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MEDICAID ACCESS & STATE FLEXIBILITY: NEGOTIATING FEDERALISM

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Medicaid is a central focus of the enduring debate about federal health policy. It is also a persistent target of federalism-based accusations that the federal government is infringing on states' sovereignty in the area of health care. These accusations have been used to advance proposals to reduce Medicaid funding, roll back entitlements, and shift greater responsibility to the states—all in the name of protecting state power and increasing state flexibility. Such proposals have existed since Medicaid's creation, but the 2016 elections have reinvigorated calls for Medicaid retrenchment[1] as part of the plan to repeal and replace the Affordable Care Act.[2]

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1 Sara Rosenbaum, *The American Health Care Act and Medicaid: Changing a Half-Century Federal-State Partnership*, HEALTH AFF. BLOG (Mar. 10, 2017), http://healthaffairs.org/blog/2017/03/10/the-american-health-care-act-and-medicaid-changing-a-half-century-federal-state-partnership/ ("[I]t is evident that Medicaid is a focal point of the American Health Care Act, released on March 6. Although its fate is uncertain, the bill provides a clear sense of where the Affordable Care Act repeal and replace strategy is heading. Where Medicaid is concerned, what has been discussed for years has now become real: using ACA repeal/replace as the vehicle for a wholesale restructuring of the very financial foundation of the Medicaid program as it has existed over an unparalleled, half-century federal/state partnership.").

2 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a (2012)) [hereinafter Affordable Care Act or ACA].

Although Medicaid was created as an entitlement program with some federal constraints, there are also vast areas left to state discretion. The Medicaid Act[3] gives states the power to administer the program, and the flexibility to define most elements of program design.[4] There is also a waiver process by which states can seek exemptions from certain statutory requirements.[5] Indeed, state flexibility has been viewed by the federal government as an essential tool in Medicaid program administration—states have driven payment and service delivery reforms that balance Medicaid's multifaceted goals of improving access, ensuring quality care, and containing costs.[6]

Nonetheless, there is a persistent tension in how the contours of this flexibility are defined. We have seen this tension manifested in private suits challenging certain state decisions, especially state rate cuts and other financing reforms that are seen as harming access.[7] We

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3 The term "Medicaid Act" is used to refer to the statutory provisions governing Medicaid found in Title XIX of the Social Security Act and codified at 42 U.S.C. § 1396 *et seq.*

4 *See* Christina A. Cassidy, *With Trump's Victory, Republicans Hope to Overhaul Medicaid*, L.A. DAILY NEWS (Dec. 29, 2016), http://www.dailynews.com/government-and-politics/20161229/with-trumps-victory-republicans-hope-to-overhaul-medicaid; Samantha Artiga et al., *Current Flexibility in Medicaid: An Overview of Federal Standards and State Options*, KAISER FAM. FOUND., Jan. 2017, http://files.kff.org/attachment/Issue-Brief-Current-Flexibility-in-Medicaid-An-Overview-of-Federal-Standards-and-State-Options (noting that each state is unique).

5 Elizabeth Hinton et al., *3 Key Questions: Section 1115 Medicaid Demonstration Waivers*, KAISER FAM. FOUND., Feb. 2017, http://files.kff.org/attachment/Issue-Brief-3-Key-Questions-Section-1115-Medicaid-Demonstration-Waivers ("Waivers can provide states considerable flexibility in how they operate their programs, beyond what is available under current law, and can have a significant impact on program financing. As such, waivers have important implications for beneficiaries, providers, and states. While there is great diversity in how states have used waivers over time, waivers generally reflect priorities identified by states and the Centers for Medicare and Medicaid Services (CMS) . . . . As of February 2017, 33 states had 41 approved Section 1115 waivers.").

6 Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. 67576, 67578 (Nov. 2, 2015) (to be codified at 42 C.F.R. pt. 447) (explaining the broad flexibility given to states to design service delivery systems and provider payment methodologies, and explaining how the federal government supports states efforts to drive systemic changes and manage program costs).

7 *See generally* Brietta R. Clark, *Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration is Undermining its Own Health Reform Goals*, 55 HOW. L.J. 771 (2012) [hereinafter *Medicaid Access*] (reviewing the role of courts, states, and federal regulators in Medicaid payment suits brought over several decades).

also see this tension in on-going debates about whether the federal government is too liberal or rigid in its approach to state waiver requests.[8] In both circumstances, the legislative and regulatory framework encourages state flexibility, but subject to certain procedural checks and substantive constraints. In these cases, concerns about access are often linked to calls for greater oversight and the robust enforcement of federal access protections that constrain state flexibility.

The federal government has often responded by affirming its support for greater state flexibility. For example, Congress has amended the Medicaid Act to expand the scope of state flexibility in various program areas.[9] Federal regulators have taken action to promote state flexibility and support state experimentation through the liberal use of waivers and approval of state plan amendments.[10] And, as this article will show, courts have proven sensitive to these changes and respectful of state discretion when found to be consistent with federal statutory goals. When the Supreme Court believes lower courts have overreached in allowing private suits to improperly constrain or impede state action, it reins them in. This was demonstrated most recently by two rate-setting cases that reached the Supreme Court within just three years: *Douglas v. Independent Living Center of Southern California, Inc.*[11] and *Armstrong v. Exceptional Child Center, Inc.*[12]

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8 *See* Sidney D. Watson, *Premiums and Section 1115 Waivers: What Cost Medicaid Expansion?*, 9 ST. LOUIS U. J. HEALTH L. & POL'Y 265, 266–68, 271, 280 (2016); Laura D. Hermer, *On the Expansion of "Welfare" and "Health" Under Medicaid*, 9 ST. LOUIS U. J. HEALTH L. & POL'Y 235, 257–58, 263 (2016); John V. Jacobi, *Medicaid, Managed Care, and the Mission for the Poor*, 9 ST. LOUIS U.J. HEALTH L. & POL'Y, 187, 199 (2016) (arguing for greater flexibility for states to experiment with Medicaid accountable care organizations that address the social determinants of health, including social services to address housing barriers, substance use disorder, and community reentry for ex-offenders).

9 Artiga et. al., *supra* note 4, at 3 ("Calls for increased Medicaid flexibility are not new, and the minimum standards and options have evolved over time through federal legislation.").

10 *Id. See also* MaryBeth Musumeci & Robin Rudowitz, *The ACA and Medicaid Expansion Waivers*, KAISER COMMISSION ON MEDICAID & UNINSURED (Nov. 2015), http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers.

11 Douglas v. Indep. Living Ctr. of Southern Cal., Inc. (Indep. Living Ctr.), 132 S. Ct. 1204 (2012).

12 Armstrong v. Exceptional Child Ctr., Inc. (Exceptional Child Ctr.), 135 S. Ct. 1378 (2015).

These legislative, regulatory, and judicial approaches to defining the federal-state relationship in Medicaid program administration reveal a very different understanding of the federalism dynamic than the one articulated by proponents of Medicaid retrenchment. Proponents of capping Medicaid and eliminating or significantly reducing entitlements insist that such changes are needed to return power to the states by increasing state flexibility. Two assumptions animate their argument: that cutting states' funding will force states to become more innovative and efficient in delivering care, and that eliminating entitlements will remove legal constraints that have impeded state experimentation and flexibility.[13] As to the first, proponents simply ignore the empowering function of federal funding—the fact that many state innovations could not take place without it and that funding enhances state flexibility. As to the second, most reform proponents fail to explain what additional flexibility is needed or why such drastic funding cuts, as opposed to more modest amendments to the Medicaid Act, are necessary to achieve this flexibility. Their arguments reflect an older and simplistic vision of federalism that views federal and state power as binary, or views areas of overlapping authority federal and state authority as a zero-sum proposition. They treat federal spending conditions as inherently coercive—a view that seems to motivate legal arguments attempting to eliminate or severely limit private enforcement of federal spending conditions in federal court.

This view is inconsistent with a more modern understanding of the dynamic federal-state relationship that characterizes key parts of the Medicaid program. In certain areas, such as state process for setting

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13 Paul Ryan, *Our Health Care Plan for America*, USA TODAY, http://www.usatoday.com/story/opinion/2017/03/07/health-care-obamacare-replacement-paul-ryan-column/98858696/ (last updated Mar. 8, 2017, 1:23 PM) ("Next, while Obamacare just added people to a broken Medicaid system, we will strengthen Medicaid so that states have the tools they need to take care of their poor and most vulnerable populations at a lower cost. Our plan represents the most significant entitlement reform in more than 50 years."); *A Historic Health-Care Moment: The House Plan isn't Perfect, But it's the Only Reform Opportunity Republicans Will Get*, WALL STREET J., https://www.wsj.com/articles/a-historic-health-care-moment-1488931460?mod=djemMER (last updated Mar. 7, 2017, 7:48 PM) ("The House would convert Medicaid's funding formula from an open-ended entitlement into block grants to states. The amount would be determined by per capita enrollment and grow with medical inflation. States would thus have a reason to set priorities and retarget Medicaid on the truly needy.").

Medicaid reimbursement, states are quite powerful in their ability to negotiate program terms. The administrative structure that governs some aspects of Medicaid program design is not the traditional, top-down regulatory structure in which mandates are imposed from on high. Instead, states are viewed as leaders in this endeavor—giving form and content to the goals shared by the state and the federal government. States are not passive subjects upon which the federal government acts to carry out its own goals using the lure of federal funding; states are powerful actors who creatively leverage federal funding to experiment with delivery and financing models of care that will serve their own goals and potentially influence national health policy from the bottom up.

This modern understanding of federal-state interaction—described as negotiated or dynamic federalism—is penetrating judicial decisions grappling with challenges to state program design decisions in areas of state discretion. This article explores this trend through the example of Medicaid rate setting litigation, which is a useful case study for a few reasons. First, the story of Medicaid rate setting provides a rich narrative of the interplay between Congress, federal regulators, and the courts that allows us to understand not only how these different branches interact, but also how sensitive courts are to legislative and regulatory changes to increase state flexibility. Second, the legislative history of rate-setting provisions reveals an evolution from a more rights-oriented, rules-based approach in the early years, to an approach that has come to rely on more goal-oriented legislative language. One effect is that federal regulators and courts have interpreted these provisions as increasing state discretion. At the same time, however, courts have emphasized the importance of federal regulatory oversight as a check on state exercise of discretion—specifically, the process through which the federal government reviews and approves state Medicaid plans and rate-related amendments. In theory then, Medicaid rate setting could be understood as reflecting a more modern federalist account of administration of federal spending programs, in which the statute creates space for federal and state officials to negotiate certain aspects of program administration based on the multi-faceted goals listed in the statute.

This article argues that there are two important implications of this modern understanding of the federal-state dynamic in the Medicaid program. The first is that it helps clarify the Supreme Court's recent decisions around preemption-based enforcement of Medicaid spending conditions. Although the Court's holdings were narrow, the underlying reasoning in the various justices' opinions reveals how federalism concerns shape the justices' different approaches to defining the scope of state flexibility. It explains why some justices were willing to go further than others in limiting judicial review of state Medicaid rate setting, while providing a useful framework for lower courts adjudicating challenges to other kinds of federal spending conditions. Notably, all of the justices demonstrated sensitivity to the role of state flexibility in Medicaid rate-setting; they emphasized the limited role courts should play when states are acting within the interstices of a complex and federal regulatory framework that encourages state flexibility and relies on the dynamic interaction between state and federal health officials. At the same time, five justices rejected states' invitation to foreclose private enforcement of Medicaid spending conditions more broadly. Although rate-setting requirements are explicitly linked to access goals, they provide an important contrast to the kind of access protections that allow less flexibility and which courts have consistently held are enforceable through private litigation. Together, *Independent Living Center and Exceptional Child Center* should be understood as crafting a nuanced approach to determining the availability of equitable relief that affirms the continued importance of rights enforcement in Medicaid.

The second implication of this federalism insight is that it undermines claims that a sweeping approach to Medicaid reform—eliminating or reducing federal entitlements and drastically cutting federal funds—is necessary for protecting state power and achieving needed state flexibility. Indeed, the federalism narrative used to challenge rights enforcement in the courts is similar to the narrative used to argue for transforming Medicaid from an entitlement program into a capped funding program. Given the recurring use of state flexibility as justification for these proposals, this claim should be evaluated against the reality of our current system. The rate-setting cases illustrate courts' sensitivity to even small legislative tweaks designed to promote state flexibility, as well as courts' ability and

willingness to show restraint in service to federal program goals that depend on this state flexibility. In fact, bi-partisan organizations representing state Medicaid directors and state Governors have proposed a more moderate approach to Medicaid reform that relies on targeted legislative amendments and regulatory changes designed to increase state flexibility in specific program areas. As this article will explain, this more refined approach is not only more effective at increasing states' flexibility, it seems the better way to go if we also have a goal of preserving health care access.

Part I of this Article explores the concept of state flexibility as a flashpoint for critiquing the federal-state relationship in Medicaid. It identifies three different federalism-based accounts reflected in political uses of the term "flexibility" in health reform debates, as well as in the legal dimensions of state flexibility as shaped through legislation, regulatory action, and judicial review. Part II examines the legal dimensions of state flexibility more closely through the example of Medicaid rate-setting. Section A describes the evolution of law and policy in Medicaid rate-setting, highlighting the legislative and regulatory steps taken to increase state flexibility over time. Section B describes courts' responses to these changes as legal challenges to state rate-setting persisted. Most courts proved sensitive to these changes by limiting the scope of their review of state rate-setting over time, but the Ninth Circuit was an outlier. It imposed requirements on states that were not expressly provided for in the statute, and some district courts continued to closely scrutinize rate-setting decisions. These different approaches to judicial review set the stage for the conflict that ultimately reached the Supreme Court in *Independent Living Center* and *Exceptional Child Center*.

Part III describes *Independent Living Center* and *Exceptional Child Center*—the facts underlying each dispute, the specific legal questions presented, and the narrow holdings in each case. This part also provides greater context for why this issue reached the Court twice in three years. It suggests that the changing regulatory environment, and the failure of lower courts to heed Justice Breyer's warnings in *Independent Living Center,* compelled the Court to take up the question again and led Justice Breyer to cast the deciding vote to eliminate preemption-based challenges to Medicaid rate-setting in *Exceptional Child Center*.

Part IV delves more deeply into the underlying concerns that seemed to shape the various justices' opinions in *Independent Living Center* and *Exceptional Child Center*, paying particular attention to the differences between Justice Breyer's approach and that of the other justices in the *Exceptional Child Center* majority—Chief Justice Roberts, the late Justice Scalia, and Justices Thomas and Alito. State flexibility is squarely implicated by preemption challenges, and preemption is increasingly recognized as an important site of federalist conflict. Not surprisingly, the different federalist accounts of state flexibility identified in Part I seemed to animate the different justices' approaches to dealing with preemption-based challenges that could constrain that flexibility. This is important because while all of the justices exhibited a deep respect for state flexibility in the area of rate-setting, their different visions of federalism led them to different calculations about how to balance judicial respect for this flexibility with the essential role of courts as a check on state violations of federal law.

Part V concludes by considering the implications of these conclusions for future legal challenges and for the Medicaid reform debate. Section A focuses on the legal implications of recent developments. It offers an interpretation of *Independent Living Center* and *Exceptional Child Center* that rejects the overly broad presumptions against private challenges to state action often motivated by a traditional federalist account that views spending conditions as inherently coercive. Rather, these decisions reflect a more nuanced approach informed by modern accounts of the federal-state relationship in Medicaid. They preserve the important enforcement role of courts in areas where federal law creates clear constraints on state action, while greatly limiting the role of judicial review in areas where federal spending conditions depend upon and may be defined through the exercise of state flexibility and power. Section B focuses on the Medicaid reform debate at the center of Republicans' plans to repeal and replace the ACA. If we take seriously the claim that state flexibility is at least one factor motivating calls for reform, then courts' respect for state flexibility and their growing appreciation for the dynamic nature of federal-state interactions in Medicaid are relevant to the Medicaid policy debate. In particular, it shows that a radical restructuring of Medicaid that would eliminate entitlements and cap funding is not necessary to bring about desired state flexibility. This is

important to consider when balancing proposed Medicaid reforms against the likely effects of such changes, because reducing funding to states creates de facto constraints on the very flexibility that Republicans tout as an important goal. This more nuanced understanding of the relationship between law and state flexibility enables an honest evaluation and critique of reforms justified on the basis of protecting state power, and it highlights the danger of using state flexibility as rhetorical flourish without regard to the reality of our current regulatory environment. How ironic it would be if the mantra of protecting state flexibility was used to restructure Medicaid in ways that actually undermined states' power to provide health care for their citizens and reduced their flexibility to shape health care delivery and payment design reforms.

PART I. MEDICAID PROGRAM DESIGN & THE LEGAL DIMENSIONS OF STATE FLEXIBILITY

Medicaid is a joint federal-state program that has always been optional for states. Enacted as a spending program, the federal government offers states funding for health care for the poor, subject to their compliance with certain federal conditions.[14] As an entitlement program, there are certain federal standards with which states must comply, including minimum eligibility criteria and coverage requirements. As long as individuals meet these criteria, states must provide the requisite coverage; with the federal matching funds, this means that neither states nor federal costs are fixed—as the number of enrollees and the costs of their medical needs increase, so do federal and state funding obligations.[15] In addition, states must agree to abide by other program design conditions that relate to access, such as free choice of provider provisions and requirements that states design their programs to ensure beneficiaries' timely access to care.[16]

Once a state decides to accept Medicaid funds and conditions, it has significant flexibility to shape the Medicaid program to the specific

14 Artiga et al., *supra* note 4, at 1–3.

15 *Id.*

16 *Id.* at 1–11.

goals and needs of its state. Indeed, this was an important character of the program as conceived—program administration is delegated to the states, and they have a great deal of control over program design. Medicaid creates optional categories of services and eligibility that states can adopt if they want to expand access.[17] States have some discretion to define more specifically the services covered within a particular category and to set income eligibility limits. States are empowered and encouraged to experiment with various program financing and health care delivery systems, as well as cost-containment tools such as utilization review processes, rebate programs, and managed care.[18] One of the areas where states have the most discretion—to be explored in the next Part—is setting reimbursement for Medicaid providers. This has been an essential tool for states' ability to control costs.[19] Finally, the waiver process has been an important vehicle for state innovation.[20]

In terms of health care on the ground, this state flexibility has resulted in significant variations in health care access across the U.S.[21] The most recent example of this difference is evident in the growing number of Republican-led states that have negotiated waivers with the federal government to allow them to craft a version of the Medicaid expansion tailored to their states' values and goals. But wide variations among states were evident long before, as states have taken very different approaches to health care delivery under the traditional Medicaid program. Some states have long taken advantage of the flexibility to expand access through higher income eligibility limits, expansion to optional eligibility and coverage categories, and waivers

17 *Id.* at 1–7.

18 *See* Tricia Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey*, KAISER FAM. FOUND., Jan. 2017, http://files.kff.org/attachment/report-medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2016-findings-from-a-50-state-survey (detailing the variation in Medicaid and CHIP policies across states).

19 Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. at 67578 ("States have broad flexibility under the Act to establish service delivery systems for covered health care items and services, to design the procedures for enrolling providers of such care, and to set the methods for establishing provider payment rates.").

20 *See* Hinton et al., *supra* note 5; Musumeci & Rudowitz, *supra* note 10.

21 *See* Brooks et al., *supra* note 18.

that would allow states to cover more people or provide services designed to meet the unique needs of the poor. Others have used flexibility to restrict Medicaid access, for example, adopting the strictest income limits, choosing not to provide important services deemed optional, and seeking waivers that would allow the use of Medicaid funds to "mainstream" enrollees in the private insurance system rather than expand their Medicaid rolls.

In terms of political and legal disputes about health policy, state flexibility is a concept that produces varied meanings and can function in different ways. State flexibility is the flashpoint in discussions about the relationship between states and the federal government, as it is and as people believe it should be. The concept features prominently in arguments by those on opposing sides of the debate to radically restructure Medicaid, as well as those on opposite sides of legal disputes challenging state action as violating Medicaid spending conditions. It is important to understand these different uses of state flexibility because of the different accounts of federalism they reveal.

A. State Flexibility as Proxy for State Sovereignty

When the ACA was initially being debated, opponents relied on federalist rhetoric to paint reform as a federal takeover of health care that infringed upon states' sovereignty.[22] Once the ACA was enacted, this rhetoric was used to push for repeal and raised in legal challenges to the constitutionality of the ACA.[23] Now, it is resurfacing to justify an even more radical roll back of the traditional Medicaid program, this time under the label of "state flexibility."[24]

Federalism-based concerns derive from the structure of our government as one of dual sovereignty, in which the federal government's power is limited and arises from specific enumerated powers in Article I of the Constitution, and the states are granted plenary power to regulate. The Tenth Amendment of the U.S.

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22 Brietta Clark, *Safeguarding Federalism by Saving Health Reform: Implications of National Federation of Independent Business v. Sebelius*, 46 LOY. L. REV. 541, 569–70 [hereinafter *Safeguarding Federalism*] (discussing the federalism narrative evident in political and legal arguments against the ACA).

23 *Id.*

24 See Artiga et al., *supra* note 4, at 3–4.

Constitution,[25] which provides that all rights not expressly granted to the federal government are otherwise retained by the states and the people, is viewed by some as an important check on federal power. Federalism-based concerns have animated opposition to the Medicaid expansion in the ACA, as well as longstanding objections to the structure of traditional Medicaid as an entitlement program with spending conditions enforceable against state officials.

Two basic themes seem to underlie this opposition. The first one is the idea that there is a sphere of state regulation that should be off-limits to federal power, and that the federal government is essentially invading states' turf by injecting itself so deeply and comprehensively into state health policy. Courts have long rejected this legal theory, consistently upholding the federal government's power to set health policy and implement that policy through spending programs, like Medicaid. In addition, the growth of overlapping spheres of federal and state authority in health care and other arenas has long been accepted as legitimate by legal scholars.

The second objection to the enforcement of federal spending conditions in the Medicaid program is grounded in a coercion claim. Again, as a legal matter, the view of a federal spending program as coercive typically has not had much traction in the courts. As long as the federal government structured its program as optional—that is, if states had the choice to agree to comply with certain federal laws as a condition of federal funding, or to reject the funds and thus avoid being regulated in that area—then there was no coercion. The federal government had the right to set conditions on how federal funds would be spent, and states were voluntarily choosing to participate in the program.

Despite the fact that Medicaid is structured as an optional, federal spending program, some legal scholars have argued that the Medicaid program is de facto coercive. For example, one scholar describes the conditional federal grants in the ACA as "incompatible with 'the structural framework of dual sovereignty,'" and states that "[w]herever federal programs confront states with a choice between subordinating local preferences to federal ones, on the one hand, and giving up either revenue or regulatory autonomy on the other, there is

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25 U.S. CONST. amend. X.

coercion."[26] Another scholar described the political "lock-in" that has made it effectively impossible for states to opt out of Medicaid, thus undermining the notion of voluntariness.[27] In fact, the possibility of proving coercion based on levels of funding stemmed from a 1987 Supreme Court case, *South Dakota v. Dole*.[28] Although the Court rejected the challenge to the federal program in that case, there was dicta speculating that under certain circumstances, the amount of funding Congress offers to states could be so coercive as to pass the point at which "pressure turns into compulsion" in violation of the Tenth Amendment.[29]

As a legal matter, coercion had not been successful at invalidating either the traditional Medicaid program or amendments to Medicaid until the Medicaid expansion under the ACA. Sovereignty interests were reinvigorated to limit Congressional power when the Supreme Court, in *National Federation of Independent Businesses v. Sebelius (NFIB)*, struck down the requirement that states expand Medicaid to all adults under a certain income level as a condition of Medicaid participation, instead making it optional for states.[30] The Court emphasized that the legitimacy of Congress's exercise of the spending power rests on whether the State voluntarily and knowingly accepts the conditions of the program, and that "respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system."[31]

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26 Mario Loyola, *Trojan Horse: Federal Manipulation of State Governments and the Supreme Court's Emerging Doctrine of Federalism*, 16 TEX. REV. L. & POL'Y 113, 117–118, 134 (2011) (arguing that the Medicaid expansion provisions "show how illusory state 'prerogative' really is in the conditional federal grants context.").

27 Jonathan H. Adler, *Cooperation, Commandeering, or Crowding Out? Federal Intervention and State Choices in Health Care Policy*, 20 KAN. J.L. & PUB. POL'Y 199, 207, 215 (2011).

