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Note

Ensuring Equal Access: Rethinking Enforcement of Medicaid's Equal Access Provision

Anne M. Dwyer*

In the summer of 2009, fifty-three-year-old Carol Vliet's cancer returned with renewed ferocity.¹ With tumors metastasizing in her brain, liver, kidneys, and throat, she began yet another punishing regimen of chemotherapy and radiation.² Her world crumbling around her, she managed to find a small measure of comfort in her monthly visits with her long-time primary care doctor.³ However, this sense of security quickly vanished when her doctor informed her that he would no longer be able to see her.⁴ Her Medicaid insurance paid him so little that he could no longer afford to maintain her as a patient.⁵

Unfortunately, Carol Vliet's story is an all too common experience for Medicaid patients across the country.⁶ With the poor economy fueling explosive growth in Medicaid enrollment coupled with significant state budget shortfalls, Medicaid provider payments have become a primary target of many budget-

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1. Kevin Sack, *As Medicaid Payments Shrink, Patients Are Abandoned*, N.Y. TIMES, Mar. 15, 2010, <http://www.nytimes.com/2010/03/16/health/policy/16medicaid.html?pagewanted=all&r=0>.

2. *Id.*

3. *Id.*

4. *Id.*

5. *See id.* (stating reimbursements from Medicaid were so low that Carol Vliet's doctor was losing money every time a patient walked in his exam room).

6. *See, e.g., id.* (trying to find a physician for their two-year-old son, one parent felt like a "second-class citizen[]" after multiple doctors refused to accept their Medicaid insurance).

cutting measures.⁷ Under the equal access provision of the Medicaid Act, states are to consider the impact that provider rate changes will have on access to care.⁸ Specifically, the provision requires that payments for covered care and services “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.”⁹

Nevertheless, many states lower provider payment rates to trim state budgets without analyzing the impact payment cuts may have on the number of providers willing to accept patients with Medicaid.¹⁰ As a result of reduced provider reimbursement rates, the care and services available to Medicaid beneficiaries is often not the same as the care and services available to the general population.¹¹ This has left many of the sixty million Americans who rely on Medicaid without access to needed care.¹²

7. *See id.*; *see also* NICHOLAS JOHNSON ET AL., CTR. ON BUDGET & POLICY PRIORITIES, AN UPDATE ON STATE BUDGET CUTS: AT LEAST 46 STATES HAVE IMPOSED CUTS THAT HURT VULNERABLE RESIDENTS AND CAUSE JOB LOSS 9 (2011), *available at* <http://www.cbpp.org/cms/index.cfm?fa=view&id=1214> (finding that twenty-two states have enacted cuts in Medicaid and the Children’s Health Insurance Program, including reduced or frozen reimbursements to health care providers).

8. *See* 42 U.S.C. § 1396a(a)(30)(A) (2006) (“A State plan for medical assistance must . . . provide such methods and procedures . . . 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 . . .”).

9. *Id.*

10. *See, e.g.*, Sack, *supra* note 1 (explaining that in 2009 Michigan cut provider payments by an additional 8% to help close a large budget shortfall leading to a reduction in participating providers).

11. *See, e.g.*, Sandra L. Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, but Rising Fees May Help*, 31 HEALTH AFF. 1673, 1675 (2012) (finding that 31% of physicians were unwilling to accept any new Medicaid patients compared to 17% unwilling to accept new Medicare patients and 18% unwilling to accept new privately insured patients). One patient commented on her state-issued Medicaid insurance card, “It’s a useless piece of plastic. I can’t find an orthopedic surgeon or a pain management doctor who will accept Medicaid.” Robert Pear, *Cuts Leave Patients with Medicaid Cards, but No Specialist to See*, N.Y. TIMES, Apr. 1, 2011, <http://www.nytimes.com/2011/04/02/health/policy/02medicaid.html>.

12. *See* KAISER COMM’N ON MEDICAID & UNINSURED, KAISER FAMILY FOUND., THE MEDICAID PROGRAM AT A GLANCE 1, 2 (2012), *available at* <http://www.kff.org/medicaid/upload/7235-05.pdf> [hereinafter MEDICAID PROGRAM AT A GLANCE] (“Medicaid, the largest public health insurance program in the

Traditionally, Medicaid beneficiaries and providers have relied on the courts to enforce Medicaid's equal access provision and prevent harsh provider rate cuts.¹³ However, a number of factors—including inconsistent circuit rulings interpreting the legal requirements of Medicaid's equal access provision, inconsistent court rulings concerning whether Medicaid beneficiaries or providers are able to bring an equal access suit, and a number of other pragmatic and ethical considerations—have made it increasingly difficult and impractical to employ judicial enforcement measures to ensure equal access.¹⁴

This Note argues that because the current judicial enforcement mechanism is unable to adequately address equal access violations, the federal government must implement an alternative enforcement mechanism to ensure equal access to care for Medicaid beneficiaries. Part I provides a brief overview of the Medicaid program and the evolution of the judicial enforcement of Medicaid's equal access provision. Part II explores why the current judicial enforcement mechanism is unable to adequately address these violations. Part III recommends implementation of a federal regulatory enforcement approach supported by adequate financial assistance as an alternative means to enforce Medicaid's equal access provision. This Note concludes that a robust federal regulatory scheme is an essential component of a Medicaid system that ensures access to providers consistent with Medicaid's equal access provision.

United States, covers over 60 million low-income individuals—roughly 1 in every 5 Americans.”); see also Edward C. Wang et al., *Inequality of Access to Surgical Specialty Health Care: Why Children with Government-Funded Insurance Have Less Access than Those with Private Insurance in Southern California*, 114 PEDIATRICS e584, e584 (2004), available at <http://pediatrics.aappublications.org/content/114/5/e584.full.html> (finding that ninety-seven surgeons would offer an office appointment to a child with commercial insurance compared to only twenty-seven surgeons for a child with Medi-Cal; reasons for not offering an office appointment or surgery for a child with Medi-Cal included low monetary reimbursement); Pear, *supra* note 11 (“I have tried for more than a year to find a child psychiatrist or psychologist to get [my son] evaluated, but the mental health professionals in this area have told me they absolutely do not take Medicaid.”).

13. See Abigail R. Moncrieff, Comment, *Payments to Medicaid Doctors: Interpreting the “Equal Access” Provision*, 73 U. CHI. L. REV. 673, 677 (2006) (explaining that in attempts to enforce Medicaid's equal access provision, “providers and patients have sued state health agencies, claiming that state-set rates are legally insufficient”).

14. See *infra* Part II.

I. MEDICAID'S EQUAL ACCESS PROVISION

Medicaid's equal access provision operates within the larger framework of the Medicaid program. Accordingly, this Part first provides a brief overview of the development and structure of the Medicaid program. It then examines Medicaid's provider payment policy, its effects on provider participation, and the role of Medicaid's equal access provision in ensuring access to care. Finally, this Part explores the evolution of judicial enforcement of Medicaid's equal access provision.

A. THE MEDICAID PROGRAM

Prior to enactment of the Medicaid Act in 1965,¹⁵ America had a two-tiered, income-based healthcare system. Wealthy Americans in the top tier were cared for by private providers while the nation's poor occupied the bottom tier where their access to care was limited to emergency rooms and charitable hospitals.¹⁶

Codified as Title XIX of the Social Security Act,¹⁷ the Medicaid Act was intended to address America's separate and unequal two-tiered health care system by providing passage for many of the nation's poor and disabled into the upper tier of the health care system.¹⁸ As a result, the creation of the Medicaid program represented a fundamental philosophical shift in how the government viewed its role in caring for the health of the poor and disabled.¹⁹ It significantly expanded the government's role in financing health care and codified access by medically indigent persons to "mainstream" medical care.²⁰ At present, the four main categories of low-income individuals covered by the Medicaid program are children and their caretakers, preg-

15. Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (2006)).

16. Rosemary B. Gultinan, Note, *Enforcing a Critical Entitlement: Preemption Claims as an Alternative Way to Protect Medicaid Recipients' Access to Healthcare*, 51 B.C. L. REV. 1583, 1590 (2010); Moncrieff, *supra* note 13, at 675.

17. 79 Stat. 343.

18. Moncrieff, *supra* note 13, at 675 (citing *Medicare and Medicaid: Hearings Before the S. Comm. on Fin.*, 91st Cong. 57 (1970) (statement of Hon. John G. Veneman, Under Secretary, Dep't of Health, Educ., and Welfare)).

19. Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 9 (2006).

