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PREEMPTION OR BUST: A REVIEW OF THE RECENT TRENDS IN MEDICAID PREEMPTION ACTIONS

*Bradley J. Sayles**

I. INTRODUCTION

As 2009 approached, many states faced astronomical budget deficits. State legislatures made quick efforts to close the deficit gaps and funds previously allocated to State Medicaid Programs were often the first and most trimmed back.¹ As state deficit problems continued to grow, Congress took action by passing the American Recovery and Reinvestment Act (ARRA), which President Barack Obama signed into law on February 17, 2009.² One facet of the ARRA is a temporary increase of \$87 billion in the federal share of Medicaid costs.³ However, the increased federal funds expire on December 31, 2010.⁴ Consequently, states are predicted to suffer

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1. See Elizabeth Fernandez, *Medi-Cal Cuts Put Pressure on Counties*, S.F. CHRONICLE, Feb. 20, 2009, at A13 (noting that the California budget shifts \$54 million away from county and UC hospitals through reductions in Medicaid); Kevin Sack & Katie Zezima, *Growing Need for Medicaid Strains States*, N.Y. TIMES, Jan. 22, 2009, at A25 (describing provider payment cuts in Florida, Nevada, California, Minnesota, South Carolina, Utah, among others); Julie Appleby, *States Forced to Cut Health Coverage for Poor*, USA TODAY (Oct. 10, 2008), http://www.usatoday.com/news/health/2008-10-28-health-cuts_N.htm (noting Medicaid funding cuts for Hawaii, South Carolina, California and Massachusetts and quoting Elizabeth McNichol, "Health care gets hit hard when states have to cut back").

2. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat 115 (2009); KAISER FAMILY FOUND., *American Recovery and Reinvestment Act (ARRA): Medicaid and Health Care Provisions* (Mar. 2009), <http://www.kff.org/medicaid/upload/7872.pdf>.

3. KAISER FAMILY FOUND., *supra* note 2, at 1. In order to receive these increased funds, the ARRA requires states to maintain certain aspects of their current Medicaid plans; such as pre-ARRA covered benefits and enrollment levels. *Id.*

4. *Id.*

even larger budget deficits.⁵ Absent additional federal support, it is likely that states will again look to cut Medicaid funding.⁶

Although beneficiaries suffer the greatest injuries when states trim Medicaid funds, providers are often the first to suffer the associated financial consequences. When states reduce funds from their Medicaid programs, the simplest reduction is often made by decreasing payment rates to those that provide medical services to Medicaid enrollees.⁷ Yet, Congress and the courts have spent the last twenty years stripping providers of any means to protect themselves against rate reductions that directly conflict with, or obstruct, the goals and objectives of the Medicaid Act.⁸ Despite the previous actions of Congress and the courts, providers may still have at least one route to the courthouse door: the Supremacy Clause.⁹

This Article examines how Medicaid providers may use the Supremacy Clause as a tool to prevent states from arbitrarily reducing Medicaid reimbursement rates. Part II provides pertinent background information regarding the Medicaid Act and discusses the history behind 42 U.S.C. §§ 1396a(a)(30) and 1983.¹⁰ Part III discusses the Supremacy Clause and the Preemption Doctrine including what establishes federal jurisdiction and the remedies available to aggrieved parties. Part III also discusses the Supreme Court's decision in *Pharmaceutical Research and Manufacturers of America v. Walsh* and the lower courts' interpretation of that case. Finally, Part IV provides analysis of the current state of the law and maintains that providers should argue that the Secretary of the Department of Health and Human Services (the Secretary) not be afforded any deference and that providers assume the burden of production.

5. Elizabeth McNichol & Nicholas Johnson, *Recession Continues to Batter State Budgets; State Responses Could Slow Recovery* (Feb. 25, 2010), <http://www.cbpp.org/files/9-8-08sfp.pdf>.

6. *Medicaid's Continuing Crunch In a Recession: A Mid-Year Update for State FY 2010 and Preview for FY 2011*, KAISER FAMILY FOUND. 1, 2 (Feb. 2010), <http://www.kff.org/medicaid/upload/8049.pdf> ("Many governors' proposed budgets for state fiscal year 2011 include drastic cuts to Medicaid.").

