Medicaid Payment Rate Lawsuits:
Evolving Court Views Mean Uncertain Future for Medi-Cal

California HealthCare Foundation

Introduction

Between April 2008 and April 2009, five lawsuits[1] were filed against the State of California to stop scheduled reductions (to rehabilitation providers, non-emergency medical transportation providers, pharmacies, physicians, and emergency physicians) in Medi-Cal payment rates. These legal challenges reflect California's generally low payment rates: In the case of physician payments, for example, California ranked 47th of 50 Medicaid programs in 2008.[2] Relying on various state and federal law claims, all the lawsuits shared a common legal theory: that the Medi-Cal provider payment rate cuts violated the federal Medicaid "equal access" statute. This statutory provision requires that Medicaid provider payments "be 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."[3]

These lawsuits are among the latest in a long line of legal actions brought in California and elsewhere that challenge low or reduced Medicaid provider payment rates. Together, these cases shine a light on one of Medicaid's great policy dilemmas: low compensation rates that deter provider participation[4] and place significant financial strains on providers that participate extensively in the Medicaid program and thus depend on it for survival. For financially strapped states, limiting or cutting provider payments is often more appealing than directly reducing eligibility or benefits. But persistently low payments can depress access to health care and can result in a shift to more expensive care settings, such as hospital emergency departments.

Some of the Medicaid equal access court challenges have succeeded, while others have not.[5] This issue brief explores the evolution of these Medicaid lawsuits and the lessons they provide for the future of Medi-Cal rate setting, as well as their implications for the direction of equal access litigation. This brief's primary focus is on the Medi-Cal equal access cases, which have proved to be important not only in California but also in other jurisdictions as a result of their influence on other court decisions.

These cases illustrate how evolving judicial philosophy, culminating with the United States Supreme Court's 2002 decision in *Gonzaga University v. Doe,*[6] has limited the ability of private litigants to claim a violation of federal rights under Medicaid's equal access statute. However, these cases also demonstrate that even as rights-based legal theories have failed in recent years in an equal access context, at least one federal appeals court — the large, influential Ninth Circuit — has allowed equal access lawsuits to proceed under a longstanding legal theory that permits private individuals to challenge government actions that contravene federal laws and thus violate the Supremacy Clause of the United States Constitution.[7] Using this Supremacy Clause approach, a number of private Medi-Cal litigants have succeeded in getting their post-*Gonzaga* claims heard in courts within the Ninth Circuit.

In June 2009, the United States Supreme Court rejected the State of California's petition to overturn the decision of the United States Court of Appeals for the Ninth Circuit in *Independent Living Center of Southern California (ILC) v.*

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Shewry, which had extended the Supremacy Clause theory to Medicaid equal access claims. The Supreme Court can reject a review petition for many reasons, which the court in this, as in most cases, did not disclose. But a decision by the Supreme Court not to hear a significant case such as *ILC v. Shewry* can be expected to add weight to the Ninth Circuit's reasoning on this issue, as other federal trial and appeals courts consider similar claims. A consequence of the *ILC v. Shewry* decision is that while most private legal challenges to Medi-Cal rate cuts in the wake of *Gonzaga* have been be subject to rapid dismissal by the courts, the approach endorsed in *ILC v. Shewry* has breathed new life into private Medi-Cal rate litigation.

At the same time, the longer-term implications of a Supremacy Clause approach to the private enforcement of federal Medicaid claims are less clear. Unlike cases based on the concept of a rights violation by state agencies, federal law does not provide for attorneys fees in Supremacy Clause cases. This inability to seek attorney fee compensation under claims based on the Supremacy Clause may make it less likely that beneficiaries and some provider groups will be able or willing to mount legal challenges, ultimately affecting both the number and substance of the cases filed. Furthermore, while the *ILC v. Shewry* decision has been given a boost by the Supreme Court's refusal to review it, federal appeals courts in other circuits are not required to follow the *ILC v. Shewry* opinion's reasoning and may decide the issue in a contrary manner, leaving the ultimate fate of Supremacy Clause challenges to Medicaid rate setting for the Supreme Court to resolve at a later date.

The brief discusses these cases and developments, and their implications, in four sections:

- The first section provides an overview of federal Medicaid law as it relates to provider payments, with a special focus on a particular provision known as the equal access statute, and describes the role of state law in Medicaid provider payment cases.
- The section "Enforcing Federal Medicaid Requirements" examines mechanisms for enforcing state agency obligations under federal Medicaid law, including enforcement by the United States Department of Health and Human Services and court actions by private litigants, including both providers and beneficiaries. It also discusses how private enforcement actions by beneficiaries and providers have been made more difficult in recent years by changing legal doctrine.
- The section "Analysis of Medicaid Provider Payment Litigation in California" summarizes the principal Medi-Cal provider payment equal access cases that have resulted in federal judicial decisions since 1990.
- The brief concludes with a discussion of the implications of these cases for health care access, quality, and efficiency.

Overview of Medicaid Law

Underlying the history of Medicaid provider payment litigation is federal Medicaid law itself. The Medicaid program rests on a statute of enormous breadth and complexity that in many respects lacks detailed guidance for how states should administer their programs. In the case of provider payments, the Centers for Medicare and Medicaid Services (CMS),[8] the federal agency that administers Medicaid, has issued only limited guidelines regarding procedures that states should use to set rates. As a result, over the years courts have played a central role in defining the provisions of federal Medicaid law that relate to provider payment.

Federal Medicaid Law and Provider Payment Rates

Medicaid, which entitles eligible individuals to publicly financed health insurance, is the largest of all federal means-tested programs and the largest program of direct financial transfers to state governments. In fiscal year 2007, Medicaid expenditures nationally totaled $320 billion, with an overall federal contribution rate of

nearly 57 percent;[9] in December 2006, 42 million people were enrolled in Medicaid, including 6.3 million enrolled in Medi-Cal.