20. *Id.*

nant women, people with disabilities, and the elderly.²¹ In addition, under the Patient Protection and Affordable Care Act, states have the option of extending Medicaid coverage to individuals not presently eligible for the program, including childless adults.²² As a result, Medicaid enrollment is expected to increase by four to fifteen million between 2012 and 2021.²³

Medicaid is structured as a cooperative federal-state program in which the federal government provides partial financial assistance to states so that they may furnish health care to low-income individuals.²⁴ In order to participate in the Medicaid program and receive federal matching funds, a state must have a Medicaid plan that is approved by the Secretary of Health and Human Services (HHS).²⁵ The state plan must describe the scope and nature of the state's Medicaid program and comply with the requirements of the Medicaid Act.²⁶ As one of the federal government's grant-in-aid programs, enacted under Congress's Spending Clause powers, a state's receipt of federal Medicaid funds is conditioned on compliance with federal requirements.²⁷ If a state wishes to change the way its Medicaid program is administered, it must submit a state plan amendment for a determination as to whether the proposed change complies with federal requirements.²⁸ If the federal government finds that the plan does not comply with the Medicaid Act, the Secretary of HHS has the authority to abolish the state's federal Medicaid funding.²⁹

21. Guiltinan, *supra* note 16, at 1590 ("Income, immigration, and residency restrictions must also be met."); *see also* 42 U.S.C. § 1396a(a)(10)(A) (2006).

22. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001, 124 Stat. 119 (2010) (expanding Medicaid eligibility to individuals with incomes at or below 133% of the federal poverty level).

23. DELOITTE, ISSUE BRIEF: STATE MEDICAID PROGRAM MANAGEMENT UPDATE AND CONSIDERATIONS 4 (2012), *available at* http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Reform%20Issues%20Briefs/us_chs_2012StateMedicaidProgramManagement_092012.pdf.

24. *See* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990) (discussing the structure and functions of the Medicaid program).

25. ANDY SCHNEIDER ET AL., KAISER COMM'N ON MEDICAID & UNINSURED, THE MEDICAID RESOURCE BOOK 136 (2002), *available at* <http://www.kff.org/medicaid/2236-index.cfm>.

26. Guiltinan, *supra* note 16, at 1590.

27. Rosenbaum, *supra* note 19, at 10; *see also* SCHNEIDER ET AL., *supra* note 25, at 134 ("There are 63 separate federal statutory requirements that state Medicaid plans must meet.").

28. SCHNEIDER ET AL., *supra* note 25, at 136.

29. *Id.*

Although state participation in the Medicaid program is entirely voluntary, every state has chosen to participate.³⁰ Under the Medicaid Act, states are given responsibility for administering the program on a day-to-day basis within broad requirements set by the federal government.³¹ Within these broad federal guidelines, states maintain a large degree of flexibility in operating the program, including determining eligibility requirements, establishing the scope of covered benefits, and setting rates for provider reimbursement.³² As a result of this flexibility, each state has a separate and distinct Medicaid program with significantly different eligibility, benefits, and provider payment policies.³³

B. MEDICAID PROVIDER PAYMENT POLICY

State Medicaid programs vary widely; however, a basic commonality among them is their reliance on the private sector to provide care for Medicaid beneficiaries.³⁴ In procuring access to care, each state Medicaid program typically interacts with private providers in one of two ways.³⁵ Under a fee-for-service approach, the state acts as a third-party payer and purchases private-market health care on behalf of Medicaid beneficiaries.³⁶ Alternatively, under a managed care approach, the state contracts with private managed care organizations on a capitated rate basis³⁷ to provide care to Medicaid participants.³⁸ States generally have flexibility to decide whether to buy covered services on a fee-for-service or managed care basis.³⁹

30. *Id.* at 130.

31. *Id.*

32. *Id.*

33. *Id.*

34. Moncrieff, *supra* note 13, at 676.

35. The term “providers” includes individual physicians, hospitals, nursing homes, dentists, and non-physician health practitioners including nurses and psychologists. *Id.* at 674 n.8.

36. *Id.* at 676; SCHNEIDER ET AL., *supra* note 25, at 141.

37. See SCHNEIDER ET AL., *supra* note 25, at 102 (describing how fee-for-service rates are influential in setting capitation rates). Under a capitated payment system, a “physician, hospital, or other health care provider is paid a set rate for each member . . . regardless of the number or nature of services provided.” FREE DICTIONARY, <http://medical-dictionary.thefreedictionary.com/capitation> (last visited Mar. 9, 2013).

38. See SCHNEIDER ET AL., *supra* note 25, at 141–42 (describing rates payable to managed care organizations); Moncrieff, *supra* note 13, at 676 (stating that Medicaid “pays private managed care organizations (MCOs) to provide both insurance and services to Medicaid patients”).

39. SCHNEIDER ET AL., *supra* note 25, at 141.

States also have broad discretion in setting Medicaid provider payment rates.⁴⁰ Federal regulations impose upper limits on the amount state Medicaid programs can pay for certain institutional services as well as outpatient hospital and clinical services.⁴¹ There are, however, no federal requirements controlling floors on Medicaid payment rates to physicians and other individual providers.⁴²

Originally, a provision of the Medicaid Act referred to as the Boren Amendment governed states' Medicaid payments to certain institutional care facilities.⁴³ Payments to these providers had to be sufficient to cover the cost of "efficiently and economically operated facilities."⁴⁴ However, in 1997 the Boren Amendment was repealed leaving no federal floor governing payment rates to institutional providers.⁴⁵ As a result, Medicaid payment methodologies and levels vary considerably by state.⁴⁶ Nevertheless, the Medicaid Act does, through its equal access provisions, indirectly constrain states' otherwise broad discretion to set Medicaid reimbursement rates.⁴⁷

Provider participation in the Medicaid program is optional.⁴⁸ There are a variety of factors that influence provider participation in the Medicaid program, including "the administrative burden of billing Medicaid, delays in payment, capacity

40. *Id.*

41. *Id.* The institutional services include "inpatient hospital, nursing facilities, and intermediate care facilities for the mentally retarded." *Id.*; see also 42 C.F.R. § 447.1–56 (2011).

42. However, two groups of fee-for-service providers are protected by payment floors: federally-qualified health centers and hospice facilities. SCHNEIDER ET AL., *supra* note 25, at 141.

43. 42 U.S.C. § 1396a(a)(13)(A) (1994) (repealed 1997).

44. *Id.*

45. SCHNEIDER ET AL., *supra* note 25, at 141.

46. See DEBORAH BACHRACH, CTR. FOR HEALTH CARE STRATEGIES, PAYMENT REFORM: CREATING A SUSTAINABLE FUTURE FOR MEDICAID 2 (2010), available at http://www.chcs.org/usr_doc/Medicaid_Payment_Reform_Brief.pdf.

47. Citing separate access review procedures set forth in Part 438 of the Code of the Federal Regulations, the federal government takes the position that this provision does not apply to managed care arrangements. See Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, 25,343 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447).

48. Sean Jessee, Comment, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 796–98 (2009).

constraints, and high clinical burdens.”⁴⁹ However, one of the most commonly cited reasons for refraining from participation in the Medicaid program is inadequate reimbursement.⁵⁰ If providers are able to fill their schedules with higher-reimbursing privately insured patients, then they have no financial incentive to take Medicaid patients. Accordingly, because states rely on private providers to furnish care to Medicaid beneficiaries, ensuring that states adequately reimburse providers is essential to ensuring that a sufficient number of providers enroll in and accept patients from the Medicaid program.⁵¹

Acknowledging the importance of provider participation in the Medicaid program, in 1989 Congress amended the Medicaid Act in response to attempts by states to restrain provider payment rates as a way of controlling program costs.⁵² With the enactment of the equal access provision, states were required to reimburse providers at a level that promoted efficiency and

49. MEDICAID & CHIP PAYMENT & ACCESS COMM’N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP 132 (2011), available at http://healthreform.kff.org/~media/Files/KHS/docfinder/MACPAC_March2011_web.pdf [hereinafter MEDICAID & CHIP PAYMENT]; see also Steve Berman et al., *Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients*, 110 PEDIATRICS 239, 243 (2002) (finding that states with higher average concerns about Medicaid paperwork had lower pediatrician provider participation rates); Peter J. Cunningham & Ann S. O’Malley, *Do Reimbursement Delays Discourage Medicaid Participation by Physicians?*, 28 HEALTH AFF. w17, w17 (2009) (finding that payment delays and administrative burdens affect provider participation in Medicaid).

50. See Wang et al., *supra* note 12, at e586 (finding that among surgeons surveyed, 92% cited low monetary reimbursement for surgery as a reason for not offering surgery for children with Medi-Cal); see also Berman et al., *supra* note 49, at 244 (finding that low payment rates relate to low Medicaid participating by primary care office-based pediatricians); Decker, *supra* note 11, at 1676 (finding that acceptance rates of new Medicaid patients were higher in states with higher Medicaid-to-Medicare fee ratios).

51. See Wang et al., *supra* note 12, at e586 (describing how surgeons refused to take Medi-Cal patients based on low reimbursement rates).

