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Where There Is a Right, There Must Be a Remedy (Even in Medicaid)

Nicole Huberfeld^a

“The Government of the United States has been emphatically termed a government of laws, and not of men. It will certainly cease to deserve this high appellation, if the laws furnish no remedy for the violation of a vested legal right.”²

INTRODUCTION

THE Medicaid Act invites a power struggle in its opening language, which states: “[T]here is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.”³ Like the Spending Clause in which it is rooted,⁴ this language is deceptively straightforward, because it creates the potential for a permanent relationship between the federal executive branch, states, and the individual providers and beneficiaries benefited by Medicaid, but it addresses only the beginning of Medicaid’s programmatic operations. The question of what should happen if a state does not adhere to its own “plan for medical assistance” is not addressed by the Medicaid Act, other than to permit the Secretary of the Department of Health and Human Services (HHS) to withdraw funding,⁵ but this is deemed a nuclear option because of the harm that withdrawal of funds would do to program enrollees.

The power struggle invited by the Medicaid Act will be magnified by the substantial Medicaid expansion facilitated by the Patient Protection and Affordable Care Act (ACA).⁶ Medicaid is generally treated as either an afterthought or a political football.⁷ This afterthought will add millions of new

1 H. Wendell Cherry Professor of Law and Bioethics Associate, University of Kentucky. Many thanks to my co-panelists and the participants in the Health Law Professors Conference and the Medicaid Matters workshop. Thanks to Christopher Held for diligent, persistent research assistance. Thanks always DT. Comments are welcome: nicole.huberfeld@uky.edu.

2 *Marbury v. Madison*, 5 U.S. 137, 163 (1803).

3 42 U.S.C. § 1396–1 (2012).

4 See U.S. CONST. art. I, § 8, cl. 1.

5 42 U.S.C. § 1396c (2012).

6 Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 432 (2011).

7 See ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA* 51 (1974) (“Compared with Medicare, which had cut-and-dried provisions for eligibility and benefits, Medicaid . . . was relatively ill-designed, its future vague.”); LAURA KATZ OLSON, *THE POLITICS OF*

enrollees by the ACA's expansion of eligibility as of January 1, 2014.⁸ The states that are expanding their Medicaid enrollment are concerned about the future costs of the newly enrolled population, despite the federal government funding the expansion completely for the first several years of its implementation. One method by which Medicaid costs can be controlled without federal oversight is by decreasing payment to healthcare providers who care for Medicaid beneficiaries.⁹ But, providers will face an influx of new enrollees with only a short-lived federal increase in their payment rates, leading to the possibility that providers will seek to enjoin states from cutting payment rates in a wave of litigation potentially unparalleled in Medicaid's history.

This anticipated growth of Medicaid under the ACA and the litigation that may follow it highlights the quagmire surrounding private enforcement of the Medicaid Act, which the states have been trying to quash for decades.¹⁰ The Medicaid Act does not provide a private right of action except when a person who is eligible for Medicaid is denied entry into the program.¹¹ Nevertheless, historically, both Medicaid providers and beneficiaries have been able to protect their rights through 42 U.S.C. § 1983, which allows individuals to seek redress against states in federal court for violations of statutory or constitutional rights, or through the Supremacy Clause, which prevents states from enacting laws that violate superseding federal laws.¹² These actions both shield the individuals who seek federal court protection and flag state noncompliance for the understaffed HHS, but such litigation is imperiled by aggressive state sovereignty arguments and by a conservatively leaning Supreme Court.

States have argued that no private right of action is available to Medicaid providers or beneficiaries because the Medicaid Act itself does not create a private enforcement mechanism. They reason that anything other than federal agency negotiation and enforcement does not meet the Court's standard for clear notice of conditions on federal spending programs and is a state sovereignty violation.¹³ In other words, states have claimed that federalism

MEDICAID 10-11 (2010) (describing Medicaid as a typically "low profile" issue until politicians fight about it).

8 See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119, 271-79 (2010) (codified as 42 U.S.C. § 1396a(a)(10)(A)(i) (Supp. IV 2011)).

9 See OLSON, *supra* note 7, at 59 (noting that states commonly limit Medicaid expenses by targeting provider reimbursement); see also Memorandum from Kathleen S. Swendiman, Legislative Att'y, & Evelyne B. Baumrucker, Analyst in Health Care Financing, Cong. Research Serv., Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act 5-6 (July 16, 2012) (on file with author) (noting that the ACA's maintenance of effort, MOE, provision does not prevent a state from "reducing provider reimbursement rates or from limiting optional benefits").

10 See *infra* Parts I.B, I.C and accompanying text.

11 42 U.S.C. § 1396a(a)(3) (2012); 42 C.F.R. §§ 431.151-154, 431.200-245 (2012) (administrative process for simple claim denial); 42 C.F.R. § 435.911 (2012) (denial of eligibility for enrollment).

12 42 U.S.C. § 1983 (2012).

13 These concepts are rooted in the early Rehnquist-era conditional spending case, *Pennhurst*

protects them from being hailed into federal court by Medicaid providers or beneficiaries because they are answerable only to the Secretary.¹⁴ Some federal courts have agreed with this analysis, though many have not, and no Supreme Court holding has directly prevented private litigants from addressing state failures in the Medicaid program.¹⁵ The question is which story the Supreme Court will believe the next time a state successfully petitions for certiorari.

This Article will explore the power struggle that Medicaid invites and its potential elevation due to the pressures that will follow the ACA's expansion. Part I of this Article will describe the three phases of private enforcement litigation and how they have affected Medicaid reimbursement rates. This Part also will highlight the deceptive stability that has taken root in the lower federal courts by describing the recent state attempts to end private enforcement actions. The first Part will conclude by briefly considering the nature of the federalism arguments that states are making. Part II will explain why lawmakers missed an important opportunity to add an explicit right of action to the Medicaid Act when drafting the ACA, while at the same time they created a law that will increase the need for federal oversight. The second Part will then explore how the ACA contributes to the Medicaid power struggle. The Article concludes that private actions in federal court provide indispensable balance as well as a much needed de facto oversight mechanism for the already overextended, underfunded HHS.

I. COOPERATIVE FEDERALISM AND MEDICAID ENFORCEMENT

Medicaid is a federal program that provides matching funds to states that agree to abide by the requirements of the Medicaid Act.¹⁶ The Medicaid Act creates a foundation for the program, requiring participating states to ensure that Medicaid beneficiaries receive care that is equal to the access of other patients in their geographic region, setting forth mandatory elements of the Medicaid program, and allowing states to choose additional coverage through optional elements of the program.¹⁷ States that agree to participate in Medicaid (they all have done so for decades now) must submit a State Plan to HHS describing how the state will comply with the Medicaid Act and which options

State Sch. & Hosp. v. Halderman, 451 U.S. 1 (1981).

¹⁴ And yet, states claim the protection of federal courts when they believe they are being “coerced” by the federal government in the Medicaid program. *See, e.g.*, Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012) (holding that states cannot be required by the ACA to participate in the Medicaid expansion because it unconstitutionally coerces them); *see also* Planned Parenthood of Indiana, Inc. v. Comm’r of Indiana State Dept. Health, 699 F.3d 962, 973 (7th Cir. 2012) (describing the spending power analysis in *NFIB* as protecting states from agreeing to conditions they could not know exist in the context of private rights of action to enforce the Medicaid Act).

¹⁵ *See infra* Parts 1.A.3, 1.B and accompanying text.

¹⁶ 42 U.S.C. §§ 1396–1396w (2012).

¹⁷ This is sometimes called “equal access” or the “30(A)” requirement. 42 U.S.C. § 1396a(a)(30)(A) (2012).

it chooses to provide to its impoverished citizens. Any changes to the State Plan must be submitted as a State Plan Amendment, called an SPA, and SPAs are also submitted when the Medicaid Act is modified.¹⁸ Additionally, states can apply for “waivers” from HHS, which allow states to create their own Medicaid programs by violating, with HHS permission, elements of the Medicaid Act.¹⁹ People who qualify for Medicaid have an enforceable right to the medical assistance that states must provide through the program.²⁰ However, if the state modifies its Medicaid program, there is very little beneficiaries or healthcare providers can do aside from seek redress in federal court, as the Medicaid Act does not provide specific enforcement mechanisms.²¹

The interaction between the states and the federal government in Medicaid is a living, breathing, cooperative federalism saga. This section will explore one aspect of that story by studying mechanisms by which states are reined in when they run afoul of the Medicaid Act.

A. Three Phases of Private Enforcement

Medicaid-related litigation can be thought of in three phases, each of which is keyed to a Supreme Court decision regarding § 1983 causes of action, and each of which roughly corresponds to the status of a statutory element of the Medicaid Act called the Boren Amendment.²² Each phase also closely tracks the Court’s interpretation of the enforceability of federalism principles. First is the *Maine v. Thiboutot*²³ phase, in which the Court explicitly opened the courthouse doors to enforcing Medicaid statutory rights through § 1983 in the pivotal *Wilder v. Virginia Hospital Association* decision.²⁴ The second is the *Blessing v. Freestone*²⁵ phase, in which the Court began to limit all such private rights of action by delineating a three-part test that explained when private parties could pursue statutory rights under § 1983. Third is the *Gonzaga University v. Doe*²⁶ phase, in which the Court seemingly limited the *Blessing*

18 See 42 U.S.C. § 1396a (2012); 42 C.F.R. §§ 430.10–.12 (2012) (covering the State Plan and State Plan Amendment).

19 See 42 U.S.C. § 1396n (2012); 42 C.F.R. § 430.25 (covering waivers to State Plan Amendments).

20 42 U.S.C. § 1396a(a)(10) (2012) (“A State plan for medical assistance must . . . provide—for making medical assistance available, including at least the care and services listed . . . to—all individuals . . .” who meet the categorical and financial eligibility requirements of the Medicaid Act).

21 See Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 418–27 (2008) [hereinafter Huberfeld, *Bizarre Love Triangle*] (describing the Medicaid program more fully).

22 The Boren Amendment was repealed in 1997. 42 U.S.C. § 1396a(a)(13)(A) (2012).

23 *Maine v. Thiboutot*, 448 U.S. 1 (1980).

24 *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498 (1990).

25 *Blessing v. Freestone*, 520 U.S. 329 (1997).