7. See Sack & Zezima, *supra* note 1, at A25.

8. See *infra* Part II.B.

9. U.S. CONST. art. VI, § 1, cl. 2.

10. 42 U.S.C. §§ 1396(a)(30) & 1983 (2003).

II. BACKGROUND

A. *The Medicaid Act*

In 1965, Congress enacted Titles XVIII and XIX to the Social Security Act.¹¹ Title XVIII created the Medicare program and Title XIX established Medicaid.¹² Although both Medicaid and Medicare were launched simultaneously and provide healthcare to specified demographics, the similarities end there. The purpose of each act reflects the obvious distinction: Congress designed Medicare to provide hospital insurance for the aged, while intending Medicaid to enable each state to furnish medical assistance to low income persons.¹³ The implementation of each program demonstrates arguably the most significant distinction. Medicare is a federally administered program, while Medicaid is a cooperative federal-state program.¹⁴ As a cooperative program, Medicaid gives states a choice in participating,¹⁵ but includes several incentives that ensure wide-scale participation.¹⁶ By 1969, only four years after its enactment, all but two

11. See 42 U.S.C. §§ 1395-96 (2009).

12. *Id.*

13. See *Amgen, Inc. v. Smith*, 357 F.3d 103, 110 (D.C. Cir. 2004) (“The broad purpose of the Medicare Act [is] to provide more adequate and feasible health insurance protection for the elderly.”); *Newark Parents Ass’n v. Newark Pub. Schs.*, 547 F.3d 199, 207 (3d Cir. 2008) (“[Medicaid Act] established a cooperative federal-state program under which the federal government furnishes funding to states for the purpose of providing medical assistance to eligible low-income persons.”).

14. See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) (codified as amended in subchapter XVIII of 42 U.S.C.); see generally ROBERT STEVENS & ROSEMARY STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* 68 (1974); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL’Y 5 (2006) (for further analysis of the Medicaid’s history).

15. See 42 U.S.C. § 1396a; *Harris v. McRae*, 448 U.S. 297, 308 (1980).

16. STEVENS & STEVENS, *supra* note 14, at 61.

states joined the cooperative program.¹⁷ Since 1982, every state has taken part in Medicaid.¹⁸

Once a state agrees to participate in the Medicaid program, it must create a plan that complies with the provisions of relevant federal statutes and regulations (the State Plan)¹⁹ and meets the approval of the Secretary.²⁰ However, the Secretary does not review the State Plan's payment methods and standards; instead, approval is based on the assurances made by each state that the plan meets all federal requirements.²¹ The Secretary has since delegated the approval authority to the Regional Administrators of the Centers for Medicare & Medicaid Services (CMS).²²

Health care providers, similar to states, opt-in to the Medicaid program.²³ Medicaid providers, in most cases, are paid directly for the services they provide to eligible beneficiaries.²⁴ These payments must be accepted as payment in full.²⁵ Providers, nonetheless, may choose not to participate in Medicaid, but for many providers, non-participation is not an easy decision. For example, non-profit hospitals with emergency departments risk not only the loss of their tax exempt status, but may still be forced to provide care to eligible individuals because of other statutory requirements.²⁶ These

17. *Id.*

18. ARIZ. REV. STAT. ANN. § 36-2901-2998 (1982); ALASKA STAT. § 47.07.010-900 (1972).

19. 42 C.F.R. § 430.15(a)(1) (2009); *see also Harris*, 448 U.S. at 297; *Dep't of Health Servs. v. Sec'y of Health & Human Servs.*, 823 F.2d 323, 325 (9th Cir. 1987).

20. 42 U.S.C. § 1396a(b).

21. 42 C.F.R. § 447.256(2) (2009).

22. *Id.* at § 430.15(b).

23. 42 U.S.C. § 1396a(a)(30)(A).

24. 42 C.F.R. § 447.10 (2009).

25. *Rehab. Ass'n of Va. v. Kozlowski*, 42 F.3d 1444, 1447 (4th Cir. 1994); *See* 42 C.F.R. § 447.15 (2009).