52. A Congressional Report issued by the House Committee on the Budget noted, “As the National Governors’ Association testified before the Subcommittee on Health and the Environment . . . ‘States have restrained physician fees as one method of controlling program costs.’” H.R. REP. NO. 101-247, at 390 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2116. As a result, the report concluded that although “the Committee recognizes that payment levels are only one determinant of physician participation . . . the Committee believes that, without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program.” *Id.*

economy but also ensured quality of care and sufficient provider participation.⁵³

Nonetheless, many states reduce provider reimbursement rates in an attempt to cut Medicaid costs and decrease state budget deficits.⁵⁴ Insufficient provider reimbursement rates have led to violations of Medicaid's equal access provision. For example, one study found that of office-based primary care physicians only 65% were accepting new Medicaid patients, compared to 74% for Medicare and 88% for privately insured patients.⁵⁵ Another study found that in states with the lowest provider payment rates, only about half of primary care pediatricians are willing to serve Medicaid patients who request care.⁵⁶

Unfortunately, the adverse impact of low Medicaid provider payments has been further exacerbated by the economic crisis.⁵⁷ The recession left millions of individuals without jobs and, as a result, without their accompanying employer-based health insurance.⁵⁸ With few if any other options, many individuals turned to Medicaid for access to health care.⁵⁹ As a result, Medicaid enrollment has risen considerably since 2008.⁶⁰

In 2009, the federal government stepped in to provide states with extra federal matching funds to help cover Medicaid cost increases resulting from the large number of new enrol-

53. See 42 U.S.C. § 1396a(a)(30)(A) (2006) (requiring that payments for covered care and services "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").

54. See Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, 26,343 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447) (describing how some states are lowering payments in difficult fiscal times).

55. MEDICAID & CHIP PAYMENT, *supra* note 49, at 132.

56. Berman et al., *supra* note 49, at 243.

57. See Phil Galewitz, *State Medicaid Spending Skyrockets*, KAISER HEALTH NEWS (Oct. 27, 2011), <http://www.kaiserhealthnews.org/stories/2011/october/27/state-medicaid-spending-increase.aspx> (describing how states will have to make up for the end of stimulus money).

58. *Id.*

59. *Id.*

60. See *id.* (finding that Medicaid enrollment grew by 3% in 2008, 7.8% in 2009, and 7.2% in 2010). Between June 2010 and June 2011, an additional 2.2 million people enrolled in the Medicaid program (a 4.4% growth rate). KAISER COMM'N ON MEDICAID & UNINSURED, KAISER FAMILY FOUND., MEDICAID AND MANAGED CARE: KEY DATA, MEDICAID ENROLLMENT: JUNE 2011 DATA SNAPSHOT 1 (2012), available at <http://www.kff.org/medicaid/upload/8050-05.pdf>.

lees.⁶¹ That subsidy ended in June of 2011.⁶² With the end of increased federal Medicaid matching funds and the ongoing economic instability, many states have been left with significant budget shortfalls.⁶³

Unfortunately, Medicaid has become a primary target of many state budget-cutting measures further exacerbating the problem of low provider payment rates.⁶⁴ Federal law currently limits states' authority to cut back Medicaid enrollment.⁶⁵ Consequently, reducing provider reimbursement rates is seen as one of the main ways to reduce Medicaid costs and save state dollars.⁶⁶ In 2012, forty-five states reduced provider payment rates and forty-two states plan on further cuts in 2013.⁶⁷

C. ENFORCEMENT OF MEDICAID'S EQUAL ACCESS PROVISION

The Medicaid Act does not promulgate specific administrative procedures allowing Medicaid beneficiaries or providers to enforce the equal access provision through administrative action.⁶⁸ As a result, both Medicaid beneficiaries and providers rely on judicial enforcement via lawsuits brought against state

61. See Galewitz, *supra* note 57 (stating that federal stimulus funds provided states with an additional \$87 billion in federal funding for Medicaid).

62. *Id.*

63. *Id.*

64. See *id.* (stating that forty-six states plan on lowering provider payments); see also N.C. Aizenman, *State Spending on Medicaid up Sharply*, WASH. POST, Oct. 27, 2011, http://www.washingtonpost.com/national/health-science/state-spending-on-medicaid-up-sharply/2011/10/27/gIQAxjSNM_story.html (stating that many states have "turned to tough measures to trim Medicaid costs, such as . . . reducing payment rates to doctors and hospitals"); Tami Luhby, *Medicaid Costs Balloon for Cash-Strapped States*, CNN MONEY (Oct. 27, 2011), http://www.money.cnn.com/2011/10/27/news/economy/Medicaid_state_spending/index.htm (arguing that states "have aggressively been trying to reduce their Medicaid costs . . . especially since the stimulus and health care reform acts restricted them from cutting enrollment").

65. The 2010 health law contains a "maintenance of effort" provision, which bars states from tightening their eligibility rules for Medicaid through 2014, when Medicaid will be expanded to cover currently ineligible individuals mainly at the federal government's expense. Aizenman, *supra* note 64.

66. Galewitz, *supra* note 57; see also Luhby, *supra* note 64 (stating that slashing provider payment rates has been the most common strategy to reduce Medicaid costs).

67. VERNON K. SMITH ET AL., KAISER COMM'N ON MEDICAID & UNINSURED, MEDICAID TODAY; PREPARING FOR TOMORROW: A LOOK AT STATE MEDICAID PROGRAM SPENDING, ENROLLMENT AND POLICY TRENDS 7 (2012), available at <http://www.kff.org/medicaid/upload/8380.pdf> (referring to fiscal years 2012 and 2013).

68. Jessee, *supra* note 48, at 799.

Medicaid agencies as the provision's main enforcement mechanism.⁶⁹

Prior to 2002, Medicaid providers and patients relied on § 1983 of the Civil Rights Act to enforce Medicaid's equal access provision.⁷⁰ Section 1983 allows citizens to bring private rights of action against state officials in order to enforce constitutional and federal statutory rights.⁷¹ In the 1980 case *Maine v. Thiboutot*, the Supreme Court held that in addition to protecting constitutional rights, § 1983 also protects federal statutory rights.⁷² As a result of this holding, a plaintiff could invoke § 1983 to seek redress for a violation of a statutory right conferred by a federal statute which does not otherwise include a private right of action, like the Medicaid Act.⁷³

Following the Supreme Court's holding that federal statutes can create enforceable rights under § 1983, in 1990 the Court found that the Medicaid Act created an individual federal right enforceable under § 1983.⁷⁴ In *Wilder v. Virginia Hospital Ass'n*, the Court held that the Boren Amendment conferred

69. See Moncrieff, *supra* note 13, at 677 (explaining that in attempts to enforce Medicaid's equal access provision, providers and patients have sued state health agencies, claiming that state-set rates are legally insufficient).

70. See ALAN E. SCHABES ET AL., HEALTH LAW HANDBOOK § 6:7 (2006) (explaining that in 2002 the Supreme Court modified other requirements for stating a cause of action under § 1983); Jesse, *supra* note 48, at 799–802 (explaining Supreme Court guidelines for enforcing a statutory right under § 1983).

71. Gultinan, *supra* note 16, at 1596 (citing 42 U.S.C. § 1983 and *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980)); see also 42 U.S.C. § 1983 (2006) (“Every person who, under color of any [state] statute, ordinance, regulation, custom, or usage . . . subjects, or causes to be subjected, any . . . person . . . to the deprivation of any rights, privileges or immunities secured by the Constitution and laws, shall be liable . . .” (emphasis added)); *Thiboutot*, 448 U.S. at 4 (finding that the phrase “and laws,” suggests that the § 1983 remedy broadly encompasses violations of federal statutory as well as constitutional law).

72. Gultinan, *supra* note 16, at 1596 (citing *Thiboutot*, 448 U.S. at 4).

73. *Id.* (citing *Thiboutot*, 448 U.S. at 5). The Supreme Court later clarified the test for determining whether a particular statutory provision gives rise to a federal right enforceable via § 1983. In *Blessing v. Freestone*, the Court held that to successfully enforce a federally conferred statutory right a plaintiff must show that: (1) Congress intended the provision in question to benefit the plaintiff; (2) the statutory right asserted is not “so vague and amorphous that its enforcement would strain judicial competence;” and (3) the statute unambiguously imposes a binding obligation on the state in “mandatory rather than precatory terms.” *Id.* at 1596–97 (quoting *Blessing v. Freestone*, 520 U.S. 329, 340–41 (1997)).