28 S. Dakota v. Dole, 483 U.S. 203 (1987) (upholding the National Minimum Drinking Age Act, which directed the Secretary of Transportation to withhold 5 percent of the federal highway funds otherwise payable to a state if that state permitted the purchase of alcoholic beverages by individuals under twenty-one years of age).

29 Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2634 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

30 *Id.* at 2602–06 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ).

31 *Id.* at 2602–07.

Disappointed that the Court did not strike the Medicaid expansion completely, ACA opponents redirected their federalism-based arguments to the political arena, arguing that the Medicaid program allowed the federal government to infringe on states' rights to shape health policy for its citizens. This view has echoes of an older framing of federalism as a "choice between federal and state action [as] simply binary."[32] Even among federalism scholars who acknowledge a more nuanced view of federalism, some of their arguments nonetheless reflect this federal-state dichotomy, which is grounded in normative assumptions about the benefits of state versus federal action. These scholars insist that our constitutional structure reflects a preference for decentralized decision-making and thus a presumption against federal regulation.[33] Through this lens, federal regulation is viewed as inherently problematic and a serious threat to state power.

We see this most clearly in the current political rhetoric used to push for a roll back of Medicaid. Republican legislators say their reforms will increase state flexibility and return control back to the states. But they do not talk about how much funding would be cut by these reforms, or the implications for states' financial ability to continue to shape the Medicaid program to meet their residents' needs. Instead, the recurring image is of lawmakers coming to the rescue of states who have lost their power to the federal government for too long—a power that can be restored through Medicaid retrenchment. Federal-state conflict dominates the narrative, and states come off as vulnerable and in need of protection.

B. State Flexibility as Evidence of Cooperative Federalism

A more centrist view—and the dominant federalism narrative—used to characterize Medicaid has been one of cooperative federalism. Cooperative federalism describes how states and the federal government can view their powers as complementary as opposed to dichotomous. Spending programs, generally, have been understood as a vehicle for cooperation between the federal government and states, allowing them to leverage their respective assets to achieve shared

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32 *See* Adler, *supra* note 27, at 207.

33 *See Safeguarding Federalism*, *supra* note 22, at 570–71.

goals by solving problems that touch on local and national concerns. The Medicaid program, in particular, has been touted as the quintessential example of cooperative federalism by scholars[34] and courts.[35] For example, in *Independent Living Center*, Justice Breyer began his discussion of the facts by describing Medicaid as "a cooperative federal-state program."[36] And in *NFIB* Justice Ginsburg went to great lengths to emphasize the cooperative nature of Medicaid:

> Through Medicaid, Congress has offered the States an opportunity to furnish health care to the poor with the aid of federal financing. Medicaid is a prototypical example of federal-state cooperation in serving the Nation's general welfare. Rather than authorizing a federal agency to administer a uniform national health-care system for the poor, Congress offered States the opportunity to tailor Medicaid grants to their particular needs, so long as they remain within bounds set by federal law.[37]

Among those in the political and legal arenas who embrace this cooperative vision of health policy, two dominant themes emerge. The first is that state flexibility is viewed as important counter evidence to those alleging federal coercion. For example, in *NFIB* Justice Ginsburg dissented from the holding that tying the Medicaid expansion to the traditional Medicaid program was coercive, highlighting the "considerable autonomy States enjoy under the Act."[38] According to Justice Ginsburg, "[f]ar from 'conscript[ing] state agencies into the national bureaucratic army,' Medicaid was designed to advance cooperative federalism and states 'have leveraged this policy

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34 *See, e.g.*, Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1750 (2013); Abigail R. Moncrieff & Eric Lee, *The Positive Case for Centralization in Health Care Regulation: The Federalism Failures of the ACA*, 20 KAN. J.L. & PUB. POL'Y 266, 267-68 (2011) (viewing our current structure of health policy as an example of cooperative federalism that "entrusts large swaths of its implementation to the states."); Philip J. Weiser, *Towards a Constitutional Architecture for Cooperative Federalism*, 79 N.C. L. REV. 663, 668 (2001).

35 *See, e.g.*, Indep. Living Ctr., 132 S. Ct. at 1208; Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. at 2629 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

36 Indep. Living Ctr., 132 S. Ct. at 1208.

37 Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. at 2629 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

38 *Id.* at 2632.

discretion to generate a myriad of dramatically different Medicaid programs over the past several decades.'"[39] Health policy analysts[40] and legal scholars[41] have also emphasized the scope and nature of the flexibility that states have as evidence of Medicaid's cooperative nature and rejection of the coercion framing. Indeed, some have gone so far as to express concern that states have too much flexibility under the Medicaid Act, which relates to the second theme running through cooperative federalism frame—the importance of federal law in defining the contours of state flexibility.

Though state flexibility is a hallmark of Medicaid under cooperative federalism, for health advocates, beneficiaries, and providers, the role of federal law in defining the boundaries of that flexibility is equally important.[42] This view highlights the distinct interests of the states and the federal government and the importance of understanding the bargain that has been struck. Federal program conditions play an important role in this cooperative venture, as states sometimes run afoul of federal program conditions. In some areas, the statute enumerates clear mandates that constrain state actions; consequently, these federal conditions are treated as privately enforceable rights that do not depend solely on federal regulatory enforcement, but rather allow affected individuals to bring actions in federal court to prevent state violations. Perhaps the least controversial and most consistent example of this involves eligibility—the Medicaid Act creates entitlements for individuals who fit certain criteria. People who have been denied coverage can seek legal recourse in the courts. The statute also creates a clear right of Medicaid beneficiaries to a free choice of provider, prohibiting states from banning reimbursement to providers absent significant quality of care issues or termination of provider status due to Medicaid fraud. Consequently, when states have tried to ban Medicaid funding to Planned Parenthood on

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39 *Id.*

40 *See, e.g.*, Artiga et al., *supra* note 4.

41 *See, e.g.*, *Safeguarding Federalism*, *supra* note 22.

42 *See, e.g.*, Gluck, *supra* note 34, at 1750; Weiser, *supra* note 34, at 668 (describing Medicaid as a variation of cooperative federalism in which Congress relies on a federal regulatory agency to develop certain standards for the state agencies to follow).

ideological grounds, providers and beneficiaries were able to successfully stop them in federal court.[43]

For areas in which the statute may not provide as clear guidance, health advocates and scholars insist that federal oversight is critical, and concerns have been raised about whether states have been given too much flexibility to implement reforms that undermine Medicaid's access goals.[44] The flexibility states have had with respect to Medicaid rate-setting presents a particular area of concern for advocates, especially where states have demonstrated a pattern of disregarding federal access goals.[45] Health advocates believe that program goals should serve as meaningful constraints on state action to ensure that the state is truly exercising its flexibility in an informed way—making intentional policy judgments that balance all of the goals identified in the federal statute—as opposed to simply ignoring them. The version of cooperative federalism operating in Medicaid reflects a balancing of federal and state interests, where state flexibility is tied to other program goals. We saw evidence of this in how federal regulators under the Obama administration supported state innovations designed to balance access, quality, and cost goals.[46] Health policy

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43 *See infra* note 153.

44 Laura D. Hermer, *Federal/State Tensions in Fulfilling Medicaid's Purpose*, 21 ANN. HEALTH L. 615, 620–624 (2012) (arguing for stronger federal control of health policy). Professor Hermer notes that under the prior two Bush administrations, states arguably had greater leeway under the waiver program than ever before, and that the Bush administration failed to adhere to the requirement that limits authorized waivers to those helping to promote Medicaid's purposes. In particular, some states used their flexibility to private Medicaid delivery in ways that limited care, resulted in market dislocation, and resulted in severe churning in both plans and providers. *Id. See also* Leonardo Cuello, *Section 1332 Waivers for State Innovation and Medicaid*, HEALTH ADVOCATE, Apr. 2016 (noting that Section 1332 waiver authority under the ACA is not inherently good or bad, and highlighting four important limits on how this authority should be used).

45 *See generally, infra* Part II.

46 *Methods for Assuring Access to Covered Medicaid Services*, 80 Fed. Reg. at 67578; 42 C.F.R Part 447 ("For instance, many states provide medical assistance primarily through capitated managed care arrangements, while others use FFS payment arrangements . . . . Increasingly, states are developing service delivery models that emphasize medical homes, health homes, or broader integrated care models to provide and coordinate medical services. The delivery system design and accompanying payment methodologies can significantly shape beneficiaries' abilities to access needed care by facilitating the availability of such care. In addition, the delivery system model and payment methodologies can improve access to care by making available care management teams, physician assistants, community care

analysts and advocates have similarly touted the state's use of its flexibility to innovate in ways that achieve cost-efficiency while also improving service delivery.[47]

Unlike the sovereignty model described in Section A, the cooperative model does not conceive of state flexibility as inherently in tension with federal authority or inherently good. It is important evidence of lack of coercion, but federal limits are important and valid. That said, when private challenges have been brought, courts have considered whether the state understood that it would be subject to private enforcement of a particular spending condition as part of the bargain struck. In this way, state sovereignty concerns remain important; courts want to know that states' knowingly and voluntarily agreed to give up that aspect of power in exchange for Medicaid funds. Thus, while courts view the Medicaid Act as a whole as an example of cooperative federalism that is consistent with our constitutional structure, it may look more closely at certain kinds of claims to ensure that state sovereignty is not being undermined in particular cases.

C. State Flexibility as State Agency and the Emergence of Negotiated Federalism

While the cooperative federalism frame has long dominated descriptions of Medicaid in legal scholarship and by courts, this view is evolving to account for those areas of Medicaid program design that may allow an even more powerful role for states—as agents actively defining the relevant program standards and shaping health policy from the bottom up, rather than as mere recipients of federal mandates from on high. As noted above, the cooperative model presumes state flexibility is constrained by federal standards or mandates. But in some areas of program design, this model does not fit reality very well, because there may not be federal mandates or standards that clearly define how states should make certain kinds of decisions. Instead,

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coordinators, telemedicine and telehealth, nurse help lines, health information technology and other methods for providing coordinated care and services and support in a setting and timeframe that meet beneficiary needs.").

47 *See, e.g.*, Artiga et al., *supra* note 4; Wayne Turner et al., *What Makes Medicaid, Medicaid? Services*, NAT'L HEALTH L. PROGRAM (Mar. 1, 2017), http://www.healthlaw.org/about/staff/catherine-mckee/all-publications/what-makes-medicaid-medicaid-services#.WPQZrf3atFV.

states are expected to fill in the details of program design, and even define the content of the very federal standards that supposedly limit state action. An example of this is the evolution that occurred in the rate-setting context discussed further in Part II—certain federal requirements in rate setting, established in the early Medicaid years, were eventually rolled back by Congress and federal regulators to give states greater flexibility to design processes that balanced various program goals. Eventually, states were viewed as leaders in driving payment reforms and making Medicaid more cost-efficient, establishing new models for service delivery and financing that shaped federal health policy.

Alternatively, states may try to exert their power to reject existing constraints and redefine program design parameters according to the primacy of state needs or goals. As already noted, the waiver process had long provided an opportunity for states to assume this kind of leadership role in innovation, but the shifting balance of power towards the states is perhaps best illustrated by the more recent federal-state interactions taking place under the ACA. From the beginning of the ACA, the federal government demonstrated a willingness to negotiate with states seeking even greater flexibility in the implementation of private and public insurance reforms.[48] This includes Republican-led states negotiating waivers allowing them to expand Medicaid on their own terms.

Finally, the role of money cannot be ignored in this federalism dynamic. Although traditional federalist accounts consider the significant amount of money at stake evidence of coercion, the reality is that states have been perceived as adept at manipulating and leveraging federal funding to serve their own interests. Indeed, there have even been concerns raised about some states' taking advantage of the federal government through creative accounting tricks that have allowed them to get federal matches for state funds that were not spent on health care as contemplated by Congress.[49] The picture of the

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48 Christina M. Rodríguez, *Negotiating Conflict Through Federalism: Institutional and Popular Perspectives*, 123 YALE L.J. 2094, 2094 (2014) (describing "[t]he contours of our federal system [as] under constant negotiation, as governments construct the scope of one another's interests and powers while pursuing their agendas" and arguing that "federalism does not consist of a fixed set of relationships.").

49 *See* TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-

federal government as powerful and state as vulnerable gets flipped in such cases.

As scholars have begun to focus their attention on these areas of state discretion and states' ability to leverage federal funding, a more nuanced picture of the federal-state relationship emerges that challenges assumptions underlying other federalism accounts. In contrast to the characterization of the Medicaid program as a way for the federal government to take over health care and impose its will on the states, the Medicaid program increasingly looks like a platform for on-going negotiation between equal partners. The bargaining that takes place is not finished at the moment a state decides to participate in Medicaid. Instead, states are actively negotiating the terms of their relationship with the federal government at multiple levels and continually over time.

Under this view, state flexibility is not simply a narrow space carved out for states in a statute otherwise defined by federal mandates. Rather, in some program areas, the federal government increasingly treats its relationship with the state as dynamic and views state flexibility as essential to the federal government's desire for states to drive health policy. Far from evidencing a federal takeover of health care, the federal government has consistently shown its preference for states to "own" this arena. The waiver process is just one example of how the federal government encourages, and even assumes, states will exercise their flexibility in ways unforeseen by the Medicaid Act. The government's increasingly liberal granting of waivers pre-ACA has been cited as evidence of growing state power in Medicaid,[50] and there is a strong argument that under the ACA, states have become even more powerful. With the Supreme Court effectively making Medicaid expansion optional, and the statute itself making state run-insurance exchanges optional, the Obama Administration depended on states for the ACA's success. If the federal government wanted to expand access

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CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 172–73 (2003) (describing states that have limited eligibility expansions and tried to manipulate the Medicaid system to maximize federal expenditures for minimal state effort.").

50 Elizabeth Weeks Leonard, *Crafting a Narrative for the Red State Option*, 102 KY. L.J. 381, 397 (2013–2014) (describing the "evolution of the Medicaid waiver process and other flexible options are part of a larger trend of federal-state negotiations over program design and implementation.").

to care, it would need the states as much as the states would need the support of the federal government.

While the term cooperative federalism arguably still applies to this relationship, newer terms have emerged to more precisely describe the character of this kind of partnership—negotiated federalism, dynamic federalism, and iterative federalism are a few examples. These terms connote a more equal partnership, in which both sides—the state and the federal government—are actively engaged in shaping the terms of the partnership generally, as well as the standards governing more specific aspects of program design.[51] The negotiation does not stop at the decision of whether to accept federal funding and conditions. Rather, it continues as states continually rethink program design and seek new and different ways to deliver and finance care. Where states may have originally been seen as subjects acted upon or used for purposes of advancing federal goals, states are increasingly seen as the powerful ones, leveraging federal dollars toward important state goals and ends.[52]

The terminology used reflects an important shift in the understanding of the federal-state relationships that is not merely academic, but could influence policymaking among states resistant to health reform. In an article titled *Crafting the Red State Narrative*, Professor Leonard describes the resistance of red states to the ACA as driven by "fundamental principles of federalism and deeply held aversions to the expansion of federal authority that must be heeded."[53]

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51 Heather K. Gerken, *Federalism as the New Nationalism: An Overview*, 123 YALE L.J. 1889, 1893 (2014) ("A nationalist account of federalism may not resemble the conventional one, with its emphasis on autonomy and independent state policy making. But this work shows why state power in all its forms matters to a thriving national democracy. Too often federalism scholars have treated sovereignty and autonomy as if they were the only form of state power, as if the states and national government were in a zero-sum policymaking game. They've neglected the different but equally important form of state powers that are at the heart of the nationalist school's work on federalism. The power states enjoy as national government agents. The power states exercise in driving national policy and debates. The power states wield in implementing and integrating federal law.").

52 Deborah Bachrach et al., *Medicaid at a Crossroads: What's at Stake for the Nation's Largest Health Insurer*, ST. HEALTH REFORM ASSISTANCE NETWORK (Feb. 2017), http://www.statenetwork.org/wp-low-content/uploads/2017/02/State-Network-Manatt-Medicaid-at-a-Crossroads-February-2017.pdf (describing the modernization and payment reforms led by the states with critical funding from the federal government).

53 Leonard, *supra* note 50, at 382.

She predicted that to persuade red states to expand, the federal government would need to give some "concession" as "a tangible reminder that on some essential level states, not the federal government, are ultimately calling the shots."[54] She argues that the Medicaid expansion dynamic is a salient example of negotiated federalism at work.[55] In her article *Negotiating Federalism*, Professor Ryan offers a similar descriptive and normative critique about the role of federalism values in federal-state negotiations over authority:

> State and federal negotiators are not only driven by issue-specific needs such as funding, authority or other forms of regulatory capacity. Sometimes bargaining results are influenced by regard for the American system of federalism itself—the desire to reach an outcome that respects the constitutional design and that harness the ways in which divided local and national authority serve the ultimate purposes of government. This more ethereal currency may best be understood as regard among the participants for the values of federalism themselves, and it is often present even when negotiators are not using the specific vocabulary of federalism to define it.[56]

Like older federalism accounts, negotiated federalism treats state flexibility as an important sign of state power, but the implications are different. Whereas older federalism accounts use notions of state laboratories of democracy and state power to argue against federal regulation of health care, the negotiated federalism narrative suggests that states can be empowered through federal spending programs. The idea of state experimentation that is so often associated with the federalist movement to insulate states from federal action has become the defining characteristic of many aspects of the Medicaid program—rather than the federal government imposing a particular health regime on the states, states receive generous federal funding to enable them to experiment with health care delivery and financing designs to improve health care for their citizens in ways they otherwise could not. This narrative may have successfully convinced Republican-led states to embrace the Medicaid expansion, but it is also certain to fuel advocates' concerns about flexibility being used in ways that are

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54 *Id.*

55 *Id.*

56 Erin Ryan, *Negotiating Federalism*, 52 B.C. L. REV. 1, 95 (2011).

inconsistent with and apathetic to federal goals. If tensions arise in areas of Medicaid program design that fit this more dynamic federalism narrative, this raises important questions about what kind of check, if any, exists to ensure such flexibility is consistent with federal program goals. Indeed, this is precisely the question that has fueled legislative, regulatory, and judicial action in the rate-setting context.

PART II. MEDICAID RATE-SETTING CASE STUDY: HOW LEGISLATION, THE REGULATORY ENVIRONMENT, AND FEDERAL COURTS SHAPE STATE FLEXIBILITY

Rate setting is one of the program design elements for which states have always had primary responsibility. Section A briefly describes the evolution of law and policy in Medicaid rate-setting, highlighting the legislative and regulatory changes that have shaped this flexibility.[57] Although the statute has contained statutory provisions governing rate-setting, including a provision linking rate-setting to access guarantees, over time, the law was amended to increase state flexibility. At the same time, a lack of legislative or regulatory clarity around state rate-setting requirements meant that courts were forced to confront questions about the outer limits of state flexibility. Section B describes courts' approaches to this question. The dominant approach was to view rate-setting as existing in the interstices of a federal law attempting to balance multiple legal and policy goals. Absent an obvious and egregious violation of the statute, rate setting was viewed as an inherently complex and technical undertaking best suited to the agency with the appropriate expertise. This meant a gradual limiting of judicial review in cases where it seemed courts were being asked to second guess state health policy officials and federal regulators. There was some variation, as the Ninth Circuit took a more active approach to interpreting statutory rate-setting requirements in the absence of federal regulatory guidance, inferring specific requirements and scrutinizing the states' process closely. This variation sets the stage for understanding what was at stake in the rate-

57 For a more detailed history and legal analysis, see *Medicaid Access*, *supra* note 7.

setting disputes that ultimately reached the Supreme Court twice in three years. This is discussed in greater detail in Part III.

A. Evolution of Rate-Setting Requirements & Increasing State Flexibility

The Medicaid program was created to ensure health care access for those considered among the most vulnerable in society—those most in need and likely unable to otherwise access care until too late. At the same time, cost was a significant concern, and states were expected to balance expanding access with cost-effective ways to deliver care. These were not merely policy aspirations. The Medicaid Act has long codified efficiency, economy, access, and quality requirements in a variety of ways. In terms of access, for example, states must ensure that services are widely available and fairly distributed[58] and that beneficiaries have timely access to care.[59] The Act also requires states to administer the program with regard to what is in the "best interest" of program recipients.[60] But the tension between cost concerns and access guarantees is particularly salient in the rate-setting provisions.

1. Rate Regulation & Access in the Early Years: An Active Federal

58 The "statewideness" requirement comes from 42 U.S.C. § 1396a(a)(1), which provides that the State Medicaid plan "shall be in effect in all political subdivisions of the State . . . ." 42 U.S.C. § 1396a(a)(1) (2006). The implementing regulation requires that each state plan "be in operation statewide." 42 C.F.R. § 431.50 (2012). The "comparability" requirement refers to 42 U.S.C. § 1396a(a)(10)(B), which requires that the medical assistance made available to any recipient "shall not be less in amount, duration, or scope than the medical assistance made available" to other recipients. 42 U.S.C. § 1396a(a)(10)(B) (2006). Together, these provisions require medical benefits to be available throughout the state and to all eligible persons, across different communities, expressly taking into account patients' needs.

59 42 U.S.C. § 1396a(a)(8) requires the State plan to "provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8) (2006). Courts have interpreted this as applying not only to coverage, but to the delivery of care. *See, e.g.*, Sabree *ex rel.* v. Richman, 367 F.3d 180 (3d Cir. 2004). *But see* Westside Mothers v. Olszewski, 454 F.3d 532 (6th Cir. 2006) (limiting promptness requirement to payment for services only).

60 42 U.S.C. § 1396a(a)(19) (2006) ("[The State Plan must] provide such safeguards, as may be necessary to assure that eligibility for care and services under the plan will be determined, and such services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients.").

Regulator

Almost immediately after Medicaid was enacted, federal regulators and legislators were concerned that states would set reimbursement too low to ensure adequate provider participation. This concern was particularly acute in the case of hospital inpatient services and skilled nursing care, as Medicaid was viewed as the primary means through which people with low incomes would access care for serious medical conditions. Although the federal Medicaid Act did not create a uniform method of setting reimbursement for services, federal law did require state agencies to pay hospitals the "reasonable cost" of inpatient services they rendered to Medicaid recipients.[61] In addition, the law charged program oversight to a federal regulator, at that time the U.S. Department of Health, Education, and Welfare (DHEW), but today the U.S. Department of Health and Human Services (HHS).[62]

DHEW had the authority to review and either approve or deny states' proposed rate-setting methodology, typically through the state's submission of a State Plan Amendment (SPA).[63] At the program's inception, DHEW actively regulated rates with these access concerns in mind. The Medicaid requirement was linked to the term "reasonable cost" as defined in the federal Medicare program,[64] and DHEW emphasized parity by deeming Medicare rates presumptively reasonable for Medicaid.[65] In addition, hospital costs were typically reimbursed retrospectively, with rates determined by the providers' actual costs.[66]

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61 See Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 505–507 (1990) (detailing the history of rate regulation in Medicaid and identifying rising health care costs as the motivation for the Boren Amendment).

62 The U.S. Department of Health and Human Services (HHS) originated as part of DHEW, which no longer exists. Currently, CMS (the Centers for Medicare and Medicaid Services) is the division of HHS charged with Medicaid oversight.

63 State waiver requests must also set forth rate-setting methodology for federal approval.

64 *See* Wilder, 496 U.S. at 505–07.

65 *See* Miss. Hosp. Ass'n v. Heckler, 701 F.2d 511, 515 (5th Cir. 1983).

66 Because this method operated retrospectively, hospitals would receive an interim rate during the fiscal year based on initial estimates, and then receive adjustments (or corrections) at the end of the year once they established their actual, allowable costs for the year. *See* Wilder, 496 U.S. at 507 n.7.

The more important and lasting step by DHEW, however, was its promulgation of a regulation in 1969 that put access concerns on par with efficiency and economy goals, and explicitly linked the amount of reimbursement to access goals.[67] This regulation was the precursor for today's Equal Access requirement, or Section 30(A)—the primary basis for rate-setting challenges discussed below. The clear message was that the success of the Medicaid program depended on private providers' participation and their participation depended, in turn, on sufficient reimbursement.