26 *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002).

test, but which shows that lower federal courts have struggled to determine *Gonzaga's* proper application.²⁷

1. *Thiboutot and the Implementation of the Boren Amendment: Phase One.*—The first phase of Medicaid litigation followed the Court's declaration that federal statutes can be enforced through § 1983 in *Maine v. Thiboutot*.²⁸ Section 1983 is one of America's oldest federal laws, dating to the Reconstruction Era and designed to protect people from state violations of federal protections.²⁹ Prior decisions supported the theory that § 1983 is available to provide a remedy for all state violations of federally-protected rights, but *Thiboutot* was the first clear articulation of the principle that the phrase "and laws" in § 1983 means that any federal law can be subject to § 1983 litigation, not just civil rights laws.³⁰ Section 1983 claims, as applicable here, allow the intended beneficiaries of federal statutes to bring claims in federal court when there has been a deprivation of the "rights, privileges, and immunities" provided by the statute. The dissent expressed concern that state sovereignty was infringed by the Court's decision to allow private enforcement of all laws rather than just laws enforcing equal protection principles.³¹ Nevertheless, many litigants have sought protection in federal court from state inaction or outright violation of federal laws, especially federal conditional spending laws, in the wake of *Thiboutot*. The Court refined *Thiboutot* nine years later, holding that a violation of federal law is not enough for a § 1983 cause of action to exist; rather, the litigant must have a "federal right" that is violated, meaning that the "provision in question [must be] 'intend[ed] to benefit' the putative plaintiff."³²

One law that was oft litigated during this first phase was the "Boren Amendment," which was enacted in the same year that *Thiboutot* was decided.³³ At states' urging, the Boren Amendment was written to give states flexibility in determining how much and by what method they would reimburse institutional

27 But see Edward Alan Miller, *Federal Oversight, State Policy Making, and the Courts: An Empirical Analysis of Nursing Facility Litigation Under the Boren Amendment*, 3 J. EMPIRICAL LEGAL STUD. 145 (2006) (tracking and analyzing three phases of Medicaid litigation specific to the Boren Amendment's promise of sufficient pay for nursing homes).

28 *Thiboutot*, 448 U.S. at 4 (holding that the plain language of § 1983, "and laws," indicated Congress's intent to allow private rights of action against states that violate federal statutes and thus that welfare recipients could sue a state for retroactive benefits because the enabling statute created a right to the benefits).

29 *Id.* at 4–5. The popular title of the law is the Civil Rights Act of 1871. See *id.* at 15.

30 *Id.* at 4–8.

31 *Id.* at 11–12 (Powell, J., dissenting).

32 *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989) (quoting *Wright v. Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418, 431–432 (1987)).

33 See Miller, *supra* note 27, at 152 (describing three phases of Boren Amendment litigation). Professor Miller did not describe *Thiboutot* as the starting point for Boren litigation, but it happens that Boren was passed in the same year the Court decided *Thiboutot*.

healthcare providers for their services to Medicaid enrollees.³⁴ The Boren Amendment allowed states to pay hospitals and nursing homes in manners alternative to the traditional cost-reimbursement system that had been in place for both Medicaid and Medicare.³⁵ The Boren Amendment contained language designed to give states free rein but that required states to ensure that their payments were “reasonable and adequate” to meet the expenses of “efficiently and economically operated facilities.”³⁶ HHS had no authority to second-guess states’ payment methods unless states did not submit assurances or if those assurances of adequate payment were patently false on their face.³⁷

It soon became clear that states were not effectuating the “reasonable and adequate” requirement in any meaningful manner, as most states reduced payment rates to suit state budgets and stopped paying provider costs in the wake of Boren.³⁸ Thus, Medicaid advocates, including enrollees, institutional providers, physicians, and attendant professional associations, began to sue under § 1983 to compel states to pay “reasonable and adequate” amounts to Medicaid providers.³⁹ Although the federal executive branch had lost authority over state payment methods, the federal judiciary was about to gain that oversight.⁴⁰

The pivotal case in the so-called Boren litigation was *Wilder v. Virginia Hospital Association*, in which the Court held that § 1983 could be used to initiate private rights of action against states that failed to adhere to the terms of the Medicaid Act.⁴¹ Chief Justice Rehnquist disputed the availability of § 1983 rights of action for Medicaid providers, but the majority dismissed both the dissent’s and Virginia’s concerns about private rights of action.⁴² The majority found persuasive not only the language of the Boren Amendment itself, which specified that states “must” provide for payment at rates that were reasonable

34 DAVID G. SMITH & JUDITH D. MOORE, *MEDICAID POLITICS AND POLICY 1965–2007*, at 129 (2008).

35 Though typically called the “Boren Amendment,” 42 U.S.C. 1396a(a)(13)(A) was itself amended numerous times to expand the institutional providers covered by its terms. See Pub. L. 96–499, § 962(a); 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V); see also Miller, *supra* note 27, at 147 (reviewing the Omnibus Budget Reconciliation Acts of 1981, 1987, and 1990 that modified the Boren Amendment). This list of institutional providers also included intermediate care facilities for mentally retarded (ICFMR) enrollees. The National Governors’ Association was pivotal in the passage of the Boren Amendment. See Malcolm J. Harkins III, *Be Careful What You Ask for: The Repeal of the Boren Amendment and Continuing Federal Responsibility to Ensure that State Medicaid Programs Pay for Cost Effective Quality Nursing Facility Care*, 4 J. HEALTH CARE L. & POL’Y 159, 159–60 (2001).

36 *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 502–03, citing 42 U.S.C. §1396a(a)(13)(A) (1982 ed., Supp. V).

37 See Harkins, *supra* note 35, at 169–71 (describing the flexibility and lack of oversight intended to be presented by the Boren Amendment).

38 OLSON, *supra* note 7, at 60.

39 See Harkins, *supra* note 35, at 181–85.

40 See Harkins, *supra* note 35, at 179.

41 *Wilder*, 496 U.S. at 524.

42 *Id.* at 525 (Rehnquist, C.J., dissenting).

and adequate to meet costs, but also the legislative history of prior amendments to the Medicaid Act that indicated Congress knew of and expected private rights of action against those states that ran afoul of the program's boundaries.⁴³ In other words, the Court held that Boren gave healthcare providers a statutory right to reasonable reimbursement rates that they could enforce through § 1983 litigation. Quite simply, *Wilder* pushed open the courthouse doors to Medicaid litigation against the states.⁴⁴

Medicaid litigation existed before *Wilder*, and Congress knew of such litigation,⁴⁵ but *Wilder* was a game-changer for Boren litigants. In the years immediately following *Wilder*, Boren litigants became much more successful having federal courts instruct states to pay “adequate” reimbursement to Medicaid providers.⁴⁶ The successes were multiple. Providers and beneficiaries were more successful being heard, as a procedural matter, when they sought adequate payments under Boren because *Wilder* followed the *Thiboutot* precedent of allowing statutory enforcement through § 1983.⁴⁷ They were also more successful, substantively, by persuading federal courts that the Boren Amendment was enforceable against states, leading federal courts to review state processes in setting rates as well as leading courts to increase reimbursement rates.⁴⁸ Ultimately, this litigation was so successful that states increased payment rates to healthcare providers when Boren litigation was threatened.⁴⁹

In addition to opening federal courts to Medicaid litigation, *Wilder* demonstrated the resistance that has become a constant sub-theme in § 1983 claims, which has come from at least two directions: states and conservatively leaning jurists.⁵⁰ First, states have argued that § 1983 should not afford healthcare providers or enrollees private causes of action against the states

43 *Id.* at 517–18 (relaying comments from the Congressional Record that described Congress's intent to facilitate, not end, private parties seeking injunctive relief against states that did not comply with the Medicaid Act).

44 It certainly pushed the doors open to Boren litigation. See Miller, *supra* note 27, at 167–68 (summarizing the phases of Boren litigation and concluding from empirical data that the post-*Wilder* period resulted in the most federal judicial intervention between states and Medicaid providers).

45 *Wilder*, 496 U.S. at 516 (“[P]rior to the passage of the Boren Amendment, Congress intended that health care providers be able to sue in federal court for injunctive relief to ensure that they were reimbursed according to reasonable rates. During the 1970's, provider suits in the federal courts were commonplace.”).

46 See OLSON, *supra* note 7, at 60–61 (noting the drastic increase in Boren litigation).

47 See *Wilder*, 496 U.S. at 508 (relying squarely on *Thiboutot*).

48 See generally Harkins, *supra* note 35, at 159.

49 See OLSON, *supra* note 7, at 61 (“Even the mere threat of a Boren amendment lawsuit intimidated elected officials, fostering increased compensation in a number of cases.”)

50 See William N. Eskridge, *The New Textualism and Normative Canons*, 113 COLUM. L. REV. 531, 554–55 (2013) (reviewing ANTONIN SCALIA & BRYAN A. GARNER, *READING LAW: THE INTERPRETATION OF LEGAL TEXTS* (2012)) (describing the misplaced reliance on federalism as a statutory construction canon due to its inherently normative nature and the extensive reach of the federalism-based mode of interpretation).

for violations of the Medicaid Act. The states have contended that only the Secretary of HHS should enforce the Medicaid Act.⁵¹ Notably, the Secretary has never withheld all of a state's Medicaid funds, no matter how far the state has diverged from the Medicaid Act, but federal courts have forced states to pay higher reimbursement rates through § 1983 litigation.⁵² And, under the Boren Amendment and its replacement provision, states were given the opportunity to prove their ability to set Medicaid payment rates, but they consistently were found lacking in their methodologies and payment rates.⁵³

Second, certain jurists have, since *Wilder* (and *Thiboutot* before it), objected to § 1983 rights of action against states in conditional spending programs.⁵⁴ This objection appears to derive from at least three ideas. First, the dissents expressed trepidation about states being hailed into federal court, naming state sovereignty concerns.⁵⁵ Second, the justices have articulated concerns about clear notice rules, meaning they expect Congress to describe all aspects of the legislation it passes, leaving nothing to the imagination, especially when states are asked to adhere to that legislation.⁵⁶ Underlying the clear notice rule is a strong state sovereignty norm, one that deems states to be winners by default when the federal government does not explicitly write its own rules. Third is what I call "spending power exceptionalism," a jurisprudential judgment that considers the spending power to be a lesser enumerated power for Congress.⁵⁷ These objections have emerged repeatedly in the three phases of private Medicaid litigation.

2. *Blessing and the Repeal of Boren: Phase Two.*—The second phase of litigating Medicaid grievances through § 1983 narrowed the path to the courthouse for Medicaid plaintiffs. This period began with *Blessing v. Freestone*⁵⁸ and arguably

⁵¹ *Wilder*, 496 U.S. at 508–09 (“Petitioners argue first that the Boren Amendment does not create any ‘enforceable rights’ . . .”).

⁵² See generally Miller, *supra* note 27, at 156, 159–60.

⁵³ *Id.*

⁵⁴ *Wilder*, 496 U.S. at 525–26 (Rehnquist, C.J., dissenting).

⁵⁵ See, e.g., *Maine v. Thiboutot*, 448 U.S. 1, 11–12 (1980) (Powell, J., dissenting) (expressing concerns about state sovereignty with the expansion of § 1983 actions against state and local actors).

⁵⁶ See Eskridge, *supra* note 50, at 554.

⁵⁷ See, e.g., *United States v. Comstock*, 560 U.S. 126, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring). Justice Kennedy wrote:

It should be remembered, moreover, that the spending power is not designated as such in the Constitution but rather is implied from the power to lay and collect taxes and other specified exactions in order, among other purposes, “to pay the Debts and provide for the common Defence and general Welfare of the United States.” The limits upon the spending power have not been much discussed, but if the relevant standard is parallel to the Commerce Clause cases, then the limits and the analytic approach in those precedents should be respected.