74. See *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 509–10 (1990).

on Medicaid providers a right to “reasonable and adequate” reimbursement rates.⁷⁵

After the Court’s finding in *Wilder*, Medicaid providers and recipients across the country initiated suits under § 1983 to enforce various provisions of the Medicaid Act, including the equal access provision.⁷⁶ In some cases, equal access suits brought by Medicaid recipients and providers pursuant to § 1983 were successful in preventing state Medicaid programs from reducing provider reimbursement rates.⁷⁷ For example, the Eighth Circuit Court of Appeals found that a reduction in provider reimbursement rates by Arkansas’s Medicaid program violated the equal access provision because the impact of the 20% rate reduction on access, economy, efficiency, and quality of care had not been considered.⁷⁸

However, in 2002 the Supreme Court adjusted the requirements for stating a cause of action under § 1983, severely limiting the ability of Medicaid providers and beneficiaries to bring an equal access claim against the state by way of § 1983.⁷⁹ In *Gonzaga University v. Doe*, the Court disallowed a § 1983 claim brought under Spending Clause legislation, finding that the legislation did not create the type of individual right enforceable under § 1983.⁸⁰ The Court held that only unambiguously conferred “rights, not . . . broader or vaguer ‘benefits’ or ‘interests,’” are enforceable under § 1983.⁸¹

Following the Court’s decision in *Gonzaga*, federal courts have generally accepted § 1983 claims brought pursuant to provisions within the Medicaid Act that reference “individuals”

75. *Id.* at 512. The Boren Amendment has since been repealed. *See supra* notes 43–45 and accompanying text.

76. Gultinan, *supra* note 16, at 1598; *id.* at 1598 n.109 (citing *Visiting Nurse Ass’n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 1005 (1st Cir. 1996); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Ark. Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519, 527–28 (8th Cir. 1993)).

77. Gultinan, *supra* note 16, at 1598 n.110 (citing *Reynolds*, in which the court found that Arkansas’s reduction in provider payments violated the equal access provision and comparing it to the decision in *Sullivan*, in which the court held that Indiana’s Medicaid program did not violate the equal access provision in setting reimbursement rates).

78. *Id.*

79. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282–83 (2002) (adjusting the first prong of the *Blessing* test to require an “unambiguously conferred” right to bring a § 1983 claim). *See* Gultinan, *supra* note 16, at 1599–1600 for a more comprehensive analysis of the *Gonzaga* decision.

80. 536 U.S. at 276; *see also*, SCHABES ET AL., *supra* note 70.

81. *Gonzaga*, 536 U.S. at 283.

or “families,”⁸² and rejected § 1983 claims brought to enforce provisions containing broader, more generalized language.⁸³ This has created a split among the federal circuits as to whether the language of the equal access provision confers individual rights on Medicaid beneficiaries enforceable under § 1983.⁸⁴ As a result, beneficiaries in many states are left without legal recourse in the case of Medicaid equal access violations.⁸⁵ In addition, since 2002, every federal circuit court that has considered a § 1983 equal access claim brought by providers has held that the language of the equal access provision does not confer individual rights on Medicaid *providers*.⁸⁶ Consequently, enforcement of the equal access provision under a § 1983 cause of action is constructively prohibited for providers.

Due to the erosion of private rights of action under § 1983, some Medicaid beneficiaries and providers have turned to the Supremacy Clause to provide an alternative cause of action in pursuing judicial enforcement of Medicaid’s equal access provision.⁸⁷ Under the Supremacy Clause’s preemption doctrine, state laws are deemed invalid if they are contrary to or interfere with federal law.⁸⁸ In the 2008 Ninth Circuit case *Inde-*

82. Gultinan, *supra* note 16, at 1599 & n.120 (citing 42 U.S.C. § 1396a(a)(10)(A) (2006); *Watson v. Weeks*, 436 F.3d 1152, 1159–60 (9th Cir. 2006); S.D. *ex rel.* *Dickson v. Hood*, 391 F.3d 581, 603 (5th Cir. 2004); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 183 (3d Cir. 2004)).

83. Gultinan, *supra* note 16, at 1599–1600; *id.* at 1599 n.121 (citing *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 703 (5th Cir. 2007); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542–43 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1060 (9th Cir. 2005); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 58–59 (1st Cir. 2004)).

84. Compare *supra* note 83 and cases cited, with *Bontrager v. Ind. Family & Soc. Servs. Admin.*, 697 F.3d 604, 607 (7th Cir. 2012) (holding that the plaintiff could bring a § 1983 claim based on rights in § 1396a(a)(10)(A) of the Medicaid Act), and *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005, 1015–16 (8th Cir. 2006) (same), *vacated on other grounds sub nom. Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142, 1142 (2007).

85. See *supra* note 83.

86. See Bradley J. Sayles, *Preemption or Bust: A Review of the Recent Trends in Medicaid Preemption Actions*, 27 J. CONTEMP. HEALTH L. & POL’Y 120, 130–31 (2010) (examining the evolution of equal access claims under a § 1983 cause of action post-*Gonzaga*); see also, e.g., sources cited *supra* note 83.

87. SCHABES ET AL., *supra* note 70, § 6:7.

88. See U.S. CONST. art. VI; *Free v. Bland*, 369 U.S. 663, 666 (1962) (“The relative importance to the State of its own law is not material when there is a conflict with a valid federal law, for the Framers of our Constitution provided that the federal law must prevail.”).

pendent Living Center of Southern California, Inc. v. Shewry, Medicaid providers and beneficiaries successfully argued that Medicaid's equal access provision could be enforced through an implied cause of action under the Supremacy Clause.⁸⁹ The suit was a result of the passage of several laws by the California Legislature reducing Medicaid provider payment rates.⁹⁰ Medicaid providers and beneficiaries challenged the rate reductions, arguing that the cuts violated—and were thus preempted by—Medicaid's equal access provision.⁹¹ In upholding the plaintiff's preemption claim, the Ninth Circuit concluded that the state Medicaid Director did in fact violate the federal Medicaid equal access provision when he implemented rate reductions mandated by the state legislature.⁹²

However, the Supremacy Clause basis for judicial enforcement of the equal access provision may be in jeopardy. In January of 2011, the Supreme Court granted the *Independent Living* defendant's petition for writ of certiorari.⁹³ In a 5-4 decision issued in February of 2012, the Court declined to resolve the question of whether Medicaid providers and beneficiaries stated a valid cause of action under the Supremacy Clause.⁹⁴ The Court, finding that actions taken by the State since the suit was filed changed the facts of the case, vacated the judgment and remanded the case back to the Ninth Circuit Court of Appeals.⁹⁵ Should the Court eventually find that the Supremacy

89. *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1047, 1048–49 (9th Cir. 2008) [hereinafter *Indep. Living Ctr. I*] (holding that a plaintiff may bring suit under the Supremacy Clause “regardless of whether the federal statute at issue confers an express ‘right’”), *cert. denied*, 129 S. Ct. 2828 (2009), *on remand to* No. CV 08-3315, 2008 WL 3891211 (C.D. Cal. Aug. 18, 2008), *aff’d sub nom. Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) [hereinafter *Indep. Living Ctr. II*], *motion to vacate denied*, 590 F.3d 725 (9th Cir. 2009).

90. Robert Pear, *Administration Opposes Challenges to Medicaid Cuts*, N.Y. TIMES, May 28, 2011, <http://www.nytimes.com/2011/05/29/us/29medicaid.html>.

91. *Id.*

92. *Indep. Living Ctr. II*, 572 F.3d at 648, 625.

93. *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., Inc.*, 590 F.3d 725 (9th Cir. 2009), *cert. granted*, 78 U.S.L.W. 3500 (U.S. Jan. 18, 2011) (No. 09-958).

94. *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1211–12 (2012).

95. *Id.* Since the case was filed, the federal government approved some elements of California's proposed rate changes. California also withdrew other proposed rate changes being challenged in the case. See Jason Millman, *SCOTUS Punts on California Medicaid Suit*, POLITICO (Feb. 22, 2012, 11:20 AM), <http://politico.com/news/stories/0212/73165.html>. As a result of these actions, on remand, the Ninth Circuit rejected the Plaintiff's Supremacy Clause

Clause does not provide a valid cause of action, many Medicaid providers and beneficiaries will again be unable to enforce Medicaid's equal access provision through legal action.

II. INADEQUACY OF THE CURRENT JUDICIAL ENFORCEMENT MECHANISM

While the Supreme Court has not directly ruled on whether Medicaid beneficiaries and providers are able to enforce Medicaid's equal access provision through § 1983⁹⁶ or under the Supremacy Clause,⁹⁷ there are a number of factors that suggest that the current judicial enforcement mechanism is not a suitable instrument for addressing equal access violations. This Part first explores the inconsistent circuit rulings interpreting the legal requirements of Medicaid's equal access provision. Then, it examines the inconsistent court rulings concerning whether Medicaid beneficiaries or providers are even able to bring a Medicaid equal access suit. Finally, this Part concludes that even if the Supreme Court upholds judicial enforcement of Medicaid's equal access provision through a § 1983 cause of action or under the Supremacy Clause, judicial enforcement does not comport with congressional intent, federal administrative interpretation, or practical, economic and ethical considerations.