Medicaid participation obligates a state to comply with federal law, which covers virtually all aspects of program administration, including eligibility, enrollment, coverage, provider certification and payment, and program management standards. In the area of provider payment, federal law:

- Sets minimum payment standards and methodologies for federally qualified health centers and rural health clinics,[10] as well as for hospitals (known as DSH facilities) that serve a disproportionate share of low-income patients with special needs.[11]
- Requires a transparent, public process in the setting of payment rates for certain facility services, including for hospitals, nursing facilities, intermediate care facilities, and DSH facilities.[12]
- Contains certain broad requirements that have been applied in provider payment cases, including "statewideness"[13] and "comparability,"[14] which (respectively) require that medical assistance benefits be available throughout the state and to all eligible persons. Federal law also mandates that medical assistance benefits be furnished with "reasonable promptness,"[15] which has been interpreted by some courts as requiring not only prompt coverage but also prompt access to health care itself.[16] In addition, federal law imposes on state Medicaid programs a general fiduciary obligation to operate in the "best interests" of program recipients.[17]
- Requires state Medicaid agencies to meet specific payment standards that relate to access, efficiency, and quality. This provision is often referred to as the "equal access" statute (see below).[18]

Medicaid's "Equal Access" Statute

Medicaid's "equal access" statute has played a particularly important role in Medicaid provider payment cases. The concept of provider payments sufficient to assure access, quality, and efficiency has been basic to Medicaid since the law's 1965 enactment, consistent with the program's original purpose to promote access to "mainstream" health care. Indeed, equal access language was contained in the earliest statements of federal Medicaid payment policies,[19] which ultimately were incorporated into formal program regulations[20] mandating the establishment of provider rates that:

> … 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.[21]

In 1989, Congress imported this rule directly into the Social Security Act at §1902(a)(30)(A),[22] emphasizing the federal government's policy regarding Medicaid's role not only in paying for health care but also in assuring access to care itself.

State Law Requirements

State laws may impose obligations on state Medicaid agency operations in addition to those mandated by federal law. For example, state laws generally impose administrative procedure rules on its public agencies, requiring that an agency's actions be reasonable and supported by evidence. Certain states, including California, also enact their own extensive laws governing Medicaid program standards, as well as agency administration requirements. These state laws can act independently of federal Medicaid law to create additional obligations on state agencies. For example, while federal law establishes no specific Medicaid rate-setting methodology for state Medicaid programs, a state legislature has the authority to require its agency to use

a specific substantive approach to rate-setting, as long as that approach does not contravene federal requirements.

Where state laws are implicated in Medicaid provider payment cases, a lawsuit can be brought that challenges agency actions based on state law alone. For example, in *California Medical Association v. Shewry,*[23] filed in 2008, the California Medical Association focused its claims on whether the Medi-Cal program had adhered to state Medicaid law governing provider payments and administrative procedures.

Enforcing Federal Medicaid Requirements

Federal Agency Enforcement

Medicaid is administered by CMS, within the United States Department of Health and Human Services (HHS). In addition to setting broad federal Medicaid policies through regulations and informal guidance, the HHS Secretary is given broad authority to review state Medicaid plans and program administration practices and to withhold federal funding, terminate program participation rights, or take other steps if a state plan or program is determined to be out of compliance with federal law.[24]

In practice, federal agency oversight and action primarily has been focused on restricting state payments to providers, while enforcement of beneficiary safeguards has been relatively limited.[25] Furthermore, the courts have done little during this time to direct agency enforcement of beneficiary access. Under broad principles of administrative law, courts defer to a federal agency charged with program enforcement, allowing the agency considerable leeway in interpreting and applying the law.[26] This high level of deference to federal agencies is the result of a landmark decision by the United States Supreme Court, *Chevron U.S.A. v. Natural Resources Defense Council,* which established the modern judicial deference standard.[27] Under *Chevron,* a court may overturn an agency action only when the "agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise."[28]

Under this judicial deference doctrine, if HHS decides not to enforce the access dimensions of the federal equal access statute, the courts are not likely to intervene even where payment reductions are deep, because of judicial reticence over forcing agency officials to take affirmative steps. In other words, courts are more likely to stop an agency action than to require an action. In the equal access context, the *Chevron* deference standard has meant that even when there is no evidence that HHS considered the access impact of a provider rate cut, federal courts will not interfere with the agency's rate reduction — ordered for reasons of "efficiency" — even where that cut affects essential health services to medically underserved populations.[29]

Private Enforcement

Given Medicaid's size and importance, as well as the historically limited direct role of HHS in enforcing the law's equal access requirements, private legal actions by beneficiaries and providers have been a significant feature of the Medicaid program virtually since its enactment.[30] But private Medicaid litigants have faced major hurdles in getting their cases into federal court and keeping them there.

To begin with, laws restricting the reach of federal courts — supplemented by strong currents in judicial philosophy regarding when the courts should be accessible to individuals who believe they have been legally wronged — combine to limit the courts' willingness or ability to intervene in disputes, unless certain preconditions are satisfied.[36] Over the past two decades, these philosophical currents have worked to limit judicial recognition of individual federal rights that can be

The Medicaid Law's Ambiguity

Termed by one judge 32 years ago "an aggravated assault on the English language,"[31] the federal Medicaid statute is very large, complex, and filled with ambiguity. It is considered, by all who grapple with it, to be impervious to straightforward understanding, and provides only a limited roadmap to assist in its interpretation.[32] As a result, over the years the courts have had to play a central role in articulating the meaning of the statute's provisions and the reach of its requirements, including the circumstances under which Medicaid creates privately enforceable rights.

In contrast to the Medicaid statute, Congress has made its intentions clear with regard to private enforcement of both Medicare and the State Children's Health Insurance Program (SCHIP). On one hand, Medicare is specifically drafted as a legal entitlement,[33] and individuals are expressly given the power to enforce their claims against the government in court. On the other hand, and to the contrary, the SCHIP law explicitly states that nothing in the terms of the program is to be interpreted as conferring a legal entitlement in any individual,[34] and the states have followed this lead, refusing to use their own state law powers to create legal rights in the eligible children they assist.[35]

vindicated in court. Furthermore, even when a plaintiff succeeds in convincing a court that there is a legal right, the claim of right alone does not necessarily result in judicial victory. Instead, a court may find that although a right exists, it has not been violated in the particular case.

Thus litigation, particularly federal litigation, presents a sequence of barriers to individual plaintiffs. They first must demonstrate that a court has the authority to hear their claim.[37] They must then demonstrate that there is a right at stake, of the type that will support judicial intervention. Only then would a court reach the merits of a claim, and at this point again the court may rule against the plaintiffs. The cases in the appendix to this brief illustrate these points. For example, in its 1996 decision in *VNA v. Bullen,* the Court of Appeals for the First Circuit found that the equal access statute did indeed create enforceable rights. Following that finding, however, the court concluded that the state's Medicaid rates were in fact both lawful and lawfully set. Nearly ten years later, in the aftermath of *Gonzaga,* the Ninth Circuit ruled in *Sanchez v. Johnson* that regardless of the merits, the Medicaid equal access statute created no privately enforceable rights. Therefore, the court held, it did not matter if the plaintiffs were right on the merits of their arguments that the rate cuts at issue were unlawful. Without the ability to enforce their claims, the providers and beneficiaries in *Sanchez* went without redress.