Id. (citations omitted).

⁵⁸ *Blessing v. Freestone*, 520 U.S. 329 (1997).

ended, or at least merged, with *Gonzaga* just five years later.⁵⁹ Justice O'Connor's majority opinion in *Blessing* articulated a three-part test for determining whether a federal statute could be enforced through § 1983.⁶⁰ This limiting three-part test created a "rebuttable presumption" for § 1983 rights of action, meaning that Congress can prevent § 1983 actions by specifying the statutory remedy it intends or by specifically foreclosing resort to § 1983.⁶¹ The *Blessing* majority explicitly declined to overrule *Thiboutot* or to protect states from § 1983 by the Eleventh Amendment, both of which were strategies employed by Arizona to protect itself from welfare plaintiffs.⁶² Nevertheless, Justices Scalia and Kennedy issued a concurrence questioning all § 1983 actions for all spending statutes.⁶³ The concurrence called the individual plaintiffs "third party beneficiaries" who would not have been able to seek relief at the time § 1983 was written under the law of contracts as it existed in 1871.⁶⁴ This third party beneficiary analysis has arisen repeatedly as states have been sued by Medicaid providers and enrollees.

Congress repealed the Boren Amendment in 1997, the same year that *Blessing* was decided.⁶⁵ States found that federal courts interpreted the language of the amendment to require a certain level of care in establishing reimbursement rates. Though the states had lobbied Congress successfully to limit federal executive oversight of their reimbursement methods and rates in the creation of the Boren Amendment, they did not predict that the federal judiciary would step into the power vacuum that Boren was intended to create.⁶⁶ In addition, lawsuits that occurred during the first phase of § 1983 litigation resulted in noticeably increased Medicaid costs⁶⁷ because lower federal courts often found state rate setting to be arbitrary and the rates themselves to be too low.⁶⁸ Consequently, the states successfully lobbied Congress to repeal the very

⁵⁹ *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002).

⁶⁰ *Blessing*, 520 U.S. at 340–41 (citations omitted). The *Blessing* test provided:

First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms.

Id. (citations omitted).

⁶¹ *Id.* at 341 ("Even if a plaintiff demonstrates that a federal statute creates an individual right, there is only a rebuttable presumption that the right is enforceable under § 1983.").

⁶² *Id.* at 340.

⁶³ *Id.* at 349 (Scalia, J., concurring).

⁶⁴ *Id.* at 349–50 (Scalia, J., concurring).

⁶⁵ See OLSON, *supra* note 7, at 66. The Balanced Budget Act of 1997 not only repealed the Boren Amendment, it also ushered in the widespread use of managed care in Medicaid. See *id.*

⁶⁶ See Harkins, *supra* note 35, at 183–87.

⁶⁷ See TERESA A. COUGHLIN, LEIGHTON KU & JOHN HOLAHAN, MEDICAID SINCE 1980, at 105 (1994).

⁶⁸ See, e.g., *West Virginia Univ. Hosp. v. Casey*, 885 F.2d 11 (3d Cir. 1989) (invalidating Penn-

amendment they had requested a decade and a half earlier.⁶⁹

The states wielded significant bargaining power in this situation. In both the creation and the destruction of the Boren Amendment, the states drove Medicaid policy making. When they were unsuccessful asserting their sovereignty in federal courts, they turned to the legislative branch and received the respite they sought. But Medicaid litigation did not end, because states tend to make economic decisions about the medical assistance promised by Medicaid, and those cost-cutting decisions often do not deliver on Medicaid's promises.

3. *Gonzaga and Post-Boren Medicaid: Phase Three.*—Soon after *Blessing*, the Court held in *Gonzaga University v. Doe* that a statute must confer personal rights for a plaintiff to successfully enforce that law by § 1983, ushering in the third phase of § 1983 litigation.⁷⁰ Chief Justice Rehnquist's majority opinion stressed that very few Supreme Court decisions had recognized the ability to pursue § 1983 actions in spending programs.⁷¹ In fact, the Chief Justice named only two such cases, one of which was *Wilder*.⁷² The Court did not specify how *Gonzaga* modified *Blessing*; rather, it summarized prior precedent and indicated the primacy of determining whether Congress intended to confer a private right of action.⁷³ The Court's positive reliance on *Wilder* indicated that *Wilder* was still good law.⁷⁴ But, *Wilder* addressed only one provision of the Medicaid Act out of many possible statutory sections that litigants have sought to enforce.

In this modern era of § 1983 litigation, lower federal courts have attempted to determine how *Gonzaga* limited *Blessing* given that the Court was not specific about its modification of the *Blessing* test.⁷⁵ More specifically, the question after both *Blessing* and *Gonzaga* was how the Medicaid Act's various requirements, some of which promise individual benefits to Medicaid enrollees, would fit into this more restrictive § 1983 regime. The circuits have applied § 1983 to Medicaid's many provisions with some consistency, though this stability has

sylvania's plan for reimbursing out of state hospitals at half the rate of in state hospitals for no legitimate reason).

69 Joshua M. Wiener & David G. Stevenson, *Repeal of the "Boren Amendment": Implications for Quality of Care in Nursing Homes*, URBAN INSTITUTE (1998) (the Boren Amendment was repealed at least in part because states found it too costly), <http://www.urban.org/UploadedPDF/anf30.pdf>.

70 *Gonzaga Univ. v. Doe*, 536 U.S. 273, 286 (2002) ("[Our] inquiries simply require a determination as to whether or not Congress intended to confer individual rights upon a class of beneficiaries. . . . [W]here the text and structure of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit . . .").

71 *Id.* at 281.

72 *Id.* at 280 ("Since *Pennhurst*, only twice have we found spending legislation to give rise to enforceable rights.").

73 Huberfeld, *Bizarre Love Triangle*, *supra* note 21, at 434.

74 See *Gonzaga*, 536 U.S. at 280–81.

75 See Huberfeld, *Bizarre Love Triangle*, *supra* note 21, at 442–53 (discussing the circuits' various applications of *Gonzaga* to *Blessing*).

taken approximately the last decade to develop.⁷⁶

Generally speaking, lower federal courts' approach to Medicaid enforcement actions can be characterized as permissive, with the exception of litigation designed to enforce Boren's successor, called the "equal access," "sufficiency," or "30(A)" provision.⁷⁷ This law requires states to pay "sufficient" rates to ensure equal access to medical services for the geographic location.⁷⁸ After *Gonzaga* was decided, lower federal courts faced with § 1983 actions to enforce 30(A) consistently held that the Boren Amendment's repeal, and the more vague language of equal access and payment sufficiency that replaced it, indicated Congress's intent to end private rights of action for reimbursement adequacy.⁷⁹ But, none of these decisions have held that § 1983 actions were completely unavailable for Medicaid enrollees;⁸⁰ though some have held that providers are barred from enforcing the Medicaid Act.⁸¹ The provider bar has not stopped providers from seeking redress, however, as they have either worked with enrollees as plaintiffs or have sought to enforce the Medicaid Act by Supremacy Clause actions.⁸²

In asserting a violation of the Supremacy Clause, Medicaid plaintiffs claim that a state law contradicts the Medicaid Act and thus is invalid.⁸³ Often, when raised by private parties, the Supremacy Clause is an affirmative defense to a state prosecution.⁸⁴ In the Medicaid context, however, plaintiffs have used the Supremacy Clause to bring an action for injunctive relief when a state allegedly is violating the Medicaid Act. To be clear, this is private enforcement of a constitutional principle—that federal law preempts contradictory state law, but instead of the federal government pursuing the action, a private party is doing so. States have argued that only the federal government may so engage the

76 See generally Huberfeld, *Bizarre Love Triangle*, *supra* note 21 (detailing the circuit splits that existed due to *Gonzaga*'s influence on the application of the *Blessing* test).

77 42 U.S.C. § 1396a(a)(30)(A) (2012).

78 42 U.S.C. § 1396a(a)(30)(A) (2012).

79 See Huberfeld, *Bizarre Love Triangle*, *supra* note 21, at 447–48.

80 One notable exception, *Westside Mothers v. Haveman*, was overruled by the Sixth Circuit on appeal. *Westside Mothers v. Haveman*, 133 F. Supp. 2d 549 (E.D. Mich. 2001) (holding that no § 1983 cause of action is available to Medicaid enrollees because spending programs are nothing more than contracts).

81 See, e.g., *Long Term Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57–59 (1st Cir. 2004) (reversing its pre-*Gonzaga* position that healthcare providers could enforce 30(A)).

82 See, e.g., *Douglas v. Indep. Living Ctr. of Southern California, Inc.*, 132 S. Ct. 1204 (2012) (avoiding the question of the permissibility of Supremacy Clause rights of action by deferring to the Centers for Medicare and Medicaid Services in its review of California's rate cuts).

83 See U.S. CONST. art. VI, cl. 2.

84 Catherine M. Sharkey, *Preemption as a Judicial End-Run Around the Administrative Process?*, 122 YALE L.J. ONLINE 1, 6 (2012), <http://yalelawjournal.org/2012/04/30/sharkey.html> (noting that the typical federal preemption defense involves a party claiming that a federal law preempts a state law of which that party is accused of a violation).

Supremacy Clause.⁸⁵ Nevertheless, some federal circuit courts have accepted the theory that private litigants may enforce the supremacy of the Medicaid Act against noncompliant states.⁸⁶ This has provided an alternative mechanism for private parties to challenge state Medicaid decisions that offend the Medicaid Act when HHS does not act.⁸⁷

These questions have been complicated by the repeal of the Boren Amendment. This is because the statutory language on which plaintiffs had so successfully relied changed to its modern version, which after *Gonzaga* most federal courts have determined is no longer enforceable against states.⁸⁸ Nonetheless, Supremacy Clause actions have the potential to reanimate 30(A) litigation, because preemption does not hinge on an individually enforceable “right.” The Supreme Court dodged this question in *Douglas*, but the issue is sure to arise again soon.

In addition, even in this relatively stable third phase of litigation, the two threats to private rights of action remain. States continue to press for an end to private enforcement of the Medicaid Act, and Justices continue to express skepticism regarding any private rights of action against states in the Medicaid program.⁸⁹ The next section explores this dynamic through the lens of Indiana’s push for certiorari in early 2013.

B. Near Miss—October Term 2012

Lower federal courts have been largely willing to hear most Medicaid challenges in the third phase, with the notable and important exception of 30(A) actions.⁹⁰ However, circuit courts’ application of the § 1983 framework has been

⁸⁵ *But see Ex parte Young*, 209 U.S. 123 (1908).

⁸⁶ This led to the petition for certiorari being granted in *Douglas v. Independent Living Center*, argued during the October 2011 term, which is discussed throughout this Article. *Douglas v. Indep. Living Ctr. of Southern California*, 132 S. Ct. 1204 (2012).