A. INTERPRETING THE LEGAL REQUIREMENTS OF MEDICAID'S EQUAL ACCESS PROVISION: INCONSISTENT CIRCUIT RULINGS

At present, the Third, Seventh, and Eighth Circuits allow Medicaid beneficiaries to bring private rights of action in order to enforce Medicaid's equal access provision⁹⁸ while the Ninth

claim, finding that “[p]laintiffs are unlikely to succeed on the merits of their Supremacy Clause claims against the Director because—even assuming that the Supremacy Clause provides a private right of action—the Secretary has reasonably determined that the State’s reimbursement rates comply with § 30(A).” *Managed Pharmacy Care v. Sebelius*, 705 F.3d 934, 939 (9th Cir. 2012). On January 29, 2013, Plaintiffs submitted a petition for rehearing and rehearing en banc. Joint Petition for Rehearing and Rehearing En Banc at 1, *Sebelius*, 705 F.3d 934 (9th Cir. 2012) (No. 12-55067), available at <http://www.cmanet.org/files/assets/news/2013/01/petition-for-rehearing-.pdf>.

96. See *Bontrager v. Ind. Family & Soc. Servs. Admin.*, 697 F.3d 604, 607 (7th Cir. 2012).

97. See *Douglas*, 132 S. Ct. at 1211–12.

98. See *Bontrager v. Ind. Family & Soc. Servs. Admin.*, 697 F.3d 604, 607 (7th Cir. 2012); *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005, 1015–16 (8th Cir. 2006), vacated on other grounds *sub nom.* *Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142, 1142 (2007); *Pa. Phar-*

Circuit allowed plaintiffs to bring suit for injunctive relief under the Supremacy Clause.⁹⁹ However, judicial enforcement has resulted in inconsistent rulings on what the equal access provision actually requires.¹⁰⁰ As a consequence, states have been left without clear and consistent guidelines, creating a high degree of uncertainty for states attempting to adjust their provider payment rates.¹⁰¹

States in the Ninth Circuit are required to satisfy specific procedural requirements before setting Medicaid reimbursement rates.¹⁰² The Ninth Circuit has determined compliance with Medicaid's equal access provision based solely on the state's rate-setting procedures.¹⁰³ In *Orthopaedic Hospital v. Belshe*, several hospitals brought legal action against California alleging that it violated Medicaid's equal access provision when it lowered Medicaid hospital reimbursement rates.¹⁰⁴ The court held that the equal access provision requires state agencies to set payment rates that "bear a reasonable relationship" to provider costs, based on "responsible cost studies, its own or others', that provide reliable data as basis for its rate setting."¹⁰⁵ Finding that the state failed to meet these requirements, the court remanded the case, holding that the state should "undertake responsible cost studies that will provide reliable data as to the hospitals' costs . . . [and] then set rates that have some reasonable relation to such costs, [with] the state bearing the

macists Ass'n v. Houstoun, 283 F.3d 531, 543–44 (3d Cir. 2002) (en banc). The First, Second, and Fourth Circuits have not directly addressed whether Medicaid beneficiaries are allowed to bring private rights of action under Medicaid's equal access provision.

99. See *Indep. Living Ctr. I*, 543 F.3d 1047, 1048–49 (9th Cir. 2008); cf. *Sanchez v. Johnson*, 416 F.3d 1051, 1051 (9th Cir. 2005) (holding that Medicaid's equal access provision does not create an individual right enforceable under § 1983 by Medicaid beneficiaries or providers).

100. See generally Moncrieff, *supra* note 13 (providing an in-depth discussion of the circuit split).

101. See Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, 25,343 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447).

102. See *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1500 (9th Cir. 1997) (requiring states to base rate changes on "reliable data" provided by "responsible cost studies").

103. Moncrieff, *supra* note 13, at 688.

104. *Orthopaedic Hosp.*, 103 F.3d at 1492.

105. *Id.* at 1496, 1500. This ruling was reaffirmed by the Ninth Circuit after the repeal of the Boren Amendment. See *Independent Living Ctr. II*, 572 F.3d 644, 645 (9th Cir. 2009).

burden of justifying any rate that substantially deviates from such determined costs.”¹⁰⁶

The Third and Eighth Circuits on the other hand, require states to engage in some kind of decision-making process, but do not go as far as the Ninth Circuit in laying out strict procedural requirements.¹⁰⁷ In considering a challenge to a state’s decision to cut pharmacy reimbursement rates, the Third Circuit rejected the Ninth Circuit’s interpretation that the equal access provision requires states to base rate changes on reliable data provide by responsible cost studies.¹⁰⁸ Instead, the court employed a more deferential interpretation, holding that the state “may not act arbitrarily and capriciously” in setting reimbursement rates by showing it “made a reasonable effort to anticipate the effects of its action.”¹⁰⁹ Applying this more deferential equal access interpretation, the court found that although the state “might have done a better job in its review by considering systematically and thoroughly all the implications of its rate revisions,” the deficiencies in the agency’s decision-making did “not make the overall process arbitrary and capricious.”¹¹⁰ Consequently, courts in the Third and Eighth Circuits will defer to a state’s reimbursement rate-setting decision if the state can show that it made a rational decision based on the consideration of relevant factors, whatever those factors may be.¹¹¹

106. *Orthopaedic Hosp.*, 103 F.3d at 1500.

107. See Moncrieff, *supra* note 13, at 698–99 (discussing the Third and Eighth Circuits’ arbitrary and capricious review in Medicaid equal access cases).

108. *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851–53 (3d Cir. 1999) (noting the lack of procedural requirements in § 1396a(a)(30)(A) as compared to the repealed Boren Amendment).

109. *Id.* at 852–55.

110. *Id.* at 854–55.

111. For a more extensive discussion of the Third and Eighth Circuit procedural requirements, see Moncrieff, *supra* note 13, at 698–99. As noted by Abigail Moncrieff, in *Rite Aid*, the Third Circuit laid out specific relevant factors in finding the state’s decision was not arbitrary and capricious including: consideration of “private payer’s rates, neighboring state’s rates, and pharmaceutical companies’ prices.” *Id.* (citing *Rite Aid*, 171 F.3d at 848). However, in applying the arbitrary and capricious standard in *Reynolds*, the Eighth Circuit only referred to general factors such as efficiency, economy, quality and access. See *id.* (citing *Ark. Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519, 530–31 (8th Cir. 1993)). In addition, the *Reynolds* court did not state whether consideration of all or just some of these factors was necessary. See *id.* Rather, the *Reynolds* court simply stated that reimbursement decisions based exclusively on budgetary considerations were insufficient. See *id.*

Unlike the more lenient procedural requirements set forth by the Third and Eighth Circuits, the Seventh Circuit does not require states to engage in any comprehensive procedural process before reducing provider payment rates.¹¹² In *Methodist Hospitals, Inc. v. Sullivan*, physicians and hospitals brought an action against state officials seeking to enjoin implementation of the state's new rules affecting Medicaid reimbursement for outpatient and physician services.¹¹³ The plaintiffs argued that the state violated Medicaid's equal access provision by failing to conduct adequate studies prior to changing the reimbursement plan.¹¹⁴ In the end, the court held that the Medicaid equal access provision did not require the state to conduct studies in advance of the changes.¹¹⁵ As a result, states in the Seventh Circuit are not required to conduct studies or "employ any particular methodology" before setting reimbursement rates.¹¹⁶

As a result of these confusing and inconsistent rulings regarding the legal requirements of Medicaid's equal access provision, states have been left with a lack of uniform standards to guide their rate-setting process. This has created a two-tiered rate-setting system, neither of which accomplishes the provision's goal of ensuring equal access. Some states may feel entirely free to reduce provider rates because they may cut rates without conducting prior cost studies or engaging in other procedural requirements.¹¹⁷ This has led some states to cut provider rates without considering the impact on access to care.¹¹⁸ Other states, however, may be unwilling to consider any reasonable reductions in provider rates due to concerns that any impact on access to care may violate Medicaid's equal access provision.¹¹⁹

112. *See id.* at 679 (providing a more in-depth analysis of the Court's holding in *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996)).

113. *Methodist Hosps., Inc.*, 91 F.3d at 1027–28.

114. *Id.* at 1029–30.

115. *Id.* at 1030–31.

116. *Id.*

117. For example, states in the Seventh Circuit, where there is no requirement for prior cost studies or other procedural requirements, may cut provider rates with relatively few procedural barriers. *See supra* text accompanying notes 112–116.

118. *See supra* notes 10–12, 54–67 and accompanying text.

119. For example, states in the Ninth Circuit are required to set provider payment rates that "bear a reasonable relationship" to provider costs, based on "responsible cost studies, its own or others', that provide reliable data as basis for its rate setting." *See supra* notes 102–09 and accompanying text.

B. ENFORCING MEDICAID'S EQUAL ACCESS PROVISION UNDER § 1983 AND THE SUPREMACY CLAUSE: INCONSISTENT COURT RULINGS

In addition to uncertainty regarding how courts will interpret the requirements of Medicaid's equal access provision, there is also uncertainty concerning whether Medicaid beneficiaries or providers are able to bring a Medicaid equal access suit in the first place.