The preliminary question of whether plaintiffs have enforceable rights is therefore fundamental to whether a court will decide a Medicaid case on its merits. In Medicaid litigation, private plaintiffs have pursued their claim of a judicially enforceable right using two basic theories:

- **Supremacy Clause.** If a state or state agency acts contrary to federal law, a plaintiff can claim that such conduct violates federal rights secured by the United States Constitution's Supremacy Clause (Article VI, paragraph 2). The Supremacy Clause provides that federal law (in this case, the Medicaid statute) takes precedence over state law (the particular state's interpretation or application of federal Medicaid law) to the extent that they conflict. In a viable Supremacy Clause claim, the federal courts imply a private plaintiff's right to challenge state conduct that violates the terms of a federal statute.[38]
- **A federal civil right.** A private plaintiff may claim that a state agency has violated a federal right secured under a federal statute. If such a federal right exists, the litigation can proceed under a special civil rights law enacted by Congress in the wake of the Civil War. This law—codified at 42 U.S.C. §1983 and thus giving rise to what are known as "Section 1983 cases"[39]—permits litigants not only to proceed against state officials but also potentially to have the state pay the plaintiffs' attorneys fees, an often crucial

consideration in gaining meaningful access to the courts.

The question of whether the federal Medicaid statute creates privately enforceable federal rights has been front and center in the federal courts for nearly 30 years. Over this time, a shifting political and social landscape has been reflected in a major shift in judicial philosophy about whether and when a federal welfare or social spending law can be said to create rights, and these cases (as discussed below and charted in the appendix to this report) have had an enormous impact on the course of federal Medicaid litigation. The most significant shift in federal judicial philosophy in this regard took place in *Gonzaga University v. Doe,* a case that also illustrates how Supreme Court decisions involving laws that bear no relationship to Medicaid nonetheless can exert extraordinary influence over the course of Medicaid litigation.

The *Gonzaga* Case: The Tide Turns Against Private Plaintiffs

A watershed case regarding private enforcement of federal laws was decided by the United States Supreme Court in 2002. In *Gonzaga University v. Doe,*[40] the Supreme Court held that a student who alleged an invasion of privacy by Gonzaga University could not sue the university under the aegis of 42 U.S.C. §1983 because the underlying law that gave rise to the suit (the Federal Education Records Privacy Act) created no federal individual "rights." The *Gonzaga* decision said that the particular law at issue merely set general federal standards—rather than individual legal rights—and thus could be enforced only through federal government intervention. Writing for the court majority, Chief Justice Rehnquist held that "anything short of an unambiguously conferred right to support a cause of action"[41] would fail to support a Section1983 claim. The fact that a plaintiff bears the burden of proving to a court that a statute "unambiguously" intended to create a right raises the barrier still higher for private plaintiffs.

Although it did not directly involve the Medicaid law, the effect of the *Gonzaga* decision has been profound on private enforcement actions regarding Medicaid provider payments. For an analysis of how *Gonzaga* affected the trajectory of private litigant Medicaid cases in California, see the section "Analysis of Medicaid Provider Payment Litigation in California," below; for a chart of the sea change in national Medicaid private enforcement actions before and after the *Gonzaga* case, see the appendix to this brief.

The Impact of Overcoming Initial Legal Barriers in Medicaid Cases

In defending their actions against private litigants, state Medicaid agencies usually argue either that there is no direct private interest that gives rise to a Supremacy Clause claim or, in cases brought under Section 1983, that the statutory provision in question creates no privately enforceable federal right. If a state defendant wins this preliminary argument, the court dismisses the case without considering the merits of the claims and the plaintiffs lose their ability at this initial stage to exert pressure on the state, through the courts, to change its policy or actions.

If, on the other hand, plaintiffs get past this initial barrier and win a Medicaid rate case on the merits, or even just prevail on substantial preliminary rulings, they may achieve a favorable outcome in one of two forms. A court may enjoin (order a halt to) the state's conduct and/or order the state to revise its actions. The California equal access cases illustrate this type of result, with trial court rulings that enjoined the state's rate cuts.

Alternatively, litigation may result in a negotiated settlement. A settlement can come after favorable preliminary rulings that establish the court's power to hear the case and the existence of enforceable rights. Or, a settlement might be reached later, when plaintiffs have won at least a portion of the merits of their claims. Early procedural wins and partial favorable rulings on the merits can encourage the two sides to negotiate a settlement, which then becomes subject to judicial enforcement.[42]

Appeals Court Decisions Add Considerable Weight

Where a case makes its way to a federal appeals court and results in a published appellate decision,[43] it takes on additional importance because the same and other appellate courts look to prior published decisions for guidance and insight in similar cases. Thus, a single published federal court of appeals opinion, particularly one that the United States Supreme Court declines to review, can affect the national judicial outlook with respect not only to the immediate subject of the decision but also to other types of cases in which the decision may be relevant.

For example, the Ninth Circuit's decision in *Sanchez v. Johnson,* the first post-*Gonzaga* case to hold that the Medicaid equal access statute creates no federally enforceable rights, has been discussed more than 40 times in subsequent federal and state court decisions, including in four other federal circuits.[44] Some of these decisions involved the equal access statute; others more broadly involved claims regarding the existence of other types of Medicaid rights (such as a right to prompt assistance in applying for benefits, and a right to reasonable coverage). Although *Sanchez* did not address these types of claims, its analysis of when Medicaid does and does not create enforceable rights generally is considered highly relevant.

If plaintiffs make it past the preliminary stages, their opportunity for a positive outcome immediately and dramatically increases, as has happened in recent cases in California (see "Analysis of Medicaid Provider Payment Litigation in California," below). In the first instance, the substantive stages of a lawsuit are usually long and drawn-out, requiring considerable effort on the part of the state agency to defend its position, which may incline the state toward finding a compromise with the plaintiffs. Also, during the lengthy litigation process, the plaintiffs — particularly if they include a well-organized provider group — may be able to influence the state legislature to encourage or enact a change in the state's position.

Moreover, once a court has ruled that the plaintiffs have a right to proceed, the court may preliminarily rule in favor of the plaintiffs on one or more of the lawsuit's substantive issues. As noted above, this can lead to the issuance of an injunction ordering a temporary halt — though in real terms, "temporary" may mean many months or years — to the state's conduct until the legality of that conduct can be more fully determined by the court. This often-lengthy period of restraint on the state's conduct frequently convinces the state to negotiate a compromise settlement with the plaintiffs. This is particularly true when a preliminary injunction issued by a federal trial court is upheld by a federal court of appeals, because the higher court's approval of the trial court's decision is an additional signal that the plaintiffs' case has merit. The time during which the state's action is halted also provides greater opportunity for the plaintiffs to influence the legislature to take up the issue directly.

