Connecticut Law Tribune
May 11, 2015 ctlawtribune.com An ALM Publication

HEALTH LAW

Ruling Restricts Ability to Challenge Medicaid Rates

Providers, patients both hurt by recent Supreme Court decisions

By KIM E. RINEHART and MAUREEN WEAVER

KIM E. RINEHART and MAUREEN WEAVER

On March 31, the U.S. Supreme Court handed down its ruling in *Armstrong v. Exceptional Child Center*, holding that providers cannot sue under the Supremacy Clause to invalidate Medicaid rates that conflict with the Medicaid Act's requirements that rates be sufficient to support quality care and enlist enough providers to ensure equal service access to Medicaid recipients. **Armstrong** thus removed one major avenue for providers to challenge the reasonableness of Medicaid rates. At a time when state budgetary concerns are driving the reimbursement rates for medical services provided to the neediest Americans, Armstrong is a blow to both Medicaid providers and patients. Despite the ruling, however, some avenues remain for challenging inadequate reimbursement rates.

Medicaid is a federal-state partnership. State participation is voluntary. But if a state chooses to participate and receive federal funds, it must follow federal Medicaid rules. Each state develops and administers its own state plan under the oversight of the federal Centers for Medicare and Medicaid Services (CMS). In Connecticut, the Department of Social Services (DSS) administers the Medicaid program and sets the reimbursement rates paid to providers.

Providers in Connecticut and around the country have complained that the Medicaid rates established by the states are woefully inadequate, failing to cover providers' costs. Many health care providers lose money on each Medicaid patient they serve: the more Medicaid patients served, the greater the loss. Low rates lead to poor provider

Kim E. Rinehart is a litigation partner at Wiggin and Dana, where she focuses on complex litigation and appeals. She represents health care providers in litigation matters, including administrative rate appeals. Maureen Weaver is chairwoman of the firm's health care practice. She advises hospitals, provider networks, long-term care providers, home health care agencies, hospices, physicians and other health care providers and trade associations on regulatory, patient care, reimbursement, compliance, HIPAA, operational and corporate matters.

participation, which in turn harms Medicaid recipients, who may have trouble finding a doctor to treat them.

While Congress gave states broad discretion to craft their Medicaid plans, that discretion is not limitless. The Medicaid Act requires states to "assure that payments are consistent with … quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. §1396a(a)(30)(A). Section 30(A) has been a key weapon for providers challenging inadequate Medicaid rates. Unfortunately, courts have gradually weakened that remedy, concluding that there is no private right of action to sue directly under the statute, and rejecting efforts to bring Section 1983 actions to enforce it. In recent years, providers had some success arguing that the Supremacy Clause gave federal courts authority to enjoin state plans with Medicaid rates that did not meet Section 30(A)'s standards. This issue was front and center in *Armstrong*.

Armstrong involved a group of supported living service providers who argued that Idaho violated Section 30(A) by reimbursing them at artificially low rates for purely budgetary reasons. Idaho had developed a new reimbursement system that would have substantially increased provider rates, but never implemented the system because Idaho's legislature did not allocate sufficient funds. The district court ruled in favor of the providers, finding that the rates were unlawful because they bore no relationship to the providers' costs. The U.S. Court of Appeals for the Ninth Circuit affirmed, holding that the providers could sue for injunctive relief under the Supremacy Clause to bar Idaho's payment system because it conflicted with the federal mandate set out in Section 30(A). A deeply divided Supreme Court reversed.

Led by Justice Antonin Scalia, the majority explained that the Supremacy Clause "instructs courts what to do when state and federal law clash, but is silent regarding who may enforce federal laws in court, and in what circumstances they may do so." While the majority acknowledged that the court has sometimes enjoined enforcement of state laws that conflict with federal law, those cases do not demonstrate that the Supremacy Clause creates a cause of action for its violation. Rather, those cases relied on the court's broad equitable power. Because Congress can create law, however, Congress can also explicitly or implicitly preclude private enforcement of that law.

In the majority's view, Section 30(A) "implicitly precludes private enforcement" for two reasons. First, the Medicaid Act provides a specific enforcement mechanism: CMS may withhold funds from a state failing to comply with the act's requirements. Second, Section 30(A) does not impose detailed limits, but establishes a broad and vague standard. Application of such a standard involves discretion that is well-suited to agency action, requiring experience, uniformity, consultation and expertise. It is ill-suited to judicial intervention. For the majority, this "judgment-laden standard" made sense if Congress intended CMS alone to enforce it.

Justice Sonia Sotomayor penned a vigorous dissent, joined by Justices Anthony Kennedy, Ruth Bader Ginsburg and Elena Kagan. While agreeing that there is no Supremacy Clause cause of action, they saw no intent by Congress to restrict the court's equitable authority to enforce federal law by enjoining state plans that conflict with Section 30(A). The court has generally only found such an intent where Congress expressly forbids enforcement or provides a detailed alternative remedial scheme. Here, there is no language forbidding enforcement, and Congress' provision of a blunt enforcement mechanism to CMS, which even CMS indicated was inadequate, did not establish Congress' intent to foreclose equitable judicial relief.

Concurring in most of the majority's opinion, Justice Stephen Breyer emphasized that CMS, and not the courts, was best equipped to assess Medicaid rates, despite the fact that former HHS senior officials dating back to Joseph Califano filed an amicus brief advising the court that they relied on private enforcement by providers and beneficiaries to hold states in check. Breyer's concurrence is helpful, however, because it points out that federal enforcement mechanisms are still available to providers. Providers can raise problems with proposed state plans to CMS and CMS can use its authority to disapprove such plans or withhold funds. Providers can also ask CMS to promulgate or modify its rules, thus imposing stricter guidance on the states. See 5 U.S.C. §553(e). If CMS refuses to do so, a provider can challenge the agency's action in court as arbitrary and capricious. See 5 U.S.C. §§702, 706(2)(A). A provider may also be able to challenge CMS's approval of a state plan containing unacceptable rates as arbitrary and capricious.

In addition to the federal mechanisms identified by Breyer, providers also should consider potential state law avenues for relief. For example, Connecticut requires hospital inpatient rates and the rates for special services to be based on "reasonable cost." Conn. Gen. Stat. §§17b-239(a), (b). With respect to physicians, Connecticut General Statutes §4-67c provides for a fee schedule that "shall be based on moderate and reasonable rates prevailing in the respective communities wherein the service is rendered." Additionally, Section 17b-262-530 of the Regulations of Connecticut State Agencies requires Medicaid payment schedules to be "in accordance with all applicable federal and state statutes and regulations." Thus, while providers may not be able to enforce Section 30(A) of the Medicaid Act directly, they may be able to do so through state law, which requires its application.

In many cases, providers can assert rate challenges through administrative appeals authorized by statute with the ability to appeal adverse decisions to the Superior Court. If no appeals process is authorized, providers could file a petition for declaratory ruling before DSS. Connecticut law also permits providers to petition DSS to promulgate regulations consistent with law. See Conn. Gen. Stat. §4-174. If DSS refuses, the provider may be able to challenge that refusal in court.

Armstrong has removed one weapon for challenging inadequate Medicaid rates, but others remain. The fight for reasonable rates undoubtedly will continue. ■