As previously noted, the path to enforcement of Medicaid's equal access provision through private suits has slowly eroded over the past ten years.¹²⁰ Following the Supreme Court's 2002 decision in *Gonzaga*,¹²¹ every federal circuit court to consider a § 1983 equal access claim brought by providers has held that Medicaid's equal access provision does not confer individual rights on providers.¹²² For Medicaid recipients, the current judicial enforcement mechanism has resulted in inconsistent court rulings regarding whether Medicaid *beneficiaries* may bring § 1983 equal access suits. Thus far, the Supreme Court has declined to resolve this issue.¹²³ As a result, some Medicaid providers and beneficiaries have turned to preemption claims in a last ditch effort to judicially enforce equal access.¹²⁴ However, as with § 1983 claims, it remains unclear whether Medicaid providers and beneficiaries have a cause of action on the Supremacy Clause.

The 2008 *Independent Living* case was the first case to suggest that Medicaid beneficiaries and providers can employ the Supremacy Clause to enforce Medicaid's equal access provision.¹²⁵ The U.S. District Court for the Central District of California initially rejected the plaintiff's argument that it had a cause of action under the Supremacy Clause.¹²⁶ After appealing to the Ninth Circuit, the court remanded the case holding that a plaintiff *could* bring a preemption claim to enforce Medicaid's

120. See *supra* Part I.C.

121. See *supra* notes 79–81 and accompanying text.

122. See *supra* notes 83–86.

123. See *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005 (8th Cir. 2006), *cert. denied*, 549 U.S. 1205 (2007).

124. See *supra* notes 87–92.

125. See *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, No. CV 08-3315, 2008 WL 4298223, at *4 (C.D. Cal. June 25, 2008).

126. *Id.* at *4–5.

equal access provision.¹²⁷ The state appealed all the way to the U.S. Supreme Court.¹²⁸

As noted above, the five-Justice majority declined to decide the issue of whether Medicaid providers and beneficiaries can state a valid cause of action under the Supremacy Clause by alleging that a state law reducing provider reimbursement rates conflicts with Medicaid's equal access provision.¹²⁹ However, the dissent filed by Chief Justice John Roberts, in which Justices Antonin Scalia, Clarence Thomas, and Anthony Alito joined, criticized the majority for evading the question and made it clear that this "is not a proper role for the Supremacy Clause."¹³⁰ Therefore, although the Court has not directly ruled on the question whether the Supremacy Clause may be employed to enforce Medicaid's equal access provision, the opinion suggests that at least four Justices would respond with a resounding "no."

Consequently, even if Medicaid beneficiaries and providers are willing to bring suits under a cloud of uncertainty regarding what standard the courts will apply in interpreting the requirements of Medicaid's equal access provision, many Medicaid beneficiaries and providers are still left wondering whether they have a cause of action to even initiate the case.

C. APPROPRIATENESS OF JUDICIAL ENFORCEMENT: OTHER CONSIDERATIONS

There are number of other factors including congressional intent and federal administrative interpretation, as well as practical, economic, and ethical considerations that suggest that the current judicial enforcement mechanism is not a suitable instrument to address equal access violations. Should the Supreme Court allow Medicaid beneficiaries and/or providers to bring suit against the state in order to enforce Medicaid's equal access provision, these factors must be considered.

127. See *Indep. Living Ctr. I*, 543 F.3d 1047, 1048–49 (9th Cir. 2008).

128. See *id.*, opinion issued by, 543 F.3d 1050 (9th Cir. 2008), cert. denied, 129 S. Ct. 2828 (2009), and on remand to No. CV 08-3315, 2008 WL 3891211 (C.D. Cal. Aug. 18, 2008), *aff'd sub nom.* *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009), motion to vacate denied, 590 F.3d 725 (9th Cir. 2009), and petition for cert. filed, 2009 WL 907846 (U.S. Apr. 1 2009) (No. 08-1223).

129. See *supra* Part I.B.

130. *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1213–14 (2012).

1. Congressional Intent

As noted earlier, the Boren Amendment governed states' Medicaid payments to certain institutional care facilities.¹³¹ The Amendment's language was similar to that of the equal access provision, requiring states to set institutional care provider reimbursement rates that were "reasonable and adequate" to cover the cost of "efficiently and economically operated facilities."¹³² In 1990, the Supreme Court held that the Boren Amendment created a private right of action enforceable under § 1983.¹³³ Following this ruling, federal circuit courts across the country held that Medicaid beneficiaries and providers could sue to enforce various provisions of the Medicaid Act under § 1983.¹³⁴

Legislative history suggests that Congress repealed the Boren Amendment with the express intent of reversing the Supreme Court's 1990 holding in *Wilder* that the Boren Amendment conferred an enforceable federal statutory right.¹³⁵ In a report from the House Committee on the Budget supporting the repeal of the Boren Amendment under the Balanced Budget Act, the Committee stated, "[i]t is the Committee's intention that, following enactment of this Act, neither this nor any other provision of [42 U.S.C. § 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive."¹³⁶ This suggests that by repealing the Boren Amendment, Congress intended to prevent providers from bringing suit to regulate Medicaid reimbursement rates.¹³⁷

2. Federal Administrative Interpretation

In addition to congressional intent, federal administrative interpretation of the role Medicaid's equal access provision plays within the joint federal-state Medicaid program also sug-

131. See *supra* notes 43–45 and accompanying text.

132. Gultinan, *supra* note 16, at 1597 n.104 (citing 42 U.S.C. § 1396a(a)(13)(A) (2006)).

133. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 509–10 (1990).

134. See *supra* note 76.

135. Gultinan, *supra* note 16, at 1598 (citing 104 H.R. REP. NO. 105-149, at 591 (1997)); see also H.R. REP. NO. 105-149, at 590–91 ("A number of Federal courts have ruled that State systems failed to meet the test of 'reasonableness' and some States have had to increase payments to these providers as a result of these judicial interpretations.").

136. Gultinan, *supra* note 16, at 1598 n.112.

137. See *id.* at 1598.

gests that judicial enforcement is not an appropriate mechanism to address equal access violations.

In a brief filed with the Supreme Court on behalf of the Obama Administration, the federal administration officially took a stance against the use of § 1983 by Medicaid beneficiaries or providers to enforce Medicaid's equal access provision.¹³⁸ The Obama Administration maintained that such lawsuits "would not be compatible" with the means of enforcement envisioned by Congress, which relies on the Secretary of HHS to ensure compliance.¹³⁹ The brief argued that determinations about how to measure a State's compliance with general standards of economy, efficiency, quality of care, and sufficiency of payments to ensure access are "ones properly made by HHS through the exercise of its expert judgment and its bilateral relationship with the State."¹⁴⁰ The Obama Administration also argued that the use of the Supremacy Clause to enforce Medicaid's equal access provision was inappropriate:¹⁴¹

[Medicaid's equal access provision] is a provision of a cooperative federal-state program enacted pursuant to Congress's Spending Clause authority, as to which Congress neither provided an express right of action for private parties nor conferred individually enforceable rights. Recognition of a nonstatutory cause of action for Medicaid providers and beneficiaries in this setting would be in tension with the nature of the federal-state relationship and the enforcement scheme contemplated by the statute.¹⁴²

Enforcement of Medicaid's equal access provision through a private judicial enforcement mechanism flies directly in the face of the federal government's interpretation of the role of Medicaid's equal access provision within the statute's broader federal-state Medicaid structure.

3. Practical, Economic, and Ethical Considerations

Finally, in addition to separation of powers concerns, practical, economic, and ethical considerations also suggest that judicial enforcement of Medicaid's equal access provision is inappropriate.

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

139. See *id.* at *24–25.

140. *Id.* at *31.

141. *Id.* at *16–32.

142. *Id.* at *25.

a. *Practical Considerations*

On a practical level, requiring individual low-income Medicaid beneficiaries to sue the state in order to ensure that they have access to needed health care providers is unrealistic. Most equal access suits have been brought by providers¹⁴³ or by providers in association with Medicaid beneficiaries.¹⁴⁴ This is likely due to the inability of Medicaid beneficiaries to fund their own judicial enforcement actions.¹⁴⁵ In order to qualify for Medicaid, individuals must have income and resources that total to a value less than a specified amount.¹⁴⁶ Although income eligibility levels vary by state and eligibility category (e.g., pregnant women, children, working individuals with disabilities, or low-income Medicare beneficiaries), Medicaid assistance is limited to those in financial need.¹⁴⁷ Equal access lawsuits have traditionally been brought by or in conjunction with financially equipped Medicaid providers.¹⁴⁸

However, as stated earlier, following *Gonzaga*, every federal circuit court that has considered a § 1983 equal access claim brought by *providers* has held that they do not have individual rights under Medicaid's equal access provision.¹⁴⁹ Enforcement of the equal access provision under a § 1983 cause of action is constructively prohibited for providers. As a result, Medicaid beneficiaries may no longer be able to rely on providers to fund equal access suits.

143. See, e.g., *Visiting Nurse Ass'n of N. Shore, Inc. v. Bullen*, 93 F.3d 997, 999 (1st Cir. 1996) (health care providers initiated action); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1027 (7th Cir. 1996) (physicians and hospitals brought action).