26. 42 U.S.C. § 1395dd; *see also* 26 U.S.C. § 501(c)(3) (2006); Rev. Rul. 69-545, 1969-2 C.B. 117; Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, The Internal Revenue Service and the Courts*, 16 J. HEALTH POL., POL'Y & L. 251 (1991); Nancy M. Kane, *Tax-Exempt Hospitals: What is Their*

circumstances, combined with the always-rising costs of health care,²⁷ make Medicaid reimbursements rates even more significant and create a genuine dilemma for providers.

B. The Evolution of §§ 1396a(a)(30) and 1983

A State Plan must meet specific requirements expressly provided by statute in 42 U.S.C. § 1396a. The requirement most pertinent to Medicaid providers is § 1396a(a)(30). That subsection requires, in part, that State Plans must:

[p]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.²⁸

This provision is often referred to as the “equal access” provision. Subsection 1396a(a)(30), the central federal limit on payment rates, is the subject of much litigation.²⁹

Since the adoption of the Medicaid Act in 1965, the language governing payments has changed drastically. Until 1997, § 1396a(a)(30) applied primarily to physicians.³⁰ As adopted, § 1396a(a)(30) required that Medicaid payments not be “in excess of reasonable charges consistent with efficiency, economy, and quality of care.”³¹ The 1965 legislation allowed states to determine what payment schemes to adopt, but required

Charitable Responsibility and How Should it Be Defined and Reported?, 51 ST. LOUIS U.L.J. 459 (2007).

27. *American Health Care Costs a Primer: Key Information on Health Care Costs and Their Impact*, KAISER FAMILY FOUND. (Mar. 2009), http://www.kff.org/insurance/upload/7670_02.pdf.

28. 42 U.S.C. § 1396a(a)(30)(A).

29. *See id.* at § 1396a; *see also infra* Parts II-III.

30. Balanced Budget Act of 1997, Pub. L. No. 105-33 (1997).

31. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1497 (9th Cir. 1997).

reimbursement of inpatient hospital care for reasonable costs.³² Medicare also used the term “reasonable costs” and applied the regulations interpreting the term under that Act to Medicaid.³³ This served to prevent states from restricting the most expensive form of healthcare, inpatient hospital care.³⁴ However, all other providers generally received “self-determined fees.”³⁵ As a result, by 1970, providers had become the villains of the Medicaid story.³⁶

Despite laying the blame on the provider’s doorstep, Congress initially did not act to reduce reimbursement rates by controlling expenses. Instead, the federal government, in order to resolve such issues, proposed to cut back on eligibility and covered services.³⁷ This enabled states to determine whether reimbursement rates should be cut and some states took such action.³⁸ In response to state-initiated rate cuts, a few providers sought declaratory and injunctive relief from the courts, with limited success.³⁹ In 1972, Congress began a shift towards more flexible standards for Medicaid.⁴⁰ But it was not until 1980 that Congress enacted serious changes to the interpretation of reimbursement rates.⁴¹

32. Pub. L. No. 89-97 (1965); see also STEVENS & STEVENS, *supra* note 14, at 66 (creating “a Pandora’s box for medical costs”).

33. STEVENS & STEVENS, *supra* note 14, at 187.

34. See NATIONAL CENTER FOR HEALTH SERVICES, DHHS, Pub. No. 2009-1232, *Health, United States 2008 with Special Features on Health of Young Adults 4* (2008), <http://www.cdc.gov/nchs/data/hus/hus08.pdf> (“Hospital spending . . . accounts for 31% of national health expenditures.”).

35. STEVENS & STEVENS, *supra* note 14, at 132.

36. *Id.* at 183.

37. *Id.* at 213.

38. *Id.* at 265-66.

39. See *Rhodes v. Harder*, 508 P.2d 959, 961 (Kan. 1973); *Shady Acres Nursing Home, Inc. v. Canary*, 316 N.E.2d 481, 483-84 (Ohio App. 1973); *Catholic Med. Ctr. of Brooklyn & Queens, Inc., v. Rockefeller*, 430 F.2d 1297, 1298-99 (2d Cir. 1970).

40. Social Security Amendments of 1972, Pub. L. No. 92-603 (1972).

41. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499 (1980).