⁸⁷ *See, e.g., Lankford v. Sherman*, 451 F.3d 496, 509–11 (8th Cir. 2006).

⁸⁸ *See Huberfeld, Bizarre Love Triangle*, *supra* note 21, at 447–48 (describing lower courts’ treatment of 30(A) after *Gonzaga*).

⁸⁹ *See, e.g., Douglas*, 132 S. Ct. at 1214 (Roberts, C.J., dissenting) (expressing doubt that any private rights of action exist in the Medicaid program, whether under the Supremacy Clause or otherwise).

⁹⁰ *See Binta B. ex rel SA v. Gordon*, 710 F.3d 608 (6th Cir. 2013) (allowing § 1983 action to proceed); *John B. v. Emkes*, 710 F.3d 394 (6th Cir. 2013) (not allowing 30(A) action to proceed, but allowing a 42 U.S.C. § 1396a(a)(43)(C) action to proceed); *Consejo de Salud de la Comunidad de la Playa de Ponce, Inc. v. Gonzalez-Feliciano*, 695 F.3d 83 (1st Cir. 2012) (also allowing § 1983 actions for § 1396a(bb) enforcement); *Sai Kwan Wong v. Doar*, 571 F.3d 247 (2d Cir. 2012) (assumes plaintiffs can maintain § 1983 action to enforce 42 U.S.C. § 1396p(d)(4)); *Shakhnes v. Berlin*, 689 F.3d 244 (2d Cir. 2012) (allowing § 1983 enforcement of 42 U.S.C. § 1396a(a)(3) and related regulations); *Lewis v. Alexander*, 685 F.3d 325 (3d Cir. 2012) (also allowing § 1983 enforcement of the Medicaid Act, §§ 1396p(d)(4) & 1396a(a)(18)); *E.M.A. ex rel. Plyler v. Cansler*, 674 F.3d 290 (4th Cir. 2012) (allowing § 1983 actions to enforce Medicaid’s anti-lien provision), *affirmed by Wos v. E.M.A.*, 133 S. Ct. 1391 (2013); *Bontrager v. Ind. Family and Soc. Servs. Admin.*, 697 F.3d 604 (7th Cir. 2012) (al-

uneven. Some courts ignore the *Gonzaga* modification of *Blessing*, some courts substitute *Gonzaga* for *Blessing*, but most courts see *Gonzaga* as modifying the first part of the *Blessing* test.⁹¹ The jurisprudence is stable enough for states to be nervous about private actions, especially with the ACA's Medicaid expansion pending. But, there is enough disagreement between circuits to permit states to push for certiorari, as they did this past term, and to test the two consistent objections to private actions in Medicaid: state sovereignty concerns and spending power exceptionalism.

During the spring of the October 2012 term, Indiana filed two petitions for certiorari, and the sense is that the Court's denial of the petitions was a close shave.⁹² The two cases had § 1983 at their heart, but the Seventh Circuit had no trouble finding private rights of action in each instance. The first case involved Indiana's \$1000 cap on coverage of dental care for Medicaid patients, which was challenged as a violation of Medicaid's comparability provision due to its arbitrary limitations on access to certain dental procedures.⁹³ Both the district court and the Seventh Circuit held that enrollees could seek an injunction against Indiana under § 1983 to end this limit on Medicaid coverage.⁹⁴ The second case involved Indiana's attempt to completely defund Planned Parenthood by preventing government funding, state or federal, from flowing to any entity that provides abortion services, even if privately funded.⁹⁵ Again the district court and the Seventh Circuit held that the parties had access to injunctive relief through § 1983.⁹⁶ Nevertheless, Indiana pushed the § 1983 question to the fore

allowing 42 U.S.C. § 1396a(a)(10) actions to proceed under § 1983); *Planned Parenthood of Indiana, Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012) (allowing § 1396a(a)(23) enforcement to proceed under § 1983); *Ctr. for Special Needs Trust Admin., Inc. v. Olson*, 676 F.3d 688 (8th Cir. 2012) (allowing anti-lien actions under § 1983); *Concillo de Salud Integral de Loiza, Inc. v. Perez-Perdomo*, 551 F.3d 10 (1st Cir. 2008) (allowing a § 1983 action to enforce 42 U.S.C. § 1396a(bb)); *James v. Richman*, 547 F.3d 214 (3d Cir. 2008) (allowing § 1983 enforcement of 42 U.S.C. § 1396r-5); *Equal Access for El Paso v. Hawkins*, 562 F.3d 724 (5th Cir. 2008) (allowing § 1983 actions to enforce the Medicaid Act).

91 See Huberfeld, *Bizarre Love Triangle*, *supra* note 21, at 442–43 (detailing the varying circuit approaches to applying *Gonzaga* as of 2008).

92 The Supreme Court online news source SCOTUSblog described both petitions as “petitions to watch” because they were likely to be granted. See Mary Pat Dwyer, *Petition of the day*, SCOTUSblog (Apr. 16, 2013, 9:38 PM), <http://www.scotusblog.com/2013/04/petition-of-the-day-437/> (regarding *Bontrager*); Mary Pat Dwyer, *Petition of the day*, SCOTUSblog (May 21, 2013, 9:11 PM), <http://www.scotusblog.com/2013/05/petition-of-the-day-457/> (regarding *Planned Parenthood of Indiana*); see also Nicole Huberfeld, *Indiana's Second Petition for Certiorari Denied*, HEALTHLAW-PROF BLOG (May 29, 2013), http://lawprofessors.typepad.com/healthlawprof_blog/2013/05/indianas-second-petition-for-certiorari-denied.html.

93 *Bontrager*, 697 F.3d 604.

94 *Id.*; *Bontrager v. Ind. Family & Soc. Servs. Admin.*, 829 F. Supp. 2d 688 (N.D. Ind. 2011).

95 *Planned Parenthood of Indiana, Inc. v. Comm'r of Ind. Dept. of Health*, 794 F. Supp. 2d 892, 897–98 (S.D. Ind. 2011).

96 *Planned Parenthood of Indiana, Inc. v. Comm'r of Ind. Dept. of Health*, 699 F.3d 962, 972–77 (7th Cir. 2012); *Planned Parenthood of Indiana*, 794 F. Supp. 2d at 901–03.

in its petitions for certiorari.⁹⁷ Indiana presented the petitions as companion cases and asked the Court to grant the petitions in tandem.⁹⁸ In both petitions, Indiana asked the Court to overrule *Wilder*,⁹⁹ and in both petitions, the state (supported by about ten other states) decried enforcement of Medicaid's rules by private rights of action.¹⁰⁰

The Court's denial of certiorari can be interpreted several ways, each of which is worth noting given the pressures of the oncoming Medicaid expansion and their potential to test conditional spending. First, the federalism questions offered to the Court in *Indiana v. Planned Parenthood* were ensconced in an abortion funding predicate. Many anti-abortion politicians are creating legislation in the states that is designed to test the Court's interest in upholding such precedents as *Roe v. Wade* and *Planned Parenthood v. Casey*.¹⁰¹ Additionally, states have attempted to completely block the flow of governmental funding to healthcare providers that provide abortion services alongside other reproductive healthcare.¹⁰² Indiana offered itself as the test-case for such funding limitations, and the Court did not bite, leaving in place the Seventh Circuit's holding that Indiana cannot limit funding for Medicaid providers in this way without running afoul of Medicaid's free choice of provider provision.¹⁰³

A second potential explanation is that the Court had granted a separate Seventh Circuit § 1983 case for the October 2013 term and could have used

97 Petition for Writ of Certiorari at i, *Ind. Family and Soc. Servs. Admin. v. Bontrager*, 133 S. Ct. 2002 (2013) (No. 12-1037), 2013 WL 660664 ("The question presented is: Does 42 U.S.C. § 1396a(a)(10)(A)(i) create federal 'rights' that may be privately enforced under 42 U.S.C. § 1983 by Medicaid beneficiaries?"); Petition for Writ of Certiorari at i, *Sec'y of the Ind. Family and Soc. Servs. Admin. v. Planned Parenthood of Indiana, Inc.*, 133 S. Ct. 2736 (2013) (No. 12-1039), 2013 WL 660665. The first question presented was: "Does 42 U.S.C. § 1396a(a)(23) create federal 'rights' in Medicaid beneficiaries that may be privately enforced under 42 U.S.C. § 1983 by Medicaid beneficiaries and providers?"

98 Petition for Writ of Certiorari at 10, *Sec'y of the Ind. Family and Soc. Servs. Admin.*, 133 S. Ct. 2736 (No. 12-1039) ("The Court should take this case (as well as *Bontrager* . . .) . . .").

99 *Id.* at 10; Petition for Writ of Certiorari at 12, *Ind. Family and Soc. Serv. Admin.*, 133 S. Ct. 2002 (No. 12-1037).

100 Petition for Writ of Certiorari at 11-28, *Sec'y of the Ind. Family and Soc. Serv. Admin.*, 133 S. Ct. 2736 (No. 12-1039); Petition for Writ of Certiorari at 12-32, *Ind. Family and Soc. Serv. Admin.*, 133 S. Ct. 2002 (No. 12-1037). Indiana painted a somewhat misleading picture of the confusion *Gonzaga* has created in lower federal courts in its petition, asserting that most lower federal courts were ready to eliminate § 1983 actions for Medicaid enrollees and providers when in fact it is primarily 30(A) actions that have been halted. Petition for Writ of Certiorari at 16-24, *Ind. Family and Soc. Serv. Admin.*, 133 S. Ct. 2002 (No. 12-1037); Petition for Writ of Certiorari at 13-20, *Sec'y of the Ind. Family and Soc. Serv. Admin.*, 133 S. Ct. 2736 (No. 12-1039). Other provisions of the Medicaid Act remain enforceable through § 1983 actions.

101 See *State Policy Trends 2013: Abortion Bans Move to the Fore*, GUTTMACHER INSTITUTE (April 11, 2013), <http://www.guttmacher.org/media/inthenews/2013/04/11/index.html>.

102 See *Laws Affecting Reproductive Health and Rights: 2012 State Policy Review*, GUTTMACHER INSTITUTE (last visited Nov. 9, 2013), <http://www.guttmacher.org/statecenter/updates/2012/statetrends42012.html>.