This cycle of interaction between the litigants and courts, with cases traveling back and forth several times between higher and lower courts within a federal circuit, is common in Medicaid equal access cases. During this cycle, the parties usually engage in negotiation of the substantive issues, and efforts may be made by both sides to seek legislative intervention (especially in cases involving provider payments, which are subject to legislation aimed at correcting or continuing a rate cut). When neither a negotiated settlement nor legislative intervention is obtained, however, a case may continue for years, sometime under different names as the defendants and circumstances change. This was the case in *Orthepaedic Hospital v. Belshe,* discussed below. This also was the case in *ILC v. Maxwell-Jolly,*[45] a decision that came nearly a year after *ILC v. Shewry,* the Ninth Circuit decision in the same case that focused on the preliminary question of whether plaintiffs had a right to proceed at all under the Supremacy Clause, and whose holding the Supreme Court declined to review.

Analysis of Medicaid Provider Payment Litigation in California

Over the years, numerous cases, many of them originating in California, have challenged Medicaid provider payment rates. The analysis in this section focuses on those cases that have resulted in a decision by the federal appeals court for the Ninth Circuit, which covers California, Hawaii, Alaska, Washington State, Oregon, Nevada, Idaho, and Montana, and whose rulings can control the interpretation of Medicaid (Medi-Cal) law in California.[46] Together, these cases illustrate the extent to which the state has used Medi-Cal provider rate cuts as a cost containment strategy. They also reflect the evolution of federal judicial philosophy regarding Medicaid provider payment rate litigation, including the demise of Section 1983 as the means of enforcing federal Medicaid law regarding provider payment, and the ascendance of Supremacy Clause-based cases. (For a chart of equal access cases nationally that have utilized a Section 1983 federal civil rights theory to advance their claims, see this issue brief's appendix.)

1. *CLARK V. KIZER*[47] (1990)

Considered one of the most important provider payment cases ever brought, *Clark v. Kizer* was initially filed in 1987 and resulted in at least nine separate court rulings, both published and unpublished, some procedural and some on the substance of the litigation itself.[48] The case involved a challenge to the state's low Medi-Cal dental fees and led to extensive federal court involvement in Medi-Cal's dental payment structure over a several-year period. Predating the *Gonzaga* ruling, the decision in *Clark v. Kizer* did not question the right of plaintiffs to bring the action under Section1983. The federal trial court in *Clark v. Kizer* reached the merits of the claims, finding that "Denti-Cal dentists were being reimbursed at rates 50 percent below their actual cost of providing services, that only half of the dentists in California had treated any Denti-Cal patients, that only 12.5 percent of dentists would accept any such new patients, and that Denti-Cal patients faced great difficulty in obtaining dental treatment under the program."[49] At the same time, in practical terms the case was significantly less than a full victory for the plaintiffs: In its appellate review, the Ninth Circuit permitted the state to test a far lower payment level than that sought by the plaintiffs, on the ground that the state needed time and discretion to determine how high the payments should be in order to provide a reasonable level of access.

2. *ORTHOPAEDIC HOSPITAL V. BELSHE*[50] (1997)

As in *Clark v. Kizer,* the private plaintiffs in *Orthopaedic Hospital* brought a case under Section 1983 and survived the preliminary procedural hurdles, so that the case was decided on its merits. The focus of the action was whether state Medi-Cal payments met federal requirements related to access, efficiency, and quality. Brought by a hospital and the California Hospital Association, the lawsuit challenged the state's hospital outpatient payment rate structure as violating its rights under federal Medicaid law. Coming on the heels of *Wilder v. Virginia Hospital Association,*[51] the leading United States Supreme Court case establishing Section 1983 enforceability of Medicaid rights,[52] a 1992 unpublished district court decision in the *Orthopaedic Hospital* case presumed enforceable rights without discussion.[53] The case ultimately led to a 1997 appeals court decision, with ongoing judicial involvement in the intervening years over both the methods for setting rates and the actual rates that would be paid to hospitals for outpatient services. In its 1997 opinion, the Ninth Circuit reaffirmed the ruling of the trial court that a state violates the federal rights of plaintiff hospital outpatient care providers when payment rates are set arbitrarily, without a sufficient evidentiary basis, without consideration of hospitals' actual costs, and without rate studies. The strength of the Court of Appeals' reasoning is evidenced by how widely the decision has been cited by other federal appeals courts, which have discussed the ruling at length over the years.[54]

3. *SANCHEZ V. JOHNSON*[55] (2005)

Adhering to the restrictive stance taken by the Supreme Court in *Gonzaga* regarding what constitutes a viable federal "rights" claim for purposes of Section 1983 litigation, the plaintiffs in *Sanchez* lost their Section 1983 claims at a preliminary stage, never reaching the question of whether the Medi-Cal payment rates violated federal equal access law. *Sanchez* involved claims by persons with disabilities and their home health care providers; the plaintiffs alleged that low payments affected, among other matters, their right to equal access to care.

The lengthy and detailed *Sanchez* decision offered a scholarly review of the history of equal access cases before and after *Gonzaga.* Reviewing the Medicaid statute, the Court of Appeals wrote at some length in an effort to distinguish the concept of federal requirements from federal rights. In analyzing the Medicaid statute's Section 1902(a)(30)(A), the court noted that there is nothing that:

> … unmistakably focuses on recipients or providers as individuals. Moreover, the flexible administrative standards embodied in the statute do not reflect a Congressional intent to provide a private remedy for their violation. … Under §30(A) providers are to be 'enlisted' as subordinate partners in the administration of Medicaid services. They may certainly benefit from their relationship with the State, but they are at best indirect beneficiaries, and it would strain common sense to read §30(A) as creating a right enforceable by them. … [Section] 30(A) is concerned with a number of competing interests. … The most efficient and economical system of providing care may be one that benefits taxpayers to the detriment of medical providers and recipients; likewise, the provision of 'quality' care — whatever standard may be implied by such a nebulous term — is likely to conflict with the goals of efficiency and economy. The tension between these statutory objectives supports the conclusion that §30(A) is concerned with overall methodology rather than conferring individually enforceable rights on individual Medicaid recipients.[56]

The thoroughly reasoned *Sanchez* decision, from a court of appeals known for its liberal leanings, has had a wide impact on subsequent Medicaid rate payment litigation; as previously noted, the decision has been either cited or discussed in more than 40 subsequent federal and state court actions, and continues to be a benchmark ruling — creating a formidable barrier for private plaintiffs seeking to pursue a Section 1983 claim — in challenges to state payment rate-setting.

4. *CLAYWORTH V. BONTA*[57] (2005)

Following closely on the heels of *Sanchez, Clayworth* involved equal access claims by a disabled beneficiary and her providers. These claims were summarily dismissed by the court since, as in *Sanchez,* the plaintiffs had relied on Section 1983 to enforce a federal right that the court determined did not exist.