The Omnibus Reconciliation Act of 1980 enacted the Boren Amendment, which required states to make “reasonable and adequate” payments to meet the costs incurred by “efficiently and economically” run nursing facilities.⁴² Congress intended that this provision would prevent states from reducing rates “solely on the basis of budgetary appropriations.”⁴³ However, this “Congressional admonition must be taken with a grain of salt since the subsequent federal [Medicaid funding] cutbacks obviously had an impact on a state’s financial health, a factor Congress could not have ignored.”⁴⁴ A year later, with the Omnibus Reconciliation Act of 1981, Congress removed the “in excess of reasonable charges” language from § 1396a(a)(30) and extended the Boren Amendment to cover payments for inpatient hospital care.⁴⁵ The legislative history behind the 1981 extension is more telling, stating:

In eliminating the current requirement that States pay hospitals on a Medicare “reasonable cost” basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.⁴⁶

Despite Congressional intent, the Boren Amendment became a staple in provider litigation, due in large part to Supreme Court decisions broadly interpreting § 1983.⁴⁷

Enacted in 1871 under the Klu Klux Klan Act, § 1983 states:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other

42. *Id.*

43. *Miss. Hosp. Ass’n, v. Heckler*, 701 F.2d 511, 518 (5th Cir. 1983) (citing H.R. Conf. Rep. 1479, 96th Cong., 2d Sess., at 154, *reprinted in* 1980 U.S.C.C.A.N. 5526, 5903, 5944).

44. *Coal. of Mich. Nursing Homes, Inc. v. Dempsey*, 537 F. Supp. 451, 463 n. 41 (E.D. Mich. 1982).

45. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 (1981).

46. H.R. Rep. No. 158, 97th Cong., 1st Sess., at 293 (1981).

47. *See Maine v. Thiboutot*, 448 U.S. 1 (1980).

person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution *and laws* shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.⁴⁸

In 1980, the year Congress adopted the Boren Amendment and over 100 years after the enactment of § 1983, the Supreme Court decided *Maine v. Thiboutot*, which held for the first time that § 1983's "and laws" language included federal statutes.⁴⁹ The result in *Thiboutot* established a cause of action under § 1983 for state deprivations of "rights secured" by federal statutes, not just constitutional rights.⁵⁰ The following year, in *Pennhurst State School and Hospital v. Halderman*, the Supreme Court first chipped away at *Thiboutot*'s broad holding.⁵¹

In *Pennhurst*, the Supreme Court held that language contained within the "bill of rights" provision of the Developmentally Disabled Assistance and Bill of Rights Act "spoke merely in precatory terms" and did not confer any "substantive rights."⁵² Without a "substantive right" to enforce, § 1983 is useless to a claimant.⁵³ After *Pennhurst*, the focus under § 1983 actions became whether the statute itself contained mandatory, not merely precatory, right-conferring language.⁵⁴ Following *Pennhurst*, the Supreme Court, in *Golden State Transit Corp. v. Los Angeles*, further defined § 1983 actions.⁵⁵ The result was a three-part test:

(1) Whether the provision in question creates obligations binding on the governmental unit or rather 'does no more than express a congressional preference for certain kinds of treatment.' (2) The interest the plaintiff asserts must not be 'too vague and

48. 42 U.S.C. § 1983 (emphasis added).

49. *Thiboutot*, 448 U.S. at 4-5; See Paul Wartelle & Jeffrey Hadley Loudon, *Private Enforcement of Federal Statutes: The Role of the Section 1983 Remedy*, 9 HASTINGS CONST. L.Q. 487 (1982) (discussing the *Thiboutot* decision).

50. See, e.g., *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981).

51. *Id.*

52. *Id.* at 18.

53. *Id.* at 28 n. 21.

54. *Lynch v. King*, 550 F. Supp. 325, 349 (D.C. Mass. 1982).

55. 493 U.S. 103 (1989).

amorphous' to be 'beyond the competence of the judiciary to enforce.' (3) We have also asked whether the provision in question 'was intend[ed] to benefit' the putative plaintiff.⁵⁶

Section 1983 claims, of course, became more prevalent following *Thiboutot* and *Pennhurst*. Specifically, Medicaid providers used § 1983 to enforce the newly enacted Boren Amendment. As a result, the federal circuit courts struggled with the application of the Boren Amendment and § 1983 for close to a decade.⁵⁷ But, a year after the *Golden State* decision, the Supreme Court was presented with the opportunity to measure the Boren Amendment against its § 1983 three-part test.⁵⁸ In *Wilder v. Virginia Hospital Association*, the Supreme Court held that the Boren Amendment "creates a right enforceable by health care providers under § 1983."⁵⁹ The story, however, does not end here; Congress was not done with the Medicaid Act and the Supreme Court was far from done with § 1983.

