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To:	American Health Care Association/National Center for Assisted Living, American Network of Community Options, American Pharmacists Association, America's Essential Hospitals, National Association of Chain Drug Stores, National Community Pharmacists Association
From:	Joel Hamme
Date:	March 31, 2015
Subject:	Armstrong v. Exceptional Child Center, No. 14-15 (U.S. Mar. 31, 2015)

A. Background

In a 5-4 decision issued today in the above captioned case, the Supreme Court of the United States held that Medicaid providers may not sue state officials in court for alleged violations of the Medicaid Act's rate-setting standards. Under those standards, 42 U.S.C. § 1396a(a)(30)(A), also known as the "equal access" provision, states must use rate methodologies that:

(1) assure that Medicaid payments are consistent with efficiency, economy, and quality of care; and

(2) result in payments sufficient to enlist enough providers so that care and services are as available to Medicaid beneficiaries as they are to the general population in the same geographic area.

As you are aware, this is the case in which our Coalition filed an amici curiae brief arguing that such a private right of action should be recognized.

This memorandum reviews the majority opinion, a concurring opinion, the dissenting opinion, and the implications of this decision for Medicaid providers.

B. The Majority Opinion

The majority opinion consists of four major parts.[1] The first part furnishes background concerning the Medicaid program.

[1] The majority opinion was written by Justice Scalia. Chief Justice Roberts, Justice Thomas, and Justice Alito concurred in the entire opinion. Justice Breyer concurred in the result and in parts one through three of the majority opinion.

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The second part of the majority opinion is an analysis concluding that the Supremacy Clause -- which was the grounds on which the lower courts had found a private right of action to enforce the equal access provision -- is not the source of any federal rights. Rather, suits to enjoin unconstitutional actions by state and federal officials are creatures of the equity courts.

The third part finds that Medicaid implicitly precludes private enforcement of the equal access provision both because the Secretary of Health and Human Services ("HHS") has the relevant oversight authority (and the ability to withhold federal funds if states do not comply with federal law) and because the terms of the equal access provision are "judicially unadministrable."[2]

The fourth part of the majority opinion asserts that the Medicaid Act and the equal access provision do not contain rights creating language. Medicaid providers are not the intended beneficiaries of the Act but, even if they were, suits by intended beneficiaries are generally not permitted in cases which -- as here -- involve contracts between private parties and the government.[3]

C. The Crucial Concurring Opinion

Justice Breyer furnished the determinative fifth vote and, accordingly, his concurring opinion warrants review. Essentially, Justice Breyer states that:

- The equal access provision is "broad and nonspecific".
- Administrative agencies are better suited to the ratemaking task than judges.
- The equal access provision applies broadly to providers serving many patients.[4]
- Allowing such suits would result in a proliferation of litigation and judicial ratesetting that unsettles federal administrative oversight, none of which Congress intended.
- While there could be clear cut cases for injunctive relief, there is no easy way to separate such cases from more complex cases that would ensnare the judiciary in decision-making going beyond mere review of administrative actions.[5]

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[2] In this section, the majority also emphasizes that the Medicaid providers in this case did not assert a private right of action under 42 U.S.C. § 1983 ("Section 1983") and that, in any event, the Court's most recent precedents foreclose the implications of such a right of action in this case.
[3] Justice Breyer did not concur in this part of the opinion. Consequently, it represents the views of only four justices.
[4] In support of this, Justice Breyer cites a study involving Medicaid managed care. Apparently, he is unaware that the equal access provision only applies to Medicaid fee-for-service providers, not providers participating in Medicaid managed care.
[5] Justice Breyer indicates that the Exceptional Child Center case probably belongs in the latter category and then references an unresolved factual dispute in the case as to whether state officials were setting Medicaid rates that violated the state's federally approved rate methodology.