2. The Boren Amendment: Increasing State Flexibility

Growing concerns about rising health care costs helped drive a policy shift in the federal government's approach to rate-setting. Public and private insurers became increasingly concerned about provider waste and overtreatment that was believed to be the result of a fee-for-service system and fear of malpractice that created incentives for doctors to perform too many tests and procedures, as well as a professional culture that encouraged doctors to seek new and often more expensive technological solutions for medical problems. The federal government was particularly concerned with rising hospital costs and wanted to push states to experiment with different payment mechanisms for containing these costs. Some believed that the regulators' early focus on access and parity with Medicare reimbursement kept rates artificially high, and they wanted to rein in this regulatory control so that states would have the power to reduce reimbursement. Congress amended the Medicaid Act to soften rate-setting requirements for hospital and nursing home services, and to increase state flexibility to set rates generally.[68]

In the area of in-patient services, for example, Congress delinked Medicaid rates from Medicare to allow states to set Medicaid rates lower than those for Medicare providers without being vulnerable to legal challenge.[69] But the most significant change came in 1981, when the law was amended to give states greater power to determine what

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67 *See id.* (describing the history of rate-setting regulation and legislation, and earlier iterations of the Equal Access Provision).

68 Wilder, 496 U.S. at 505–06, 515–16.

69 Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 515 (1990).

constituted reasonable cost. This amendment, called the Boren Amendment, permitted states to establish their own rate-setting methodology as long as "[t]he State *finds* and *makes assurances* satisfactory to the Secretary, that rates are *reasonable and adequate to meet the costs* which must be incurred by *efficiently and economically operated facilities*," in order to ensure reasonable access to quality care.[70] This created space for states to experiment with a different model of health care financing for inpatient services—namely, the prospective payment system (PPS).[71] Unlike the retrospective payment system, which reimbursed each facility according to its own costs, a prospective payment system sets reimbursement based on an estimate of future costs and, more importantly, allowed states to base these estimates on assumptions about what constitutes reasonable costs for economical and efficient facilities.

Practically, this meant state reimbursement was no longer tied to actual provider costs; a state could set rates based on its own assumptions about which criteria or characteristics should be relevant to identifying an economical and efficient facility, and then determine reasonable costs based on that criteria. If providers' actual costs exceeded this rate, providers had to absorb the loss. States had a powerful economic incentive to accept Congress' "invitation" to experiment with new ways to cut cost because Congress also imposed significant financial constraints on the states forcing them to contain Medicaid spending.[72] The pressure mounted as states increasingly faced their own state budgetary challenges and needed to find new ways to cut expenses.

3. Conflicting Messages: Section 30(A) v. Regulatory

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70 42 U.S.C. § 1396a(a)(13)(A) (1982) (current version at 42 U.S.C. § 1396a(13)(A) (2006) (emphasis added)).

71 *See, e.g.*, Mary Washington Hosp., Inc. v. Fisher, 635 F. Supp. 891, 894 (E.D. Va. 1985) (describing Virginia's experimentation with a prospective payment system after the Boren Amendment and upholding the state's new rate-setting methodology).

72 *See id.* at 894; *see also* JOST, *supra* note 49, at 122–123 (noting that cost was the primary driving force for most states adopting managed care; better care coordination was secondary).

Retrenchment

Although the Boren amendment relaxed rate-setting requirements and increased state flexibility, payment disputes persisted as hospitals and nursing homes brought suits challenging these new rate-setting methodologies. The Boren Amendment included important protections for providers at the same time that it increased state flexibility. While states were no longer required to reimburse facilities for their actual costs, states could not set rates arbitrarily. Boren required states to make findings showing that proposed rates would in fact be consistent with the reasonable costs of efficient and economical facilities, and states still had to comply with the beneficiary protections in the 1969 regulation requiring rates to be sufficient to ensure equal access.

Thus, even as Congress wanted to increase state flexibility to contain costs, legislators remained concerned about inadequate reimbursement. Congress even broadened the scope of services subject to the kind of equal access and quality guarantees that had been applied to hospital rate-setting. In 1989, Congress codified the equal access regulation as 42 U.S.C. §1396a(a)(30)(A), often referred to as Section 30(A). Section 30(A), which was not limited to specific kinds of services, required states to "assure" their rates were "consistent with economy, efficiency, quality care, and sufficient to enlist enough providers so services under the plan area available to recipients at least to the extent those services are available to the general population."[73] The latter requirement is often referred to as the Equal Access Provision.

Unlike the Boren Amendment, however, Section 30(A) did not include an express requirement that states make findings of 30(A) compliance. In fact, Section 30(A) did not mention provider costs or require any findings as to what would qualify as reasonable and adequate costs of efficiently and economically operated facilities. The

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[73] 42 U.S.C. § 1396a(a)(30)(A) (requiring a State Plan to "provide such methods and procedures relating to the utilization of, and the payment for, care and service available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and service and *to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.*" (emphasis added)).

implementing regulation did require states to include assurances of Section 30(A) compliance in the State Plan Amendment (SPA) it submitted to the federal regulator, and the regulator had the power to review the proposed rates' compliance with 30(A).[74]

In sum, the federal government's policy sent signals to states that were often in tension. On the one hand, cost containment was essential, and states would be the key drivers for cost reform among Medicaid providers. The federal government wanted states to use their flexibility to create new payment models that would force providers to deliver care in a more efficient and economical way. On the other hand, federal law continually reinforced the idea that Medicaid access depended on provider participation and that the adequacy of rates mattered. Thus, reducing cost could not be the sole consideration in setting reimbursement, but must be balanced against access and quality goals.

In terms of enforcement, the government sent contradictory messages as well. Through Section 30(A), Congress seemed to affirm the important role of courts in mediating these disputes. Congress was aware of provider and beneficiary suits challenging state Medicaid payment methodology, and it stated that one reason for codifying Section 30(A) was the inadequate enforcement these requirements had received when they were housed in a regulation. The reality, however, is that Congress was partially responsible for the lack of regulatory oversight of the rate-access link. Although the law required states to make "findings" under the Boren Amendment and to make "state assurances" to the federal government under Boren and Section 30(A), these statutes did not require the state to actually submit these findings

74 42 C.F.R. § 447.253(a) says that "[i]n order to receive CMS approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to CMS that the [rate-setting] requirements set forth [in the rest of this section are met]." § 447.253(b) provides that states are required to make findings with respect to the reasonableness and adequacy of rates paid for inpatient hospital services and long-term care facility services, and the State must make these findings "[w]henever the Medicaid agency makes a change in its methods and standards, but not less often than annually." Since 1981, 42 C.F.R. § 447.250(a) has required that "the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State *finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards*." *Id.*

or the underlying data to the federal agency, nor did it explicitly require the agency to review the findings. In practice, the agency relied heavily, if not solely, on state assurances of Section 30(A) compliance without any underlying documentation or scrutiny.[75] This regulatory neglect fueled providers' and beneficiaries' concerns that states were abusing their discretion to freeze or cut rates arbitrarily, leading plaintiffs to seek help in federal court.

4. Congressional Retrenchment & the Boren Repeal of 1997

The economic pressure on states to contain cost through health financing reform continued to grow stronger over the next decade. Congressional concerns about overpayments and waste were reinforced by increasing attention to the connection with iatrogenic harms. Reports, such as *To Err is Human*, shined light on how the health care system itself was often the source of harm, while other reports linked financial incentives in the traditional health care payment model with an increase in unnecessary care.[76] These economic concerns were accompanied by growing criticism of Medicaid payment suits as impeding state flexibility and contributing to excessive health care costs.

To be sure, concerns about low payments persisted. But these legal and health policy developments complicated the question of how to determine whether particular rates were consistent with economy and efficiency on the one hand and sufficient to ensure access or quality on the other. Whereas provider costs historically had been viewed as an important factor in rate-setting, the increased focus on provider waste and unnecessary care brought reforms that discounted providers' actual costs as a valid measure of economy, efficiency, or as a key

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75 *See Medicaid Access*, *supra* note 7, at 829–832; *see also* Proposed Rule: Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. at 26,344 (HHS acknowledging its failure to ensure that states submit adequate for review).

76 *See* Linda T. Kohn et al., *To Err is Human: Building a Safer Health System*, INST. MED. COMM. ON QUALITY HEALTH CARE AM. 1–2, 2000 [hereinafter *To Err is Human*] (estimating that between 44,000 and 98,000 Americans die each year from medical errors, and that the total national costs of preventable adverse events due to medical errors, including lost income, lost household productivity, disability, and health care costs, are between $17 billion and $29 billion, half of which is represented by the health care costs); *Waste Not, Want Not: The Right Care for Every Patient*, 15 ISSUE BRIEF NAT'L QUALITY F. 6 (2009) (describing the quality and cost implications of medical errors).

indicator of access and quality.[77] Consequently, decisions about the adequacy of rate setting were becoming increasingly technical, complex, and value-laden. This coincided with a growing frustration among federal courts (and some Supreme Court justices) that courts were being asked to second-guess states' rate-setting choices in cases where it looked like the state undertook a good faith and reasonable attempt to balance cost, access, and quality goals.[78] Absent a blatant disregard of federal rate-setting requirements by states, judges expressed concerns that the federal regulatory agency charged with Medicaid oversight, and not the court, was the appropriate body to determine whether a states' rate-setting process complied with Section 30(A)'s multifaceted goals.

These forces paved the way for further legislative changes designed to increase state flexibility, as well as jurisprudential developments that constrained and refined the role of courts in mediating such disputes. Legislatively, the Boren Amendment was effectively gutted in 1997 when a Republican Congress repealed two key provisions—the substantive requirement that rates must be adequate to meet providers' reasonable costs, and the procedural requirement that states must make findings to this effect.[79] Some

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77 *See, e.g.*, Methodist Hosps., Inc. v. Sullivan, 91 F.3d 1026, 1030 (7th Cir. 1996) (noting that "it is exceptionally difficult to determine demand and supply schedules for a single product" the court went on to say: "Doing this for the entire medical segment of the economy would be more than difficult; it would be impossible. A state could send out a survey, but questions such as 'Tell us the minimum amount you would accept without withdrawing from the market' would not elicit honest answers. People often do not even *know* their reservation prices; they do not willingly reveal them."). *See also* Mary Washington Hosp., Inc. v. Fisher, 635 F. Supp. 891, 902 (E.D. Va. 1985) ("Mary Washington has suggested that it may someday be forced to withdraw from the Medicaid program, but there is no reason to believe that such a result is likely or imminent. In fact, the evidence is to the contrary, *i.e.* that Mary Washington financially needs Medicaid as much as Medicaid needs Mary Washington.").

78 *See, e.g.*, Methodist Hosps., Inc., 91 F.3d at 1030 ("Nothing in the language of § 1396a(a)(30), or any implementing regulation, requires a state to conduct studies in advance of every modification. It requires each state to produce a *result*, not to employ any particular methodology for getting there . . . . [S]tates may behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30), must) raise the price until the market clears.").

79 These requirements were replaced with a far more limited public notice-and-comment process for rate-setting for hospitals and nursing homes. *See* 42 U.S.C. § 1396a(a)(13)(A) (2017). Regulations also specify that the notice must state the proposed change in methods

legislators intended this repeal to eliminate private Medicaid payment suits.[80] No change was made to Section 30(A), however, which had also been used to bring similar rate challenges beyond the hospital and nursing home context. Thus, the Boren repeal did not stop Medicaid payment challenges, because providers and beneficiaries simply started using Section 30(A) to challenge hospital and nursing rates as well.

The Boren repeal did have an effect on Medicaid payment litigation, however. First, Section 30(A) used more general, goal-oriented standards, requiring rates to be consistent with economy, efficiency, quality, and sufficient to ensure equal access; it did not contain the more explicit requirements used in the Boren Amendment, linking economy and efficiency goals with specific findings that rates were adequate to meet provider costs. Prior to Boren's repeal, courts relied on this explicit link in the Boren Amendment to inform its interpretation of what was required by Section 30(A). Repealing this language created questions about whether Section 30(A) would remain an effective tool for challenging payment rates—whether such suits could continue to be brought, how courts would interpret Section 30(A) requirements, and what level of deference or scrutiny courts would apply to federal approval of rate cuts.[81] But as discussed below, much more would happen to influence the answers to these questions: the judicial narrowing of federal rights enforcement; relentless attempts by states to try to eliminate rate-setting claims completely; and a newly engaged federal regulatory agency under the Obama administration that used its power to affirm the importance of state flexibility.

B. Impact of Legislative Changes & Regulatory Action on

and standards, and explain why the agency is proposing the change. 42 C.F.R. § 447.205(c) (2017).

80 H.R. Rep. No. 94-1122, at 4 (1976), reprinted in 1976 U.S.C.C.A.N.5649, 5649–51; 121 Cong. Rec. 42,259 (1975) (statement of Sen. Robert Taft Jr.).

81 *See Medicaid Access*, *supra* note 7, 819–828 (describing the various approaches courts took in determining the role of provider cost in determining Section 30 (A) compliance).

Rights Enforcement

Almost since enactment, federal courts have been the sites of disputes over Medicaid rate-setting. As noted earlier, many of the legislative changes relaxing the requirements for hospital rates were accompanied by regulatory retrenchment. In the case of Section 30(A), there had been an almost complete absence of federal regulatory oversight of the relationship between rate cuts and access and quality requirements, a trend which only recently changed under the Obama Administration. Prior to 2011, CMS was single-mindedly focused on rates being too high, using its authority to reject state changes in methodology likely to increase rates.

Federal cuts and states' own budgetary pressures led states to reduce rates in various ways. The increased flexibility given to states by Congress, and HHS's focus on reducing cost, meant that states were encouraged to do as much as possible to cut rates without a meaningful check. This is not to say that states always abused their discretion or that every rate reform violated Section 30(A). Some state officials used their flexibility as Congress intended—experimenting with new payment and delivery models that challenged the longstanding reliance on provider cost and disrupted assumptions about what constituted reasonable cost. On the other hand, some states—typically state legislatures—made across-the-board cuts solely based on budgetary need. They did so without any inquiry into the impact on Section 30(A) factors or consideration of whether the reduced rates would compensate providers' reasonable costs. Whichever approach states took, the absence of regulatory oversight and clear guidance in this area meant that such questions often landed in federal court. Indeed, for decades, federal regulatory inaction meant that federal courts were the exclusive site for resolving complaints that rates were too low.

1. Type of Judicial Review: Defining Rate-Setting Requirements

The kinds of cases presented to courts can be simplistically labeled as either easy or hard, based on whether there is a clear violation of federal law or whether the analysis is more complex. The easy cases are ones in which the state is seeking to cut rates, but has violated some obvious procedural requirement, such as the failure to submit a State

Plan Amendment (SPA) with the proper assurances or to even consider Section 30(A) factors. The latter is a common problem where states feel budgetary pressure to cut expenses and they see Medicaid rate cuts as a quick fix. In these cases, states typically admit to ignoring Section 30(A) requirements and cut rates solely based on budgetary concerns. Section 30(A) has almost universally been found by courts to preclude rate decisions based solely on budgetary concerns.[82] Although the statute does not detail the kind of process states must follow, it clearly requires states to undertake some process in order to credibly make the required assurances with respect to economy, efficiency, access and quality. If a state fails to even consider these required factors—that is, if a state effectively engages in no process and displays blatant disregard for Section 30(A)—courts have been willing to enjoin state rate cuts.[83]

These cases have been viewed as unproblematic and squarely within courts' normal purview for a number of reasons. First, courts have viewed this kind of state action as violating a clear legal rule that does not involve second-guessing state officials' health policy judgment or expertise. Such cases do not present competing visions of how to balance cost, access, and quality goals, and typically there is no dispute about the relevant criteria used to make rate determinations. In fact, the state is not engaging in any balancing at all and thus is not using its flexibility as Congress intended. Rather, states are abdicating their obligation and power to engage in that kind of policy making, responding simply to other budgetary pressures. In terms of relief, these cases are easy as well, because courts can simply enjoin the states' proposed cuts and preserve the status quo. Plaintiffs are not asking courts to engage in rate-setting and courts typically are not deciding that the cuts themselves have resulted in payments so low that they violate Section 30(A) as a substantive matter; instead, courts are telling the states that if they want to make these cuts, they must do it the right way.

Finally, such cases have also been seen as easy because of the federal regulatory void that has allowed states to blatantly disregard federal law. While judges have noted that federal regulators with the

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82 *Id.* at 807.

83 *See Medicaid Access*, *supra* note 7, at 806–811.

requisite expertise are in a better position to evaluate state rate-setting processes, in easy cases, there is no meaningful review by the federal government. Cuts get approved by default or SPA's are rubber stamped based on paper assurance of Section 30(A) compliance. This pro forma approval of cuts has been exacerbated by a decades-long failure by the federal regulatory agency to promulgate meaningful guidance. Typically, where statutory ambiguities exist, the assumption is that agencies can and will fill in the gaps. Once the agency decides to act, deference is warranted if the agency is in fact using its expertise and discretion within the constraints of the law—that is, not acting arbitrarily or capriciously. In cases where the federal regulator has failed to act, or merely rubber stamped state action, courts' willingness to enjoin the rate cut serves an agency-forcing function.[84] It sends a message to both state and federal officials that they must engage in a meaningful process to ensure compliance with Section 30(A) in order to secure the court's deference. Federal court intervention has been viewed as necessary when state and federal officials blatantly disregard the law.

The harder cases have come in two forms. Some challenges have been brought alleging that the rates themselves were too low to satisfy the reasonable cost requirement under the Boren Amendment or to meet the access and quality guarantees under Section 30(A). Determining the sufficiency of rates, however, is a challenging question—especially as policy developments have disrupted longstanding assumptions about the link between provider costs and health care access or quality. Proving that rates are inconsistent with Section 30(A) guarantees is difficult and a murky area that courts have preferred to avoid.[85] Without clear access standards, whether these substantive guarantees are met seems inextricably linked to the quality

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84 *See* Catherine M. Sharkey, *Preemption as a Judicial End–Run Around the Administrative Process?*, 122 YALE L.J. ONLINE 1 (2012), http://yalelawjournal.org/images/pdfs/1076.pdf (describing an agency-forcing theory of judicial review); *See* Brietta R. Clark, *APA Deference After Independent Living Center: Why Informal Adjudicatory Action Needs a Hard Look*, 102 KY. L.J. 211, 246 (2014) [hereinafter *APA Deference*] (discussing Sharkey's application of her theory to the rate-setting case that reached the Supreme Court in *Independent Living Center*, and arguing that this theory helps explain most lower courts' approach to judicial review in rate-setting as well).

85 *Medicaid Access*, *supra* note 7, at 811–19, 823–28.

of the rate-setting process itself. Substantive violations are harder to prove if the process used to set rates is so defective that it could not possibly have generated meaningful information about the effect of the proposed rates on access or quality.

The more common type of challenge has involved provider and beneficiary suits that attack specific aspects of a state's rate-setting methodology as violating federal rate-setting requirements. The Boren Amendment gave hospitals and nursing homes a powerful tool for these kinds of challenges, in light of its substantive mandate that states reimburse reasonable costs and its procedural requirement that states make certain findings with respect to the rates it set. Typically, providers challenged the state methodology as not adequately taking providers' costs into account, which meant that the states could not provide the required assurances that rates would be consistent with economy or efficiency.

To be clear, the state's flexibility to experiment with new payment models, such as the prospective payment system, was not challenged in these suits—there was no question that this was precisely what Congress intended. Rather, providers challenged the implementation of these reforms and specifically the state's method for determining the "reasonable costs" of economically and efficiently run facilities. Establishing prospective payments required states to group providers according to shared characteristics, and based on these characteristics, the state would then generalize about what costs were reasonable. The Medicaid Act provided limited guidance about the relevant criteria for determining reasonable cost. States were left to make assumptions about which characteristics or factors were relevant to measuring cost generally and specifically how to account for cost factors outside of the facility's control. These assumptions were ripe for attack by providers, and courts did their best to mediate the claims.

Where courts found for the states, their reasoning revealed an intention to balance their proper role as a check on state compliance with federal law against the danger of overstepping into the policy realm and second-guessing states' value judgments. Courts were quite sympathetic to the states' interests when considered in light of growing budgetary pressures and shifting responsibility to states to drive cost reforms. State flexibility also featured prominently in these cases. The legislature's goals, the broad state discretion provided in the

statute, and the fact that some rational process was undertaken by the state were all relevant considerations in upholding even flawed state rate-setting processes.[86]

On the other hand, there were several decisions in the late 1980s and early 1990s in which courts invalidated rate changes based on a flawed rate-setting process, despite federal regulatory approval.[87] One recurring and fatal flaw was the failure to use actual cost data in estimating reasonable costs. Some courts found this to be a clear violation of the Boren Amendment's requirements; other courts held that the failure to consider actual costs, when considered along with other defects, made the state rate changes look like they were in fact driven solely by budgetary concerns and simply dressed up in a pro forma process, as opposed to a credible balancing of the Boren factors.[88] The Boren era cases show that while courts acknowledged the importance of state flexibility, the specific requirements in Boren had teeth. Some courts emphasized that Congress did not eliminate the state's obligation to pay reasonable rates and that courts had a critical role to play in enforcing this obligation.[89] At the same time, courts had a difficult line to navigate, and these were precisely the kinds of cases some judges believed were outside of the courts' expertise, and some legislators believed were impeding state payment reforms.

With the repeal of the Boren Amendment, providers lost a powerful tool. Section 30(A) did not have quite the same teeth as the Boren Amendment, and thus was not as effective in challenging state rate-setting. Some courts seemed willing to at least review the state rate-setting process to ensure that it considered Section 30(A) factors, and thus was not arbitrary.[90] But they tended to be very deferential to the states; they did not feel comfortable imposing process requirements not found in the statute or required by regulators. They

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86 *See Medicaid Access*, *supra* note 7, at 813–18, 823–25 (discussing cases in which district courts rejected challenges to states' method of implementing payment reforms).

87 *See id.* at 818–19, 820–22 (discussing cases in which providers or beneficiaries successfully challenged states' rate-setting).

88 *See id.*

89 *See id.*

90 *See id.* at 820–22.

effectively applied the kind of analysis one would in an APA claim: courts would look at the process employed to determine if it was reasonable, and absent evidence of arbitrariness or a blatant disregard of Section 30(A) factors, courts would uphold the rate cut. Some courts even rejected the claim that Section 30(A) created any procedural requirement, given the lack of any clear statutory language or guidance as to what process was required.

Courts taking a more deferential approach tended to highlight the administrative flexibility granted to states by Congress, the multiple and potentially competing values underlying the Section 30(A) factors, and the complexity of the analysis that would be required to make Section 30(A) assessments. They viewed these questions as involving the kind of policy, value, and technical judgments that are more appropriately decided by Congress or the federal regulator. The deferential approach taken by most courts meant that suits in these cases were often unsuccessful. How closely a court would look at a state's process depended in part on the facts, but there was a clear reluctance to wade into questions about the adequacy of the rate-setting process, in the absence of clear statutory or regulatory requirements.

The Ninth Circuit was an exception and has always been an outlier among the circuits in Section 30(A) disputes.[91] District courts in the Ninth Circuit have been most active in scrutinizing state rate-setting, and the Ninth Circuit is the only circuit that has read into Section 30(A) the specific requirement that states perform regular provider cost studies as part of its rate-setting process. The key case establishing this requirement is *Orthopaedic Hospital v. Belshe*,[92] a 1997 case featured prominently in the lawsuits which led to *Independent Living Center* and *Exceptional Child Center*. In this case, Orthopaedic Hospital and the California Hospital Association challenged California's prospective

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91 Not only has it been willing to provide the easy relief of enjoining rate cuts, but a California district court once embarked on the much more challenging task of forcing the state to undertake particular process to increase rates. *See* Clark v. Coye, 1992 WL 140827, *1–2 (9th Cir. June 23, 1992) (unpublished decision) (discussing the role of the magistrate in overseeing the district court's order to set new rates that comply with Section 30A and specifically the magistrate's power to order a higher level of reimbursement if the state is found noncompliant).

92 Orthopaedic Hospital v. Belshe, 103 F.3d 1491 (9th Cir. 1997).

payment system for outpatient services alleging violation of Section 30(A)'s rate-setting requirements.[93] The hospitals challenged the fact that rates were set based on the type of service provided, but without regard to the setting in which the service was performed. Consequently, hospitals and outpatient centers were reimbursed at the same rate, despite the fact that hospitals had much higher costs due to their special legal obligations and the unique range of care they provided.[94] Plaintiffs claimed that the state's failure to take these cost disparities into account in setting rates violated Section 30(A).[95]

State officials argued that Section 30(A) did not require them to take into account the higher costs that hospitals incur in setting outpatient rates. They noted that Section 30(A) contained no explicit requirement that states make findings with respect to whether rates meet reasonable costs.[96] Moreover, they argued that states had the right to set rates at a level that was based on the costs incurred by the most efficient providers of outpatient services, which in this case, were freestanding clinics or doctors' offices.[97]

This was not a case where the state clearly disregarded federal law. Rather, the dispute in this case reflected the tension created by federal pressure on states to reduce cost through payment reform. This case was decided the same year Congress repealed the Boren Amendment, removing explicit references to "reasonable cost" to further increase state flexibility for this kind of experimentation. State officials and providers presented alternative methods of effecting this payment reform to encourage more efficient care. The district court thought the state's approach was consistent with Section 30(A). But the Ninth Circuit disagreed, based on its reasoning that the state could not make good faith and rational assurances of Section 30(A) compliance

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93 *Id.* at 1498. These rates were challenged twice: The state's first attempt to cut rates occurred without any process or consideration of Section 30(A) factors and was enjoined by the court. Based on that decision, the state undertook a rate-setting process that it used to try to justify the prior rate cuts, but the rates were challenged again, this time based on inadequate process. *Id.* at 1494 (describing the prior litigation).