56. *Id.* at 106 (citations omitted).

57. *See, e.g.*, *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 30 (3d Cir. 1989) (holding the Pennsylvania reimbursement scheme violated the Boren Amendment), *cert. denied*, 46 U.S. 936 (1990); *Colo. Health Care Ass'n v. Colo. Dep't of Soc. Servs.*, 842 F.2d 1158, 1164 n.5 (10th Cir. 1988) (holding that providers could assert the rights of Medicaid recipients); *Silver v. Baggiano*, 804 F.2d 1211, 1218 (11th Cir. 1986) (expressly reserving the question); *Coos Bay Care Ctr. v. State of Oregon*, 803 F.2d 1060, 1061 (9th Cir. 1986), *vacated on other grounds*, 484 U.S. 806 (1987); *Neb. Health Care Ass'n v. Dunning*, 778 F.2d 1291, 1296 (8th Cir. 1985), *cert. denied*, 479 U.S. 1063 (1987); *Folden v. Wash. State DSHS*, 744 F. Supp. 1507, 1525 (W.D. Wash. 1990) (dismissing the plaintiffs' § 1983 claims, but finding a cause of action directly under the Boren Amendment and reviewing that claim under an arbitrary and capricious standard); *Mich. Hosp. Ass'n v. Dep't of Soc. Servs.*, 738 F. Supp. 1080, 1085-86 (W.D. Mich. 1990); *Ill. Health Care Ass'n v. Suter*, 719 F. Supp. 1419, 1427 (N.D. Ill. 1989) (holding that no private cause of action to sue the Secretary exists under the Boren Amendment); *St. Michael Hosp. v. Thompson*, 725 F. Supp. 1038, 1043-44 (W.D. Wis. 1989) (holding that a private right of action exists under the Boren Amendment but, for other reasons, refusing to decide the merits of the case); *AGI-Bluff Manor, Inc. v. Reagen*, 713 F. Supp. 1535, 1542 (W.D. Mo. 1989) (finding no § 1983 right of action under the Boren Amendment); *Coal. of Mich. Nursing Homes, Inc. v. Dempsey*, 537 F. Supp. 451, 452 (E.D. Mich. 1982) (asserting an implied right of action under the Boren Amendment rather than § 1983).

58. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 501 (1990).

59. *Id.* at 509-10.

With the Balanced Budget Act of 1997, Congress repealed the Boren Amendment.⁶⁰ This left § 1396a(a)(30), the “equal access” provision, as the primary federal guideline for state reimbursement rates. Repeal of the Boren Amendment removed the “reasonable” payment rate requirements and put the Supreme Court’s holding in *Wilder* in question. Although, *Wilder* is still considered “good” law,⁶¹ its applicability to Medicaid is questionable because of the Boren Amendment’s repeal and the Supreme Court’s propensity to continually tinker with § 1983 claims.

The Supreme Court has made two primary adjustments to the three-part test laid out in *Golden State* and as applied in *Wilder*. First, in *Blessing v. Freestone* the Court reorganized and more succinctly stated the test:

Three principal factors determine whether a statutory provision creates a privately enforceable right [under § 1983]: (1) whether the plaintiff is an intended beneficiary of the statute; (2) whether the plaintiff’s asserted interests are not so vague and amorphous as to be beyond the competence of the judiciary to enforce; and (3) whether the statute imposes a binding obligation on the State.⁶²

After applying the reworked three-part test, the Court found that the Spending Clause legislation at issue did not provide rights under § 1983. The second, and most important, adjustment came in the 2002 decision of *Gonzaga University v. Doe*, in which the Supreme Court also disallowed a § 1983 claim brought under Spending Clause legislation.⁶³ In doing so, the Court emphasized that “unless Congress ‘speak[s] with a clear voice’ and manifests an ‘unambiguous’ intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983.”⁶⁴ Circuit courts have since struggled with the meaning of *Gonzaga*, but its application to Medicaid provider appeals has been universally harsh.

