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Perspective

Medicaid and Access to the Courts

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The Medicaid program is grounded in a statute that is one of the most complex of all federal laws. An insurer of more than 60 million people — and poised to begin serving 16 million more by 2019 — Medicaid will be reexamined this year, in all its legal complexities, by the U.S. Supreme Court, which has agreed to hear California's appeal in the case *Maxwell-Jolly v. Independent Living Center of Southern California.* The Court's ruling could fundamentally alter states' accountability to beneficiaries and providers when their official conduct allegedly violates Medicaid's essential federal requirements.

The *Maxwell-Jolly* case was precipitated by a series of deep cuts to provider payments that were enacted by the California legislature and aimed at services used predominantly by the state's most severely disabled beneficiaries. The payment reductions were halted by the U.S. Court of Appeals for the Ninth Circuit, but this action by no means ended the dispute. Indeed, the question before the Supreme Court is of far greater consequence than that of specific provider payments: it is whether beneficiaries and providers have the right to seek judicial redress when they allege that state conduct abridges federal law and threatens health and safety.

The statute regulating Medicaid, unlike that underlying Medicare, does not expressly address the question of whether private persons deserve access to the courts in order to prevent harm arising from potentially unlawful state conduct. Virtually since Medicaid's inception,[1] states have disputed the ability of beneficiaries and providers to hold Medicaid programs judicially accountable under federal law. Over the years, a series of Supreme Court decisions have offered a partial answer: private individuals can sue when they believe a state's conduct has violated a *right* under Medicaid. In such cases, the suit is brought under a law dating back to the Civil War Amendments and commonly referred to by its U.S. Code number, Section 1983, which enables private parties to sue to stop state interference with a federal legal right.

But many of Medicaid's requirements, including some of the most important ones that give real meaning to the legal right to coverage itself, have never been definitively determined

to fall either within or outside the realm of legal "right." One such duty directly addresses the crucial issue of access to care by requiring states to assure that provider payments are not only economical and efficient but also "sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population in the geographic area."[2] The purpose of this equal-access duty could not be clearer: to assure that the right to Medicaid is more than an empty promise of care. Indeed, the Affordable Care Act (ACA) further strengthened Congress's expectation that Medicaid would result in access to care, by separately clarifying states' obligation to ensure that services are made available with reasonable promptness.[3]

It would appear axiomatic that when a state duty directly undergirding the Medicaid entitlement is alleged to have been violated, the courts will be available to intervene. Indeed, the Supreme Court has concluded that the courts were available to the pharmaceutical industry when it sued to halt an alleged violation by the state of Maine of Medicaid's prescription-drug coverage requirements. In a case brought by the Pharmaceutical Research and Manufacturers of America (PhRMA), the Court ultimately ruled that Maine's law was consistent with federal standards[4] — yet the majority of the justices did not question the appropriateness of the lawsuit itself. Since it involved no federal "rights," no action could be taken under Section 1983. But PhRMA's claim centered on an alleged conflict between state and federal law, so the industry group was presumed to have the right to proceed directly under the U.S. Constitution's Supremacy Clause, which renders unconstitutional any state law that conflicts with federal law, regardless of whether the federal law at issue creates a "right."

In *Maxwell-Jolly*, the Ninth Circuit similarly relied on the Supremacy Clause in finding a right to sue. In its ruling, the court noted that Medicaid's equal-access statute itself did not confer a Section 1983 right, but it found that the allegation of a conflict between state action and federal law brought the claims within the scope of the Supremacy Clause, thereby conferring on plaintiffs the right to go to court. It is this critical holding — that even where no federal right is involved, Medicaid beneficiaries and providers can sue to prevent unconstitutional conduct — that is now before the Supreme Court.

To blunt the implications of their desired ruling that private individuals have no means to challenge states' potentially unconstitutional conduct, the states argue that enforcement of Medicaid law by the federal government is sufficient. They further argue that Supremacy Clause litigation should be curbed only in the case of challenges to state conduct under welfare spending programs such as Medicaid, whose constitutional basis is the Spending Clause (which grants Congress the power to collect taxes and spend them for the country's general welfare), not challenges to state conduct that allegedly violates other types of federal laws. But nothing in the Supremacy Clause cases decided by the Court to date allows such a distinction: until now, all claims that state conduct violates the Constitution have been treated equally in the eyes of the law.

The states' claim that federal oversight is sufficient is particularly ironic given the history of federal enforcement of the equal-access statute. Despite the fact that this protection has been part of the federal Medicaid statute for 22 years, the Department of Health and Human Services (DHHS) has never issued detailed compliance standards, much less enforced them. In 2010, the federal government promised to issue standards and in fact ultimately disapproved California's rate cuts, but disapproval came years after the cuts took effect and long after they were enjoined in court. Even if final rules are issued (a process that could take years), there is no guarantee of enforcement. Indeed, DHHS's track record for Medicaid oversight is abysmal, and for good reason: the statute offers the secretary of health and human services virtually no meaningful enforcement tools. She can refuse to approve the state's payment rates (as DHHS ultimately did in this case) and can threaten to withhold all federal funding until the violation is fixed. But the law contains no practical steps such as providing incentives to increase payment rates, ordering an adjustment, or imposing intermediate penalties for failure to comply. Furthermore, the federal administrative review process is painfully slow, leaving beneficiaries with no protection against immediate injury. A decision by the Court in California's favor would shield states from judicial accountability un-

less a separate state law could be found to serve as the basis to sue; beneficiaries could be left unprotected against conduct that immediately threatens health and life.

It is hardly news where Medicaid is concerned that states are reeling from a combination of bad economic conditions, high poverty, a weak employer insurance market, escalating medical costs, and an approach to federal Medicaid financing that, while nominally generous, in fact places far too great a burden on weakened state economies. But the imperative to restructure federal–state Medicaid financing is separate from the question whether the poor should be barred from seeking judicial redress for violations of the very requirements that give Medicaid its power and meaning.

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1. Stevens R, Stevens R. Welfare medicine in America: a case study of Medicaid. New York: Free Press, 1974.
2. 42 U.S.C. §1396a(a)(30) (2009).
3. 42 U.S.C. §1396a(a)(8) as revised by the Patient Protection and Affordable Care Act §2304.
4. 538 U.S. 644 (2003).