94 *Id.* at 1495.

95 *Id.*

96 *Id.* at 1498–99.

97 *Id.* at 1496.

without gathering data on providers' actual costs.[98] It invalidated the state's proposed rates because of its failure to consider the hospitals' unique costs.[99]

State officials appealed to the Supreme Court, but certiorari was denied.[100] Thus, even after the Boren repeal, states were vulnerable to provider suits. Most courts were deferential to the states, but as *Orthopaedic Hospital* showed, not all states could count on this deference.

2. The Availability of Judicial Review: From Section 1983 to Private Preemption Claims

The repeal of Boren not only impacted how the merits of such challenges were handled, it made suits vulnerable to another threat: the narrowing of federal rights enforcement by the Supreme Court. At no time have the Medicaid Act's rate-setting provisions created an express right of action for providers or beneficiaries to sue states. Instead, such claims were brought using a federal civil rights statute, 42 U.S.C. § 1983, also known as Section 1983, which provides a cause of action for "the deprivation of any rights, privileges, or immunities secured by the Constitution and laws" of the United States.[101] Prior to 2002, providers and beneficiaries successfully used Section 1983 to challenge rates or state rate-setting processes that violated the Boren Amendment and Section 30A.[102]

This changed in 2002 as the result of the Supreme Court's decision in *Gonzaga University v. Doe*.[103] *Gonzaga* involved a question about when private individuals could use Section 1983 to enforce a federal education law, but the Court's holding had broader implications for

98 *Id.* at 1498.

99 *Id.* at 1499.

100 Belshe v. Orthopaedic Hospital, 103 F.3d 1491 (9th Cir. 1997), *cert. denied,* 522 U.S. 1044 (1998).

101 42 U.S.C. § 1983 (2017).

102 *See* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 524 (1990); *see also* Sanchez v. Johnson, 416 F.3d 1051, 1058 (9th Cir. 2005) (listing the Circuits holding that providers and recipients could use Section 1983 to enforce Section 30A obligations prior to *Gonzaga*).

103 Gonzaga University v. Doe, 536 U.S. 273, 273 (2002).

other spending programs, like Medicaid.[104] The Gonzaga court issued a decision that severely narrowed the test for when Section 1983 could be used to enforce federal law. It held that a Section 1983 action is only available to enforce provisions of a spending statute where Congress uses explicit, individually focused, rights-creating language that reveals congressional intent to create an individually enforceable right.[105] Notably, the Court seemed particularly skeptical about Congressional intent to create a right to sue to enforce conditions attached to spending statutes, especially where the conditions related to the more complex administrative aspects of the program.[106] Most federal courts hearing payment suits after *Gonzaga* agreed that based on this new test, claims that a state's rate-setting process were inadequate could no longer be challenged using Section 1983.[107] Courts held that the language of Section 30(A) was not definite or specific enough to be enforceable under Section 1983. This conclusion seemed consistent with the frustrations already expressed by most courts that Section 30(A)'s statutory provisions simply did not provide enough guidance to courts for meaningful enforcement.

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104 *Gonzaga* involved an alleged violation of the Family Educational Rights and Privacy Act of 1974 ("FERPA"), which prohibits "the federal funding of educational institutions that have a policy and practice of releasing educational records to unauthorized persons." *Id.* at 276. The Court held that FERPA did not create personal rights enforceable under 42 U.S.C. § 1983. *Id.*

105 The Court held that in order for a statute to create a right enforceable under Section 1983, three factors must be considered: (i) whether Congress "intended that the provision in question benefit the plaintiff"; (ii) the right protected by the statute cannot be so "vague and amorphous" that its enforcement would strain judicial competence, and (iii) "the statute must unambiguously impose a binding obligation on the States"; "[i]n other words, the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms." *Id.* at 282 (quoting Blessing v. Freestone, 520 U.S. 329, 340–41 (1997)). The *Gonzaga* Court then made clear that despite reference to a "benefit" in the first factor of the *Blessing* test, Section 1983 is only available to enforce provisions of a federal statute where Congress uses "explicit, rights-creating terms" that "manifest[ ] an intent 'to create not just a private right but also a private remedy.'" *Id.* at 284 (quoting Alexander v. Sandoval, 532 U.S. 275, 286 (2001)).

106 *Id.* ("[In *Pennhurst*] [w]e made clear that unless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement by Section 1983. Since *Pennhurst* only twice have we found spending legislation to give rise to enforceable rights.").

107 *See, e.g.*, Sanchez, 416 F.3d at 1061; Long Term Care Pharm. All. v. Ferguson, 362 F.3d 50, 59 (1st Cir. 2004).

Nonetheless, Medicaid payment suits proved resilient because of an alternative legal theory: providers and beneficiaries brought challenges under the Supremacy Clause, arguing that a state law or regulatory action that reduced rates in violation of Section 30(A) was preempted by federal law and thus invalid. Courts were embracing this theory in rate-setting cases[108] and in other cases involving private plaintiffs' attempts to enforce federal spending conditions in the absence of a statutory right of action.[109] Interestingly, this change in legal theory did not appear to greatly impact courts' existing approach to rate-setting challenges.[110] Most circuits continued to be extremely deferential to state rates approved by the federal regulator, while the Ninth Circuit continued its approach of closer judicial scrutiny.[111]

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108 *See* Douglas v. Indep. Living Ctr. of Southern California, Inc. (Indep. Living Ctr.), 132 S. Ct. at 1222 (explaining that plaintiffs began using the Supremacy Clause to enforce Section 30(A) obligations once federal courts began finding that 30(A) did not create rights enforceable by private parties through Section 1983). *See generally* SARA ROSENBAUM, CAL. HEALTHCARE FOUND., MEDICAID PAYMENT RATE LAWSUITS: EVOLVING COURT VIEWS MEAN UNCERTAIN FUTURE FOR MEDI–CAL 1, 9–11 (2009), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalProviderRateLitigation.pdf.

109 *See, e.g.*, Detgen ex rel. Detgen v. Janek, 752 F.3d 627 (5th Cir. 2014) ("The plaintiffs' theory of an implied cause of action does not depend on any rights-creating language in the Medicaid Act; rather, they rely on the Supremacy Clause . . . . In light of the [Supreme] Court's failure in *Independent Living Center* to hold to the contrary, this appeal is governed by [Fifth Circuit precedent which says] that the Supremacy Clause confers an implied private cause of action to enforce *all* Spending Clause legislation by bringing preemption actions.") (emphasis added) (citing to Planned Parenthood of Houston & Southeast Texas v. Sanchez (PPHST), 403 F.3d 324, 330–35 (5th Cir. 2005)). In distinguishing this new cause of action from Section 1983 or implied right of action claims, courts relied on established precedent that plaintiffs did not have to rely on rights-creating language in the statute, to seek equitable relief from preempted state laws under the Supremacy Clause. *See* Shaw v. Delta Air Lines, 463 U.S. 85, 96, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983) ("A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is preempted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve."); Lewis v. Alexander, 685 F.3d 325, 345–46 (3d Cir.2012) (concluding Supreme Court precedent dictates Supremacy Clause provides plaintiffs with independent basis for private right of action); Koenning v. Suehs, 897 F.Supp.2d 528, 543, No. V–11–6, 2012 WL 4127956, at *12 (S.D. Tex. Sept. 18, 2012) (noting the court was "compelled to hold that the Supremacy Clause provides a private right of action here.").

110 This shift did mean that plaintiffs could no longer get past damages, and were now limited to seeking prospective, injunctive relief.

111 *See Medicaid Access*, *supra* note 7, at 813–828.

Balance has been a dominant theme in the rate setting arena. States must balance cost, access and quality goals. The regulatory framework in the Act balances federal oversight with state flexibility to experiment and tailor the program to state needs. And Section B shows how courts have struggled to balance policy and legal considerations, attempting to enforce federal rate-setting requirements without improperly impeding state discretion in policymaking. This struggle has been primarily reflected in the merits question—whether a state's rate methodology conflicted with and thus was preempted by Section 30(A). The question of the availability of judicial review seemed settled, that is, until the Supreme Court finally decided to take up the question in *Independent Living Center v. Douglas*.

PART III. RATE-SETTING CHALLENGES REACH THE SUPREME COURT

From the moment providers began using the Supremacy Clause as an affirmative weapon to invalidate state laws or executive action on preemption grounds, states mounted a counteroffensive that had been largely unsuccessful in the lower federal courts. States challenged suits on procedural and substantive grounds.[112] Procedurally, they argued that private plaintiffs did not have a federal cause of action to challenge state law and that HHS was vested with exclusive regulatory authority.[113] Substantively, they challenged how lower courts interpreted federal law and what they considered an expansive application of conflict preemption to invalidate state laws.[114] At the heart of both questions was concern about state flexibility—specifically the character and scope of that flexibility given to states in the Medicaid Act—and the extent to which allowing judicial enforcement of rate-setting requirements, as well as the level of review

112 *See* Rosenbaum, *supra* note 108, at 8–11 (discussing the evolution of payment suits and the shift in legal theories after the demise of private challenges under Section 1983).

113 *See APA Deference*, *supra* note 84, at 221–23; *see also* Brief for Nat'l Governors Ass'n et al. as Amici Curiae Supporting Petitioner, Douglas v. Indep. Living Ctr. of Southern California, Inc., 132 S. Ct. 1204 (2012) (Nos. 09-958, 09-1158,10-283), 2011 WL 2132704, at *22.

114 *See APA Deference*, *supra* note 84, at 221–23.

applied by courts, either reinforced or undermined the federal-state bargain.

Despite the fact that the Supremacy Clause question seemed like settled law, the Supreme Court decided to weigh in, granting certiorari in two private rate-setting preemption suits in the span of just three years. Each time, the question taken up by the Court was whether providers could use the Supremacy Clause as a basis for seeking prospective relief from a state law allegedly preempted by the federal rate setting requirements in Section 30(A). It reached the Court twice because the first time the Court granted certiorari, it did not answer the question; instead, it reframed the question and remanded the case in light of changed circumstances. Ultimately the Supreme Court eliminated preemption-based challenges to state rate setting. Together these decisions seem narrowly drawn, refining and limiting the role of judicial review specifically in rate-setting cases. But the reasoning by the justices, including the shifting alliance of Justice Breyer between the two decisions, reveals important insight into the connection between the Court's federalism and separation of power concerns on the one hand and its understanding of the character of state flexibility evident in the Medicaid rate-setting provisions, on the other. This insight not only provides hints at how the Court might consider other challenges to state action as preempted by or violative of the Medicaid Act, it affirms the Court's respect for the important balance struck between state flexibility and rights enforcement.

A. *Independent Living Center*: Judicial Deference & Respect for Federal Regulatory Action

1. Path to the Supreme Court: The Stakes in Independent Living Center

In *Independent Living Center*, Medicaid providers and beneficiaries sued in federal court to challenge cuts to reimbursement rates for Medi-Cal, California's Medicaid program, alleging the cuts violated Section 30(A) access and quality protections.[115] At the time the suit was filed, the case seemed like a compelling case. The state legislature had

[115] Douglas v. Indep. Living Ctr. of Southern California, Inc. (Indep. Living Ctr.), 132 S. Ct. 1204, 1204 (2012).

enacted an across-the-board cut in reimbursement for most health care services, and state officials admitted that the cuts were motivated purely by budgetary considerations; there was no dispute that the cuts were enacted without any consideration of how they would impact Section 30(A) assurances of access and quality.[116] This was done despite the fact that California already had among the lowest Medicaid reimbursement rates in the nation, there were documented access problems due to low provider participation, and there were surveys which attributed low participation, in part, to low rates.[117]

Neither the district court nor the Ninth Circuit ruled on the adequacy of the rates themselves; that is, they did not decide whether the rates were consistent with economy, efficiency and quality and sufficient to ensure equal access. Instead, the lower courts found that California officials' blatant disregard of Section 30(A), including their failure to gather any data about provider costs or access, meant they could not have made the requisite assurances of Section 30(A) compliance.[118] As a result, the district court enjoined the cuts, and the Ninth Circuit affirmed.[119]

State officials appealed on two grounds. They challenged the Ninth Circuit's decision on the merits and specifically its reliance on *Orthopaedic Hospital's* interpretation of Section 30(A) as requiring cost studies.[120] But the Court did not grant certiorari on this ground. Officials also appealed on the ground that providers had no right to bring a challenge based on the Supremacy Clause, regardless of the

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116 *See* Indep. Living Ctr. of Southern California, Inc. v. Maxwell-Jolly, 572 F.3d 644, 655–56 (9th Cir. 2009) ("In this case, the record supports the district court's conclusion that 'the only reason for imposing the cuts was California's current fiscal emergency.' . . . Thus, . . . the State's decision to reduce Medi–Cal reimbursement rates based solely on state budgetary concerns violated federal law."), *vacated sub nom.* Douglas v. Indep. Living Ctr. of Southern California, Inc., 132 S. Ct. 1204 (2012).

117 *See* Eryn Brown, *No plans for California to make up for expiring 'Medicaid fee bump'*, L.A. TIMES (Dec. 31, 2014, 8:37 PM), http://www.latimes.com/local/california/la-me-doctor-pay-20150101-story.html.

118 Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly, 572 F.3d 644, 652–53 (9th Cir. 2009), *vacated and remanded sub nom.*; Douglas v. Indep. Living Ctr. of Southern Cal., Inc. (Indep. Living Ctr.), 132 S. Ct. 1204 (2012).

119 *Id.*

120 Petition for Writ of Certiorari, Maxwell-Jolly v. Indep. Living Ctr. of Southern Cal., Inc., 2010 WL 599171 (2010).

merits, and this is the question the Court took up.[121] By granting certiorari on this procedural question only, the Supreme Court reinvigorated objections to the right of private individuals to enforce Medicaid spending conditions in the rate-setting context; states, health advocates, and providers saw much at stake.

Providers and patient advocates feared the Court was signaling its intent to eliminate the use of a preemption-based (or Supremacy Clause) claim to prevent illegal state cuts which was the plaintiffs' tool of last resort after the narrowing of Section 1983 claims. This was concerning given the history of states' blatant disregard of federal rate-setting provisions in the face of federal regulatory neglect. Indeed, the cuts at issue in *Independent Living Center* were simply the latest in California's particularly troubling history of disregarding Section 30(A).

States, on the other hand, have long complained that Medicaid payment suits interfered with their ability to manage their budgets and undermined the flexibility they were given in the Medicaid Act.[122] In defending against rate challenges, states have pointed to the Supreme Court's Section 1983 jurisprudence and argued that the use of the Supremacy Clause in these cases was inappropriate because it was effectively an end-run around Section 1983.[123] States and the Obama Administration also highlighted the character of rate-setting that made it inappropriate for court review. In particular, they explained that rate setting requires decision makers to balance multiple statutory goals that may be in tension with one another and are value-laden.[124] Such decisions involve political considerations and technical expertise that should be made by the agency with the requisite expertise, not by courts.

One of the states' arguments that had the broadest implications for rights enforcement had to do with the fact that Medicaid was a federal spending program and that the provisions plaintiffs sought to

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121 Indep. Living Ctr. of Southern Cal., Inc., 132 S. Ct. at 1207.

122 *See Medicaid Access*, *supra* note 7 (discussing states' use of provider rate cuts to deal with budgetary problems and their claims that provider rate challenges improperly interfere with their ability to manage their budgets).

123 *See APA Deference*, *supra* note 84, at 222.

124 *Id*. at 222–223.

enforce were conditions on the receipt of federal funds. They argued a theory that had long been rejected by the Supreme Court—that federal spending conditions administered through a state-federal partnership should be treated more like contract conditions between the federal regulatory agency and state government, enforceable only by those entities.[125] States were hoping that *Independent Living Center* would not only foreclose rate-setting claims, but that it could be used to eliminate or drastically shrink rights enforcement claims tied to Medicaid spending conditions more broadly.

2. The Decision: Reframing the Question in Light of "Changed Circumstances"

The Supreme Court never answered the question on which it granted cert—whether patients and providers could challenge Medicaid rate cuts in federal court using the Supremacy Clause. In a 5-4 decision, the Court reframed the question and remanded it back to the Ninth Circuit due to "changed circumstances"—namely, that CMS approved the proposed rates as consistent with federal law while litigation was pending.[126] At the point the plaintiffs filed suit, CMS had begun though not completed its rate review; but during the litigation, CMS completed its review and ultimately approved the rates.[127] Justice Breyer's opinion was brief and much of it was dicta, but it explains why a majority the Court thought that review and approval of the rates by CMS may have changed the posture of the case in a legally significant way.[128]

Justice Breyer suggested that federal agency action could impact the question presented by creating a preferred avenue for judicial review under the Administrative Procedure Act (APA), which allows

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125 Rochelle Bobroff, *Ex parte* Young *as a Tool to Enforce Safety-Net and Civil-Rights Statutes*, 40 U. TOL. L. REV. 819, 838 (2009) (spending clause conditions are authorized through the spending power of the General Welfare Clause, and thus should be viewed as "enforceable as any other constitutional provision.").

126 Douglas v. Indep. Living Ctr. of Southern Cal., Inc. (Indep. Living Ctr.), 132 S. Ct. 1204, 1208 (2012).

127 *Id.* at 1207–08.

128 *Id.* at 1210.

challenges to actions by administrative agencies.[129] The majority noted its discomfort with the idea of Supremacy Clause claims in this context, because if the same claim could be brought under the APA, this would make Supremacy Clause claims redundant at best.[130] At worst, the majority speculated, courts hearing Supremacy Clause challenges may apply a different standard or be less deferential to agency determinations than they would under an APA claim.[131] This could generate confusion and inconsistency in the application of Section 30(A) that could undermine federal goals.[132] The court went on to assert that CMS's approval of state Medicaid rates is "the kind of legal question ordinarily calling for APA review," and thus deference, "as CMS is comparatively expert in the statute's subject matter, its decision carries weight."[133]

One challenge with gleaning guidance from this opinion is that the Court was merely speculating about the standards of review lower courts had been using under the Supremacy Clause, because the issue had not been briefed.[134] What was clear, however, was that the Ninth Circuit's approach to defining Section 30(A) in *Orthopaedic Hospital*, as recently affirmed in *Independent Living Center*, fed into the majority's fear. The Court specifically noted that inconsistency could occur because of the Ninth Circuit's decision in *Orthopaedic Hospital* interpreting Section 30(A) as requiring cost studies, an approach rejected by other federal courts and more recently by CMS.[135] The majority reminded lower courts that in light of CMS's role, the APA would be a proper basis for a claim challenging rates approved by the federal government and that the APA standards for review emphasize judicial deference to agency determinations.[136]

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129 *Id.*

130 *Id.*

131 *Id.* at 1210–11.

132 Douglas v. Indep. Living Ctr. of Southern Cal., Inc. (Indep. Living Ctr.), 132 S. Ct. 1204, 1210–11.

133 *Id.*

134 *Id.* at 1211.

135 *Id. See* APA Deference, *supra* note 84, at 226–27.

136 Indep. Living Ctr. of S. Cal., Inc., 132 S. Ct. at 1208.

Although Justice Breyer did not answer the procedural questions regarding the use of implied supremacy clause claims to challenge rates, two things are clear from the opinion. Justice Breyer was concerned about which institutional actor (federal courts or federal agencies) should decide these questions. And although the Court did not take up the merits question, Justice Breyer saw an important connection between the procedural, institutional choice question, and his concern that courts get the decision "right" on the merits. Justice Breyer believed that the proper deference and respect owed to the administrative agency could impact the merits of the decision, and he worried that the source of the claim (the APA or the Supremacy Clause) could potentially impact the amount of deference courts thought they should apply.

3. Impact of Independent Living Center: APA Deference Promotes Greater State Flexibility

After the initial lawsuit was filed and lower courts enjoined the cuts, California officials passed legislation cutting Medicaid rates again.[137] The cuts were almost identical to the ones challenged in *Independent Living Center*, but this time the process looked very different. First, the state legislation conditioned the proposed cuts on Section 30(A) compliance and authorized the director of the California Department of Health Care Services (DHCS) to make this determination.[138] The director, subsequently, directed DHCS officials to undertake an access review as part of its rate-setting process, before resubmitting its SPA to the Centers for Medicare and Medicaid Services (CMS), the division of HHS charged with Medicaid oversight.[139] As discussed further below, this was likely in response to a proposed rule issued by CMS, giving states much needed guidance

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137 *See* Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1242 (9th Cir. 2013).

138 Assemb. B. 97, 2011–12 Gen. Assemb., Reg. Sess. (Cal. 2011) (emphasis added) (focusing on finding places to cut only "where *reimbursement levels are higher than required* under the standard provided in [Section 30(A)] and *can be reduced in accordance with federal law.*"). The statute authorized the Director to identify such opportunities for legal reductions and specifically prohibited the Director from implementing rate reductions unless and until the Director (1) determined that the reductions would comply with applicable federal Medicaid requirements and (2) were approved by CMS.

139 *See* Managed Pharmacy Care, 716 F.3d at 1242.

as to what Section 30(A) required. In addition, CMS took an uncharacteristically active role in reviewing California's SPA, including identifying areas of concern and requesting additional information it needed to assess DHCS's assurances of compliance.[140] Ultimately, the state concluded that a ten percent across-the-board payment reduction—the same reduction originally attempted by the state without any rate-setting process—would comply with federal law, and CMS approved the cuts over provider and beneficiary objections.[141]

Several law suits were brought by providers and beneficiaries, once again using the Supremacy Clause to argue that such cuts were preempted by Section 30(A). The same California district court preliminarily enjoined the cuts in all four cases, despite CMS approval.[142] While there were some differences in the respective opinions based on the particular services impacted by each type of rate cut, the underlying reasoning in the four cases was essentially the same. The district court found that the state violated federal law by failing to do credible studies of provider costs to determine whether the proposed rates were consistent with economy and efficiency.[143] It

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140 *See* Letter from Donald Berwick, Administrator, Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health and Human Servs., to Toby Douglas, Dir. of Health Care Programs, Cal. Dep't of Health Care Servs. (Oct. 27, 2011) (submitting two SPAs for CMS approval). CMS did not approve right away; it issued a letter to DHSC requesting additional information concerning the impact of the proposed rate reduction on access. In response, DHCS submitted access studies and plans for monitoring access. CMS ultimately approved the SPAs in "succinct" letters noting "the data CMS reviewed, the monitoring plan, and [CMS's] consideration of stakeholder input" as evidence of Section 30(A) compliance. The letter went on to note that "the State was able to provide metrics that adequately demonstrated beneficiary access" including the: (1) "Total number of providers by type and geographic location and participating Medi–Cal providers by type and geographic area," (2) "Total number of Medi–Cal beneficiaries by eligibility type," (3) "[u]tilization of services by eligibility type over time," and (4) "Analysis of benchmark service utilization where available."

141 *See* Managed Pharmacy Care, 716 F.3d at 1242.

142 Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1235 (9th Cir. 2013); Cal. Med. Ass'n v. Douglas, 848 F. Supp. 2d 1117 (C.D. Cal. 2012), *rev'd in part, appeal dismissed in part sub nom.*; Cal. Hosp. Ass'n v. Douglas, No. CV 11–9078 CAS (MANx), 2011 WL 6820229 (C.D. Cal. Dec. 28, 2011), *modified*, 2012 WL 760646 (C.D. Cal. Mar. 8, 2012), *and rev'd sub nom.* Managed Pharmacy Care v. Sebelius, 716 F.3d 1235 (9th Cir. 2013); Cal. Med. Transportation Ass'n v. Douglas, No. CV 11–09830 CAS (MANx), (C.D. Cal. Jan. 10, 2012), *rev'd sub nom.* Managed Pharmacy Care v. Sebelius, 716 F.3d 1235 (9th Cir. 2013).