60. Balanced Budget Act of 1997, Pub. L. No. 105-33 (1997).

61. See *Pediatric Specialty Care, Inc. v. Ark. Dept. of Human Servs.*, 443 F.3d 1005, 1015 (8th Cir. 2006); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 184 (3rd Cir. 2004); see also Rochell Bobroff, *Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes*, 10 LOY. J. PUB. INT. L. 27, 85 (2008).

62. *Blessing v. Freestone*, 520 U.S. 329, 329-30 (1997).

63. *Gonzaga v. Doe*, 536 U.S. 273, 290 (2002); see also Sasha Samberg-Champion, *How to Read Gonzaga: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 COLUM. L. REV. 1838, 1840 (2003) (noting that “some analysts conclude that *Gonzaga* signals the end of Section 1983 actions to enforce at least all Spending Clause statutes.”).

64. *Gonzaga*, 536 U.S. at 280 (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 28 n.21 (1981)).

Prior to *Gonzaga*, but after *Blessing* and the Boren Amendment's repeal, federal circuit courts split regarding whether providers are the intended beneficiaries of the equal access provision.⁶⁵ Post-*Gonzaga*, there remains a split among the federal circuits as to whether Congress intended the equal access provision to confer individual rights upon eligible beneficiaries.⁶⁶ As applied to providers, however, each court, when confronted with the issue, found that providers are not conferred rights under § 1396a(a)(30).⁶⁷ The Supreme Court has yet to take any interest in hearing appeals based on these decisions,⁶⁸ and without further guidance from the Supreme Court, § 1983 remains closed to providers.

But not all is lost. Many providers have recently used the Supremacy Clause's preemption doctrine to hold states accountable for reimbursement

65. See e.g., *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 543-44 (3d Cir. 2002) (en banc) (positing, in dicta, a right for recipients while rejecting such a right for providers); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 910 (5th Cir. 2000); *Visiting Nurse Ass'n of North Shore v. Bullen*, 93 F.3d 997, 1004 n.7 (1st Cir. 1996) (holding a right existed for providers and beneficiaries); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993).

66. See *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007) (holding that § 1396a(a)(30), does not confer individual private rights that are enforceable under § 1983); *Mandy v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006) (holding § 1396a(a)(30) does not create a federal right enforceable under § 1983); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542-43 (6th Cir. 2006) (holding that § 1396a(a)(30) "has an aggregate focus rather than an individual focus" and is "ill-suited to judicial remedy;" therefore, no § 1983 right of action for providers or beneficiaries); *Sanchez v. Johnson*, 416 F.3d 1051, 1059 (9th Cir. 2005) (holding there is no enforceable private right for recipients or providers); *Long Term Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004) (finding no enforceable private right for providers because § 1396a(a)(30) "has no 'rights creating language' and identifies no discrete class of beneficiaries"); *but see Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1015-16 (8th Cir. 2006) (following prior circuit precedent that § 1396a(a)(30) created an enforceable private right for recipients and providers, despite *Gonzaga*), *judgment vacated*, *Selig v. Pediatric Specialty Care, Inc.*, 551 U.S. 1142, 1142 (2007) (instructing the lower court to dismiss the appeal as moot).

67. See sources cited *supra* note 66.

68. See e.g. *Hawkins*, 129 S. Ct. at 34; *but see* Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 469-70 (2009) (suggesting that *Gonzaga* is ripe for reconsideration, but revisiting *Gonzaga* may result in an elimination of private causes of actions altogether).

rate reductions.⁶⁹ Although the Supremacy Clause is a road back to the courthouse door, it is a journey yet to be completed.