- Significantly, Medicaid providers may ask HHS to change or enforce its rate setting rules and, if they are not satisfied with what HHS does, they may initiate proceedings for judicial review against HHS under the Administrative Procedure Act ("APA").[6]

D. <u>The Dissent</u>

The dissent reasons that the Court has previously held that HHS's Medicaid enforcement authority does not foreclose private actions to uphold Medicaid requirements.[7] Further, Congress was unquestionably aware of the fact that courts routinely enjoin state actions that are preempted by federal law.[8] According to the dissent, there is no evidence that Congress considered HHS's remedial enforcement authority to be exclusive. Finally, the language of the equal access provision mirrors in many respects the terms of the Boren Amendment which the Court found to be privately enforceable in <u>Wilder v. Virginia Hospital Association</u>, 496 U.S. 498 (1990). As such, the equal access provision cannot be considered judicially unadministrable.

E. <u>The Implications For Medicaid Providers</u>

The decision in <u>Armstrong v. Exceptional Child Center</u> effectively means that, so long as the composition of the current Court remains static, federal law does not provide an avenue for Medicaid providers to sue state officials regarding rate adequacy or legality. What, then, can the provider community do? The following steps or points should be considered:

(1) Engage HHS on a series of levels:

(a) To finalize the equal access regulations that were issued in proposed form in 2011; these regulations would govern fee-for-service Medicaid provider rates.

(b) To strengthen standards and agency oversight regarding the establishment and payment of Medicaid rates in the managed care context; and

(c) To create or clarify the procedures whereby Medicaid providers and beneficiaries may submit comments on and otherwise participate in agency deliberations involving:

i. Pending state plan amendments or waivers affecting Medicaid reimbursement;

ii. States acting in violation of their federally approved rate methodologies; and

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[6] Justice Breyer then cautions that, given the broad discretion vested in HHS, it would be difficult for providers to prevail in such cases.
[7] The dissent was authored by Justice Sotomayor, joined by Justices Kennedy, Ginsburg, and Kagan.
[8] The dissent notes that such equitable actions differ from implied right of action or Section 1983 cases because the latter types of cases may seek a variety of remedies, including damages. Unfortunately, the dissent does not mention that there is no such distinction in these cases because federal courts are precluded from levying monetary damages against states under the 11th Amendment.

iii. States proceeding with rate methodology changes in the absence of a proposed state plan amendment, waiver request, or waiver modification.

(2) Consider initiatives to have Congress legislatively overturn or modify the Supreme Court's ruling by creating private rights of action regarding Medicaid rate setting.[9]

(3) Assess whether controlling state laws or regulations permit Medicaid rate suits in individual states and develop and pursue legislative proposals in states that may be receptive to such provisions.

(4) Work with affected provider groups to determine whether APA litigation should be undertaken against HHS in cases where:

(a) a state is setting rates that do not comply with its approved rate methodology;

(b) a state has altered its rate methodology but has not bothered to seek federal approval of a proposed state plan amendment, a waiver, or a waiver modification; or

(c) HHS has approved the challenged rate methodology.

F. Conclusion

The result in the Exceptional Child Center case is dismaying because, for now, it would appear to end decades of case law permitting affected Medicaid providers to seek redress in court over rates that may not meet federal requirements. At the same time, there are a number of viable options, as suggested here, to try to assure that there is meaningful scrutiny of Medicaid rates by federal officials and, possibly, by the courts.

If you have questions on this memorandum, please contact Joel Hamme (joel.hamme@ppsv.com or 202-872-6761).

[9] This may be unrealistic as to the current Congress but, at the least, beginning such a process and educating legislators may provide longer term benefits. It should be underscored that there are existing Medicaid statutes (e.g., 42 U.S.C. §§ 1320a-2 and 1320a-10) that raise important questions as to whether the Supreme Court's decision actually complies with congressional directives. Our Coalition filed an amici curiae brief on these points in the Exceptional Child Center case. Unfortunately, the Court ignored them even though they fit nicely with some of the discussion in the dissent and even in Justice Breyer's concurring opinion. Of course, it is also possible that other Medicaid providers might make use of such an analysis in a future Medicaid rate case.