103 42 U.S.C. § 1396a(a)(23) (2012).

that petition's question to revisit § 1983.¹⁰⁴ The petition was grounded in the Age Discrimination in Employment Act rather than Medicaid; notably, the ADEA has a remedial scheme whereas Medicaid does not. Under existing ADEA precedent, the § 1983 right of action did not seem to be strong. The case was dismissed as improvidently granted based on a procedural technicality, but the Court could hear *Madigan v. Levin* or a similar case again, depending on lower federal courts' disposition of the case on rehearing.¹⁰⁵

This leads to a related third possibility, which is that the Court could have decided a low-profile case this past term based on § 1983 but did not do so. In March, the Court held in *Wos v. E.M.A.* that states must make an effort to calculate actual medical expenses when claiming part of a Medicaid enrollee's tort recovery because of the Anti-Lien provisions of the Medicaid Act.¹⁰⁶ The state claimed more money from the settlement than the plaintiff believed to be appropriately allocated to medical expenses, so E.M.A. sought to recover from the state; the Court held that the state law describing the irrebuttable one-third presumption of tort recovery was preempted by the Medicaid Act.¹⁰⁷

For purposes of this paper, *Wos* has two interesting aspects. First, E.M.A. and her parents filed the lawsuit under § 1983 to enjoin the state from violating the Medicaid Act. The majority opinion authored by Justice Kennedy noted this procedure, but then wrote nothing more about § 1983.¹⁰⁸ Second, the opinion explicitly described the state law as preempted by the Medicaid Act.¹⁰⁹ Both § 1983 and Medicaid Act preemption of state laws have been hot button issues, and so it may be tempting to perceive *Wos* as putting those issues to rest.¹¹⁰ Neither the majority nor the dissent in *Wos* engaged the federalism-

¹⁰⁴ *Levin v. Madigan*, 692 F.3d 607 (7th Cir. 2012), cert. granted, 133 S.Ct. 1600 (U.S. 2013).

¹⁰⁵ *Madigan v. Levin*, 134 S. Ct. 2 (2013) (per curiam, dismissed as improvidently granted without comment).

¹⁰⁶ North Carolina had instituted a one-third rule that made it so that no matter the size of the recovery or the nature of the allocation, North Carolina would claim one-third of a plaintiff's tort recovery, calling it the state's portion of the medical care expenses paid for by Medicaid. *Wos v. E.M.A. ex rel. Johnson*, 133 S. Ct. 1391, 1402 (2013) (holding that the Anti-Lien provisions of the Medicaid Act prevented a state from claiming any portion of a tort recovery other than those designated as medical expense payments).

¹⁰⁷ The Anti-Lien provision prevents states from placing a lien on tort recoveries for people who are enrolled in Medicaid because of an injury that leaves them permanently disabled. 42 U.S.C. § 1396p(a)(1) (2012). In *Wos*, the enrollee was a child who was severely injured during the labor and delivery process and who suffered permanent mental and physical damage. *Wos*, 133 S. Ct. at 1395.

¹⁰⁸ *Wos*, 133 S. Ct. at 1395–96. In the language of 1983, the parents were seeking to have the court enjoin the state from violating E.M.A.'s statutory rights under the Medicaid Act.

¹⁰⁹ *Id.* at 1398.

¹¹⁰ See, e.g., Simon Lazarus, *Victory for Enforcement of Medicaid in Wos v. E.M.A.*, THE CONSTITUTIONAL ACCOUNTABILITY CENTER (Mar. 22, 2013), <http://theconstitution.org/text-history/1895/victory-enforcement-medicaid-wos-v-ema> (writing that the majority's acceptance of both the § 1983 and the preemption aspects of the plaintiffs' claims was a significant victory for private Medicaid enforcement); Simon Lazarus, *'Supreme Law'—for Medicaid Patients or Just Business?*, THE NATIONAL LAW JOURNAL (Apr. 25, 2013), <http://www.law.com/jsp/nlj/PubArticleNLJ>.

based, states' rights-aggrandizing arguments made by North Carolina and its supporting, Texas-led amici.¹¹¹

But, the Court will likely hear this set of issues again. A core group of states is supporting each effort to terminate private rights of action to enforce the terms of the Medicaid Act. In each of the three above-mentioned cases, eleven states filed a joint amicus brief describing the reasons that the Court should reject private rights of action in Medicaid.¹¹² These states are pushing the Court to consider the status of § 1983 actions against states when they do not adhere to the Medicaid Act. And, the Court did not answer the question of Supremacy Clause rights of action for private parties last term, leaving that question open as well.¹¹³ In addition, the conservatively oriented Justices on the Court may still convince Justice Kennedy that federalism does demand that either Congress write a private cause of action into the statute or no private actions can lie. A consistent line of dissents has articulated concerns for the states in the Medicaid program, most recently the strongly worded dissent authored by the Chief Justice in *Douglas v. Independent Living Center*.¹¹⁴ But, Justice Kennedy did not join that dissent, and he authored the majority in *Wos*. Finally, the opinion in *Wos* reads as a warning to states that says "we meant what we said in *Ahlborn*," which was positively cited, referenced, and otherwise relied on in *Wos*.¹¹⁵ Thus, it seems overly optimistic to read *Wos* as putting the § 1983 or the preemption question to rest.

States are aggressively asserting their sovereignty in Medicaid cases, seemingly in the hopes that they will present a desirable petition for certiorari to the Court. Though Indiana's petitions this term were denied,

jsp?id=1202597613795.

111 Brief of Texas, Alabama, Georgia, Hawaii, Idaho, Indiana, Michigan, Nebraska, New Mexico, Ohio and South Carolina as Amici Curiae in Support of Petitioner, *Delia v. E.M.A.*, 133 S. Ct. 1391, No. 12–98 (4th Cir. Nov. 16, 2012), 2012 WL 5872818 (the case later became *Wos v. E.M.A.*).

112 The overlap between the cases is substantial but not precise. *See id.*; *cf.* Brief of Amici Curiae States of Michigan, Alabama, Alaska, Arizona, Georgia, Kansas, Nebraska, Ohio, Texas and Utah in Support of Petitioners, Sec'y of the Ind. Family and Soc. Servs. Admin. v. Planned Parenthood of Indiana, Inc., 133 S. Ct. 2736 (2013) (No. 12–1039), 2013 WL 1247967; *cf.* Brief of Amici Curiae States of Michigan, Alabama, Alaska, Arizona, Georgia, Hawaii, Kansas, Nebraska, Ohio, Texas, and Utah in Support Of Petitioners, Ind. Family and Soc. Serv. Admin. v. Bontrager, 133 S. Ct. 2002 (2013) (No. 12–1037), 2013 WL 1247966.

113 *See Douglas v. Indep. Living Ctr. of Southern California, Inc.*, 132 S. Ct. 1204, 1211 (2012) (deferring to HHS to exercise primary jurisdiction over the question of whether providers payments could be cut by 10% across the board and still meet the terms of 30(a) without answering the petition's question regarding the permissibility of Supremacy Clause rights of action to enjoin Medicaid Act violations).

114 *Id.* (Roberts, C.J., dissenting) (explaining why no private party should be able to raise a preemption claim for injunctive relief in the Medicaid program). The dissent showed little regard for Medicaid's particulars and instead dove into constitutional questions. *Id.*

115 *See, e.g., Wos v. E.M.A. ex rel. Johnson*, 133 S. Ct. 1391, 1395 (2013) (citing *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268 (2006)) (starting the majority opinion with a cite to *Ahlborn's* preemption analysis).

the states undoubtedly will continue to test the fence, especially in light of their federalism win in *NFIB v. Sebelius*.¹¹⁶ The next section considers these sovereignty arguments.

C. State Sovereignty in Medicaid

When states agree to participate in the Medicaid program, they know that failure to comply with the terms of the Medicaid Act will result in either the Secretary taking action to bring the state into alignment with the Act or private enforcement of the law. Contrary to the claims they have made since *Pennhurst*,¹¹⁷ the private enforcement of the Medicaid Act is not a surprise to the states, and it has not been for decades (since at least 1980 when *Thiboutot* was decided). Yet, the states claim repeatedly that they do not have clear notice of the right to private enforcement of the Medicaid Act in the language of the statute.

The federalism argument that states have been making in § 1983 cases, that state sovereignty is offended by private remedies for violations of the Medicaid Act, is disconnected from the fact that the states have agreed to comply with the federal law and its conditions. The compliance requirement does not differ whether a federal agency or a federal court commands the conformity. And, a private right of action does not threaten state sovereignty when the state has already agreed to abide by federal law and implement its policies in exchange for substantial funding. Nevertheless, states seek to continue the Federalism Revolution, which was started by the Rehnquist Court's active enforcement of the Tenth Amendment against the federal government in exercises of the commerce power, and which the Roberts Court continued in *NFIB v. Sebelius* by applying the Tenth Amendment to exercises of the spending power.¹¹⁸ For the states urging the Court to overturn *Wilder*, it appears the next step in the Federalism Revolution is to move beyond coercion to further limit the influence of federal policy by preventing judicial enforcement of federal laws against the states.

In pressing the anti- § 1983 arguments, states are speaking to the more conservative members of the Court. They are writing to Justice Alito, who authored *Arlington v. Murphy*, a spending power decision that reinforced the “clear notice” requirement for conditions on federal spending in the name of protecting states entering cooperative federalism programs.¹¹⁹ They are writing to Chief Justice Roberts, who authored the *NFIB* plurality opinion finding

116 See Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 47–50 (2013) [hereinafter Huberfeld et al., *Plunging into Endless Difficulties*].

117 *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981).

118 See Huberfeld et al., *Plunging into Endless Difficulties*, *supra* note 116, at 47–50.

119 *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 295–96 (2006).

unconstitutional coercion in the enactment of the Medicaid expansion.¹²⁰ They are writing to Justice Kennedy, champion of federalism who authored a majority opinion in *Bond v. United States* that extolled the virtues of federalism,¹²¹ and that has been oft-cited both in the Court's opinions and in state briefs. (Notably, *Bond* was before the Court again in the October 2013 term.¹²²) Justice Kennedy also authored a concurrence in *United States v. Comstock* describing the need to limit the spending power to honor the doctrine of federalism.¹²³ They are speaking to Justice Scalia, who authored *Printz v. United States*, the Rehnquist Court's decision decrying "dragooning" of state executive actors.¹²⁴ And, they are writing to Justice Thomas, who would not recognize broad congressional authority at all.¹²⁵

Even though federal agencies have the power to enforce the Medicaid Act, and would probably be the best enforcers with the right funding and staffing, states know that HHS is a struggling supervisor that is grossly under-staffed and under-funded.¹²⁶ Former administrators of HHS described in a high-profile amicus brief how difficult fifty-state enforcement is.¹²⁷ The former administrators also described how heavily the central agency relies on private actions to alert HHS to states running afoul of the Medicaid Act.¹²⁸ Private actions raise red and yellow flags for HHS, in addition to improving the Medicaid program for the parties involved in the litigation. Regulations promulgated pursuant to the ACA will increase the flow of information to HHS regarding state compliance with 30(A), but HHS does not have

¹²⁰ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2603–04 (2012).

¹²¹ Bond v. United States, 131 S. Ct. 2355, 2364 (2011).

¹²² Bond v. United States, No. 12–158 (3d Cir. May 3, 2012).

¹²³ United States v. Comstock, 130 S. Ct. 1949, 1965–68 (2010) (Kennedy, J., concurring).

¹²⁴ Printz v. United States, 521 U.S. 898, 928 (1997).