III. SUPREMACY CLAUSE AND THE DOCTRINE OF PREEMPTION

A. *The Supremacy Clause in General; Preemption, Jurisdiction and Remedies*

The Supremacy Clause is the dividing line between the shared sovereignty of the federal and state governments. As the Supreme Court asserted, “the States possess sovereignty concurrent with that of the Federal Government, subject only to limitations imposed by the Supremacy Clause.”⁷⁰ In pertinent part, the Supremacy Clause requires:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.⁷¹

Rooted in the Supremacy Clause is the Congressional power to preempt an area of law traditionally governed by the states.⁷²

There are two different types of preemption: express and implied.⁷³ Express preemption occurs when Congress has spoken directly, excluding further state action.⁷⁴ Implied preemption, on the other hand, occurs when Congressional intent to preempt is “implicitly contained in [the statute’s] structure and purpose.”⁷⁵ Implied preemption is broken down further into two subcategories: field and conflict.⁷⁶ Field preemption occurs when the regulatory scheme implemented by Congress is “so pervasive as to make reasonable the inference that Congress left no room for the States to

69. See *infra* Part.III.C.

70. *Tafflin v. Levitt*, 493 U.S. 455, 458 (1990).

71. U.S. CONST. art. VI, § 1, cl. 2.

72. *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991).

73. *Gade v. Nat’l Solid Wastes Mgmt. Ass’n*, 505 U.S. 88, 98 (1992).

74. *Id.* (quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 525 (1977)).

75. *Gade*, 505 U.S. at 98.

76. *Id.*

supplement it.”⁷⁷ Conflict preemption comes in two different forms: impossibility and obstacle.⁷⁸ When it becomes impossible to comply with both the federal and state laws, the state law is considered preempted.⁷⁹ Implied preemption occurs when state law “stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.”⁸⁰

Any claim of preemption starts with analyzing the text of the federal statute at issue.⁸¹ The text, however, is not viewed in a vacuum. There are two guiding principles: the presumption against preemption and congressional intent.⁸² The presumption against preemption assumes that the “the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.”⁸³ There is some debate as to whether the presumption against preemption is wholly applicable.⁸⁴ However, the instances where the Supreme Court has ignored the presumption have been entirely in the realm of preemption as an affirmative defense, and not affirmative preemption, where the claim of preemption itself is the sole controversy.⁸⁵ There is little debate that in affirmative preemption matters, a court should start with a strong presumption against preemption, and even more so in Spending Clause preemption cases.⁸⁶

77. *Id.* (quoting *Fidelity Fed. Sav. & Loan Ass’n v. De la Cuesta*, 458 U.S. 141, 153 (1982)).

78. *Id.*

79. *Id.*

80. *Id.* (citing *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941)).

81. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 487 (1997).

82. *Id.*

83. *Id.*

84. Erwin Chemerinsky, *The Assumptions of Federalism*, 58 STAN. L. REV. 1763, 1785 (2006); see generally Mary J. Davis, *Unmasking the Presumption in Favor of Preemption*, 53 S.C. L. REV. 967 (2002).

85. Compare *Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 867 (2000), with *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).

86. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 662 (2003).

The second guiding principle is that “[t]he purpose of Congress is the ultimate touchstone’ in every pre-emption case.”⁸⁷ Thus, “any understanding of the scope of a pre-emption statute must rest primarily on ‘a fair understanding of *congressional purpose*.”⁸⁸ Congressional purpose is gleaned from the “statutory framework,” “the structure and purpose of the statute as a whole” and the court’s own understanding of “the way in which Congress intended the statute and its surrounding regulatory scheme to affect business, consumers, and the law.”⁸⁹ Keeping these guidelines in mind, the analysis then turns to the text of the statute or regulation and the particular circumstances surrounding the claim.

The Supremacy Clause “is not a source of any federal rights.”⁹⁰ Instead, “there is an implied right of action to enjoin state or local regulation that is pre-empted by a federal statutory or constitutional provision.”⁹¹ However, the Supreme Court has never explicitly held that an implied right of action exists.⁹² Rather, the Court has repeatedly decided preemption claims on their merits, without discussing the authority to bring suit under the Supremacy Clause.⁹³ The Court’s decisions in *Franchise Tax Board v. Construction Laborers Vacation Trust* and *Shaw v. Delta Air Lines, Inc.*, both decided the same day, are more instructive to this point.⁹⁴ In *Franchise Tax Board*, the petitioners asked the court to declare that the Employee Retirement Income Security Act (ERISA) did not preempt a state law; the

87. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1997).