5. *INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA V. SHEWRY*[58] (2008)

As with *Sanchez* and *Clayworth, ILC v. Shewry* involved a challenge by a health care provider who alleged, among other matters, that a state Medi-Cal rate cut resulted in payment levels that violated the Medicaid equal access statute. Unlike those two earlier decisions, however, the plaintiffs in *ILC v. Shewry* avoided dismissal of their case at the preliminary litigation stage by framing it not as a Section 1983 action based on a violation of federal rights but instead as a Supremacy Clause action based on the impact on them resulting from a violation of federal law. This switch in the legal theory of private enforceability — away from the concept of rights and toward the well-established theory of standing to challenge state conduct on federal Constitutional grounds — allowed plaintiffs to reach the merits of their claims. An injunction was imposed in the fall of 2008, preventing implementation of the rate cut, and remains in place.

6. *Managed Pharmacy Care v. Maxwell-Jolly*[59] (2009)

Following the lead set in *Orthopaedic Hospital* and *ILC v. Shewry,* a federal trial court in 2009 enjoined the implementation of 2008 California legislation revising earlier rate cuts and reducing pharmacy payments by 5 percent. This reduction had replaced earlier legislation making 10 percent cuts in pharmacy payments, which had been partially enjoined in *ILC v. Shewry.* That is, in the wake of the *ILC v. Shewry* injunction, the legislature enacted a smaller rate cut, which set off a new round of litigation by the same providers who had been plaintiffs in the *ILC v. Shewry* case. Finding once again that plaintiffs had standing to bring a Supremacy Clause claim, the court now concluded that while the new rate reduction was smaller, it nonetheless still violated the principles set forth in *Orthopaedic Hospital,* in particular that rates must reflect the costs of efficiently operated health care providers and may not be set arbitrarily. The court paid particular attention to the fact that the legislation in question containing the 5 percent cut:

> Was introduced… as a hazardous material bill and was amended several times as solely a hazardous material bill. However, on September 15, 2008, the bill was amended in the Senate so as to be at once turned into a trailer bill, on so many different subjects.… All without any public hearings or any hearing by any committee of the legislature; was passed shortly before midnight of the same day… was sent to the Assembly and was immediately passed by the Assembly… all within the space of a few hours.[60]

The state claimed that in fact it had completed the level of analysis required in *Orthopaedic Hospital,* but the analysis occurred six months after passage and was thus, in the court's view, insufficient. The crucial problem, in the court's opinion, was that the 5 percent reduction had been enacted arbitrarily (that is, not based on evidence), and allowed the state agency no room to modify the rate cut depending on the outcome of its later analyses.

7. *Independent Living Center (ILC) of Southern California v. Maxwell-Jolly*[61] (2009)

This case, a follow-on to *ILC v. Shewry,* reached the actual merits of the state's payment reductions. Relying on *Orthpaedic Hospital,* the Ninth Circuit upheld an injunction against the rate cuts originally imposed by the trial court in 2008, after its original dismissal of plaintiffs' claims was rejected in *ILC v. Shewry* and the case was remanded to the lower court for a trial on the merits. In *ILC v. Maxwell-Jolly,* the appeals court found a clear violation of the rate-setting requirements that it had articulated in *Orthopaedic Hospital* more than a decade earlier. The state challenged this earlier decision as an incorrect interpretation of the substantive and procedural requirements imposed on states under §1902(a)(30)(A). The court rejected this position, reaffirming its earlier holding that while federal Medicaid law vests states with considerable discretion over Medicaid payment rates, there must be responsible cost studies that consider the impact of rates on efficiency, quality, and access to care.

Implications

The seven Medi-Cal provider rate reduction cases discussed in the previous section, along with the equal access cases from all federal circuits presented in the appendix to this report, illustrate two different, significant elements of federal Medicaid litigation: first, the power of the federal courts to intervene in matters of state Medicaid program operations, and the effect of disparate court rulings on Medicaid operations nationally; and second, the challenges that face private litigants in mounting a claim against a state Medicaid program.

The Impact of Federal Litigation on Medicaid Programs

The fact that only a small number of federal court opinions directly address the meaning of the Medicaid equal access statute belies their importance. Each federal court challenge to state Medicaid agency action may become a major event in its own right. That is because if plaintiffs succeed with their legal challenge, a court may halt payment reductions — statewide — for years to

come. Also, the significant possibility of federal judicial intervention regarding Medicaid provider payments may prompt a state's legislative and executive branches to closely adhere to federal substantive and procedural legal requirements in setting rates. This means engaging in careful cost studies to determine whether the level of payment for different provider classes can be considered efficient, as well as an assessment of the likely implications of such rates on access and quality.

The threat of litigation is by no means a comprehensive fail-safe mechanism, however, for several reasons. Because mounting and negotiating the complex lawsuit process by private litigants requires enormous skill and considerable resources, in any given rate-setting situation, state legislatures and agencies might not be concerned that there will be sufficiently organized and funded opposition to that particular rate. Or, the state might believe that by the time a court actually decides a case, the immediate crisis may be past. A state might also count on convincing a court, as in *Clark v. Kizer,* not to order immediate relief from low payment rates, and that ultimately the slow course of litigation will effectively wear away opposition to the cuts.

The Medicaid provider payment cases also underscore the extent to which judicial decisions that involve unrelated laws can have an enormous impact on the course of Medicaid litigation. This is evident in *Gonzaga,* for example, the leading case governing Section 1983 litigation, which involved an education statute. Despite the fact that it had no direct connection with Medicaid, the Supreme Court's clarification in that case of when statutes can be said to create federal rights ultimately led to the state's victory in *Sanchez* and in other Medicaid rate cases that followed.

The Shift in Legal Theories

California has seen an uncommonly large number of legal challenges regarding provider payment rates, a testament perhaps to the low payment rates that characterize the Medi-Cal program. Two cases from the Ninth Circuit Court of Appeals, *Orthopaedic Hospital* and *Sanchez,* are considered important nationally. Both have been cited often: in the case of *Orthopaedic Hospital,* for its analysis of substantive Medicaid requirements related to provider rate-setting; and in the case of *Sanchez,* for its analysis of when federal Medicaid law can be said to create substantive rights for Section 1983 enforcement purposes. With the Supreme Court's decision not to review *ILC v. Shewry,* that case, too, is likely to become prominent, with other courts paying close attention to its analysis of Supremacy Clause claims involving possible violations of federal Medicaid law. As it takes on national

Loss of Section 1983 Claims Eliminates Some Plaintiffs

The replacement of Section 1983 legal claims with Supremacy Clause claims is not an even trade-off for plaintiffs. Under Section 1983, a plaintiff that prevails in a lawsuit may be awarded — that is, may have the court order the state to pay — all of the plaintiff's legal fees. This makes it possible for plaintiffs who do not have large resources (such as Medi-Cal beneficiaries and small provider groups) to enlist a legal team to litigate a complicated equal access lawsuit on a contingency basis, without having to provide a large attorney fee retainer in advance, and without obligating themselves to pay huge fees if the case does not succeed.