143 *See, e.g.*, Cal. Med. Ass'n, 848 F. Supp. 2d at 1129–1131.

also found the state's access review flawed in critical respects, which meant the state could not have accurately evaluated the potential impact of rates on equal access or quality guarantees.[144] Notably, the district court applied the APA in considering whether CMS approval should get deference but found the flaws in the process to be so significant that it made the rate-setting process, and thus CMS approval of the SPA, arbitrary and capricious and not deserving of APA deference.[145] It enjoined the cuts, and state officials appealed to the Ninth Circuit.

The cases were consolidated and ultimately heard by the Ninth Circuit in *Managed Pharmacy Care v. Sebelius*.[146] In asking the Ninth Circuit to overturn the decisions and vacate the injunctions, California and federal officials relied heavily on the dicta in the majority opinion in *Independent Living Center*, arguing that APA deference should apply to CMS's approval.[147] The Ninth Circuit agreed, highlighting several factors that supported deference: "the interstitial nature of the legal question, the related expertise of the [a]gency, the importance of the question to administration of the statute, the complexity of that administration, and the careful consideration the [a]gency has given the question over a long period of time."[148] Essentially, the Ninth Circuit's application of deference was based on two salient characteristics: the character of the program as technical and complex and the "official" character of the act—that is, the express congressional authorization for CMS to approve SPAs as an essential aspect of Medicaid administration.[149]

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144 *See, e.g.*, *id.* at 1131–32.

145 *Id*.

146 Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1235 (9th Cir. 2013).

147 *See* Brief for Federal Appellant, Managed Pharmacy Care v. Sebelius, 716 F.3d 1235 (2012) (Nos. 12-55067, 12-55332), 2012 WL 1134205, at *13-14; *see also* Consolidated Reply Brief, and Consolidated Response to Opening Cross-Appeal Briefs, of Toby Douglas, Managed Pharmacy Care v. Sebelius, 716 F.3d 1235 (2012) (Nos. 12-55103, 12-55067, 12-55068, 12-55315, 12-55331, 12-55332, 12-55334, 12-55335, 12-55535, 12-55550, 12-55554, 12-55605), 2012 WL 2564617, at *13-14.

148 Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1247 (9th Cir. 2013) (alteration in original) (quoting Barhart v. Walton, 535 U.S. 212, 222 (2002)).

149 *Id.* at 1248.

With respect to the character of the program, the Ninth Circuit noted that the complex and interstitial nature of the Medicaid Act made it the kind of program in which Congress explicitly and implicitly delegated great discretion to CMS to fill in the gaps.[150] With respect to the process flaws plaintiffs identified, the court did not spend much time. In fact, the Ninth Circuit spent virtually no time considering the merits of the district court's analysis and finding of legally significant flaws in the process. Instead, the court criticized the district court for delving into the minutiae of Medicaid and second-guessing CMS.[151] The Ninth Circuit refused to look closely at the specific circumstances of the SPA approval and was clearly swayed by the apparent robustness of the federal-state interaction during the review process, specifically the number of contacts and pages amassed.

It was clear that the federal regulator's role was an important factor to the Ninth Circuit's application of APA deference to uphold the cuts. In what appeared to be a radical departure from past practice, CMS did not simply rubber stamp these cuts or rely on paper assurances of compliance as it had in the past. Instead it exercised its regulatory authority to actively review the state's cuts, to require the state to assess the potential impact on Section 30(A) factors, and to seek additional information before approving the cuts. For this reason, one may wonder if the requirements to get APA deference may lead to greater constraints on state discretion by encouraging greater federal oversight. The answer in this case is not at all. In this arena, greater deference to federal approval effectively promotes and protects state flexibility.

This becomes clear in looking at the regulatory guidance that was being developed at the same time that these lawsuits were wending their way through the courts. During the time of this back and forth between the California legislature and the courts, there was federal agency action around the issue of Medicaid access and Section 30(A) compliance. A framework for measuring Medicaid access was recommended by the Medicaid and CHIP Payment and Access

150 *Id*. at 1247.

151 *Id*. at 1251.

Commission (MACPAC) in a 2011 report[152] and by CMS in a 2011 proposed rule on Section 30(A) compliance.[153] Despite making clear that Section 30(A) required *some* kind of access review, and even providing suggested criteria and guidelines, the rule also made clear that the MACPAC criteria were not mandatory; it repeatedly affirmed the importance of state flexibility and experimentation in designing the rate-setting process.[154] Most directly relevant to the post-*Independent Living Center* cases, CMS rejected the Ninth Circuit's interpretation of 30(A) as requiring cost studies. It appeared to devalue the importance of cost considerations by implicitly leaving the choice to consider cost to state discretion and noting that "[d]epending upon State circumstances, cost-based studies may not always be informative or necessary."[155] It did mention that cost studies were one of a number of possible approaches for setting rates, but it did not explicitly include provider cost studies or data as a measure of access or payment sufficiency in its recommended framework.

More significantly, however, in the proposed rule CMS emphasized that it wanted "States [to be] empowered to seek the best value through their rate-setting policies" and did not want to "impair States' ability to pursue that goal."[156] In fact, the background discussion began with an emphasis on state flexibility, especially with respect to cost-cutting goals, and the importance of flexibility was frequently coupled with discussion of the Section 30(A) requirement.[157] Indeed, state flexibility was used to frame so much of

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152 Medicaid & CHIP Payment & Access Comm'n, Report to the Congress on Medicaid and CHIP 126–40 (2011), https://www.macpac.gov/publication/report-to-the-congress-on-medicaid-and-chip-311/.

153 Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, 26,359 (May 6, 2011) (Proposed Rule).

154 *Id.* at 26,349 & 26,362.

155 *Id.* at 26,344.

156 *Id.* at 26,343.

157 *Id.* at 26,344 ("[S]tates must have some flexibility in designing the appropriate measures to demonstrate and monitor access to care, . . . [in which] a singular approach to meeting the statutory requirement under [30A] could prove to be ineffective given current limitations on data, local variations in service delivery, beneficiary needs, and provider practice roles. For these reasons, we are proposing to frame alternative approaches for States to demonstrate consistency with the access requirement . . . rather than setting nationwide standards . . . . [We now propose] to allow for State and Federal review of beneficiary access to evolve over

the proposed rule that rate-setting flexibility, rather than access, seemed to be the dominant theme of the proposed rule. CMS presented the proposed rule as a compromise in which there would be very few mandatory rules for states to follow, and while the federal government would provide some guidance, the most important details concerning the process-based and substantive measures of Section 30(A) standards would be left to the states' discretion. CMS explicitly rejected setting national access thresholds or even requiring states to establish and demonstrate access thresholds; it said it would rely instead on State analyses to ensure that the State-level review process operated to reasonably demonstrate substantive compliance with the access requirements.[158] In explaining its approach, it drew upon the common federalist metaphor of the state as laboratory, and it framed the federal role as one that should encourage state experimentation as this could yield information about effective approaches or the optimal benchmark.[159]

Indeed, the proposed rule's emphasis on state flexibility was consistent with its other actions during this time. This proposed rule came as the federal government was seeking state support for the public and private insurance expansions in the Affordable Care Act. The federal government needed state participation to make the ACA successful, because states were viewed as powerful partners in this endeavor; from the concessions CMS made to states at different stages of the process, states certainly seemed to be in a powerful position to negotiate. Finally, and perhaps most striking, the federal government filed a brief on behalf of California officials in the *Independent Living Center* case, siding with states seeking to prevent preemption challenges to state rate-setting.[160] The government's arguments for why the court should not recognize a right to sue stood in stark contrast to the briefs filed by former heads of HHS and members of

time.").

158 *Id.*

159 *Id.*

160 Brief for the United States as Amicus Curiae Supporting Petitioner, Douglas v. Indep. Living Ctr. of Southern Cal., Inc., 132 S. Ct. 1204 (2012) (Nos. 09–958, 09–1158, 10–283), 2011 WL 2132705.

Congress, describing the essential enforcement role that federal courts have long played in this arena.[161]

B. Exceptional Child Center: Judicial Review & the Special Character of Medicaid Rate Setting

1. The Path Back to the Supreme Court: Lower Courts Fail to Heed Independent Living Center's Warning

Just three years later, in *Exceptional Child Center*, providers of habilitation services in Idaho brought a rate-setting preemption suit against state officials in the Idaho Department of Health and Welfare (IDHW). They alleged that the state's failure to increase rates violated Section 30(A).[162] A number of factors made this a weak claim. Unlike *Independent Living Center*, in this case plaintiffs were challenging the state's existing rate methodology, which had been approved by the federal government long before they brought suit under the Supremacy Clause.[163] In addition, these plaintiffs were not challenging rate cuts; rather, the providers in *Exceptional Child Center* were challenging state inaction, specifically the failure of state officials to increase Medicaid rates for rehabilitation services.[164] The dispute arose when state health officials undertook a cost survey, the results of which led them to recommend a rate increase that was subsequently rejected by the legislature.[165] Unlike *Independent Living Center*, this case did not fall into the easy category where states attempt to cut rates in blatant disregard of Section 30(A) and with no process or consideration of the requisite factors. Indeed, just the opposite occurred: the state did undertake a process that not only considered these factors, but specifically considered cost data.[166] The problem according to the

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161 *Compare id. with* Brief for Former HHS Officials as Amici Curiae Supporting Respondents, *Douglas*, 132 S. Ct. 1204 (Nos. 09–958, 09–1158, 10–283), 2011 WL 3706105. S*ee also* Brief for Members of Congress as Amici Curiae Supporting Respondents, Indep. Living Ctr., 132 S. Ct. 1204 (Nos. 09–958, 09–1158, 10–280), 2011 WL 3467244.

162 Armstrong v. Exceptional Child Ctr., Inc. (Exceptional Child Ctr.), 135 S. Ct. 1378, 1382 (2015).

163 Exceptional Child Ctr. v. Armstrong, 567 F. App'x 496 (9th Cir. 2014).

164 *Id.*

165 *Id.*

166 *Id.*

plaintiffs, and the Ninth Circuit agreed, was that the legislature ignored this data and was solely motivated by budgetary concerns in refusing to increase rates.[167] Plaintiffs tried to emphasize this process-aspect of the case, as did the Ninth Circuit on appeal.[168] But, in reality, the posture of the case seemed to require the court to second-guess the state's judgment with respect to both the relevance of the cost data and its determination of compliance. Moreover, the plaintiffs were not asking the court simply to prevent a preempted state law from taking effect; rather it was asking the court to require the state to increase rates.

Surprisingly, providers won in the district court and at the Ninth Circuit. The district court relied on *Orthopaedic Hospital* for the principle that Section 30(A) required states to consider provider cost studies.[169] It then used this to argue that the state's failure to increase rates at the recommendation of the state health director based on those cost studies violated Section 30(A).[170] Even though the Ninth Circuit affirmed the lower court's decision, it did not seem completely convinced. In an unpublished decision, the Ninth Circuit simply followed the lower court's analysis. It also "express[ed] serious doubt over whether the Directors' inaction constitutes a 'Thing' in state law that can be preempted under the Supremacy Clause," but said that it would not address this question because it found the issue was waived.[171]

State officials attacked the plaintiffs' ability to bring this challenge using the Supremacy Clause. On this procedural question, the Ninth Circuit did not devote much time to the question of whether plaintiffs could properly bring their claim in federal court. It simply cited to precedent that providers have an implied right of action under the Supremacy Clause to seek injunctive relief against the enforcement or implementation of state legislation that conflicts with federal law.[172] It

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167 *Id.*

168 Brief of Plaintiffs-Appellees, Exceptional Child Ctr. v. Armstrong, 567 F. App'x 496 (9th Cir. 2014) (Nos. 12-35382, 1:09-cv-00634-BLW), 2013 WL 9760660*12–14.

169 Exceptional Child Ctr. v. Armstrong, 567 F. App'x 496 (9th Cir. 2014).

170 *Id.*

171 *Id.* at n.2.

172 *Id.*

also noted that its earlier decision in *Independent Living Center* had, by then, been heard by the Supreme Court, and that there was not a majority willing to eliminate implied Supremacy Clause actions.[173]

Idaho officials appealed to the Supreme Court. They sought an appeal on the merits, taking issue with the holding that the state's rate-setting methodology conflicted with federal rate-setting requirements.[174] It argued this holding was based on an outdated interpretation of Section 30(A) by the Ninth Circuit, long rejected by other circuits and contrary to recent positions taken by CMS.[175] They also argued that providers could not use the Supremacy Clause to enforce Section 30(A), citing the same arguments set forth in *Independent Living Center*.[176] Once again, the Supreme Court declined to take up the merits question but did grant certiorari on the procedural question.

2. The Exceptional Child Center Opinions: Shifting Alliances & Justice Breyer's Swing Vote

The specific question presented to the Supreme Court was whether the Supremacy Clause gave Medicaid providers a private right of action to enforce Section 30(A) against state officials where Congress chose not to create enforceable rights under that statute.[177] This time, a majority of the Court was willing to answer no. Justice Scalia wrote the majority opinion; predictably, the other *Independent Living Center* dissenters—Chief Justice Roberts and Justices Thomas and Alito—joined the opinion. The swing vote was Justice Breyer, who authored the *Independent Living Center* majority opinion refusing to answer the question the first time. Although Justice Breyer joined the majority opinion, he also wrote a concurrence emphasizing aspects of Medicaid rate-setting that influenced his decision. Justices Kennedy, Ginsburg, Kagan, and Sotomayor dissented, though aspects of their dissent suggest common areas of agreement with the majority,

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173 *Id.*

174 Petition for a Writ of Certiorari, Armstrong v. Exceptional Child Ctr., 135 S. Ct. 1378 (2015).

175 *Id.* at 24–30.

176 *Id.*

177 Armstrong v. Exceptional Child Ctr., 135 S. Ct. 1378, 1383–84 (2015).

especially Justice Breyer, relevant to the issue of balancing state flexibility in Medicaid against rights enforcement.

As part of the factual and procedural background for the dispute in *Exceptional Child Center*, Justice Scalia began the majority opinion by highlighting the Ninth Circuit's holding that "the providers had 'an implied right of action under the Supremacy cause to seek injunctive relief against the enforcement or implementation of state legislation.'"[178] He answered the question presented by first focusing on the role, if any, the Supremacy Clause plays in such statutory preemption claims, and then determining whether providers were entitled to equitable relief from state rate-setting laws quite apart from any cause of action conferred by the Supremacy Clause.[179]

First, the majority began by clarifying whether private preemption claims may be used affirmatively to enforce federal law. It emphasized that the Supremacy Clause functions as a rule of decision that guides courts when faced with a conflict, instructing courts to not give effect to state laws that conflict with federal law.[180] But the Court distinguished this from the question of how and when plaintiffs can bring preemption claims to challenge state laws, explaining that the Supremacy Clause "is silent regarding who may enforce federal laws in court, and in what circumstances they may do so."[181]

The majority expressly rejected the Ninth Circuit's characterization of the Supremacy Clause as impliedly creating a cause of action that can be used to challenge state laws that conflict with or violate federal law, because the majority believed that this understanding of the Supremacy Clause would effectively give providers a constitutionally guaranteed and hence congressionally unalterable right to enforce federal law.[182] It then rejected this extreme view of the "implied Supremacy Clause" label, in part, because it would have the perverse effect of actually undermining the supremacy of federal law:

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178 *Id.*

179 *Id.* at 1383–84.

180 *Id.*

181 *Id.* at 1383.

182 *Id.* at 1383–84.

> If the Supremacy Clause includes a private right of action, then the Constitution *requires* Congress to permit the enforcement of its laws by private actors, significantly curtailing its ability to guide the implementation of federal law. It would be strange indeed to give a clause that makes federal law supreme a reading that *limits* Congress's power to enforce that law, by imposing mandatory private enforcement.[183]

In affirming the importance of the Supremacy Clause as a rule of decision, the majority gave examples in which preemption had been used to invalidate state laws in cases that were "properly" before a court.[184] The examples included preemption being used to prevent the conviction of a defendant for violating a state criminal law that federal law prohibits, to prevent the imposition of civil liability on a person for conduct that federal law requires, or to immunize an individual from state regulation that is preempted by federal law.[185] The category of immunity from state regulation is the most relevant one to the rate-setting challenges presented, and the majority cited the Supreme Court's 1908 decision in *Ex parte Young* as establishing the court's equitable power to enjoin enforcement of state laws that are preempted by federal law.[186] The plaintiff providers and *Exceptional Child Center* dissenters relied on *Ex parte Young* as support for the right to seek equitable relief, noting that in subsequent preemption cases, the equitable power established in *Ex parte Young* had been characterized as "giving 'life to the Supremacy Clause.'"[187]

Nonetheless, the majority rejected the plaintiffs' contention that the Court's preemption jurisprudence demonstrated that the Supremacy Clause created a cause of action for its violation. Rather the Court explained that such cases are part of a broader principle that federal courts "may *in some circumstances* grant injunctive relief against

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183 Armstrong v. Exceptional Child Ctr., 135 S. Ct. 1378, 1384 (2015).

184 *Id.*

185 *Id.*

186 *Ex parte* Young, 209 U.S. 123, 123 (1908) (allowing shareholders of a railroad to seek an injunction preventing the Minnesota attorney general from enforcing a state law setting maximum railroad rates because the Eleventh Amendment did not provide the officials with immunity from such an action and the federal court had the power in equity to grant a temporary injunction).

187 Exceptional Child Ctr., 135 S. Ct. at 1391 (citation omitted).

state or federal officers who violate or are planning to violate federal law." [188] The cases only demonstrate that "in a *proper* case, relief may be given in a court of equity . . . to prevent an injurious act by a public officer."[189] According to the Court, the relevant question was whether the plaintiffs' suit could proceed against Idaho officials in equity, quite apart from any cause of action conferred by the Supremacy Clause. The remainder of the opinion focused on whether a private rate-setting challenge can be a proper case for equitable relief.

In addressing this question, the Court focused on the fact that "[t]he power of federal courts of equity to enjoin unlawful executive action is subject to express and implied statutory limitations."[190] Indeed, the only guidance the Court gave for determining a "proper" case was the Court's reference to statutory limits on enforcement. The Court identified the specific aspects of Section 30(A) it felt established Congress's intent to foreclose equitable relief in rate-setting disputes.

First, the majority emphasized the federal regulator's oversight role. It noted that the "sole remedy Congress provided for a State's failure to comply with Medicaid's requirements—for the State's 'breach' of the Spending Clause contract—is the withholding of Medicaid funds by the Secretary of [HHS]."[191] Relying on Supreme Court precedent in *Alexander v. Sandoval*, an implied right of action case, the Court explained that "the 'express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.'"[192]

But the majority did not rely solely on this factor.[193] Its conclusion that Congress implicitly foreclosed equitable relief also turned on what the majority characterized as "the judicially unadministrable nature of [Section] 30(A)'s text:"[194]

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188 Exceptional Child Ctr., 135 S. Ct. at 1384.

189 Armstrong v. Exceptional Child Ctr., 135 S. Ct. 1378, 1384 (2015) (citing Carroll v. Safford, 3 How. 441, 463 (1845).

190 Armstrong v. Exceptional Child Ctr., 135 S. Ct. 1378, 1385 (2015).

191 *Id.*

192 *Id.* (citing Alexander v. Sandoval, 532 U.S. 275, 290 (2001)).

193 *Id.* (emphasis in original) ("[T]he Secretary's enforcement by withholding funds might not, *by itself*, preclude the availability of equitable relief.").

194 *Id.*

> It is difficult to imagine a requirement broader and less specific than [Section] 30(A)'s mandate that state plans provide for payments that are "consistent with efficiency, economy, and quality of care," all the while "safeguard[ing] against unnecessary utilization of … care and services." Explicitly conferring enforcement of this judgment-laden standard upon the Secretary alone establishes, we think, that Congress "wanted to make the agency remedy that it provided exclusive," thereby achieving "the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decision-making," and avoiding the "comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional inappropriate application of the statute in a private action."
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> . . .
>
> The sheer complexity associated with enforcing [Section] 30(A), coupled with the express provision of an administrative remedy . . . shows that the Medicaid Act precludes private enforcement of [Section] 30(A) in the courts.195

This characteristic was also a salient factor in Justice Breyer's concurring opinion, and he went into even greater detail to highlight the complexity and non-judicial nature of the rate-setting task.[196] He was clearly concerned that such suits created the risk that courts would engage in direct rate setting, a task to which they are ill suited. Justice Breyer emphasized the important role of federal regulators, not just as experts better able to evaluate compliance with Section 30(A) requirements, but as the regulatory body with power to enforce these requirements in court.[197] In this way, Justice Breyer's concurring opinion in *Exceptional Child Center* reinforced his majority opinion in *Independent Living Center*, focusing on the importance of federal regulators in defining and enforcing Section 30(A). Justice Breyer did acknowledge the long-established custom of courts reviewing agency rate-setting determinations for reasonableness or constitutionality, but he distinguished this case as asking federal courts to do something more: that is to engage in *direct rate-setting* outside the ordinary

195 *Id.* (citing Gonzaga Univ. v. Doe, 536 U.S. 273, 292 (2002) (Breyer, J. concurring in judgment)).

196 Armstrong v. Exceptional Child Ctr., 135 S. Ct. 1378, 1388 (2015) (Breyer, J. concurring in judgment).

197 *Id.*

channel of federal judicial review of agency decision-making.[198] Indeed, Justice Breyer's confusion about, and frustration with, the specific task that providers were asking the courts to undertake in *Exceptional Child Center* was palpable during oral arguments.

Although the dissenters disagreed with the majority's decision to eliminate preemption-based challenges to state Medicaid rate setting, they agreed that a court's power to grant equitable relief is subject to statutory limitations.[199] The problem, of course, is that Congress often does not speak directly to this issue and did not in the case of Medicaid rate setting.

3. The Impact of Exceptional Child Center: Balancing Enforcement with State Flexibility

In the context of rate-setting, it is not clear how much more protection *Exceptional Child Center* gives states. First, despite foreclosing a preemption-based challenge to Medicaid rates, Justice Breyer made clear in *Independent Living Center*, and reiterated in *Exceptional Child Center*, that providers have another avenue for relief—an APA claim that challenges federal regulatory approval of state cuts in violation of federal law.[200] It is not surprising that Justice Breyer would want to affirm this tool in light of the underlying facts that led to the *Independent Living Center* suit—blatant state disregard of Section 30(A) against a history of federal regulatory neglect.

Second, most courts have long taken the kind of deferential approach suggested in *Independent Living Center*, even during the pre-Obama era of regulatory under-enforcement when implied Supremacy Clause claims were allowed. Third, although the Obama Administration ushered in a new era of regulatory activity in this area, practically, this increased regulatory activity has been used to protect

198 *Id.* at 1389.

199 *Id.* at 1392.

200 Justice Breyer noted in both *Independent Living Center* and *Exceptional Child Center* that the APA as the source of providers' rate-setting challenges may make it more difficult for providers to challenge state action that is approved by federal regulators on the merits, as the APA requires judicial deference to agency determinations absent arbitrary, capricious or otherwise egregious acts; *see also APA Deference, supra* note 84 (discussing the implications of this for rate-setting claims).

and promote state flexibility and to reject the more rigid process-based requirements, such as cost studies, that some federal courts tried to impose.[201] Ironically, increased deference to federal regulators' determination about when a state rate law conflicted with Section 30(A) has empowered and protected states.

On the other hand, the district courts in the Ninth Circuit have been outliers, and it is clear that some courts did not heed the warning of *Independent Living Center*. Their persistence in requiring cost studies and applying a more active review has delayed some states' attempts to lower rates. Thus, for some states, *Exceptional Child Center* provided much needed relief and clarification.

Less clear, however, is what broader lesson can be gleaned from *Exceptional Child Center*. One could argue that *Exceptional Child Center* put an exclamation point on the conversation begun in *Independent Living Center*: affirming the Court's view of the essential enforcement role that the federal regulator is expected to play in rate setting, as well as the Court's concern about judicial overreach. But what impact, if any, might this have on the enforcement of other spending conditions? And how might this, in turn, shape policy discussions about reforms to Medicaid that would alter the existing federal-state relationship?