¹²⁵ Justice Thomas's dissents and concurrences in the line of cases narrowing the commerce power protest every time that he would not recognize Congress's ability to regulate activities that have a substantial effect on interstate commerce. See, e.g., *NFIB*, 132 S. Ct. at 2677 (Thomas, J., dissenting) (detailing the opinions in which Thomas has so protested; interestingly, the other Justices never join his "original understanding" argument).

¹²⁶ See Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2380–82 (2010) (arguing that agency enforcement is more efficient, exercises appropriate expertise, and is a generally better option than the piecemeal enforcement of federal courts, but only if federal agencies are properly equipped).

¹²⁷ Brief of Former HHS Officials as Amici Curiae in Support of Respondents at 18, Douglas v. Indep. Living Ctr. of Southern California, Inc., 132 S. Ct. 1204 (2012) (Nos. 09–958, 09–1158, & 10–283), 2011 WL 3706105 at 18.

¹²⁸ *Id.* at 2. The brief opens:

[I]t has consistently been HHS's position that private enforcement of § 30(A) is not just appropriate, but also necessary to ensure that states comply with this critical regulatory mandate. Nor is there anything to the Justice Department's suggestion that private enforcement would interfere with the Secretary's discretion. As a matter of both historical practice and current law, private enforcement only complements the Secretary's authority.

increased funding, staffing, or power necessary to respond effectively to state self-reporting.¹²⁹

This discussion has conflated § 1983 rights of action and Supremacy Clause actions by Medicaid providers and enrollees because both offer access to federal courts. The discussion also has conflated these separate actions because they have worked side-by-side in the Medicaid context to persuade states to comply with the federal statute. But, importantly, these actions are not the same. Section 1983 actions involve the use of one federal statute to enforce the rights protected by another federal statute. Section 1983 exists because the Fourteenth Amendment was read not to protect former slaves from private acts that furthered segregation and violence against African Americans, even though those private acts were protected by the states through state inaction.¹³⁰ Thus, § 1983 is a statutory action that enforces individual rights when the Constitution does not clearly protect those rights.

On the other hand, Supremacy Clause actions enforce a constitutional principle, that states must abide by the supreme law of the land, whether it be Constitution, treaty, or federal law.¹³¹ When Medicaid providers and enrollees seek federal court protection in a Supremacy Clause action, they are asking federal courts to enjoin states from violating the Supremacy Clause because they are ignoring a federal law that they have already agreed to obey. The constitutional aspect of these actions appears to have been irrelevant to the *Douglas* dissent, which did not distinguish between the Supremacy Clause cause of action and implied rights of action.¹³² Instead, the dissent argued that the Supremacy Clause action would create an “end-run” around the body of law that increasingly limits implied rights of action.¹³³ This is not correct. The Supremacy Clause does not offer an “end-run,” it provides clear constitutional notice to the states that they are expected to abide by federal law or their

¹²⁹ 76 Fed. Reg. 26342 (May 6, 2011) (to be codified at 42 C.F.R. pt. 447).

¹³⁰ The Civil Rights Cases, 109 U.S. 3, 25–26 (1883) (finding that private acts cannot be imputed to the states and therefore are not covered by the language of the Fourteenth Amendment); See also *Mitchum v. Foster*, 407 U.S. 225, 238–42 (1972) (tracing the history of the Civil Rights Act of 1871 (§ 1983)).

¹³¹ U.S. CONST. art. VI, cl. 2–3. The Supremacy Clause states:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby . . . the Members of the several State Legislatures . . . shall be bound by Oath or Affirmation to support this Constitution

Id.

¹³² See Stephen I. Vladeck, *Douglas and the Fate of Ex Parte Young*, 122 YALE L.J. ONLINE 13, 17 (2012), <http://www.yalelawjournal.org/the-yale-law-journal-pocket-part/supreme-court/douglas-and-the-fate-of-ex-parte-young/> (writing that the Roberts dissent failed to explain adequately the analogy between § 1983 and Supremacy Clause actions when the two implicate different issues).

¹³³ *Douglas v. Indep. Living Ctr. of Southern California, Inc.*, 132 S. Ct. 1204, 1213 (2012) (Roberts, C.J., dissenting).

offending actions will fail.¹³⁴ Otherwise, states are able to effectively nullify the Medicaid Act, and nullification laws have long been understood to be invalid.¹³⁵

The *Douglas* dissent provided important insight for federal courts' role in Medicaid enforcement. If Justices on the Supreme Court are not willing to distinguish between statutory and constitutional rights of action, then lower federal courts are not likely to do so either. Rather than being bothered that states are talking out both sides of their mouths, the Court has actually encouraged states to use federal courts as a shield against federal legislation as well as a sword against private actions. States are thus doubly protected, while Medicaid participants face the possibility of no protection.

II. THE LOST OPPORTUNITY OF THE ACA

Depending on the number of states that participate in the Medicaid expansion, approximately sixteen million new enrollees will be added to the sixty million already enrolled in the Medicaid program.¹³⁶ This means that about one-quarter of the United States population will be covered by Medicaid. This significant growth in the Medicaid program will undoubtedly strain the already tense relationship between the federal government and the states, and it will exacerbate a number of existing problems in the program's current structure.

¹³⁴ 1 LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1026 (3d ed. 2000) (stating that without the Supremacy Clause, "the Union as we know it could not exist.").

¹³⁵ See, e.g., *Cooper v. Aaron*, 358 U.S. 1, 17 (1958). The Court wrote of the state's effort to "nullify" federally-ordered desegregation:

In short, the constitutional rights of children not to be discriminated against in school admission on grounds of race or color declared by this Court in the *Brown* case can neither be nullified openly and directly by state legislators or state executive or judicial officers, nor nullified indirectly by them through evasive schemes for segregation whether attempted 'ingeniously or ingenuously.'

Id. (citing *Smith v. Texas*, 311 U.S. 128 (1940)). The Court continued:

No state legislator or executive or judicial officer can war against the Constitution without violating his undertaking to support it. Chief Justice Marshall spoke for a unanimous Court in saying that: 'If the legislatures of the several states may, at will, annul the judgments of the courts of the United States, and destroy the rights acquired under those judgments, the constitution itself becomes a solemn mockery * * *.' A Governor who asserts a power to nullify a federal court order is similarly restrained. If he had such power, said Chief Justice Hughes, in 1932, also for a unanimous Court, 'it is manifest that the fiat of a state Governor, and not the Constitution of the United States, would be the supreme law of the land; that the restrictions of the Federal Constitution upon the exercise of state power would be but impotent phrases * * *.'

Id. at 18–19 (citing *United States v. Peters*, 5 Cranch 115, 136 (1809); *Sterling v. Constantin*, 287 U.S. 378, 397–398 (1932)).

¹³⁶ See generally Carter C. Price & Christine Eibner, *For States that Opt Out of Medicaid Expansion: 3.6 Million Fewer Insured and \$8.4 Billion Less in Federal Payments*, 32 *HEALTH AFF.* 1030 (June 2013), available at <http://content.healthaffairs.org/content/32/6/1030.full.pdf+html> (describing and quantifying the financial and coverage implications of the states opting out of Medicaid). The financial ramifications are outside the scope of this Article, but Price and Eibner described in hard, quantifiable terms that states opting out of Medicaid not only lose out on major funding but also jeopardize their poor populations who will not be covered anywhere. See *id.* at 1033–35.

The ACA could have addressed the statutory silence that the Medicaid Act suffers with regard to private enforcement of the states' behavior in the program. In fact, the ACA did address an interpretive problem brewing in lower federal courts regarding whether Medicaid promises care and payment or just payment (the former is correct).¹³⁷ But, Congress failed to address in the ACA one of the greatest sources of Medicaid turmoil: whether private parties can force states to comply with the Medicaid Act.

Part I explored the lack of administrative remedies available to private parties harmed by state noncompliance, and the contours of providers' and enrollees' reliance on either § 1983 or Supremacy Clause actions to rein in rogue states (or, more likely, to get states to pay "sufficiently" for providers to participate in the program). This Part will address how this major omission will be exacerbated by implementation of the ACA through the additional pressure that the legion of new enrollees will place on an overburdened program and the increased tensions that will result in Medicaid's extant, multi-layered power struggle.

A. Enrollment Pressure

Because the Medicaid expansion was rendered optional by the plurality in *NFIB*,¹³⁸ guessing how many will be added to the Medicaid rolls has become a full-time job while state governors and legislatures play a game of political chicken deciding whether they will opt in or opt out of the expansion.¹³⁹ Current estimates¹⁴⁰ indicate that Medicaid will become the predominant method of healthcare payment in the country.¹⁴¹ The increased enrollment is due not only to the Medicaid expansion, but also to the "welcome mat" or "woodwork" effect

¹³⁷ For further description of this Circuit Court misinterpretation of the Medicaid Act's intent, see Huberfeld, *Bizarre Love Triangle*, *supra* note 21, at 453–58 (explaining the Seventh Circuit's misinterpretation of the key "medical assistance" language of the Medicaid Act).

¹³⁸ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2607 (2012).

¹³⁹ Data on state choices varies slightly depending on the news media source, but the reporting is essentially consistent. See, e.g., Juliette Mullin, *A Year Later, 13 Governors Still Oppose Medicaid Expansion*, THE ADVISORY BOARD COMPANY (June 28, 2013), <http://www.advisory.com/Daily-Briefing/Blog/2013/06/13-governors-still-oppose-Medicaid-expansion>; THE HENRY J. KAISER FAMILY FOUND., STATUS OF STATE ACTION ON THE MEDICAID EXPANSION DECISION, AS OF SEPTEMBER 30, 2013, <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act> (last visited Nov. 9, 2013).

¹⁴⁰ See Price & Eibner, *supra* note 136, at 1034.

¹⁴¹ Dominant in terms of number of lives covered, though not necessarily in terms of political or medical power. See KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUND., MEDICAID: A PRIMER (March 2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>. The *Primer* states: "Medicaid now covers over 62 million Americans, more than Medicare or any single private insurer. Medicaid covers more than 1 in 3 children and over 40% of births. . . . More than 60% of people living in nursing homes are covered by Medicaid." *Id.* at 1 (emphasis added).

of the ACA's goal of universal coverage.¹⁴² This enormous influx of covered lives will place pressure on a number of weak spots in HHS oversight of the Medicaid program.