Such attorney fee awards are not available, however, in cases litigated under a Supremacy Clause theory. This means that some parties significantly affected by a provider rate cut may not be able to mount a legal challenge even though they have a valid complaint and a legal theory (the Supremacy Clause) that would allow it to be heard in court. Although there may be a well-organized and sufficiently-financed statewide provider organization to mount a legal challenge in some rate-setting situations, that is not always the case. Also, in some cases the interests of certain providers who are able to prosecute a lawsuit may not be identical with the interests of other providers, or with the beneficiaries they serve.

judicial attention, *ILC v. Shewry* may breathe new life into Medicaid equal access claims, whose viability after *Gonzaga* has diminished, as the cases in the appendix illustrate. To the extent that courts are willing to accept the Supremacy Clause theory in Medicaid challenges, this may indicate their concern that courts maintain some degree of oversight over major governmental actions with ramifications for large populations, such as Medi-Cal rate-setting efforts by legislatures overwhelmed with the need to reduce spending.

These recent provider rate cases from California may send an important message nationally: Despite the elimination of Section 1983 challenges, when provider payment levels are set or reduced, private plaintiffs around the nation may still have access to courts to challenge the process by which rate-setting takes place, in order to assure that federal requirements are met. According to these recent California federal cases, the Medicaid statute provides significant discretion to a state Medicaid agency to undertake rate-setting, but it must do so transparently and based upon evidence, so that the resulting payment rates accurately reflect the costs of efficient providers.

An Uncertain Future for Medicaid Legal Challenges

At least for the immediate future, the Supremacy Clause theory remains a viable lifeline for private plaintiffs—providers and beneficiaries—who seek to legally challenge Medi-Cal provider payment rates. However, another significant legal issue remains uncertain: the meaning of Medicaid's equal access statute. The Ninth Circuit views this portion of the Medicaid law as imposing substantive and procedural requirements on state programs. And while its decision in *ILC v. Maxwell-Jolly* suggests that other circuits agree on these points, the actual provisions of the statute are hardly a model of clarity.

In response to the vagueness of the statute's language, which opens the possibility of conflicting judicial interpretations, Congress could amend the statute to more explicitly direct HHS to take specific steps to enforce the equal access law. Congress could, for example, require the development of specific "availability" standards to guide rate determinations. Or, lawmakers could require that HHS make specific findings of fact regarding the effects of rates on access before a state may be permitted either to increase or reduce provider payment rates. Congress also could require that HHS specifically consider access when setting Medicaid provider payment-setting rules. Congress has not directed HHS to take these or any other specific standard-setting or data collection actions, however. As a result, courts continue to accord considerable deference to HHS over both its action and inaction with regard to Medicaid rate-setting by the states, and private plaintiffs continue to face a complex and difficult task in challenging those rates through litigation.

Appendix: The Impact of *Gonzaga* on Enforcement of the Medicaid Equal Access Statute

Over the past twenty years, there has been a considerable shift in judicial philosophy away from recognizing various provisions of federal Medicaid law as creating private rights enforceable in the courts under a Section 1983 cause of action. A review of federal court of appeals decisions involving the Medicaid "equal access" statute [42 U.S.C. §1396a(a)(30)(A)], beginning with the United States Supreme Court's decision in *Wilder v. Virginia Hospital Association* (1990), shows the impact of the Supreme Court's opinion in *Gonzaga University v. Doe*, 576 U.S.273 (2002), on courts' willingness to consider the Medicaid equal access statute as establishing federal rights enforceable under Section 1983. When a court permits a private plaintiff to proceed under a Section 1983 theory, it not only allows the case to proceed to its merits but also makes possible the recovery of attorney fees — a crucial element in permitting low-income beneficiaries or small-scale providers to mount a legal challenge. In eight of ten cases decided prior to *Gonzaga,* the federal circuit courts that considered the issue found that providers and beneficiaries had enforceable rights under the Medicaid law. Following *Gonzaga,* the federal circuit courts moved away from this view, in all but one of nine cases holding that the Medicaid equal access statute does not create such rights.

Section 1983 Decisions Before *Gonzaga University v. Doe*

CASE	NATURE OF LEGAL CHALLENGE	WAS SECTION 1983 CLAIM PERMITTED?*
1. *Clark v. Kizer,* 758 F.Supp. 572 (E.D.Cal. 1990); aff'd in part, rev'd in part, *Clark v. Coye,* 967 F.2d 585 (9th Cir. 1992)	Providers and beneficiaries in California challenged dental payment rates.	Yes
2. *Arkansas Medical Society v. Reynolds,* 6 F.3d 519 (8th Cir. 1993)	Providers, beneficiaries, and professional organizations challenged a payment rate reduction by Arkansas for certain non-institutional services.	Yes
3. *Methodist Hospital v. Sullivan,* 91 F.3d 1026 (7th Cir. 1996)	Physicians and hospitals challenged Indiana rate-setting methodology.	Yes
4. *VNA v. Bullen,* 93 F.3d 997 (1st Cir. 1996)	Providers challenged Massachusetts rate-setting methodology.	Yes
5. *Orthopaedic Hospital v. Belshe,* 103 F.3d 1491 (9th Cir. 1997); cert. den., *Belshe v. Orthopaedic Hospital,* 522 U.S. 1044 (1998)	Hospitals challenged the reasonableness of California's hospital outpatient rate-setting methodology.	Yes
6. *Minnesota Home Care Association v. Gomez,* 108 F.3d 917 (8th Cir. 1997)	Minnesota home care providers challenged the state's rate-setting methodology.	Yes
7. *Rite Aid v. Houston,* 171 F.3d 842 (3rd Cir. 1999)	Pharmacy company and association challenged Pennsylvania pharmacy and dispensing fee rate-setting.	Yes
8. *Evergreen Presbyterian Ministries v. Hood,* 235 F.3d 908 (5th Cir. 2000) (reh. and reh. en banc den. 2001)	Health care providers and beneficiaries in Louisiana challenged a provider rate reduction.	Yes (for beneficiaries only)
9. *Walgreen v. Hood,* 275 F.3d 475 (5th Cir. 2001)	Pharmacy challenged Louisiana reimbursement methodology used for chain pharmacies.	No
10. *Pennsylvania Pharmacist Association v. Houston,* 283 F.3d 521 (3d Cir. 2002)	Pharmacy and pharmacy trade association challenged Pennsylvania rate-setting methodology.	No

*Was private enforceability of the Medicaid equal access statute [42 U.S.C. §1396a(a)(30)(A)] permitted as a Section 1983 "right"?