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201 Methods for Assuring Access to Covered Medicaid Services, 80 Fed. Reg. In the final rule, flexibility is mentioned thirty-six times. CMS also emphasizes the reasons behind giving states this flexibility and how it tried to balance this against enforcement of Section 30(A): "In the May 6, 2011 proposed rule, we recognized that states must have some flexibility in designing appropriate approaches to demonstrate and monitor access to care, which reflects unique and evolving state service delivery models and service rate structures. Within the proposed rule, we discussed how a uniform approach to meeting the statutory requirement under section 1902(a)(30)(A) of the Act could prove difficult given current limitations on data, local variations in service delivery, beneficiary needs, and provider practice roles. For these reasons, we proposed federal guidelines to frame alternative approaches for states to demonstrate consistency with the access requirement using a standardized, transparent process, rather than setting nationwide standards. In this final rule with comment period, we are providing increased state flexibility within a framework to document measures supporting beneficiary access to services. While states will continue to have the discretion to set program rates and improve access to care through a variety of strategies, this final rule will increase the information available to CMS, to ensure that rates meet the requirements of [Section 30(A)] and that access improvement strategies work to improve care delivery when there are deficiencies. States have broad flexibility under the Act to establish service delivery systems for covered health care items and services, to design the procedures for enrolling providers of such care, and to set the methods for establishing provider payment rates." *Id.* at 67577. CMS also noted that "we do not require that states establish access by reviewing the relationship of payment rates to provider costs." *Id.* at 67583, 67593.

At one end of the spectrum are those hoping to use *Exceptional Child Center* to more dramatically contract private plaintiffs' ability to enforce Medicaid and other federal spending conditions. For example, since *Exceptional Child Center* was decided, states have tried unsuccessfully to use it to attack Section 1983 as a viable tool for enforcing other access conditions, even those held by courts to be unambiguously conferred rights in the Medicaid Act.[202] States have also used both *Independent Living Center*[203] and *Exceptional Child Center*[204] to argue for a sweeping rollback of preemption-based enforcement of spending conditions, despite the fact that the holdings in both decisions were crafted quite narrowly and despite the fact that Justice Breyer, the swing vote, expressly rejected the idea that the court could come up with "a simple, fixed legal formula separating federal statutes that may underlie this kind of injunctive action from those that may not."[205]

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202 *See, e.g.*, Planned Parenthood Southeast, Inc. v. Bentley, No. 2:15-CV-620-MHT, 2015 WL 6517875 (2015) ("The defendants argue that [Armstrong] warrants reconsideration of the . . . precedents establishing that recipients have enforceable rights under the free-choice-of-provider provision. However, Armstrong does not cast significant doubt on this now-well-established proposition.").

203 Indeed, some courts were willing to change course, and even go against their own precedent, based on the four dissenters in *Independent Living Center,* suggesting a potentially significant shift in the terrain of health care enforcement. *See, e.g.*, Boston Med. v. Sec. of Executive Office, 974 N.E.2d 1114, 1127–28 (Mass. 2012) (noting several Massachusetts hospitals and a managed care organization brought an action against a state health official alleging that she violated her obligation to reimburse them for the reasonable costs incurred in providing medical services to Medicaid enrollees. The plaintiffs raised several claims, including a claim that the state's rate setting process and rates were preempted under the Supremacy Clause of the United States Constitution, based on Section 30(A). The Massachusetts Supreme Court cited the *Independent Living Center* dissent by Chief Justice Roberts, in concluding that the Supremacy Clause could not be the basis of the plaintiffs' private right of action to claim a violation of Section 30(A)). *But see* Dartmouth-Hitchcock Clinic v. Toumpas, 2012 WL 4482857, No. 11-cv-358-SM (NH D. Ct 2012) (noting in a similar challenge to Medicaid rate reimbursements in New Hampshire, a New Hampshire District Court was not willing to go that far, because of the lack of a majority in *Independent Living Center* willing to eliminate such claims. The court did observe, however, that the differing views expressed in *Independent Living Center* "concededly add up to serious doubt about the future viability of private suits like this one.").

204 *See, e.g.*, Planned Parenthood v. Mosier, 2016 WL 3597457 (D. Ka. 2016) (narrowing *Exceptional Child Center* and noting that Section 30(A) does not create the kind of specific rights-creating language found in the Medicaid freedom of choice provision).

205 Armstrong v. Exceptional Child Ctr., 135 S. Ct. 1378, 1388 (2015) (Breyer, J. concurring in

In this respect, it is important to note what the Court did not do. In terms of the most sweeping changes the Court was invited to make, it is clear there were not enough justices willing to take up the invitation. Only four justices (the dissenters in *Independent Living Center)* were willing to equate the tests for Section 1983 and preemption-based claims as a way to foreclose a broad category of preemption-based claims,[206] but the majority opinion in *Exceptional Child Center* did not explicitly equate these tests. In addition, the majority opinion in *Exceptional Child Center* did not advance any other theories that could be understood as requiring the wholesale elimination of preemption-based claims or other rights enforcement of federal spending conditions.[207] In fact, in rejecting the use of blanket presumptions or simple formulas, Justice Breyer made clear that such determinations could only be made by reference to the specific language and purposes of the statute at issue.[208] Finally, Justice Breyer did not sign on to Part IV of Justice Scalia's opinion in *Exceptional Child Center*, which contained language with potentially more sweeping implications for the elimination of private enforcement of spending clause legislation generally.[209]

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judgment) (citing to Gonzaga Univ. v. Doe, 536 U.S. 273, 291 (2012) (Breyer, J., concurring in judgment)).

206 Douglas v. Indep. Living Ctr. of Southern Cal., Inc., 132 S. Ct. 1204, 1212–13 (2012) (Roberts, J., dissenting).

207 There did seem to be support for this more sweeping approach among four justices, however. Part IV of Scalia's opinion, joined only by Chief Justice Roberts, and Justices Thomas and Alito, has also been viewed by states as planting the seeds for a more dramatic change. In this part of the opinion, Scalia considered a claim not asserted by the plaintiffs—whether Section 30(A) itself could be the source of a cause of action. Not surprisingly, the four justices found that Section 30(A) did not contain the sort of rights-creating language needed to imply a private right of action, but they did not stop there. They went on to assert that Spending Clause legislation "is much in the nature of a contract" between the federal government and the States, and then used modern contract jurisprudence to explain why it was doubtful that providers were intended beneficiaries. Exceptional Child Ctr., 135 S. Ct. at 1387-1388 (Part IV of the opinion by Scalia, J., and joined by Roberts, C.J. and Thomas and Alito, JJ.). The opinion cited to a concurring opinion by Justice Thomas and Scalia, in another case *Pharma v. Walsh*, in which both Scalia and Thomas advanced the Spending Clause theory for why the plaintiff lacked a cause of action. *Id.*

208 Exceptional Child Ctr., 135 S. Ct. at 1388.

209 *Id.* (Breyer, J. concurring in judgment and joining Parts I, II, and III of the Court's opinion).

Despite Justice Breyer's protestations about presumptions and formulas, the dissenting justices in *Exceptional Child Center* expressed concern that the majority's approach signaled a significant shift in preemption jurisprudence that "threatens the vitality of *Ex parte Young* jurisprudence."[210] This Article takes this concern seriously because courts will be forced to grapple with the meaning of *Exceptional Child Center* in suits seeking to enforce other kinds of spending program conditions—whether Medicaid program design decisions or decisions in other health spending programs, such as state attempts to exclude Planned Parenthood from federal family planning and disease prevention grants.[211] The next part goes deeper into the reasoning of the *Independent Living Center* and *Exceptional Child Center* decisions in order to glean relevant principles that can aid courts beyond the rate-setting context. In particular, it engages an important question left unanswered by the Court about how to navigate the balance between rights enforcement and state flexibility in federal spending programs.

PART IV. FEDERALISM THEMES IN RATE-SETTING JURISPRUDENCE

The narrow issue in *Independent Living Center* and *Exceptional Child Center* was whether a state rate law could be invalidated using a preemption-based claim. But this inquiry implicates broader questions about the character of statutory preemption claims, rights enforcement in spending programs, and the role of state flexibility. State flexibility is squarely implicated by preemption challenges, and preemption is increasingly recognized as an important site of federalist conflict. This Part takes a closer look at the justices' opinions through this lens. It suggests that the different federalist accounts of state flexibility identified in Part I may have animated the justices' approaches to the specific question presented, and, more importantly, may reveal deeper principles that would guide the justices' in future cases.

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210 *Id*. at 1392 (Sotomayor, J. dissenting).

211 *See infra* Part V.A.

A. Presumptions & Interpretive Rules

The different justices' approaches in *Exceptional Child Center* suggest a fundamental disagreement about how to determine when equitable relief is available in the face of statutory ambiguity. This disagreement is revealed in the justices' answers to the question of whether there should be a presumption in favor of or against equitable relief in the face of uncertainty about congressional intent, as well as questions about the type and sufficiency of evidence necessary to show implicit intent to foreclose equitable relief.

Presumptions and rules that shape burdens and evidentiary requirements are important precisely where there is analytical uncertainty and important principles are at stake. Such rules are used to not only identify the existence and strength of certain principles implicated by the legal question, but they also shape the parties' expectations about their rights in the absence of clear evidence to the contrary. The question of the appropriate use of a presumption or interpretive rule is not about overriding clear or explicit congressional intent—rather, it is about delineating the level of specificity and clarity necessary for eliciting that intent when it is not clear from the statutory text.

The dissenters engage this question most directly in *Exceptional Child Center*. According to the dissent, there should be a presumption in favor of equitable relief that requires a clearer indication of congressional intent to foreclose equitable relief.[212] This degree of clarity and specificity, higher than what typically would be required in an ordinary statutory analysis, means that practically it should be difficult to prove such intent. This approach seems rooted, in part, in the dissent's understanding of the constitutional character of statutory preemption:

> A claim that a state law contravenes a federal statute is "basically constitutional in nature, deriving its force from the operation of the Supremacy Clause," and the application of preempted state law is therefore "unconstitutional." We have thus long entertained suits in which a party seeks prospective equitable protection from an injurious and preempted state law without regard to whether the federal statute at issue itself provided a right to bring an action. Indeed, for this reason,

212 *Exceptional Child Ctr.*, 135 S. Ct. at 1392 (Sotomayor, J. dissenting).

> we have characterized "the availability of prospective relief of the sort awarded in *Ex parte Young*" as giving "life to the Supremacy Clause."[213]

The dissent agreed with the majority that there is no such thing as an implied Supremacy Clause right of action to enforce federal law that is "constitutionally unalterable"; but the dissent also believed that the constitutional principle of the supremacy of federal law, as well as longstanding assumptions about the availability of equitable relief against preempted state law, created a strong presumption in favor of such relief in the rate-setting context—a presumption the state would have to overcome with clear evidence of Congressional intent to foreclose such relief.[214]

The majority does not clearly answer the dissent's suggestion that there should be a presumption in favor of equitable relief. It allots only a brief paragraph to respond to the dissent's proposal of a presumption in favor of equitable relief, quoted in full below:

> The dissent insists that, "because Congress is undoubtedly aware of the federal courts' long-established practice of enjoining preempted state action, it should generally be presumed to contemplate such enforcement unless it *affirmatively* manifests a contrary intent." But a "long-established practice" does not justify a rule that denies statutory text its fairest reading. Section 30(A), fairly read in the context of the Medicaid Act, "display[s] a[n] intent to foreclose" the availability of equitable relief. We have no warrant to revise Congress's scheme simply because it did not "affirmatively" preclude the availability of a judge-made action at equity.[215]

It is not clear if the majority rejected the dissent's proposed affirmative statement requirement because it was considered too high a hurdle that would effectively require explicit statutory intent. Or perhaps the majority only rejected the weight that such a presumption should get in analyzing Section 30(A) specifically, in light of what the majority saw as the "fairest reading" of Section 30(A)'s text. But if it is the latter, this leaves open the question of how to determine the fairest reading of the statute, which is related to the dissent's other concern about the ease with which the majority was willing to find evidence of

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213 *Id.* at 1391 (Sotomayor, J. dissenting) (citations omitted).

214 *Id.* at 1392.

215 *Id.* at 1386 (citations omitted).

implicit intent. Specifically, the dissent believed the evidentiary standard used by the majority was too lax to justify depriving individuals of such an important right, not only because of its importance to the individual's cause of action, but also because of its importance to ensuring the supremacy of federal law. According to the dissent, the majority's approach seemed to equate the test for determining whether a private cause of action to enforce a federal civil right exists under Section 1983 with the test for determining whether private individuals can seek equitable relief from a state law that is preempted by federal law.[216] Conflating these tests disregards any special qualities or protections that a preemption claim should have by virtue of its constitutional character. The majority seemed to downplay the dissent's criticism, ascribing their different conclusions to mere differences in statutory interpretation.[217] But one cannot ignore the fact that the majority's interpretive moves seemed to effectively shift the presumption, or at least ease the evidentiary burden, for foreclosing equitable relief in this context.

The remaining sections explore these different approaches more deeply, by considering the structural constitutional concerns likely animating the various opinions in *Independent Living Center* and *Exceptional Child Center*. These concerns are heightened by the fact that preemption is viewed as a prime site for federalist conflict, and *Exceptional Child Center* is just the latest example of how preemption questions are increasingly motivated by federalism and institutional choice concerns.[218] We see these concerns operating at two levels. The most obvious one is the question of who decides whether plaintiffs' can seek equitable relief on statute preemption grounds—the specific question taken up by the Court in *Exceptional Child Center* and discussed in Section B below. But Section C suggests that the majority's approach also reflects its concern about the federalism implications of the merits of certain kinds of preemption cases, which in turn motivates its concern about which institutional actors—courts or

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216 *Id.* at 1392–93 (Sotomayor, J. dissenting). This is not an unreasonable reading of the majority, given that at least four of the justices explicitly made this interpretive move in the *Independent Living Center* dissent.

217 *Id.* at 1386–1387.

218 *See* Thomas Merrill, *Preemption & Institutional Choice,* 102 NW. U.L. REV. 727 (2008).

administrative agencies—are in the best position to resolve these questions.

B. Who Decides the Question of Access to Equitable Relief?

Both the majority and the dissent agree that courts' power to grant equitable relief is subject to statutory limitations, making clear that the Supremacy Clause cannot be used to undermine Congress' ability to define or limit the rights and remedies it creates in legislation. The problem, of course, is that Congress often does not speak directly to this issue, and did not in the case of Medicaid rate setting.

The dissent's presumption in favor of equitable relief requires Congress to speak more clearly to evidence this intent. The majority, however, was willing to find implicit intent on very little evidence, in contrast to a number of other federal courts before this time. The majority's approach creates ambiguity and space for courts to interpret statutes in ways that potentially undermine federal law. Indeed, based on amicus briefs from former HHS officials and members of Congress, there is a good argument that the *Exceptional Child Center* majority got the statutory interpretation question wrong.

And yet, at least four justices—Justices Scalia, Thomas, and Alito, and Chief Justice Roberts—believed they got it right because their approach aligned Supremacy Clause jurisprudence with the Court's implied right of action and Section 1983 jurisprudence, in the context of Section 30(A) rate-setting challenges. The reasoning is not explicit in *Exceptional Child Center*, but it is in the *Independent Living Center* dissent. In *Independent Living Center*, Chief Justice Roberts explained the federalism implications of this alignment:

> [T]o say that there is a federal statutory right enforceable under the Supremacy Clause, when there is no such right under the pertinent statute itself, would effect a complete end-run around this Court's implied right of action and 42 U.S.C. §1983 jurisprudence.
>
> . . .
>
> Here the law established by Congress is that there is no remedy available to private parties to enforce the federal rules against the State. For a court to reach a contrary conclusion under its general equitable powers would raise the most serious concerns regarding both the separation of powers (Congress, not the Judiciary, decides whether there is a private right of action to enforce a federal statute) and

> federalism (the States under the Spending Clause agree only to conditions clearly specified by Congress, not any implied on an ad hoc basis by the courts).[219]

Chief Justice Roberts did offer a caveat: where the courts' equitable powers give effect to federal law rather than contravene it, then such a claim is properly before the court.[220] But he made clear that providers' rate challenges did not fall into this category. In Supremacy Clause jurisprudence, courts had created a "legal fiction" to distinguish prohibited statutory claims for damages due to past violations of federal spending conditions under Section 1983, from the equitable relief sought to ensure adequate reimbursement prospectively that was allowed under a Supremacy Clause theory, but Roberts did not accept this fiction. To Chief Justice Roberts, providers were "simply seek[ing] a private cause of action Congress chose not to provide."[221] Thus, given what the court was being asked to do, the presumption asserted by the dissent was at odds with the interpretive choice the Court had already made with respect to Section 1983 claims. *Exceptional Child Center* simply aligned the doctrines to give effect to the federalism principles driving the prior interpretive choice.[222]

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219 Douglas v. Indep. Living Ctr. of Southern Cal., Inc., 132 S. Ct. 1204, 1212 (2012).

220 *Id.* at 1213.

221 *Id*. at 1213 (citations omitted).

222 Gonzaga Univ. v. Doe, 536 U.S. 273, 286 (2002) (citations omitted). In *Gonzaga*, the majority rejected Justice Stephens' argument about why the test for an enforceable right under Section 1983 and *Sandoval's* implied right of action test should be different:

> Accordingly, where 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, whether under § 1983 or under an implied right of action. Justice Stevens disagrees with this conclusion principally because separation-of-powers concerns are, in his view, more pronounced in the implied right of action context as opposed to the § 1983 context. But we fail to see how relations between the branches are served by having courts apply a multifactor balancing test to pick and choose which federal requirements may be enforced by § 1983 and which may not. Nor are separation-of-powers concerns within the Federal Government the only guideposts in this sort of analysis.

Id. at 285–286; *See* Will v. Michigan Dept. of State Police, 491 U.S. 58, 65, 109 S. Ct. 2304, 105 L.Ed.2d 45 (1989) ("[I]f Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.'").

Some may view this as the latest example of a movement by the Court to use presumptions or interpretive rules to limit individuals' private rights of action to enforce federal law. But an alternative view is that such presumptions are important because they are democracy enhancing—they force a more transparent deliberation about hard political questions and encourage Congress to speak more clearly on such issues. Paul Stephan makes this point in his examination of Justice Powell's reasons for proposing a presumption against implied causes of action, when it first emerged in a solo dissent in 1979:

> At bottom, [such a presumption] rest[s] on a theory about legislative deliberations and the impact of judicial activity. Powell depicts the decision to authorize private enforcement as "often controversial" and resting on "hard political choices." This implies that the question of whether private enforcement is a good thing, from the perspective of a detached observer, is morally neutral and subject to a contestable welfare analysis. Powell's argument presumes that Congress pays attention to judicial choices and alters its behavior in response to them. Judicial willingness to assume the burden of making the private enforcement decision, Powell stated, means that "Congress is encouraged to shirk its constitutional obligation." This shirking comes at a cost: "[T]he legislative process with its public scrutiny and participation has been bypassed, with attendant prejudice to everyone concerned . . . . [T]he public generally is denied the benefits that are derived from the making of important societal choices through the open debate of the democratic process."[223]

This reflects traditional federalism concerns of protecting state sovereignty—ensuring that states get adequate notice of legal obligations so that states' acceptance of these conditions of funding are knowing and voluntary. This also reflects institutional concerns about the deliberative process through which such decisions are made. Specifically, such a rule can be seen as helping to ensure not only that Congress speaks more clearly about private rights of action, but that the ultimate decision is the result of a robust participatory and deliberative democratic process.

But these traditional concerns about protecting state sovereignty did not seem to feature as prominently in the narrower path that

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223 Paul B. Stephan, Bond v. United States *and Information-Forcing Defaults: The Work That Presumptions Do*, 90 NOTRE DAME L. REV. 1465, 1475 (2015) (citing to Canon v. Univ. of Chicago, 441 US 677, 730-49 (1979) (Powell, J., dissenting)).

Justice Breyer carved for himself. This is not to say that they played no role, but that they were not strong enough to lead him to believe that a presumption against such a cause of action was justified. In fact, when Justice Breyer has faced similar questions before, he has consistently grounded his analysis in the specific characteristics of the state decision being challenged and the regulatory framework established in the relevant statute. For example, in *Gonzaga* v. *Doe*, when the Court created a presumption against Section 1983 claims, Justice Breyer did not sign on to that part of the opinion.[224] He agreed that Congress likely did not intend private judicial enforcement of the provision of a federal law that prohibited federal funding of schools that have a policy or practice of permitting the release of students' education records without their parents' written consent.[225] But his conclusion was based on the particular characteristics and nature of the dispute in that case, as well as his belief that uncertainty about the legal requirements made it more likely that Congress wanted to make the agency remedy exclusive.[226]

That said, Justice Breyer's analysis of such cases does seem grounded in federalism concerns— namely, the federalism implications of the underlying merits of the dispute, as well as the institutional choice question about whether the court or regulatory agency should decide these merits questions. As explored further below, *Exceptional Child Center* provides a nice example of how merits concerns shaped Justice Breyer's interpretation of whether a preemption-based claim could be used to enforce Section 30(A) and motivated his shifting alliance from *Independent Living Center* to *Exceptional Child Center*. Moreover, a closer look at the relevance of the merits question in the *Exceptional Child Center* opinions also reveals

224 Gonzaga Univ., 536 U.S. at 291 (Breyer, J. concurring in the judgment).

225 *Id.* at 291–92 (Family Educational Rights and Privacy Act ("FERPA")).

226 *Id.* ("Under these circumstances, Congress may well have wanted to make the agency remedy that it provided exclusive—both to achieve the expertise, uniformity, wide-spread consultation, and resulting administrative guidance that can accompany agency decision-making and to avoid the comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional inappropriate application of the statute in a private action for damages. This factor, together with the others to which the majority refers, convinces me that Congress did not intend private judicial enforcement actions here.").

shared principles among Justice Breyer and the *Exceptional Child Center* dissenters that may be relevant to future cases.

C. Who Decides the Merits of Preemption Claims?

Recall that the *Exceptional Child Center* case was extremely weak on the merits, and it is very likely that the lower courts got the underlying preemption question wrong. One read of the case is that concern about the merits, that is whether federal courts are correctly interpreting federal law in the case of obstacle preemption claims, is tied to the question about whether federal courts should hear these claims at all. This is particularly so in light of a regulatory scheme that charges a specialized regulatory body with rate oversight, that delegates tremendous authority and flexibility to states for rate setting, and where federal spending conditions identify multiple and competing goals without delineating a specific process for achieving or balancing those goals. *Exceptional Child Center* illustrates the importance of this connection in the analysis of whether equitable relief is implicitly foreclosed. To flesh this out, this section first draws on preemption literature to identify the federalism concerns triggered by how courts resolve statutory preemption claims. It then locates these merits concerns in the Court's answer to the specific question presented in *Exceptional Child Center*.

1. Conflict Preemption as a Federalism Battleground

Before delving into a discussion of the federalism implications of preemption doctrine generally, it is important to acknowledge that the task of even identifying a preemption doctrine is challenging. Indeed, scholars have lamented the lack of a coherent preemption doctrine, noting the absence of any analytical consistency or pattern across cases.[227] This is especially true in light of the promulgation of complex statutory schemes, which according to one scholar "seem endlessly to

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227 Viet D. Dinh, *Reassessing the Law of Preemption*, 88 GEO. L.J. 2085 (2000) ("Notwithstanding its repeated claims to the contrary, the Supreme Court's numerous preemption cases follow no predicable jurisprudential or analytical pattern."); Candice S. Hoke, *Preemption Pathologies and Civic Republican Values*, 71 B.U. L. REV. 685 (1991) [hereinafter *Preemption Pathologies*] ("Unfortunately, the US Supreme Court has failed to articulate a coherent standard for deciding preemption cases, and its haphazard approach fails to provide meaningful guidance to lower courts, legislators, and citizens.").

breed preemption cases."[228] In statutory preemption cases, courts have noted that "the purpose of Congress is the ultimate touchstone'[sic] in every preemption case," producing results or approaches that are as diverse as the statutory schemes with which the courts must engage.[229]

Nonetheless, scholars have called for greater attention to preemption doctrine as an important site of federalism battles over states' rights and the proper balance of power between federal and state regulatory authority.[230] A number of people have noted that with the growth in complex federal statutory and regulatory schemes, the concurrent jurisdiction of state and federal governments is increasingly a site for conflict.[231] A common theme among scholars addressing these concerns is that not enough attention is paid to helping courts develop a principled or coherent doctrinal approach to preemption questions that adequately considers federalist implications. For example, Professor Young views preemption as the "functional heart of the Court's federalism doctrine"[232] and urges that "preemption doctrine should align more closely to the broader imperatives of constitutional federalism doctrine in the post-New Deal

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228 Candice S. Hoke, *Transcending Conventional Supremacy: A Reconstruction of the Supremacy Clause*, 24 CONN. L. REV. 829, 887 (1992) [hereinafter *Transcending Conventional Supremacy*].