144. See, e.g., *Indep. Living Ctr. I*, 543 F.3d 1047, 1048–50 (9th Cir. 2008) (action brought by Medi-Cal providers and beneficiaries); *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 699–701 (5th Cir. 2007) (action brought by providers in association with Medicaid beneficiaries); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1009 (8th Cir. 2006) (action brought by providers and parents of three Medicaid recipients); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 522 (8th Cir. 1993) (action brought by Medicaid providers, professional associations, and beneficiaries).

145. See SCHNEIDER ET AL., *supra* note 25, at 6–7 (noting that in order to qualify for Medicaid, individuals must meet income and resource eligibility requirements).

146. See *id.*

147. See *id.*

148. See cases cited *supra* notes 143–44.

149. See sources cited *supra* note 83; see also Sayles, *supra* note 86, at 130 (“[E]ach court, when confronted with the issue, found that providers are not conferred rights under § 1396a(a)(30).”).

Even if the Supreme Court holds that providers may bring suit using a preemption claim, providers may be less likely to instigate action due to the limited relief available under the Supremacy Clause. Unlike § 1983 actions, plaintiffs cannot receive money damages or attorney fees in a suit brought under the Supremacy Clause.¹⁵⁰ Plaintiffs may seek prospective injunctive and declaratory relief, but are prohibited from receiving relief for past violations.¹⁵¹ Due to the limited relief available under the Supremacy Clause, providers may be less likely to initiate an equal access suit.

b. Economic Considerations

On an economic level, requiring Medicaid beneficiaries and providers to bring suit in order to enforce Medicaid's equal access provision makes inefficient use of resources. Plaintiffs and judges are generally not experts on the Medicaid program.¹⁵² As a result, judicial enforcement of Medicaid's equal access provision has led to the development and application of different legal standards. As noted previously, the Ninth, Seventh, Third, and Eighth Circuits apply different legal standards when interpreting the requirements of Medicaid's equal access provision.¹⁵³ Acknowledging this fact, the Sixth Circuit Court of Appeals found that Medicaid's equal access provision was "ill-suited to judicial remedy."¹⁵⁴ In coming to its holding, the court held that the interpretation and balancing of the provision's objectives of "efficiency, economy, and quality of care . . . would involve making policy decisions for which [the] court has little expertise."¹⁵⁵

The federal government has advanced the argument that federal health officials are better equipped than judges to balance equal access concerns with other policy objectives.¹⁵⁶ In its brief submitted to the Supreme Court, the federal government argued that federal administrative process provides the necessary "expertise, uniformity, widespread consultation, and re-

150. Guiltinan, *supra* note 16, at 1620 (citing David Sloss, *Constitutional Remedies for Statutory Violations*, 89 IOWA L. REV. 355, 389 (2004)).

151. *Id.*

152. See *Westside Mothers v. Olszewski*, 454 F.3d 532, 543 (6th Cir. 2006) (arguing that the judiciary is "ill-suited" to enforce Medicaid's equal access provision).

153. See *supra* Part II.A.

154. *Westside Mothers*, 454 F.3d at 543.

155. *Id.* (citations omitted) (internal quotation marks omitted).

156. See *Pear*, *supra* note 90.

sulting administrative guidance” that often accompanies agency decision-making.¹⁵⁷ For these reasons, federal health officials are better equipped to enforce Medicaid’s equal access provision in a consistent and efficient manner.

c. Ethical Considerations

Finally, administration of Medicaid’s equal access provision through an enforcement system which is not uniform in its decision making and readily accessible to beneficiaries may be considered unethical by some.

Congress enacted the Medicaid Act with the intent of lending a helping hand to many of the nation’s most needy individuals.¹⁵⁸ Subsequently, acknowledging the importance of providing not only health care coverage, but also meaningful access to care, Congress enacted the equal access provision.¹⁵⁹ The goal of these congressional enactments was to lessen the hardships carried by our nation’s poorest and neediest citizens. Yet, congressional intent may be compromised by placing the burden of equal access enforcement on those least able to bear it.

With financial and expert resources, the state and federal governments are better able to bear the burden of ensuring enforcement of the equal access provision.¹⁶⁰ It is for this reason that a federal regulatory enforcement approach may be considered a more ethical and appropriate way to assure access to health care through oversight and enforcement of Medicaid’s equal access provision.

III. A FEDERAL REGULATORY ENFORCEMENT APPROACH

As demonstrated throughout Part II, many factors suggest the need for an alternative equal access enforcement approach. This Note proposes implementation of robust federal regulatory

157. Brief for the United States as Amicus Curiae Supporting Petitioner, *supra* note 138, at *32 (quoting *Gonzaga Univ. v. Doe*, 536 U.S. 273, 292 (2002) (Breyer, J., concurring in judgment)).

158. See Moncrieff, *supra* note 13, at 675 (noting that enactment of the Medicaid Act was intended to provide many of the nation’s poor passage into the upper tier of the health care system).

159. See *supra* note 52 and accompanying text.

160. See Brief for the United States as Amicus Curiae Supporting Petitioner, *supra* note 138, at *31–32 (arguing that unlike plaintiffs and judges, the federal government has the requisite expertise to address equal access violations); SCHNEIDER ET AL., *supra* note 25, at 6 (noting that Medicaid beneficiaries are financially needy).

enforcement supported by adequate financial assistance as an alternative means by which to enforce Medicaid's equal access provision. This Part first examines the current federal enforcement system and suggests support for a federal regulatory framework that promulgates clear and consistent guidelines for states to follow when setting reimbursement rates. Next, it argues that in order for states to accept and implement a comprehensive federally imposed equal access regulatory framework, the system must be supported by sufficient financial assistance. Finally, it explains why the federal government has both the power and the duty to create a standardized federally based regulatory enforcement scheme.

A. THE CURRENT FEDERAL ENFORCEMENT MECHANISM

States must set their reimbursement policies in state Medicaid plans, and changes in those policies must be reflected in state-plan amendments (SPAs), which are then reviewed by HHS.¹⁶¹ When the federal government asks states to provide justification for the rate changes, they usually respond with a general statement assuring that access will not be affected.¹⁶² When the government then asks for further details on the methodology used by the state in its determination, generally only a few states show that they relied on actual data in making this determination.¹⁶³ Absent actual data, the federal government generally relies on a state's general assurances.¹⁶⁴ As a result, states have been able to implement rate changes with relatively little fear that the federal government will reject their SPAs for violating Medicaid's equal access provision.¹⁶⁵ To assure uniformity in the application of the Medicaid equal access provision, the federal government must implement a more robust regulatory approach to the enforcement of this provision.

161. See *supra* notes 25–29 and accompanying text.

162. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,343, 26,348 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447).

163. *Id.* Additionally, of the states that actually rely on data, most focus “on historical levels of provider enrollment and their” substantively foundationless “belief that providers would not disenroll based on a reduction in payment[.]” *Id.*

164. See *id.* at 26,348–49 (“[W]e [HHS] have generally relied upon State assurances . . . to make decisions on proposed rate reduction SPAs.”).

165. The federal government has only rejected SPAs with proposed rate reductions in a few extreme instances. See *id.* at 26,349.

B. A ROBUST FEDERAL REGULATORY FRAMEWORK

Under the Medicaid Act, the Secretary of HHS has broad authority to issue regulations “as may be necessary to the efficient administration of the functions with which [she] is charged under [the Medicaid Act].”¹⁶⁶ For example, the Secretary has invoked this power to impose upper payment limits.¹⁶⁷ The Secretary may also use this power to implement a robust federal regulatory framework to enforce Medicaid’s equal access provision.

1. Proposed Federal Enforcement Scheme

Invoking this power in May 2011, the federal government through the Centers of Medicare and Medicaid Services (CMS) proposed a rule that would create a standardized, transparent process for states to follow in assuring that provider payments are consistent with “efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available.”¹⁶⁸ The proposed rule offers guidelines on data collection efforts and the public process that states must follow in order to demonstrate that the rate-setting process is consistent with the requirements of Medicaid’s equal access provision.¹⁶⁹

Under the proposed rule, states would be required to submit equal access analyses based on data collected during the prior year along with any SPA that reduces or restructures provider payment rates.¹⁷⁰ CMS would then review these analyses to make sure the state collected and analyzed all relevant data to ensure substantive compliance with equal access requirements.¹⁷¹ While the sufficiency of this process is somewhat debated,¹⁷² this regulatory proposal is a key starting point for

166. SCHNEIDER ET AL., *supra* note 25, at 136 (citing 42 U.S.C. § 1302(a) (2006)).

167. *See id.*

168. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. at 26,342 (quoting 42 U.S.C. § 1396a(30)(A)). As of April 2013, nearly two years after it was first proposed, no action has been taken on the proposed rule.

169. *Id.* at 26,349.