Section 1983 Decisions After *Gonzaga University v. Doe*

CASE	NATURE OF LEGAL CHALLENGE	WAS SECTION 1983 CLAIM PERMITTED?
11. *Longterm Care Pharmacy Alliance v. Ferguson,* 362 F.3d 50 (1st Cir. 2004)	Pharmacy trade association furnishing drugs to nursing home patients challenged Rhode Island rate reduction.	No
12. *Sanchez v. Johnson,* 416 F.3d 1051 (9th Cir. 2005)	Beneficiaries and providers of community-based services challenged payment rates for home and community-based services in California.	No
13. *Clayworth v. Bonta* (unpublished), 140 Fed. Appx. 677 (9th Cir. 2005)	Beneficiaries and providers in California challenged provider rate reductions.	No
14. *Pediatric Specialty Care v. Arkansas Dept. of Human Services,* 443 F.3d 1005 (8th Cir. 2006), cert. den., 549 U.S. 1205 (2007)	Beneficiaries and providers challenged Arkansas rate reductions as part of budget cutbacks in state EPSDT benefits.	Yes
15. *Westside Mothers v. Olszewski,* 454 F.3d 532 (6th Cir. 2006); cert. den., *Haveman v. Westside Mothers,* 537 U.S. 1045 (2002)	Welfare rights organization challenged accessibility of Michigan's EPSDT services, including claim that equal access provision was violated.	No
16. *Mandy R. v. Owens,* 464 F.3d 1139 (10th Cir. 2006); cert. den., *Mandy R. ex rel. Mr. and Mrs. R. v. Ritter,* 549 U.S. 1305 (2007)	Beneficiaries and providers challenged access to home and community services and sufficiency of Colorado's payment rates for such services (equal access claim raised only by provider association).	No
17. *Oklahoma Chapter of American Academy of Pediatrics (OKAAP) v. Fogarty,* 472 F.3d 1208 (10th Cir. 2007); cert. den., *OKAAP v. Fogarty,* 128 S.Ct. 68 (2008)	Beneficiaries and providers claimed that Oklahoma EPSDT services were not accessible, raising violation of the equal access statute.	No
18. *Equal Access for El Paso v. Hawkins,* 509 F.3d 697 (5th Cir. 2007); cert. den., 129 S.Ct. 34 (2008)	Beneficiaries and providers challenged Texas Medicaid reimbursement rates.	No
19. *Ball v. Rogers,* 492 F.3d 1094 (9th Cir. 2007)	Beneficiaries challenged the accessibility of community-based long term care services as violating numerous provisions, including equal access statute.	No

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Endnotes

1. *Centinela Freeman Emergency Medical Association v. Shewry,* No. BC406372 (Sup. Ct. Cal., L.A. County) (filed January 27, 2009); *Managed Pharmacy Care v. Maxwell-Jolly,* 603 F.Supp.2d 1230 (C.D. Cal. 2009) (filed January 16, 2009); *California Pharmacists Association v. Maxwell-Jolly,* 563 F.3d 847 (9th Cir. 2009) (filed April 6, 2009); *California Medical Association v. Shewry,* No. BC390126 (Sup. Ct. Cal. L.A. Cty) (filed July 16, 2008); and *Independent Living Center of Southern California (ILC) v. Shewry,* 543 F.3d 1050 (9th Cir. 2008) (filed April 22, 2008); cert. den. *Maxwell-Jolly v. Independent Living Center of Southern California,* 129 S. Ct. 2828 (2009). In July 2009, the Ninth Circuit reached the merits of the *ILC* case, rejecting the state's claims that its analysis of the impact of the rate reductions met federal requirements. *ILC v. Maxwell-Jolly,* 572 F.3d 644 (2009). In August 2009, the Court of Appeals issued an unpublished opinion, *ILC v. Maxwell-Jolly* (No. 08-57016, August 7) extending its reasoning to non-emergency transportation and home health care providers. See also, *Mission Hospital Regional Medical Center v. Shewry,* 168 Cal.App.4th 460 (Cal. Ct. App. 2008) (filed July 13, 2007), a Medi-Cal rate case involving 2004 – 2005 payments which, in striking down the state's payment rate for non-contract hospitals, relied on the Ninth Circuit's decision in *ILC v. Shewry.* See also "California Court Halts Some Medicaid Cuts," *Amednews* (April 13, 2009), American Medical Association, **www.ama-assn.org/amednews/2009/04/13/gvsc0413.htm**. On September 10, 2009, the United States District Court for the Northern District of California (Oakland Division) preliminarily enjoined funding cuts (number of covered days, rather than rates) in the Medi-Cal Adult Day Health Care program. *Brantley v Maxwell-Jolly* 2009 WL 2941519 (N.D.Cal.). The court expressly cited *ILC v. Shewry* as a basis for enjoining the cuts.
2. Zuckerman, S., A. Williams, and K. Stockley. April 2009. "Trends in Medicaid Physician Fees, 2003–2009," *Health Affairs Web Exclusive* 28 (3); w510 – w519 (published online 28 April, 2009); S. Zuckerman, A. Williams, and K. Stockley. 2009. *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare.* California Health Care Foundation, **www.chcf.org/topics/medi-cal/index.cfm?itemID=133926**.
3. 42 U.S.C. §1396a(a)(30)(A).
4. Cunningham, P. and J. May. *Medicaid Patients Increasingly Concentrated Among Physicians.* August 2006. Center for Studying Health Systems Change (Tracking Brief #16), **www.hschange.com/CONTENT/866/#ib1**.
5. See the appendix, which reviews federal appeals court cases that have considered state Medicaid agency provider payment actions over the years.
6. 576 U.S. 273 (2002).
7. Bobroff, R. Fall 2008. "Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes." 10 *Loy. J. Pub. Int. L.* 27.
8. An agency of the United States Department of Health and Human Services.

9. Kaiser Family Foundation, **statehealthfacts.org/comparemaptable.jsp?ind=636&cat=4** (accessed April 20, 2009).

10. 42 U.S.C. §1396bb.

11. 42 U.S.C. §§1396a(a)(13)(A) and 1396r-4.

12. 42 U.S.C. §1396a(a)(13)(A).

13. 42 U.S.C. §1396a(a)(1).

14. 42 U.S.C. §1396a(a)(10).

15. 42 U.S.C. §1396a(a)(8).