First, the number of enrollees will increase much more than the number of physicians participating in the Medicaid program. Even though the Health Care and Education Reconciliation Act of 2013 (HCERA), companion legislation to the ACA, increased primary care physician payments to Medicare levels for 2013 and 2014,¹⁴³ the increases may not last long enough¹⁴⁴ for physicians to want to participate in Medicaid to experience this increase in enrollees at the prior, lower payment rates.¹⁴⁵ Thus, a higher enrollee to provider ratio is likely to exist because the number of physicians serving Medicaid patients is unlikely to increase proportionately to the number of new enrollees in Medicaid, making access to care more difficult.¹⁴⁶ Medicaid participating physicians will indubitably experience greater dissatisfaction with the low rates states pay. When providers are dissatisfied with the state payment levels and methodologies, they typically will first appeal to the state's Medicaid agency. If that is unsuccessful, then providers will team up with patients to enjoin the state's low payment rates in federal court. As was described above, this may occur either under § 1983 or the Supremacy Clause, as 30(A) can no longer be enforced by providers and sometimes enrollees through § 1983 actions.¹⁴⁷ But, providers will already be stretched thin and may be more likely to drop out of Medicaid rather than bother with challenging the state.

Second, the influx of covered lives will exacerbate the admitted oversight

¹⁴² See generally Julie Sonier, Michel H. Boudreaux & Lynn A. Blewert, *Medicaid "Welcome Mat" Effect of Affordable Care Act Implementation Could Be Substantial*, 32 HEALTH AFF. 1319 (July 2013), available at <http://content.healthaffairs.org/content/32/7/1319.abstract> (describing why the ACA will increase Medicaid enrollment by encouraging people already eligible for Medicaid to enroll in addition to the newly eligible population).

¹⁴³ Health Care and Education Reconciliation Act of 2010, Pub L. No. 111-152, 124 Stat. 1029 (2010).

¹⁴⁴ See, e.g., Benjamin Sommers, Emily Arntson, Genevieve Kenney, & Arnold Epstein, *Lessons from Early Medicaid Expansions Under the Affordable Care Act*, HEALTH AFF. BLOG (June 14, 2013), <http://healthaffairs.org/blog/2013/06/14/lessons-from-early-medicare-expansions-under-the-affordable-care-act> (noting that states experimenting with early adoption of the Medicaid expansion experienced access barriers, particularly in rural areas, and that the "state Medicaid officials we interviewed were fairly skeptical that the temporary pay increase would significantly increase provider participation in Medicaid.").

¹⁴⁵ See Phil Galewitz, *Few Medicaid Docs Have Seen 2013 Pay Raise*, KAISER HEALTH NEWS (July 16, 2013), http://articles.washingtonpost.com/2013-07-16/national/40598337_1_pay-raise-obama-administration-california-medicare (noting that the pay raise was implemented late and will not last long enough to draw new physicians to serve Medicaid patients).

¹⁴⁶ See Sandra L. Decker, *Two-Thirds of Primary Care Physicians Accepted New Medicaid Patients in 2011-12: A Baseline to Measure Future Acceptance Rates*, 32 HEALTH AFF. 1183, 1186 (July 2013), available at <http://content.healthaffairs.org/content/32/7/1183.short> (cautioning that increased payments may not be enough to encourage physicians to accept Medicaid as reimbursement for their services and that the limited increase in payments will self-mitigate).

¹⁴⁷ See Huberfeld, *Bizarre Love Triangle*, *supra* note 21, at 447.

limitations of the Centers for Medicare and Medicaid Services (CMS). This is due to a number of factors, only one of which is the number of new enrollees that will be covered by Medicaid. More important is that the new enrollees are likely to “churn” in and out of Medicaid, and in large numbers.¹⁴⁸ In this case, it means those newly eligible enrollees will churn between public insurance and private insurance, jumping from Medicaid to federally-subsidized private health insurance.¹⁴⁹ Unless a state has a waiver to create a system like that approved for Arkansas, which will place the newly eligible population in private insurance by way of premium assistance, the newly enrolled will be a population in perpetual flux.¹⁵⁰ CMS will likely strain, given its acknowledged limited supervisory capacity, to track this churning new enrollee population and its needs.¹⁵¹ Some predict that millions of people will churn in and out of Medicaid each year, which can lead to lower quality of care and inconsistent care, more visits to emergency departments, and delay in necessary medical care.¹⁵²

These challenges for CMS are likely to be complicated by the predicted primary care provider shortage described above. Providers often protect enrollee interests by protecting their own interest in adequate payment, which helps to ensure adequate access to non-emergency medical care. But, existing Medicaid providers are seeing more enrollees, and the higher provider-enrollee ratio will make it more difficult for providers to seek federal interference when a state proposes changes to its program that could harm enrollees or does not deliver on Medicaid promises. Also, being stretched thin may influence more providers to cease participation in Medicaid, thereby diminishing CMS’s de facto administrators. In addition, advocate resource strain will make it so that private, non-profit entities that act as watchdogs for Medicaid will have a harder time raising the yellow and red flags that CMS also admits to relying on for programmatic oversight.

148 Sara Rosenbaum & Benjamin D. Sommers, *Using Medicaid to Buy Private Health Insurance —The Great New Experiment?*, 369 NEW ENG. J. MED. 7, 8 (2013) (“Our research suggests that low-income adults experience so much income fluctuation that 28 million annually could “churn” across the Medicaid-exchange divide . . .”).

149 See Matthew Wayt, ‘Churning’: The Latest Watchword for States Working on Health Reform, CALIFORNIA HEALTHLINE (July 31, 2013), <http://www.californiahealthline.org/road-to-reform/2013/churning-the-latest-watchword-for-states-working-on-health-reform> (describing how “life events” like marriage, the birth of children, divorce, job changes, and the like can cause income to fluctuate and impact health insurance coverage above or below the 138% line for Medicaid coverage, and that California has no current means to work through the phenomenon of “churn”).

150 Rosenbaum and Sommers see this as a potential benefit of the Arkansas-style waiver (easier tracking of the Medicaid enrollee population). See Rosenbaum & Sommers, *supra* note 148, at 8–9.

151 Brief of Former HHS Officials as Amici Curiae in Support of Respondents, *supra* note 127, at 4, 12–26.

152 Benjamin D. Sommers & Sara Rosenbaum, *Issues in Health Reform: How Changes In Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, 30 HEALTH AFF. 228, 232–35 (2011) (predicting the magnitude and quality of the churning in and out of Medicaid that is likely to occur in the next several years).

Third, *NFIB* placed previously unimagined limits on HHS authority. The Roberts plurality determined that Congress unconstitutionally coerced states into participating in the Medicaid expansion when it mandated expansion and left in place the Medicaid Act's statement of the Secretary's power to withhold or withdraw all or part of a state's funding when the state does not comply with the Medicaid Act.¹⁵³ The remedy for that coercion was not, however, to strike the Medicaid expansion from the ACA; instead, the remedy was to limit the Secretary's ability to penalize noncompliant states by only allowing withholding of the funds offered in the ACA. In other words, the Secretary could not withhold or withdraw all of a state's funds for noncompliance with the expansion, she could only withhold the extra funding that would come with expansion. This severing of the Secretary's power was unprecedented. And so, even though the Court was at pains to limit the reach of its holding to the perhaps unique circumstances of the ACA, that does not mean that the Court will not tie the Secretary's hands again.

Each of these factors underlines the missed opportunity of the ACA to create a clear remedy for Medicaid providers and beneficiaries when states fail in their Medicaid programs. The enrollment growth described above will also exacerbate the existing power struggle within Medicaid. Adding millions to the Medicaid rolls is indubitably beneficial for the lives being covered, but the enrollment pressure will lead to greater tensions between providers and states, as well as states and the federal government.

B. Power Struggle Escalation

The Boren Amendment experiment demonstrated that Medicaid litigation can work to change state choices in Medicaid implementation. It also demonstrated that Medicaid litigation can backfire, as the states successfully convinced Congress to eliminate this source of conflict and litigable payment rights. And, it should be acknowledged that litigation has pros and cons. One major downside to litigating each provision of the Medicaid Act separately is that programmatic uniformity is not usually the goal for either litigants or courts, so each circuit may have a different manner of describing Medicaid's requirements. This is inconsistent with the Medicaid Act itself, which created a national baseline for the poor to access medical care. On the other hand, federal courts' fear of full dockets is not a downside to this litigation, merely a statement of juridical concern. The reason it is not a downside is that, as the Boren experiment showed, federal courts can vindicate Medicaid entitlements in meaningful ways, and they are much closer to the individuals suffering state shortcuts than HHS, due to the nature of litigation itself. In other words, the people being harmed know that they can seek redress in federal court, but they do not have a sense that complaining to HHS is an effective process. Here is

¹⁵³ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012).

where the Medicaid power struggle really matters.

The federal executive branch prioritizes cooperation with states, so HHS has created a largely non-adversarial environment in which states negotiate their Medicaid failures with little chance of actually losing Medicaid funds.¹⁵⁴ The reason is straightforward: adversarial processes could harm the very people Medicaid was intended to benefit. If CMS were to cease funding a state's Medicaid program due to noncompliance, the enrollees in the state would lose access to care, and bear the brunt of the penalty rather than the offending state's politicians responsible for the noncompliance.¹⁵⁵ In fact, HHS has never withheld all of a state's Medicaid funding. Also, HHS typically does not command a state to pay retroactively when the state does run afoul of the Medicaid Act by, for example, paying healthcare providers too little under the Equal Access provision. So, the federal executive branch appears to protect the Medicaid program and its enrollees at the global level rather than on a micro-level. Federal courts do not feel constrained in the same way. Consequently, part of the power struggle is occurring between the federal executive and federal judicial branches.

This clash was demonstrated recently in *Douglas v. Independent Living Center*, a 2012 Supreme Court decision in which California's provider rate cuts were challenged as violating the Equal Access provision of the Medicaid Act and thus the Supremacy Clause.¹⁵⁶ The Court avoided the Supremacy Clause question by remanding to the Ninth Circuit so that HHS could exercise primary jurisdiction in the case, but a heated dissent authored by Chief Justice Roberts would have disallowed the Supremacy Clause cause of action for Medicaid providers and beneficiaries.¹⁵⁷ The United States Solicitor General's Office supported California's advocacy in this regard, filing a stunning amicus brief that argued no Supremacy Clause actions should be available.¹⁵⁸ The Secretary of HHS pointedly did not join this amicus, apparently after failing to persuade the Acting Solicitor General that such a position would be harmful to the Medicaid program.¹⁵⁹ The HHS position was represented by a high profile amicus brief

¹⁵⁴ See Huberfeld et al., *Plunging into Endless Difficulties* *supra* note 116, at 17 (describing the negotiating process between HHS and states, which has never resulted in total funding withdrawal), 75–76 (describing confusion over this fact during oral arguments).

¹⁵⁵ Solicitor General Verrilli had a hard time articulating this conundrum during oral arguments defending the Medicaid expansion. Transcript of Oral Argument at 55–56, *Florida v. HHS*, 132 S. Ct. 2566 (2012) (No. 11–400). Justice Breyer tried to help the Solicitor General, but Verrilli did not pick up on the lifeline. See *id.*; see also Huberfeld et al., *Plunging into Endless Difficulties*, *supra* note 116, at 75.

¹⁵⁶ *Douglas v. Indep. Living Ctr. of Southern California, Inc.*, 132 S. Ct. 1204, 1205 (2012).

