Mfrs. Ass’n of U.S. Inc. v. State Farm Mut. Auto Ins. Co., SCOTUS has steadfastly held that agency action must be supported by substantial evidence, and will fail under the “arbitrary and capricious” standard if the agency has relied on factors other than those intended by Congress, or failed to consider “an important aspect” of the issue confronting the agency. Under this standard, CMS approval of a rate reduction adopted by State plan amendment or a waiver should be vulnerable if the State has relied exclusively on budgetary considerations or failed to engage in more than a superficial analysis to support its “assurances” that the Section 30(A) access standards will be met. It was on this basis that the Third Circuit rejected Pennsylvania’s nursing home rate revisions in Christ the King Manor. Because agency action is judicially reviewed under the APA based on the record before the agency, it is crucial that interested parties take every advantage of opportunities to “make a record” both before the State (when it proposes the rate reductions as part of the required public process) and in commenting on SPAs or waiver proposals to CMS.

A related issue is the role that Chevron (or Auer) level deference may play in the review of both the forthcoming Section 30(A) Rule and CMS approvals of State-specific Medicaid rates. If CMS sticks to the approach taken in the Proposed Rule, an obvious question will be

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36 See e.g., CRS Report for Congress: Medicaid Regulation of Governmental Providers (Mar. 25, 2008); U.S. Governmental Accountability Office, Medicaid: States’ Efforts to Maximize Federal Oversight, GAO-05-838T.
whether CMS has relied on factors other than those prescribed by Congress by divorcing “access” from consideration of the sufficiency of the rates themselves—given that the text of Section 30(A) refers twice to the sufficiency of “payments,” and that the legislative history of Section 30(A) which expressly links access to care with “adequate payment levels” and comparability to “average community rates.”

There also is a separate question of whether the Secretary’s short form, cursory “approvals” of State plan amendments qualify as statutory interpretations entitled to Chevron-level deference. That issue, which has yet to be resolved by SCOTUS, was decided in the affirmative by the Ninth Circuit in Managed Pharmacy Care v. Sebelius, which relied on an earlier decision of the D.C. Circuit. The Ninth Circuit reversed its own prior interpretation of Section 30(A) (that rates must be shown in advance to bear a reasonable relation to provider costs) under the Brand X doctrine—treating the Secretary’s approval of California SPAs that were not supported by a cost-coverage studies and relied solely on the State’s plan to “monitor” the impact of the budgeted rate reductions as an implied “interpretation” of Section 30(A). The Third Circuit, in Christ the King Manor, agreed with the Ninth Circuit that SPA approvals are due Chevron level judicial deference. But the court rejected CMS’s approval of Pennsylvania’s SPA based on nothing more than budgetary considerations as arbitrary and capricious. The Ninth Circuit similarly voided California’s rate cuts for services for developmentally disabled beneficiaries in The ARC of Calif. v. Douglas, finding CMS’s approval of the same as arbitrary and capricious for lack of consideration of the Section 30(A) standards.

The recent SCOTUS decision in Perez v. Mortgage Bankers Ass’n yielded three concurring opinions (by Justices Scalia, Alito and Thomas) questioning whether agency action should continue to be shielded by a high degree of judicial deference when the agency flip-flops on the interpretation of its own rules. It remains to be seen whether SCOTUS, in entrusting the Secretary to review Medicaid rate reductions to the exclusion of stakeholders’ suits against States, will balance the equation by applying meaningfully searching judicial scrutiny to the Secretary’s review of her State partners’ ratesetting actions in the future.

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42 757 F.3d 975.
43 See also Calif. Ass’n of Rural Clinics v. Douglas, 738 F.3d 1007 (9th Cir. 2013) (finding that CMS’s approval of a State plan eliminating coverage of certain medical services was contrary to the plain language of the statute).