16. Certain federal circuits recognize the "reasonable promptness" requirement as one that relates to services themselves, not merely to payment for services. Others — reflecting the variation in how federal circuits may interpret and apply the same law — have ruled that the reasonable promptness statute applies only to payment for services. Compare, e.g., *Sabree v. Richman* 367 F.3d 180 (3rd Cir. 2004) (finding that the reasonable promptness statute reaches access to care) with *Westside Mothers v. Olszewski,* 454 F.3d 532 (6th Cir. 2006) (statutory rights are limited to payment for services, not access to care).

17. 42 U.S.C. §1396a(a)(19).

18. 42 U.S.C. §1396a(a)(30)(A).

19. Social and Rehabilitation Services. 1966. *Handbook of Public Assistance (Supplement D).*

20. 42 C.F.R. §447.204 (1989). The regulation was recodified in 1979 but had existed as a formal part of the Medicaid regulatory fabric since soon after Medicaid's enactment.

21. Ibid.

22. 42 U.S.C. §1396a(a)(30)(A).

23. Cal. Super. Ct., No. BC390126 (July 29, 2008) (147 HCDR, July 31, 2008).

24. See, e.g., *Alaska Department of Health and Social Services v. Centers for Medicare and Medicaid Services,* 424 F.3d 931 (9th Cir. 2005).

25. See *Alaska Department,* note 24. See also *Iowa v. Centers for Medicare and Medicaid Services,* 2009 WL 2514148 (8th Cir. 2009). Although not an equal access case, the *Iowa* decision focuses on CMS's efforts to control Medicaid provider payments by states that seek to expand access to certain types of services, in this case, brand name prescription drugs.

26. One highly unusual, much older Medicaid case, *Estate of Smith v. Heckler,* 747 F.2d 583 (10th Cir. 1984), resulted in a ruling by a federal appeals court that the Secretary had violated the law by failing to develop a comprehensive scheme for the enforcement of nursing home quality standards. The case, which was not appealed, ultimately helped lead to the landmark 1987 Medicaid nursing home reform amendments.

27. 467 U.S. 837 (1984).

28. *Alaska Department,* supra, 424 F.3d at 937–938.

29. When Alaska appealed the rate cut in the *Alaska Department* case, CMS responded that it might consider evidence related to the validity of the rate setting but never indicated that countervailing access concerns might justify a higher rate.

30. See, e.g., Stevens, R. and R. 1975. *Welfare Medicine in America: A Case Study of Medicaid.* New York: Basic Books; and R. Rosenblatt, S. Law, and S. Rosenbaum. 1997. *Law and the American Health Care System* (2001–2002 Supplement), Chapter 2. New York: Foundation Press.

31. *Friedman v. Berger,* 409 F.Supp.1225, 1225 (D.C.N.Y., 1976), aff'd 547 F.2d 724 (2d Cir. 1976).

32. Jost, T. S. *Disentitlement.* 2003. Oxford University Press; R. Rosenblatt, S. Law, and S. Rosenbaum. *Law and the American Health Care System.* 1997. New York: Foundation Press; and R. Rosenblatt, S. Rosenbaum, and D. Frankford. 2002. *Law and the American Health Care System* (2001–2002 Supplement), Chapter 2. New York: Foundation Press.

33. *Disentitlement,* supra.

34. 42 U.S.C. §1397bb.

35. *The Devolution of Authority and Public Health Insurance Design,* supra.

36. Chemerinsky, E. 2006. *Constitutional Law,* Chapter 2. New York: Aspen Publishing.

37. State constitutions and statutes govern plaintiffs' access to their state court systems. State courts can consider claims of both state and federal law.

38. See, e.g., *Pharmaceutical Research and Manufacturers of America v. Walsh,* 538 U.S. 644 (2003).

39. *Maine v. Thibotout,* 448 U.S. 1 (1980).

40. 576 U.S. 273 (2002).

41. Id., at 283.

42. See e.g., *Frew v. Hawkins,* 549 U.S. 1118 (2007), which addresses the enforceability of ongoing Medicaid settlement decrees. For an example of one of the longest-running Medicaid settlement decree litigation cases, see *Salazar v. District of Columbia,* 596 F.Supp.2d 67 (D.D.C. 2009).

43. Courts may designate their decisions as ones that will be published as significant opinions or remain in an unpublished status. Unpublished decisions can be read and searched online, but they may not be relied on by other courts, giving them far narrower significance than decisions designated for publication.

44. Westlaw. Review conducted by the author, September 4, 2009.

45. 572 F.3d 644 (9th Cir. 2009).

46. A federal circuit (appeals) court decision is binding on all of the lower federal courts in that same circuit. Additionally, state courts look to the federal circuit in which they are located when deciding a question of federal law. Thus, if the Court of Appeals for the Ninth Circuit determines that the Medi-Cal program has engaged in conduct that violates federal law, its decision binds all federal trial courts located in the Ninth Circuit and would tend to be followed by California's state courts when confronted with the same federal question.

47. 758 F.Supp. 572 (E.D.Cal. 1990); aff'd in part, rev'd in part, *Clark v. Coye,* 967 F.2d 585 (9th Cir. 1992).

48. Westlaw. Search by the author, February 28, 2009.

49. *Clark v. Coye,* 967 F.2d 585, 587 (9th Cir. 1992).

50. 103 F.3d 1491 (9th Cir. 1997); cert. den. *Belshe v. Orthopaedic Hospital,* 522 U.S. 1044 (1998).

51. 496 U.S. 498 (1990).

52. *Wilder* involved hospital claims against a state Medicaid program for violation of the so-called Boren Amendment [42 U.S.C. §1396a(a)(13)(A)]. Now repealed, the Boren Amendment specified an actual payment rate methodology for hospital services, rather than just a process. This provision was repealed by the Balanced Budget Act of 1997, which replaced it with a provision requiring a transparent rate-setting process, but no specific rate-setting methodology.

53. *Orthopaedic Hospital v. Kizer,* 1992 WL 345652 (C.D.Cal. 1992).

54. The case has been cited in at least 77 separate court opinions, most in agreement with the Ninth Circuit's reasoning. Westlaw search by the author, May 23, 2009.

55. 416 F.3d 1051 (9th Cir. 2005).

56. *Sanchez v. Johnson,* supra, 436 F.3d at 1059–1060.

57. 140 Fed.Appx. 677 (9th Cir. 2005) (unpublished).

58. 543 F.3d 1047 (9th Cir. 2008); cert. den. *Maxwell-Jolly v. ILC,* 129 S.Ct. 2828 (2009).

59. 603 F.Supp.2d 1230 (C.D.Cal. 2009).

60. 603 F.Supp.2d 1237.

61. 572 F.3d 644 (9th Cir. 2009).