229 *See, e.g.*, Ernest A. Young, "*The Ordinary Diet of the Law*": *The Presumption Against Preemption in the Roberts Court*, 2011 SUP. CT. REV. 253, 255–56, 269 (2011) ("Congress' preemptive intent, in other words, varies by context, and courts faithful to interpreting that intent will thus produce varying results from one context to another.").

230 *See, e.g.*, *id*. Young argues that "[i]n this world of concurrent jurisdiction, 'the key task of federalism is to manage the overlap of state and federal law.'" *Id.* at 254. He goes on to describe the doctrine of preemption as "the key instrument by which the law manages this overlap" and preemption cases as "mak[ing] up the functional heart of the Court's federalism doctrine." *Id.* In *Backdoor Federalization*, Issacharoff and Sharkey find it "curious" that "preemption cases have not played a dominant role in the perennial federalism debates, as if the question of the source of substantive law governing everyday conduct were not the core of the constitutional assignment of authority between the states and the federal government." Samuel Issacharoff & Catherine M. Sharkey, *Backdoor Federalization,* 53 UCLA L. Rev. 1353, 1365 (2006).

231 *See generally Preemption Pathologies*, *supra* note 227; Young, *supra* note 229; Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 225–26 (2000) ("The extent to which a federal statute displaces (or 'preempts') state law affects both the substantive legal rules under which we live and the distribution of authority between the states and the federal government.").

232 Young, *supra* note 229, at 254.

era."[233] Other scholars are concerned about how private actors increasingly use preemption not as a means to resolve an actual conflict in the face of state enforcement action, but rather as an offensive tool to avoid state regulation perceived as too burdensome or more aggressive than federal law.[234] Describing the "jurispathic nature" of preemption, Professor Hoke has highlighted the significant practical implications of the failure to find constraining principles for preemption.[235] She says that federal preemption decisions "impede the ability of those governmental bodies that are structured to be most responsive to citizens' public values and ideas—state and local governments—and have concomitantly undermined citizens' rights to participate directly in governing themselves."[236]

In some statutes, Congress is clear about its intent to exclusively regulate certain matters, such that state regulation is expressly preempted. In such cases, there seems to be agreement that the conflict question can and should be answered by reference to the statutory language, and that this is the appropriate way to give effect to the supremacy of federal law. More commonly, though, federal and state governments have concurrent jurisdiction to regulate in areas governed by complex regulatory schemes. When states try to regulate in ways that some believe are inconsistent with federal law, the question of whether a legal conflict exists is often open to interpretation.[237] Under implied preemption, a conflict exists if either

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233 *Id.* at 256 ("Those imperatives, as I see them, can be captured in three broad propositions: First, national and state authority is largely concurrent, not limited by exclusive subject-matter spheres. Second, the limits of national authority stem primarily (although not exclusively) from the representation of the states in Congress and the Constitution's rigorous procedural constraints on federal lawmaking. And, third, it follows that the courts' role in protecting federalism should focus on facilitating and enhancing the operation of these political and procedural checks on national authority. The imperatives highlight the critical importance of the 'presumption against preemption' developed in Rice v. Santa Fe Elevator Corp. and similar cases.").

234 *See, e.g.*, *Preemption Pathologies*, *supra* note 227.

235 *Id.* at 694.

236 *Id.* at 687.

237 *Id. See also,* Merrill, *supra* note 218, at 729, 738–742 ("[T]he key question in most preemption cases entails a discretionary judgment about the permissible degree of tension between federal and state law, a question that typically cannot be answered using the tools of statutory interpretation.").

compliance with both the state and federal law is a physical impossibility or state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.[238] Actual conflict is clear where, for example, state law requires something that federal law prohibits or state law prohibits something that federal law requires. But the vast majority of cases seem to fall into the category of obstacle preemption. This category of implied preemption has triggered the most interest in and concern for federalism implications.

Scholars have raised concerns about how easily a state law can be displaced because it frustrates some broadly defined purpose of Congress. They fear an unjustified expansion of preemption that undermines the legitimate, concurrent state regulatory authority envisioned by many statutory schemes.[239] A few scholars have proposed addressing this by more narrowly defining a conflict using the physically impossibility test—a proposal that would dramatically reduce the preemptive scope of federal statutes.[240] But this is not very practical, as even the most ardent federalists on the court have embraced obstacle preemption.[241]

238 *See* Dinh, *supra* note 227, at 738–742 (describing conflict and obstacle preemption).

239 *See, e.g., Preemption Pathologies*, *supra* note 227; Young, *supra* note 229; Nelson, *supra* note 231.

240 *See generally* Nelson, *supra* note 231, (describing and critiquing proposals for narrowing the test for conflict preemption).

241 *See* Gregory M. Dickinson, *An Empirical Study of Obstacle Preemption in the Supreme Court*, 89 NEB. L.R. 682, 682 (2010) (noting that "[p]reemption defies traditional conservative-liberal alignment"), http://digitalcommons.unl.edu/nlr/vol89/iss4/3. Dickinson goes on to explain this phenomenon:

> As many studies have shown, political ideology is an important determinant of Supreme Court decisions. Justices' votes can be explained, at least in part, by their political preferences. In a typical federalism case, for instance, conservative justices tend to favor states' rights, while more liberal justices tend to favor a strong central government. In the preemption context, however, political ideology often pulls in opposite directions. A decision against preemption in favor of states' rights, typically considered conservative, may have a liberal outcome, and vice versa. "[A] 'liberal' vote for the federal government (and against the states) is also a vote for 'big business' (and against pro-regulatory constituencies that want states to regulate above the federal baseline). Justices' political preferences stand in tension, making for 'odd coalitions that appear to defy conventional left/right, liberal/conservative analysis.'"/In response to this tension, says conventional wisdom, the conservative and liberal wings of the Court flip from their positions on federalism. Conservatives can be expected to vote in favor of preemption and

Other scholars propose more moderate interpretive moves that they believe will help courts appropriately balance supremacy or nationalism interests with federalism concerns. For example, a common suggestion is that federalism interests support a general presumption against preemption that would effectively make it more difficult to find preemption and require Congress to do more to make its intent to preempt laws under a theory of obstacle preemption clearer.[242] Indeed, scholars point to the fact that the Supreme Court has referred to such a presumption in *Rice v. Santa Fe Elevator Corp*.[243] At the same time, scholars view the Court's embrace of a general theory of obstacle preemption as evidence that no such general presumption exists in application.[244] Courts simply assume the availability of obstacle preemption and focus their analysis on uncovering the relevant goals or purposes in federal law to assess the existence of a conflict with state law.

In the face of this reality, scholars, like Professors Hoke and Dinh, have tried to offer some guiding principles for preemption jurisprudence and urged courts to think more critically about the deeper questions implicated in courts' approaches to obstacle preemption claims. For example, in *Reassessing the Law of Preemption,* Dinh agrees that the Supreme Court's cases follow "no predictable jurisprudential or analytical pattern."[245] Nonetheless, he attempts to

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> liberals to vote against it, with the odd result that the liberals find themselves promoting states' rights while conservatives counter with a plea for a robust national regulatory system. Empirical evidence supports this conventional wisdom.

Id. at 686 (citations omitted).

242 *See, e.g., Preemption Pathologies*, *supra* note 227, at 760–61 (arguing that "[t]he Court's presumptions disfavoring preemption should be more consistently applied.").

243 *See* Young, *supra* note 229, at 276 (citing to *Rice*, 331 U.S. 218 (1947)). The Court in *Rice* states: "[W]e start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* But the Court goes on to say that "[s]uch a purpose may be evidenced in several ways [including that] the state policy may produce a result inconsistent with the objective of the federal statute." *Id.*

244 *See, e.g.*, Dinh, *supra* note 227; Young, *supra* note 229*; Preemption Pathologies, supra* note 227*;* Nelson, *supra* note 231. There is evidence that courts increasingly apply such a presumption in field preemption cases.

245 Dinh, *supra* note 227, at 2085.

"make sense of the preemption mess by going back to first principles: by defining preemption and supremacy within the constitutional structure; by critically assessing the validity and meaning of core assumptions and principles the Court professes to follow in preemption cases; and by explaining how preemption analysis, properly conceived, can rationalize seeming inconsistencies."[246] Dinh concludes that, as a matter of constitutional structure, there should be no general systematic presumption against or in favor of preemption; he insists that this question should turn on an inquiry into the statute and a presumption could risk upsetting the proper balance of power by undermining Congress's intent.[247] Dinh acknowledges that an important question remains as to what constitutes sufficient evidence of congressional purpose to preempt state law, but for this question he does not provide much in the way of guidance. He highlights how a general theory of obstacle preemption "both relax[es] the standard for conflict—from direct conflict to obstacle to accomplishment—and expand[s] the evidence of congressional intent—from statutory text to purposes and objectives," which "infuse[s] more ambiguity into the analysis."[248] Unfortunately, he does not explain how the constitutional structure should inform how courts deal with this ambiguity.

Hoke similarly highlights the ambiguity created by a broad obstacle preemption theory, noting that as a doctrinal matter, courts have not explained how much tension is permitted in determining whether there is a conflict or how they are making that determination. Hoke criticizes courts' failure to confront subtle and critical questions about what "contrary" means in determining whether preemption of a particular state law should occur,[249] and she sees the Court's jurisprudence as evidencing an "unjustified expansion of the use of the Supremacy Clause in the name of nationalism."[250] Hoke demands

246 *Id.*

247 *Id.* at 2092–2093.

248 *Id. at 2104.*

249 Hoke, *supra* note 228, at 853–54 ("Lexicological sources suggest a tonal nuance to the type of differences that are properly deemed 'contrary.' . . . Most federal preemption questions do not present a situation of logical contraries, where the feds say 'not A' and a state responds 'A!' Rather, the types of conflicts presented for adjudication are more subtle.").

250 *Preemption Pathologies*, *supra* note 227, at 687 ("Federal preemption decisions impede the ability of those governmental bodies that are structured to be most responsive to citizens'

recognition by courts that obstacle preemption implicates deeper questions about how much tension should be permitted and what kind of evidence should be required to indicate intent to constrain state authority. More importantly, she believes that the answer to these questions should be informed by federalist concerns.

In fact, Hoke sees a connection between her concerns about an overly broad preemption doctrine that does not properly account for federalist concerns and the very question that *Independent Living Center* and *Exceptional Child Center* took up regarding the role of the Supremacy Clause in statutory preemption claims. In arguing against the idea of an implied Supremacy Clause claim, Hoke linked the procedural question about the role of the Supremacy clause to the values question that ultimately shapes the merits analysis in preemption cases:

> [Is the Supremacy] Clause itself properly the source of the claim, or is preemption better understood as a claim arising under and secured to the particular body of federal substantive law that is urged to be preemptive? Could it be that instead of serving as a primary source of generative constitutional principles, the Clause is empty of any substantive content that can give rise to substantive claims for relief? That it functions primarily as a rule of decision, rather than as a source of substantive claims? . . . *That the Supremacy Clause functions as a rule of decision rather than as the source of substantive claims may not, at first blush, seem the most exciting of insights. But what is at stake is precisely the balance of the Constitution as it speaks to federalism. If, like Chief Justice Marshall in McCulloch, we take the Supremacy Clause as conclusive evidence of the Constitution's determined nationalism a grudging view of state regulatory power will ensue. Further, if the Clause is permitted to function as the textual basis of a superintending value and objective of national preeminence, the interpretation of every other federal constitutional power vis-à-vis the states will be vulnerable to infection and distortion. Only if we reassess this nationalistic preference currently fastened to the Supremacy Clause can we both return the Clause to the function that is discernible from the text and*

public values and ideas—state and local governments—and have concomitantly undermined citizens' rights to participate directly in governing themselves."). *See also* Issacharoff & Sharkey, *supra* note 230, at 1354–55 ("Two primary arguments are advanced for the contemporary functional importance of federalist constraints on centralized political power. The first is captured in Justice Brandeis's famous invocation of the states as the laboratories of democracy in which 'a single courageous State' may blaze new paths by trying 'novel social and economic experiments.' The second ties the smaller, decentralized scale of subnational units to a more robust democratic accountability, by which 'government is brought closer to the people, and democratic ideals are more fully realized.'").

> *structure – that of a switch – and take the supremacist thumb off the scales when weighing state versus national power*.[251]

Hoke says the Supremacy Clause does not expressly answer important questions about how courts should determine conflict in difficult cases: when differences, although not constituting logical contraries, are sufficient to displace state law; whether the relative importance to a state of its challenged law may be permissible in analyzing the law for proscribed conflict; whether courts have a duty to harmonize the federal and state statutes or whether the task is to construe and compare the statutes with no presumptions favoring preservation of state law.[252] Thus how the Supremacy Clause is understood as shaping preemption doctrine "is a question of values than one of neutral textual explication."[253]

For Hoke, then, a view of the Supremacy Clause as creating a substantive right informed by a nationalist lens through which preemption analysis would be conducted creates an unstated preference for erring on the side of finding a conflict in grey areas. Hoke offers a different framing for resolving questions about conflict, which she argues is more faithful to the role of the supremacy clause as an historical matter and a practical one.[254] Through this lens, Hoke urges that "mere interference with federal law" is not sufficient to warrant preemption and that "courts should be directed to channel their interpretive energies toward harmonizing the law of the two sovereigns into a functional scheme."[255] Only if the laws cannot be

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251 Hoke, *supra* note 228, at 855, 883 (emphasis added).

252 *Id.* at 853

253 *Id*.

254 *Id.* ("Under my theory, then, preemption analysis should be understood to have two parts. First, [it] should be conceptualized as a type of statutory claim that arises not under the Supremacy Clause but under the particular federal act urged to be preemptive. The conclusion as to whether a given state law is preempted depends on a substantive evaluation of its 'conflict' with federal law. Second, determination of what counts as a 'conflict' is something that cannot be resolved merely through ordinary statutory construction. Here the inquiry must remain ultimately tethered to the Supremacy Clause. Only a lens based on our understanding of the text, context and purpose of the Clause, and a pragmatic understanding of what is at stake politically, allows us to define what counts as a conflict between state and fed law.").

255 *Id*. at 890.

harmonized should state law be displaced. Even in such a case, according to Hoke, courts "must identify precisely what state law cannot be harmonized, seeking at all times to preserve maximum state regulatory authority unless Congress has specifically directed courts to develop and to protect an exclusively federal scheme."[256]

2. Obstacle Preemption & the Exceptional Child Center Opinions

Exceptional Child Center was not about the merits of the plaintiffs' preemption claims. The Court did not expressly engage questions about the proper use of obstacle preemption in general or specifically about the Idaho court's application of the doctrine in this case. For this reason, it is difficult to know for sure whether the justices' disagreements over statutory interpretation reflect divisions in the justices' beliefs about the doctrine of obstacle preemption and its underlying constitutional implications. But there are indications of such concerns. At least two justices in *Exceptional Child Center* have taken the opportunity in other cases to recognize the federalism implications of statutory preemption questions and to express concern about an overly broad obstacle preemption doctrine that may not strike the right balance between federal and state regulatory authority.

These concerns were expressed when the merits of a statutory preemption challenge to a different kind of state Medicaid law reached the Supreme Court in 2003, in *PHARMA v. Walsh*.[257] In this case, pharmaceutical manufacturers challenged Maine's drug rebate program as preempted by federal law.[258] During that period, a number of states were experimenting with policy reforms designed to reduce the cost of prescription drugs by negotiating rebates above the amount required by federal law.[259] As an incentive to drug companies to provide greater rebates, states would place these drugs on a preferred drug list and exempt them from prior authorization requirements.[260] In this particular case, manufacturers alleged an

256 *Id.*

257 Pharm. Research and Manufacturers of Amer. v. Walsh et al., 123 S. Ct. 1855, 1855 (2003).

258 *Id.* at 1860.

259 *Id.*

260 *Id.* at 1863.

implied conflict with the Medicaid Act, claiming that Maine's program posed an obstacle to the accomplishment and execution of the full purposes and objectives of Congress .[261] The district court preliminarily enjoined Maine officials from implementing its prescription drug rebate program on this basis, but the First Circuit Court of Appeals vacated the injunction and reversed the decision.[262] The Supreme Court affirmed the decision of the Court of Appeals, finding that the district court abused its discretion by enjoining the state's program.[263] But there was no majority opinion with respect to the specific holding about how the theory of obstacle preemption should be applied.

The plurality opinion by Justice Stevens, joined by Justices Souter and Ginsburg, found that the petition did not make a sufficient showing that the Medicaid Act likely preempted Maine's Rx Program for purposes of an injunction. It rejected what it saw as the district court's lax standard for determining obstacle preemption, noting that it was "incorrect for the District Court to assume that any impediment, '[n]o matter how modest,' to a patient's ability to obtain the drug of her choice at state expense would invalidate the Maine's Rx Program."[264] In addition, the plurality suggested that there was a presumption against federal preemption in this case, based on the fact that the state and federal governments seem to be "pursuing 'common purposes'"[265] and the Secretary had not decided to the contrary.[266]

Justice Breyer wrote separately, emphasizing his agreement with the plurality that the district court's standard understated the strength of the showing the petitioner needed to make to show preemption. Instead, he said, the manufacturers should have to demonstrate that

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261 *Id.* at 1865.

262 *Id.*

263 Pharm. Research and Manufacturers of Amer. v. Walsh et al., 123 S. Ct. 1855, 1855 (2003).

264 *Id.* at 1868 (Stevens, J. joined by Souter and Ginsburg, JJ.).

265 *Id.* at 1869 (noting that the state's goal of encouraging the use of cost-effective medications without diminishing safety or efficacy: "[a]voiding unnecessary costs in the administration of a State's Medicaid program obviously serves the interests of both the Federal Government and the States that pay the cost of providing prescription drugs to Medicaid patients.").

266 *Id.* at 1869 (citing Hillsborough County v. Automated Medical Laboratories, Inc., 105 S.Ct. 2371, 2371 (1985) and N.Y. State Dept. of Social Servs. v. Dublino, 93 S.Ct. 2507, 2507 (1973)).

Maine's Rx program would "seriously compromise important federal interests."[267] He thought that the improper legal standard led the district court to the wrong conclusion, given statutory language that authorized prior authorization programs, the fact that such programs may be consistent with the federal government's cost-savings goals, and the fact that the Secretary had approved at least one such program.[268] In other words, Justice Breyer relied heavily on the specific nature of the regulatory scheme under which this concurrent authority existed to argue for a higher standard to show preemption.

Justice Breyer was concerned about the court's ability to get this preemption question right; he emphasized that a "proper determination of the pre-emption question will demand a more careful balancing of Medicaid-related harms and benefits than the District Court undertook."[269] He then suggested that HHS was in the best position to make this kind of determination, because it was "better able than a court to assemble relevant facts (*e.g.*, regarding harm caused to present Medicaid patients) and to make relevant predictions (*e.g.*, regarding furtherance of Medicaid-related goals)."[270] Finally, he noted that significant weight should be granted to any legal conclusion by the Secretary as to whether a program such as Maine's is consistent with Medicaid's objectives.[271] Justice Breyer's solution was not to reject the claims outright or to create a blanket presumption against preemption. Instead, based on Justice Breyer's understanding of the underlying conflict question, he emphasized the important role that regulatory agencies played in answering these questions and advised lower courts to seek and heed agency guidance.[272]

Justice Thomas has been one of the most outspoken critics of an overly broad obstacle preemption doctrine. In *Walsh*, Justice Thomas expressed his concern about the Court's application of an obstacle preemption claim in the context of the Medicaid Act. He highlighted

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267 *Id.* at 1871 (Breyer, J. concurring in part and concurring in the judgment).

268 *Id.* at 1872 (Breyer, J. concurring in part and concurring in the judgment).

269 Pharm. Research and Manufacturers of Amer. v. Walsh et al., 123 S. Ct. 1855, 1872 (2003) (Breyer, J., concurring in part and concurring in the judgment).

270 *Id.*

271 *Id.*

272 *Id.*

the challenge of attempting to distill the Medicaid Act's "purpose" considering the "delicate balance Congress struck between competing interests—care and cost, mandates and flexibility, oversight and discretion."[273] And in a more recent case that did not involve Medicaid, Justice Thomas expressed a more fundamental concern with implied preemption generally:

> I cannot join the majority's implicit endorsement of far-reaching implied pre-emption doctrines. In particular, I have become increasingly skeptical of this Court's "purposes and objectives" pre-emption jurisprudence. Under this approach, the Court routinely invalidates state laws based on perceived conflicts with broad federal policy objectives, legislative history, or generalized notions of congressional purposes that are not embodied within the text of federal law. [I]mplied pre-emption doctrines that wander far from the statutory text are inconsistent with the Constitution . . . .[274]

Thomas went on to discuss the federalist principles implicated in such "far-reaching implied pre-emption doctrines," emphasizing the concurrent, dual sovereignty by the federal government and the states that is part of the constitutional structure.[275] While acknowledging the advantage the Supremacy Clause gives the federal government where there is an actual conflict between federal and state law, he emphasized the delicate balance that must be maintained between federal and state sovereigns. Like Hoke, Thomas highlighted the important state interests at stake, namely, "a decentralized government more sensitive to the diverse needs of a heterogeneous society and providing a greater opportunity for citizen participation."[276] He characterized the existing doctrine as permitting

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273 *Id*. at 1874 (Thomas, J., concurring in the judgment). Unlike Justice Breyer, Justices Scalia and Thomas were willing to remove the claims from the federal courts completely. Pharma v. Walsh, 123 S. Ct. at 1874 (Scalia, J. concurring in the judgment) (noting that he would reject the petitioner's statutory preemption claim based on the fact that providers' do not have a statutory right of action under prior cases.); *id.* at 1873 (Thomas, J. concurring in the judgment) ("I make one final observation with respect to petitioner's pre-emption claim. The Court has stated that Spending Clause legislation "is much in the nature of a contract." This contract analogy raises serious questions as to whether third parties may sue to enforce Spending Clause legislation—through preemption or otherwise.").

274 Wyeth v. Levine, 129 S. Ct. 1187, 1205 (2009) (J. Thomas, concurring).

275 *Id.* (J. Thomas, concurring).

276 *Id.*

a "freewheeling judicial inquiry into whether a state statute is in tension with federal objectives."[277]

While Justice Thomas' concern about the federalist implications of an overly broad preemption doctrine may not be surprising, doctrinal approaches to preemption decisions do not typically divide along the usual ideological or partisan lines.[278] Outside of the Medicaid context, Justice Breyer has also expressed concern about the federalism implications of an overly broad preemption doctrine. In a 2001 case, for example, Justice Breyer offered the following admonition:

> [T]he Court has recognized the practical importance of preserving local independence, at retail, *i.e.,* by applying pre-emption analysis with care, statute by statute, line by line, in order to determine how best to reconcile a federal statute's language and purpose with federalism's need to preserve state autonomy. Indeed, in today's world, filled with legal complexity, the true test of federalist principles may lie, not in the occasional constitutional effort to trim Congress' commerce power at its edges, or to protect a State's treasury from a private damages action, but rather in those many statutory cases where courts interpret the mass of technical detail that is the ordinary diet of the law.[279]

In theory, the question of the availability of equitable relief is distinct from the question of whether a state law is preempted by federal law. Indeed, the *Exceptional Child Center* dissenters seemed to agree that the lower courts got the merits of the claim wrong,[280] but they did not think the court should eliminate a preemption-based claim as an avenue for challenging state rate-setting. The dissent criticized the majority's response to the lower court's overreach as

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277 *Id.* at 1208 (Thomas, J., concurring).

278 *Id.* In the same case, Justices Alito and Scalia, and Chief Justice Roberts dissented, finding that state law was impliedly preempted by the federal drug law. The dissenting justices reiterated that "the purpose of Congress is the ultimate touchstone in every pre-emption case," and they read into the statute a very specific Congressional purpose - authorizing the FDA and not state tort juries to determine when and under what circumstances a drug is "safe"—which would have significantly narrowed the states' concurrent regulatory authority without explicit intent that this was what Congress intended. According to the dissenters: "[T]he ordinary principles of conflict pre-emption turn solely on whether a State has upset the regulatory balance struck by the federal agency." *Id.*

279 Egelhoff v. Egelhoff, 532 U.S. 141, 160–61 (2001) (Breyer, J. dissenting).

280 The use of preemption in the context of Section 30(A) in *Exceptional Child Center* is arguably consistent with fears of an overly broad preemption doctrine that does not have a principled basis for allocating the balance of power between federal and state governments.

itself an overreaction, accusing Justice Breyer of confusing the merits question with the question the Court granted certiorari to address.[281]

In reality, however, the merit and procedure questions work together in determining whether and how easy it is to invalidate state laws, and this is particularly true in rate setting. As should be clear from the above cases, the justices' concern about an overly broad obstacle preemption doctrine influences their decisions about the proper institution to decide preemption questions. This is especially true where the nature of the decision in dispute is complex, value laden, and subject to oversight by a specialized federal body. In other words, concerns about getting the conflict question right are very much tied to concerns about which institutional actor—the court or the federal regulatory agency—is in the better position to make the right decision.

