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Are Healthcare Provider Challenges to Medicaid Cuts Dead?

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With the demise of the Boren Amendment[1], healthcare providers and Medicaid recipients have searched for an effective avenue to challenge state proposed Medicaid rate reductions that threaten access to healthcare services by Medicaid beneficiaries. With the implementation of the Affordable Care Act and significant expansion of Medicaid beneficiaries expected in the very near future, whether healthcare providers and Medicaid recipients can challenge Medicaid rate reductions takes on added importance. On May 24, 2013, the Ninth Circuit drastically reduced the legal avenues that can be taken to challenge Medicaid rate reductions. *Managed Pharmacy Care v. Sebelius*, ___ F.3d ___ (9th Cir. 2013) (*Managed Pharmacy Care*), significantly weakened the ability of healthcare providers and Medicaid recipients to challenge Medicaid rate reductions.

Once the Boren Amendment was repealed, healthcare providers continued to bring challenges to reductions in Medicaid reimbursement under other sections of 42 U.S.C. § 1396a that survived. Prominent among the surviving sections was § 1396a(a)(30)(A)[2], which requires a state Medicaid plan to establish Medicaid payment rates that "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." Since 1997 healthcare providers have relied upon *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997) (*Orthopaedic Hospital*), for the proposition that a State wanting to reduce Medicaid payment rates must first consider cost data prior to submitting a State Plan Amendment (SPA) to CMS to reduce rates to establish that the proposed rate reduction would not also reduce a Medicaid beneficiary's access thus violating § 30(A). The cases addressing § 30(A) were premised on the logic that cost data had to be evaluated *prior to* the SPA being sent to CMS for approval in order for the State to demonstrate that its proposed Medicaid rate reductions would not lessen the number of healthcare entities providing those services to Medicaid recipients to an unacceptably low level.

In 2011, the state of California Medicaid program proposed two SPAs that would reduce Medicaid payment rates 10% or more. California justified these proposed rate reductions on data reviews that even the State conceded did not include data "with respect to

most of the services subject to the rate reduction." These "studies" concluded that the proposed Medicaid rate reductions were "unlikely to diminish access" by Medicaid recipients. California also submitted to the Secretary with the SPAs an 82-page monitoring plan which claimed it would "study on a recurring basis to ensure the SPAs do not negatively affect beneficiary access." However, there was nothing in the monitoring plan that stated what the State would do should it conclude that there was a negative affect on beneficiary access.

The Secretary approved both SPAs and the cuts in Medicaid reimbursement. A group of challengers filed suit to have the State enjoined from implementing the Medicaid payment cuts detailed in the SPAs and were successful in the federal district court. The Ninth Circuit reversed the lower court decision holding that the lower court "misapplied the applicable legal rules."

Managed Pharmacy Care undermined *Orthopaedic Hospital* so severely that little, if any of it remains. *Managed Pharmacy Care* noted that the Secretary of Health and Human Services was not a party in *Orthopaedic Hospital*. The Court stated that since the Secretary was not a party in the prior case the *Orthopaedic Hospital* court never addressed the salient issue of what degree of deference was owed to the Secretary after the Secretary had approved a SPA. *Managed Pharmacy Care* concludes that the Secretary is owed great deference.

Managed Pharmacy Care notes that "Congress expressly delegated to the Secretary the responsibility and the authority to administer the Medicaid program and to review state Medicaid plans and plan amendments for compliance with federal law." As such, the Secretary's approval cannot be set aside unless that action is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." The court stated that challengers to the Secretary must meet the "heavy burden of showing that the [Secretary] 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 [Secretary], or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." In other words, once the Secretary approves a SPA that decision is virtually unassailable.

Underscoring the strength of the Secretary's position, the Court stated that "§ 30(A) does not prescribe any particular methodology a State must follow before its proposed [Medicaid] rate may be approved." Thus, the Court allowed the Medicaid rate reductions detailed in the SPA to stand while simultaneously noting that the State "did not review cost data with respect to most of the services subject to the [Medicaid] rate reduction." The Court went even further and flatly stated that "the lack of cost studies did not preclude . . . reducing [Medicaid] reimbursement rates." The Court stressed the Secretary's expertise "in all things Medicaid" and stated that the Secretary was entitled to deference with respect to SPA approvals.

"The position that costs might or might not be one appropriate measure by which to study [Medicaid] beneficiary access, depending on the circumstances of each State's plan, is entirely reasonable," said the Court. The Court said that once the Secretary determined that the SPA complied with federal law that was "the end of the matter for purposes of this appeal . . . ."

Managed Pharmacy Care appears to curtail additional challenges to Medicaid rate reductions based on § 30(A) unless the challenger is able to bring its action without the Secretary being a party to the action or unless the issue being challenged is one where the Secretary has not yet exercised her discretion or unless the challenger can show that the Secretary has acted in an arbitrary and capricious manner.

The challengers to the Medicaid cuts still have the option of seeking appeal of *Managed Pharmacy Care* before the United States Supreme Court. Also, there is still an open question of whether healthcare providers and Medicaid beneficiaries could maintain a private cause of action under the Supremacy Clause to enforce Medicaid law. Nevertheless, unless *Managed Pharmacy Care* is successfully challenged before the United States Supreme Court, challenges to Medicaid reimbursement cuts will be much more difficult in the future.

Healthcare provider challenges to proposed Medicaid payment cuts may not be dead but this recent decision, if not reversed, will severely impair them.

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[1]The Boren Amendment required States to find and make assurances to the Secretary of Health and Human Services that Medicaid payment rates were "reasonable and adequate to meet the costs which must be incurred by economically and efficiently operated [healthcare] facilities." 42 U.S.C. § 1396a(a)(13)(A). *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990). The Boren Amendment was repealed in October of 1997.

[2]Hereafter referred to as § 30(A).