¹⁵⁷ *Id.* at 1206–08, 1212.

¹⁵⁸ Brief for the United States as Amicus Curiae Supporting Petitioner at 24–25, *Douglas v. Indep. Living Ctr. of S. California, Inc.*, (2012) (Nos. 09–958, 09–1158, 10–283), 2011 WL 2132705 at *24–25.

¹⁵⁹ See Nicole Huberfeld, *Post-Reform Medicaid Before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS HEALTH L. 513, 520–22 (2012) (discussing the conflict between

written by former HHS administrators that described how important private rights of action are to policing states in Medicaid.¹⁶⁰ Members of Congress also submitted a brief explaining that Congress has considered eradicating private actions for 30(A), and such deliberations led to Congress intentionally leaving 30(A) in the Medicaid Act, with no bar on private actions.¹⁶¹ This fight emphasizes how far off base the states' sovereignty arguments are in the context of private enforcement of Medicaid and underlines executive branch tensions.

Further, federal court actions can yield synergies with the purposes of the Medicaid program. For example, when the courts were taking Boren Amendment cases in the 1980's and 1990's, their inclination to enforce statutory payment provisions resulted in increased state payments to providers, which naturally helps to facilitate enrollee access. At the same time, Congress was adding mandatory categories of eligibility to the program, thereby also expanding access to Medicaid.¹⁶² Thus, the judiciary and the legislature were not working at cross-purposes, even though they were not purposefully working together to facilitate such expansion. Also, the circuits sometimes follow one another's lead in deciding the enforceability of Medicaid provisions, thereby creating some national uniformity and adhering to the purposes of creating a national medical program for the poor. And, the courts can "prompt" agencies to act, especially when litigation highlights problems the agency was otherwise unaware of.¹⁶³

Nevertheless, if the exceptionalist theory of spending statutes becomes the majority view on the Court, then the judiciary and the administrative arm of the executive branch will be working at cross-purposes, potentially creating a separation of powers dilemma. This theory has surfaced in spending power decisions for decades, and it recently surfaced again in Chief Justice Roberts'

HHS and the Solicitor General's office) [hereinafter Huberfeld, *Post-Reform Medicaid Before the Court*].

¹⁶⁰ See generally Brief of Former HHS Officials as Amici Curiae in Support of Respondents, *supra* note 127, at 15–16. This intra-branch dispute was watched closely for what it portended in the ACA litigation that followed. Interestingly, the most important aspect of the decision for *NFIB* purposes was probably that the Roberts dissent paid scant attention to the finer points of the Medicaid program, instead showing concern for constitutional principles that were housed in a health-care vehicle, much like the factually fallacious plurality in *NFIB*. Douglas, 132 S. Ct. at 1212 (Roberts, C.J., dissenting) (focusing on the spending power rather than the intricacies of the Medicaid program); see generally Huberfeld et al., *Plunging into Endless Difficulties*, *supra* note 116 (deconstructing the factual and constitutional problems in the Medicaid aspect of the *NFIB* decision).

¹⁶¹ Brief of Members of Congress as Amici Curiae Support of Respondents at 21–23, *Douglas v. Indep. Living Ctr. of S. California, Inc.*, (2012) (Nos. 09–958, 09–1158, 10–280), 2011 WL 3467244, at *21–23 (discussing Congress's choice not to terminate private causes of action enforcing the Medicaid Act).

¹⁶² See Huberfeld et al., *Plunging into Endless Difficulties*, *supra* note 116, at 20–24 (recounting prior Medicaid expansions that were mandatory for states participating in the program).

¹⁶³ See Sharkey, *supra* note 84, at 5–6 (describing federal courts' role as "prompting" agency actions when agencies cannot or do not otherwise manage their regulatory domain).

Douglas dissent.¹⁶⁴ This theory would eradicate private rights of action to enforce the conditions placed on states in federal spending programs under the belief that spending statutes are a different, lesser form of federal legislation that is so much like a contract that only the federal government and the state agreeing to accept the funding can negotiate the terms of that program.¹⁶⁵ Thus, only the enforcing agency has power over a digressive state, because program enrollees are essentially third-party beneficiaries with no power to intervene, given that contracts were not enforceable at the time § 1983 was enacted.¹⁶⁶ This theory hinges on the lack of explicit private action language in the Medicaid Act, irrespective of Congress' longstanding complicity in private Medicaid enforcement actions.¹⁶⁷ If Congress were to modify the Medicaid Act to include such language, which it should have done in the ACA's sweep, then interpretation of that right would be much more straightforward than actions through either § 1983 or the Supremacy Clause.¹⁶⁸

A complex power struggle exists between the states and the federal government as well. The federal government has shown itself to be divided by branch, and even intra-branch, in running the Medicaid program.¹⁶⁹ Again, to use the example of *Douglas*, the state's interest was aligned with the enforcement arm of the executive branch, which agreed with California's assertion that no Supremacy Clause action was valid. But, the administrative arm of the executive branch disagreed, creating an intra-branch dispute.¹⁷⁰ California's interest was rejected by members of Congress, some of whom filed an amicus brief in the case.¹⁷¹ The federal agency's views were aligned with the majority in the Court's decision, given that it avoided the constitutional question of private rights of action, but the state was aligned with the strongly worded dissent, displaying

164 *Douglas*, 132 S. Ct. at 1214 (Roberts, C.J., dissenting).

165 *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 28 (1981). Then-Justice Rehnquist wrote, in language seemingly intended to limit *Thiboutot* (decided only the year before): "In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State." *Id.* at 28.

166 *Blessing v. Freestone*, 520 U.S. 329, 349–50 (1997) (Scalia, J., concurring) (questioning whether § 1983 "ever authorizes the beneficiaries of a federal-state funding and spending agreement" to litigate state compliance and likening the beneficiaries of federal spending to third-party beneficiaries of contracts).

167 Amicus Brief of Members of Congress Support of Respondents, *supra* note 161, at 8–11 (asserting that Congress expects a private right of action to exist and that Congress has debated and rejected amendments to 30(A) that would eradicate private actions but rejected such proposals).

168 See Huberfeld, *Bizarre Love Triangle*, *supra* note 21, at 467 (suggesting that Congress modify the Medicaid Act to incorporate the action that it assumes exists).

169 See Huberfeld, *Post-Reform Medicaid Before the Court*, *supra* note 159, at 533–40 (analyzing the discordant positions the federal government presented in the two Medicaid cases before the Court in the October 2011 term).

170 See notes 158–161 and accompanying text.

171 Brief of Members of Congress as Amici Curiae Support of Respondents, *supra* note 161, at 8–11.

another intra-branch dispute. Multiple vectors would be required to diagram this set of tensions, adding to the sense that federalism does not capture the nature of the disputes here.

Importantly, neither Congress nor HHS opposes private rights of action as a whole. But, in the *Douglas* case the agency had not completed its review of California's reimbursement decisions, and so the administrative process was incomplete.¹⁷² The Medicaid enrollees and providers who sought federal court protection were concerned that California would cut reimbursement rates while HHS considered its proposed State Plan Amendment. Thus, the federal court did not just act as a mediator between disagreeing parties at the federal and state levels, it gave voice to both the federal agency and the program's beneficiaries and healthcare providers.

When CMS approves or rejects a State Plan Amendment, citizens have no role in that life-impacting decision (other than to participate in the notice and comment process). And, perhaps most importantly, the state can act on its proposed reductions or other limitations while CMS reviews the proposed Amendment, which can take months if not years.¹⁷³ In the meantime, providers may be under-reimbursed or enrollees may not receive needed services, and they have no redress without the ability to petition federal courts. Thus, the federal courthouse doors must remain open, but for more than agency-forcing. The agency may not always act in the best interests of those who Medicaid is intended to benefit.¹⁷⁴ To come back to *Douglas*, after the Court's decision, CMS approved California's rate reductions despite their lack of data collection regarding the medical access impact of across-the-board payment reductions.¹⁷⁵ CMS should not have deferred; and, even though CMS has supported private rights of action, the agency's approval of California's cuts thwarted the private action in California.

Medicaid stakeholders are engaging in an ongoing fight over whose power and interests should be predominant. States want more federal money but

¹⁷² Professor Sharkey has suggested that when the agency's interests align with the states' interests in a cooperative federalism program, federal courts have a special role to play by forcing the agency to act. See Sharkey, *supra* note 84, at 9 ("[C]ourts may need to step up in their role as guardians and enforcers of the supremacy of federal law" when interests align).

¹⁷³ California submitted its proposed State Plan Amendment months after it had already effected cuts in provider reimbursement. Brief of Members of Congress as Amici Curiae Support of Respondents, *supra* note 161, at 24 n.3.

¹⁷⁴ One response might be that the agency's action would then be deemed arbitrary and capricious, but that outcome is often wishful, as CMS lightly reviews such state actions as rate reductions. The regulations drafted to address the payment sufficiency standard in 30(A) do not require much more than reporting, which facilitates oversight but does not give CMS more options in responding to unreasonable payment decreases.

¹⁷⁵ The HHS approval of California's reimbursement rate cuts lead to additional litigation in the Ninth Circuit. See generally *Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235 (9th Cir. 2013) (reviewing HHS's approval of California's rate cuts and affording the Secretary *Chevron* deference for the decision); see also Brietta Clark, *APA Deference After Independent Living Center: Why Informal Adjudicatory Action Needs a Hard Look*, 102 KY. L.J. 211 (2014).

fewer federal conditions and less federal oversight. The enforcement arm of the executive branch appears to want states and the administrative arm of the executive branch to work out their differences amicably. The administrative arm of the executive branch wants to enforce the statute through cooperation, but it also needs and wants help supervising the states in these endeavors. The federal courts probably do not want to continue to supervise the implementation of the Medicaid program, but they continue to provide an important counterbalance to the other players. And, this independent perspective, and power, will become more important as the Medicaid expansion is implemented, especially because providers and patients are at the mercy of these competing interests with no recourse if the courthouse doors are closed.

CONCLUSION

Each of the participants in Medicaid—states, healthcare providers, enrollees, the federal executive branch—believes it is the heart of the Medicaid program. But the Medicaid program is a federal program that assists the states so that they can help to deliver healthcare to the poor. Thus, despite state and other stakeholder claims to the contrary, Medicaid is not for states, it is for people.¹⁷⁶

To protect the people enrolled in the Medicaid program, until Congress amends the Medicaid Act to provide statutory enforcement mechanisms to providers and patients, federal courts must keep their doors open to private rights of action that keep states in line with the Medicaid Act. Such private actions are consistent with the language and intent of the Medicaid Act, and they have the important effect of alerting HHS to state failures as well as providing direct remedies to the people who are harmed the most by state inattentiveness to the strictures of the Medicaid Act.

¹⁷⁶ Brief of Members of Congress as Amici Curiae Support of Respondents, *supra* note 161, at 18 (stating that states are “partners” in Medicaid but they are not the “intended beneficiaries of Medicaid”).