170. *Id.*

171. *Id.*

172. *See, e.g.*, Joint Comments of Physician Organizations at 2–5, commenting on Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, available at <http://www.ama-assn.org/resources/doc/washington/medicaid-access-review-sign-on-letter-05july2011>

the creation of clear and consistent guidelines for state to follow in setting provider reimbursement rates in compliance with Medicaid's equal access provision.

2. Increased Federal Financial Assistance

However, in order to create a uniform and transparent process that is palatable to the states, a successful federal regulatory scheme should include increased federal financial assistance to conduct the time- and resource-intensive equal access analyses.

As stated previously, state participation in the Medicaid program is entirely optional.¹⁷³ Until this point in time, every state has chosen to participate in the joint state-federal program.¹⁷⁴ However, challenged by strict federal requirements, potential expansion of Medicaid eligibility, and budget shortfalls, lawmakers in nearly a dozen states have stated that they are considering opting out of the Medicaid program altogether.¹⁷⁵ They argue that states could provide more efficient and cost-effective care for children, individuals with disabilities and the impoverished by opting out of the Medicaid program and establishing a state-based health insurance system.¹⁷⁶

Although it is debated whether opting out of the joint state-federal Medicaid program would be a viable option for states,¹⁷⁷ should this happen, eligible beneficiaries in these states would no longer be protected under Medicaid's equal access provision. While implementation of a federal regulatory framework is an important first step to improving the enforcement of Medicaid's equal access provision, without the provision of additional financial assistance, states may view the federal government's proposed equal access enforcement rule as the final incentive for their decision to opt out of the joint state-federal program.

.pdf (questioning adequacy of data elements requirements, enforcement and oversight mechanisms, and exclusion of managed care).

173. SCHNEIDER ET AL., *supra* note 25, at 130.

174. *Id.*

175. See Emily Ramshaw & Marilyn Serafini, *Battle Lines Drawn over Medicaid in Texas*, N.Y. TIMES, Nov. 11, 2010, <http://www.nytimes.com/2010/11/12/us/politics/12ttmedicaid.html> (citing Republican lawmakers in Texas arguing that strings attached to Medicaid and the Children's Health Insurance Program are bankrupting the state).

176. *Id.*

177. *See id.*

One way to ease the administrative burden placed on states by the proposed federal rule would be to fully fund or, at a minimum, provide a higher federal administrative matching rate to conduct equal access analyses. The federal government matches administrative cost incurred by state Medicaid programs.¹⁷⁸ Most types of allowable administrative costs are matched at 50%.¹⁷⁹ However, state expenditures for certain types of administrative functions are matched at a higher rate of 75%.¹⁸⁰ In addition, the federal government matches 90% of start-up expenses related to the operation of Medicaid information management systems and state Medicaid fraud control units.¹⁸¹

In its proposed rule, CMS proposes that states have the ongoing responsibility to monitor access to care and conduct periodic reviews of compliance with Medicaid's equal access provision.¹⁸² Under an increased federal matching approach, the federal government could match state Medicaid programs at 90% for administrative costs related to the start-up of Medicaid equal access monitoring and compliance management systems. Additionally, because some states may not have previously engaged in many or any equal access reviews, the start-up phase could also include higher matching rates for initial equal access reviews investigating and resolving current violations. Once the initial equal access monitoring systems have been established, the federal government could match state expenditures related to equal access data collection efforts at 75%.¹⁸³ The in-

178. SCHNEIDER ET AL., *supra* note 25, at 144–45. Federal Medicaid funding comes from general revenues. APRIL GRADY, CONG. RESEARCH SERV., RS 22849, MEDICAID FINANCING CRS-3 (2008), available at http://assets.opencrs.com/rpts/RS22849_20080326.pdf.

179. SCHNEIDER ET AL., *supra* note 25, at 145.

180. *Id.* These administrative services include:

[C]ompensation or training of physicians, nurses, and other skilled professional medical personnel used by the state Medicaid agency (or other state or local agencies) to administer the program; operation of a Medicaid management information system[]; surveys and certification of nursing facilities; performance of medical and utilization review or quality assurance by a Quality Improvement Organization . . . or External Quality Review Organization []; operation of state Medicaid fraud control units.

Id.

181. *Id.*

182. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,342, 26,344 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447).

183. *See id.* at 26,344–61 (requiring states to conduct these data collection

creased federal matching system would incentivize states to establish equal access compliance mechanisms and conduct ongoing periodic reviews of compliance with Medicaid's equal access provision.

C. CHALLENGES TO A "FEDERAL" REGULATORY APPROACH

In addition to concerns related to the administrative and financial burdens placed on states by a federal regulatory enforcement scheme, some states have also expressed concern with the federal government's role in state Medicaid affairs.

As noted previously, Medicaid is structured as a cooperative federal-state program.¹⁸⁴ Under the joint federal-state Medicaid system, states have broad flexibility to establish service delivery systems, "to design the procedures for enrolling providers . . . , and to set the methods for establishing provider payment rates."¹⁸⁵ Some opponents of a standardized federal regulatory approach argue that this structure is evidence of Congress's intent for states to have broad flexibility to set provider rates.¹⁸⁶ In addition, they argue that such flexibility is critical in order to allow review of beneficiary access to evolve over time, and for states to be able to implement effective and efficient approaches that are appropriate to their local and changing circumstances.¹⁸⁷ Consequently, agencies and officials responsible for administering the Medicaid program in a number of states have taken a stance against the federal government's proposed rule contending that the federally-based equal enforcement scheme infringes upon the state's broad discretion to set provider rates.¹⁸⁸

However, the federal government has both the power and the duty under the Medicaid Act to issue regulations aimed at ensuring equal access to care. As noted above, the Secretary of HHS has the power to issue regulations necessary to efficiently

efforts when the state proposes a rate change and on a regular periodic basis).

184. See *supra* note 24 and accompanying text.

185. See Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. at 26,343.

186. See Joint Comments of 17 States and State Medicaid Agencies, *Comments on the Medicaid Program: Methods for Assuring Access to Covered Medicaid Services*, REGULATIONS.GOV (July 10, 2011), <http://www.regulations.gov/#!documentDetail;D=CMS-2011-0062-0179> (follow "View Attachment" hyperlink).

187. See *id.* at 2.

188. See *id.* at 1–11.

administer the Medicaid program.¹⁸⁹ In addition, the federal government also concedes that it has a “responsibility” under the Medicaid Act to ensure sufficient beneficiary access to covered services.¹⁹⁰

Due to the lack of prior federal guidance on this issue, states have been able to make provider rate changes without considering the impact on access to care for Medicaid beneficiaries.¹⁹¹ This is due in part to the lack of guidance regarding the procedures that must be followed in complying with the requirements of Medicaid’s equal access provision.¹⁹² Aware of the issues that have arisen due to the lack of federal guidance,¹⁹³ it is the duty of the federal government to create a uniform and transparent process for states to follow to ensure equal access.

Implementation of a robust federal regulatory enforcement approach is a necessary and important part of a successful equal access enforcement scheme. A federal regulatory scheme will help ensure equal access by providing states with clear and consistent guidelines to follow when setting reimbursement rates. However, it is imperative to provide ample financial support to make this federally centered regulatory approach palatable to cash-strapped states.

CONCLUSION

With over sixty million poor and disabled Americans relying on Medicaid to provide access to health care and millions more expected to join the ranks over the next few years,¹⁹⁴ ensuring that beneficiaries have meaningful access to health care providers is of utmost importance. However, if healthcare providers are unwilling to participate in the Medicaid program, many beneficiaries will be left without access to needed care. Acknowledging the importance of ensuring provider participation in the Medicaid program, Congress passed the equal access provision to ensure that states reimburse providers at a level

189. See *supra* note 166 and accompanying text.

190. See Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. at 26,344.

191. *Id.* at 26,343; see *supra* notes 10–11, 54–56, 117–19 and accompanying text.

192. See *supra* notes 117–19 and accompanying text.

193. Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26,344 (acknowledging that issues have arisen due to the lack of federal guidance).

194. See MEDICAID PROGRAM AT A GLANCE, *supra* note 12; see also *supra* note 23 and accompanying text.

that ensures quality of care and sufficient provider participation. Nevertheless, with minimal oversight and fear of reprisal from the federal government, many states have reduced provider reimbursement rates, some in violation of Medicaid's equal access provision. As a result, both Medicaid beneficiaries and providers have had to rely on judicial enforcement via private suits brought against state Medicaid agencies to enforce Medicaid's equal access provision.

A number of factors including inconsistent circuit rulings interpreting the legal requirements of Medicaid's equal access provision and conflicting rulings on whether Medicaid beneficiaries or providers are able to bring a Medicaid equal access suit in the first place, coupled with a number of other pragmatic and ethical considerations suggest that the current judicial enforcement mechanism is not an appropriate method by which to enforce Medicaid's equal access provision. Implementation of a federal equal access regulatory approach that is supported by adequate federal financial support provides an alternative means by which to ensure equal access by creating the uniform and transparent enforcement mechanism needed to enforce Medicaid's equal access provision in a practical, economic, and ethical manner.