In this case, the majority's decision that the Supremacy Clause was merely a rule of decision and its rejection of a strong presumption in favor of equity, at least in the context of Section 30(A), could be viewed as performing exactly the function Hoke suggested: sending a signal that there would no longer be a thumb on the scale for a nationalist view that too easily allowed preemption of state law. According to Hoke, in the question of whether there is an implied Supremacy Clause claim, "what is at stake is precisely the balance of the Constitution as it speaks to federalism."[282] It seems the majority agreed.

Perhaps more important for the practical implications of these cases beyond rate-setting is the second factor used in *Exceptional Child Center* for foreclosing equitable relief—the judicial unadministrability of Section 30(A). Scholars and judges, including Justice Breyer, have called attention to the profound federalism implications of statutory preemption claims, and in particular, the dangers of an overly broad theory of obstacle preemption used to displace state law. The concern is that some obstacle preemption claims can present complex questions that courts are not equipped to answer, which is why obstacle preemption claims increasingly trigger institutional choice questions about who should decide these hard questions and under what circumstances. Indeed, despite the varying opinions in *Exceptional*

281 Egelhoff, 532 U.S. at 160–61 (2001) (Sotomayor, J. dissenting).

282 *Id*. at 883.

Child Center, all of the justices seemed to share concern about the proper forum for rate-setting decisions, where questions about implied conflict, or obstacle preemption, involve complex judgments based on technical expertise, competing policy goals, and other value judgments.

Independent Living Center may have been Justice Breyer's warning to lower courts about the proper way to handle these cases, drawing a line between improperly engaging in the complex and value-laden task of setting rates, and the more traditional, and proper, role of judicial review of the reasonableness of agency rate determinations. To the extent the lower courts in *Exceptional Child Center* failed to heed this warning, it should not be surprising that Justice Breyer switched sides.[283] In *Gonzaga*, Justice Breyer previewed his willingness to remove such decisions from the courts if he thought that the court was not the right institutional actor to answer the question.

PART V. IMPLICATIONS FOR THE FUTURE OF MEDICAID & OTHER FEDERAL SPENDING PROGRAMS

Private preemption claims test the carefully negotiated federal-state relationship in Medicaid rate-setting. Given that preemption is increasingly recognized as a site of federalist conflict, and that state flexibility is often a flashpoint for federalism based critiques of health policy, it is important to understand the underlying federalism principles at work in *Independent Living Center* and *Exceptional Child Center*. Although the holdings were narrow, Part IV considered how the different federalist accounts of state flexibility identified in Part I seemed to animate the justices' approaches. From this analysis, we can

283 Breyer's focus on the connection between the merits question and the procedural question about who should decide seems consistent with what Breyer seems to be doing almost a decade later in *Independent Living Center* and *Exceptional Child Center*. In fact, one lower court heeded this warning in rate-setting challenge brought after *Independent Living Center* and before *Exceptional Child Center*. The court in that case refused to dismiss the rate-setting challenge, based on the fact that HHS had not yet acted on the rate change as it had in *Independent Living Center*; but the court also used the doctrine of primary jurisdiction, as suggested by Justice Breyer in *Walsh*, to seek the input of federal regulators to answer the preemption question. *See* Dartmouth-Hitchcock Clinic v. Toumpas, 2012 WL 4482857 (D. Ct. NH 2012). This is an unreported decision arising after *Independent Living Center* but before *Exceptional Child Center*.

glean important lessons that help clarify the current jurisprudence around preemption-based enforcement of federal spending conditions, as well as inform the on-going policy debate about the structure of Medicaid. In short, the cases send an important message about the character of state flexibility in Medicaid that is useful for understanding how other legal challenges may be resolved and for providing much-needed context for reforms proposed in the name of state flexibility.

A. Balancing Rights Enforcement and State Flexibility

Read together, *Independent Living Center* and *Exceptional Child Center* suggest that courts, in reviewing challenges to state program decisions, should take a nuanced approach informed by modern accounts of the federal-state relationship in Medicaid. While all of the justices exhibited a deep respect for state flexibility in the area of rate-setting, their different visions of federalism seemed to lead them to different calculations about how to balance judicial respect for this flexibility with the essential role of courts as a check on state violations of federal law. In particular, Justice Breyer's shifting alliance, and his concurrence in *Exceptional Child Center*, tipped the balance in favor of a more refined and careful statutory analysis than the other four justices in the *Exceptional Child Center* majority would have applied. Justice Breyer's analysis focused on the specific character of, and regulatory framework governing, the state decision at issue, and he was unwilling to join four other justices to create a more sweeping presumption against private enforcement of federal spending conditions.

The key to understanding Justice Breyer's willingness to vote to eliminate preemption claims in the rate setting context is his concern about the limited role of courts when states are acting within the interstices of a complex and federal regulatory framework that encourages state flexibility and relies on the dynamic interaction between state and federal health officials. In this way, Justice Breyer's approach reflects the more modern understanding of federal-state interaction. Justice Sotomayor also recognized the importance of this state flexibility, but thought it better to account for this on the merits question, rather than eliminate any chance for review. Justice Breyer may have been willing to go further because of what he perceived as

the Ninth Circuit's failure to adequately account for this view, leading lower courts to improperly constrain state flexibility in ways that undermined federal and state interests.

The Ninth Circuit's approach may reflect its struggle with how to apply traditional administrative law principles to a modern conception of administration. Administrative law was originally grounded in an older model of administration that assumed legislative goals and political choices will and can be codified in clear statutory commands and rules to be implemented by the agency. But the more modern regulatory state relies less on rigid rules or top-down commands from an agency; rather, complex, administrative programs like Medicaid rely to a significant degree on more flexible, performance-based standards expected to evolve over time. This evolutionary aspect can be particularly challenging for courts because "implementation [must be understood], not only or even primarily as compliance with previously enacted norms, but as a course of discovery and elaboration."[284] Equally important, the kind of expertise we expect in a post-modern bureaucracy may not reflect static or clear standards; rather norms and practices develop from the bottom-up, through experimentation and collaboration between federal, state and local governments. In the modern administrative state, administrative legitimacy cannot always be measured by compliance with a clear rule; instead, certain kinds of program design decisions reflect a process through which agencies seek to achieve general and multi-faceted statutory goals.

The failure of this more modern account to penetrate the Ninth Circuit's decisions could explain what all of the justices saw as judicial overreach, and *Independent Living Center* could have been a warning to lower courts about this overreach. At least one scholar expressed concern that to the extent lower courts fail to properly heed such warnings, the "Court seems increasingly prone to solve this problem by restricting the classes of cases judges can review."[285] This worry has

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284 *See* Williams H. Simon, *Democracy and Organization: The Further Reformation of American Administrative Law* 3–4 (Columbia Law. Sch. Pub. Law & Legal Theory Working Paper Grp., Paper no. 12-322, 2012).

285 *See* Richard J. Pierce, Jr., *The Role of the Judiciary in Implementing an Agency Theory of Government*, 64 N.Y.U. L. REV. 1239, 1243 (1989).

proved prescient, with the Supreme Court's decision in *Exceptional Child Center*.

At the same time, courts still have an important enforcement role, despite the fact that preemption-based claims were eliminated in the rate-setting context. Five justices—Justice Breyer and the four dissenting justices in *Exceptional Child Center*—rejected states' invitation to create broader protections against private enforcement of Medicaid spending conditions. In *Gonzaga*, *Walsh*, *Independent Living Center*, and *Exceptional Child Center,* Justice Breyer repeatedly refused to adopt sweeping presumptions that would make it harder to enforce federal spending conditions. Despite states' attempts to read a sweeping presumption into a part of Justice Scalia's opinion that was only joined by three other justices, Section 1983 remains an essential and powerful tool to enforce Medicaid spending conditions that are definite and specific.[286] And despite Justice Sotomayor's critique of the majority opinion in *Exceptional Child Center*, it seemed clear from Justice Breyer's concurrence that he was unwilling to equate the test for equitable relief under a preemption claim with the test for whether a right is enforceable under Section 1983.[287] Thus, preemption-based claims for equitable relief may be available even where the underlying statute does not create a specifically enforceable right under Section 1983.

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286 For example, in the case of state attempts to terminate Planned Parenthood from the Medicaid program, all of the courts ruling on the matter have affirmed that Section 1396 a(a)(23) creates a private right enforceable under Section 1983, and Planned Parenthood has successfully used this to prevent termination of its contracts. *See, e.g.*, Planned Parenthood of Gulf Coast, Inc. v. Gee, 837 F.3d 477, 490 (5th Cir. 2016) (citing Planned Parenthood Arizona Inc. v. Betlach, 727 F.3d 960, at 966 (noting that courts addressing this provision confront "a simple factual question no different from those courts decide every day," and free from "any balancing of competing concerns or subjective policy judgments."); *see also* Planned Parenthood of Indiana, Inc. v. Comm'r of the Ind. State Dep't of Health, 699 F.3d 962 (2012); Harris v. Olszewski, 442 F.3d 962 (2012).

287 Although the dissenting justices in *Exceptional Child Center* raise serious questions about the majority's interpretive moves in analyzing Section 30(A) for implied limits on equitable relief, at least for now, Section 1983 jurisprudence remains theoretically distinct from the question of the availability of equitable relief on statutory preemption grounds. Of course, *Exceptional Child Center*'s import became even more uncertain upon Scalia's recent passing. It is possible that Scalia's replacement aligns with the dissenting justices in *Exceptional Child Center* to "restore" a presumption in favor of equitable relief—Kennedy was part of the *Exceptional Child Center* dissent and questions relating to the doctrine of preemption do not typically fall along partisan lines.

It is important to consider carefully the balance that Justice Breyer forced the majority to strike in *Exceptional Child Center* and the kind of inquiry this entails. To the extent Justice Breyer's decision relied on the character of the federal-state relationship negotiated for rate setting, this is limited to the rate-setting context. Medicaid is a massive program in which the nature of the federal-state relationship varies for different program areas. The careful, provision-by-provision statutory analysis that Justice Breyer has faithfully employed in the past should guide lower courts in future cases.

As noted in the prior part, concerns about an overly broad obstacle preemption theory being used to invalidate state law become more serious the more complex a decision becomes and the more challenging it is to distill a clear purpose that is being undermined. The cooperative nature of the spending clause program is relevant to preemption questions to the extent that such programs lead courts—whether consciously or not—to view state laws enacted pursuant to the program as presumptively serving a common purpose with the federal law. If federal regulators can better ensure the kind of careful balancing needed to determine if the federal and state laws are in harmony, then removing equitable relief claims from the courts arguably is more consistent with that statutory scheme and thus gives effect to federal law. A court should not presume, however, that every federal spending program condition reflects a complex balancing of goals dependent upon regulatory expertise or that every question of a conflict warrants a presumption that the state is acting pursuant to a common goal. Unfortunately, there is already one example of a court that has made this mistake, though this was before *Exceptional Child Center*.

In *Planned Parenthood of Kansas and Mid-Missouri (PPKM) v. Moser*,[288] the Tenth Circuit seemed eager to read *Independent Living Center* as requiring a more sweeping presumption against preemption claims to enforce program spending conditions, without careful attention to the character of the decision challenged or the regulatory context in which the federal regulator and state interact. The program at issue in this case was not Medicaid, but rather a federal program focused on family planning services, administered through Title X

288 Planned Parenthood of Kansas v. Moser, 747 F.3d 814, 814 (10th Cir. 2014).

grants—Title X is the section of the Public Health Service Act that authorizes federal funding to facilitate the provision of family-planning services.[289] Typically, these grants are awarded to the states, who in turn, distribute the funds to sub-grantees who provide the services. In Kansas, PPKM had been a subgrantee until a Kansas appropriations bill was passed that effectively excluded PPKM from receiving Title X funding. Because the appropriations restrictions were enacted in the middle of a grant period, PPKM was deprived of funds they had already been promised. PPKM challenged the state law arguing that it was preempted by a provision in Title X providing that "[l]ocal and regional entities shall be assured the right to apply for direct grants and contracts . . . and the Secretary shall by regulation fully provide for and protect such rights."[290] The Title X program does not have nearly the kind of detailed statutory scheme as Medicaid, and this provision had not been viewed as creating an enforceable right under Section 1983. In fact, even the plaintiff did not make the argument that there was an enforceable statutory right under Section 1983.[291] Instead, plaintiffs relied on the Supremacy clause to seek equitable relief on preemption grounds.

The Tenth Circuit reversed its own precedent in finding it unlikely that PPKM could bring a claim for equitable relief on preemption grounds. The court relied on the dissent in *Independent Living Center* to fashion a new test for answering this question:

> Whether to recognize a private cause of action for injunctive relief is a matter of statutory interpretation. And we cannot infer such a cause of action from Title X. HHS, the expert federal agency charged by Congress with administering Title X, has ample power to enforce the requirements of the law; private suits for injunctive relief can undermine the advantages of uniformity and expertise provided by HHS supervision; Title X does not clearly notify States that they are subject to such suits; implementation of [the state funding restriction] does not constitute state enforcement action forbidding Planned Parenthood from acting as it wishes (as opposed to state action complying with legislation simply denying subsidies for that activity); and private suits

289 42 U.S.C. §§ 300-300a-6.

290 *Id*. at § 300(b). The implementing regulations also provided that "*[a]ny* public or *nonprofit private entity* in a State may apply for a grant under this subpart." 42 C.F.R. § 59.3.

291 Planned Parenthood of Kansas, 747 F.3d at 814, 822–823.

> for injunctions are not traditionally implied in statutes enacted under the Constitution's Spending Clause.[292]

The problems with the Tenth Circuit's approach become clear in light of *Exceptional Child Center*. First, the Tenth Circuit's opinion seems heavily tinged with a general presumption against preemption claims tied to spending clause legislation—a presumption for which there was certainly evidence in the *Independent Living Center* dissent, but which did not appear in the *Exceptional Child Center* majority opinion. In addition, the Tenth Circuit's analysis does not reflect the kind of nuanced inquiry that Justice Breyer uses in his concurrence in *Exceptional Child Center*. The Tenth Circuit simply parroted language about concern for uniformity and agency expertise in explaining why Planned Parenthood's claim should not be allowed, but it did not actually dig into the nature of the dispute to explain how it would require the kind of complex balancing and judgment-laden decision that courts are not well-equipped to make. In fact, the Tenth Circuit did not analyze the district court's decision on the merits at all. Finally, it ignored other decisions finding that this question did not involve the kind of complex balancing of factors that would make it judicially unadministrable and viewing it as the quintessential statutory interpretation question that courts are expected and have the capability to answer.[293]

The analysis of *Exceptional Child Center* in this Article should discourage other courts from such misapplications in the future.

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292 *Id*. at 822–823.

293 *See, e.g.*, Planned Parenthood of Central North Carolina v. Cansler, 877 F. Supp. 2d 310 (M.D. NC 2012) (finding legislation excluding Planned Parenthood from Title X funding preempted by federal statute assuring providers the right to apply for the grant). In the case of block grants that have no comparable provisions, courts have been clear that there is no statutory basis for a preemption claim. Instead, plaintiffs have brought challenges based on the First and Fourteenth Amendments of the Constitution, with varying degrees of success. *See, e.g.*, Planned Parenthood of Greater Ohio v. Richard Hodges, 188 F. Supp. 3d 684 (invalidating Ohio law preventing Planned Parenthood from receiving funds pursuant to six health and education block grant programs) (appealed to 6th Circuit); *see also* Planned Parenthood Association of Utah (PPAU) v. Herbert, 828 F.3d 1245 (10th Cir. 2016) (enjoining the Executive Director of the Utah Department of Health (UDOH) from terminating federal funds to PPAU pursuant to federal block grants disbursed through the states for STD testing and surveillance, and for abstinence education and contraception).

B. Medicaid Reform

Understanding the balance that has been struck between state flexibility and rights enforcement—in light of the growing appreciation for the dynamic nature of federal-state interactions in Medicaid—is relevant to the policy debate on Medicaid reform. Indeed, the federalism narrative used to challenge rights enforcement in the courts is similar to the narrative used to argue for transforming Medicaid from an entitlement program with federal matching funds into a capped program. Given the prominence of state flexibility as justification for these proposals in the ongoing health reform debate, this justification should be evaluated against the reality of our current system.

When "state flexibility" is used by proponents of reforms to justify restructuring Medicaid, it is being used in a way that reflects outdated notions of federalism. Increasingly, scholars are taking traditional federalism accounts to task for failing to capture the dynamic or negotiated nature of federal-state relationships in Medicaid, and rate-setting is an area that reflects this more modern understanding of federal-state relations. It shows how federal funding can be empowering for states, enabling them to be powerful actors that shape health policy and drive payment reforms from the bottom up.[294] This is not only reflected in the reality of health reform on the ground, it is reflected in courts' attempts to balance state flexibility against rights enforcement claims related to access. Spending conditions are not inherently threatening to state flexibility. Rather the rate-setting cases illustrate how sensitive courts are to even small legislative tweaks designed to promote state flexibility, as well as courts' ability and willingness to show restraint in service to federal program goals that depend on this state flexibility.

This federalism insight undermines claims that a sweeping approach to Medicaid reform—eliminating or reducing federal entitlements and drastically cutting federal funds—is necessary for protecting state power and achieving needed state flexibility. State flexibility—especially as a proxy for state power—is not merely a

294 *See also* Abbe Gluck, Intrastatutory *Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 567 (2011) (describing the important role of the federal government in "jump starting" state experimentation).

function of legal constraints. Federal funding empowers states to experiment with service delivery and payment reforms that serve their own goals. A restructuring of the Medicaid program will not "free" states from constraints, but will result in even greater constraints—forcing states to reduce eligibility or services solely based on budgetary concerns and not based on decisions about what constitutes good health policy. Indeed, states fear the kind of "flexibility" that is tied to significant reduction of federal support because it effectively reduces states' power.[295] States will have fewer resources to finance care for their citizens or to continue innovations effective at reducing poverty-related illness, preventable crises, and overutilization of emergency rooms.[296] Former Governor of Arizona, Jan Brewer, and current Governor of Ohio, John Kasich—both Republicans—have been vocal critics of Republican plans to radically restructure Medicaid.[297] They have emphasized the cost-effective reforms they have implemented in their states as part of the Medicaid expansion, and suggest the federal government look to their states as models of success, rather than making blunt cuts to federal funds that will hamper innovation.[298]

In the health care plan proposed by Paul Ryan—which seems to be the basis for the proposed per capita approach in the latest repeal and replace plan—he notes that states have requested greater

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295 Tami Luhby, *Why GOP Governors Like Medicaid Under Obamacare. Hint $*, CNN (Jan. 19, 2017, 7:34 PM), http://money.cnn.com/2017/01/19/news/economy/medicaid-gop-governors-obamacare-repeal/; Peter Sullivan, *GOP Governors Defend Medicaid Expansion*, THE HILL (Jan. 19, 2017, 5:50 PM), http://thehill.com/policy/healthcare/315173-gop-governors-defend-medicaid-expansion.

296 Rosenbaum, *supra* note 1 (noting that "[e]xpansion states could face up to a 40-point difference between the federal funding enhancements they expected to receive in 2020 for the expansion population and what they actually would receive under the bill" and that restructuring financing of the traditional program would "shift an estimated $370 billion in financial risks to the states over the coming decade, according to the Center on Budget and Policy Priorities."). Rosenbaum says that the coverage of 11 million people who gained eligibility under the ACA Medicaid expansion is at stake. *Id*.

297 Luhby, *supra* note 295; Sullivan, *supra* note 295.

298 John Kasich, Op-Ed., *End the Partisan Warfare on Health Care*, N.Y. TIMES (Mar. 10, 2017), https://www.nytimes.com/2017/03/10/opinion/john-kasich-end-the-partisan-warfare-on-health-care.html?_r=0; Bob Christie, *Republican States that Expanded Medicaid Want it Kept*, ASSOCIATED PRESS (Nov. 27, 2016), http://bigstory.ap.org/article/30d088a6b0614c8ebd900d853fb8b07a/republican-states-expanded-medicaid-want-it-kept.

flexibility to implement cost sharing options, job training and wellness requirements, or to offer more limited benefit packages for work-capable adults.[299] Ryan also notes that states would like changes to ease the waiver process.[300] Yet all of these changes can be accomplished through targeted amendments to the Medicaid Act. In fact, bi-partisan organizations have proposed increasing flexibility through more modest changes to the Medicaid Act that avoid the service disruption and massive funding cuts of a Medicaid cap.[301]

Indeed, the dominant theme in the Ryan plan seems to be reining in Medicaid for the work-capable, and a return to the original focus of Medicaid on the most acute health care needs of the most vulnerable populations. And this is precisely what such a radical restructuring of Medicaid would accomplish. As the Medicaid program is already very lean in most states, blunt cuts would not spur health innovation. This would only cripple states' ability to continue the kind of reforms and innovations that have made Medicaid one of the leanest health insurance programs. A more targeted approach is needed—one that takes into account the efficiencies already achieved by some states, how spending varies by type of enrollee and need, and the redistributive effects of any caps.[302]

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299 Ryan, *supra* note 13, at 27.

300 *Id*.

301 Letter from Terry McAuliffe, Chair, Nat'l Governors Ass'n to Honorable Kevin McCarthy et al., Majority Leader, United States House of Representatives (Jan. 24, 2017), https://www.nga.org/cms/home/federal-relations/nga-letters/health—human-services-committee/col2-content/main-content-list/health-care-reform.html (asking Congress to not shift costs to states and suggesting that any reform proposals should protect states from unforeseen financial risks due to spike in Medicaid enrollment or increased per beneficiary costs); NAT'L ASS'N OF MEDICAID DIRECTORS, NAMD'S LEGISLATIVE PRIORITIES FOR 2017, http://medicaiddirectors.org/wp-content/uploads/2016/12/NAMD-Legislative-Top-Issues-for-2017_FINAL.pdf (statement of priorities from bi-partisan association suggesting reforms to increase state flexibility, improve federal-state collaboration, support innovation, and modernize Medicaid that do not involve capping Medicaid funding).

302 Katherine Young et al., *Medicaid Per Enrollee Spending: Variation Across States*, KAISER COMMISSION ON MEDICAID & THE UNINSURED, Jan. 2015, http://files.kff.org/attachment/issue-brief-medicaid-per-enrollee-spending-variation-across-states-2 (explaining why "understanding the complexity of variation in per enrollee spending and spending growth is critical in assessing the implications of federal policy changes, particularly those that would alter the underlying financing structure of Medicaid.").

Finally, Ryan also supports eliminating an important access protection for beneficiaries, without any evidence that it would yield cost-savings or health benefits; indeed, if anything, the change would jeopardize access and potentially increase health care costs. The Ryan Plan mentions "freeing" states to determine who should qualify as Medicaid providers, with specific reference to providers of abortion services, like Planned Parenthood.[303] Yet in the latest repeal bill to surface, instead of "freeing" states to decide for themselves, there is a mandatory federal defunding of Planned Parenthood.[304] Neither approach enhances the kind of state flexibility discussed above. And the latter approach actually forces states to discriminate against providers for ideologically-driven reasons, and in direct conflict with policy-based judgments made by state officials with the expertise and authority to make program design decisions.

All of these examples show why it is important to look beyond the political rhetoric about protecting state flexibility and power to understand exactly what kind of flexibility states seek and why, and then to fashion reforms accordingly.

CONCLUSION

Recent events have reinvigorated a longstanding debate about Medicaid in which state flexibility plays a central role. At this moment, everyone's focus is on Republican plans to restructure Medicaid as part of an ACA replacement. But concerns about state flexibility also shape the future of legal disputes, specifically courts' approaches to determining when private enforcement of spending conditions can be used to constrain state decision-making. The stakes are high in both instances. And for both, we need to move past simplistic and outdated accounts of federalism, to a more modern understanding of the dynamic federal-state relationship that characterizes much of the Medicaid program. This insight is slowly penetrating legal decisions as courts demonstrate greater respect for state flexibility in certain

303 Ryan, *supra* note 13, at 28.

304 Kaiser Fam. Found., *Summary of the American Health Care Act* (Mar. 2017), http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-the-American-Health-Care-Act.

areas. And this insight should facilitate a more rigorous critique of reforms claiming to empower states and increase flexibility.