88. *Id.* at 485-86 (emphasis added) (citing *Cipollene v. Liggett Grp., Inc.*, 505 U.S. 504, 530 (1992)).

89. *Id.* (citing *Gade v. Nat’l Solid Wastes Mgmt. Ass’n*, 505 U.S. 88, 111 (1992)) (internal quotations omitted).

90. *Golden State Transit Corp. v. L.A.*, 493 U.S. 103, 107 (1989) (quoting *Chapman v. Hous. Welfare Rights Org.*, 441 U.S. 600, 613 (1979)).

91. RICHARD H. FALLON, DANIEL J. MELTZER, & DAVID L. SHAPIRO, HART & WECHSLER’S *THE FEDERAL COURTS & THE FEDERAL SYSTEM* 903 (5th ed. 2003); see also David Sloss, *Constitutional Remedies for Statutory Violation*, 89 IOWA L. REV. 355, 362 (2004).

92. See David Sloss, *supra* note 90 at 360.

93. See, e.g., *Burbank v. Lockheed Air Terminal Inc.*, 411 U.S. 624 (1973); *Ray v. Atl. Richfield Co.*, 435 U.S. 151 (1978); *Gade*, 505 U.S. at 88.

94. *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 9-10 (1983); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 85 (1983).

Court held that the federal courts lacked jurisdiction for such a claim.⁹⁵ In *Shaw*, the petitioners sought injunctive and declaratory relief, requesting a ruling that a state law *was preempted* by ERISA; the Court agreed.⁹⁶ In a footnote to the *Shaw* opinion, the Court stated that its decision in *Franchise Tax Board* “does not call into question the lower court’s jurisdiction to decide [affirmative preemption] cases.”⁹⁷

Relying on *Shaw*, the Ninth Circuit recognized that: “A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction.”⁹⁸ As eluded to in *Shaw* and the Ninth Circuit’s opinion, actions brought under the Supremacy Clause provide only for equitable remedies, namely injunctive and declaratory relief.⁹⁹ Injunctive relief is an equitable remedy that either mandates a party take a particular action or prohibits a party from taking a particular action.¹⁰⁰ Preemption claims lend themselves primarily to prohibitory injunctions; therefore, only prohibitory injunctions will be discussed. Of the types of injunctions available, two are important to the Supremacy Clause: preliminary and permanent. A preliminary injunction is a request that a court prohibit a party from taking a particular action during the course of litigation,¹⁰¹ while a permanent injunction provides for indefinite prohibition following a trial on the merits.¹⁰² Both preliminary

95. *Franchise Tax Bd.*, 463 U.S. at 9-10.

96. *Shaw*, 463 U.S. at 109.

97. *Id.*

98. *Indep. Living Ctr. of S. Cal., Inc.*, 543 F.3d 1050, 1056-57 (9th Cir. 2008).

99. *Id.*; *see also Shaw*, 463 U.S. at 96 n.14.

100. *See Sereboff v. Mid Atl. Med. Serv., Inc.*, 547 U.S. 356, 360 (2006); *Rumsfeld v. Forum for Academic and Institutional Rights, Inc.*, 547 U.S. 47, 51 (2006).

101. *See Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 9-10 (1983).

102. *Force v. Pierce City R-VI Sch. Dist.*, 570 F. Supp. 1020, 1031-32 (W.D. Mo. 1983).

and permanent injunctions should be sought in a claim for affirmative preemption.¹⁰³

To be entitled to a preliminary injunction a party must establish: (1) a substantial likelihood that it will prevail on the merits; (2) that it will suffer irreparable injury unless the injunction issues; (3) that the threatened injury to the moving party outweighs whatever damage the proposed injunction will cause the opposing party; and (4) that the injunction would not be adverse to the public interest.¹⁰⁴ Permanent injunctions differ in two regards: first, a permanent injunction may only be issued after a trial on the merits; and second, permanent injunctions do not require proof of irreparable harm, merely proof of an inadequate legal remedy.¹⁰⁵

Although the four-part test for preliminary injunctions is generally applicable in each of the federal circuits, there are two schools of thought as to the weight given to each factor.¹⁰⁶ The first approach applies each part of the test with equal weight; this is often referred to as the “traditional” test.¹⁰⁷ The second test is referred to as the “alternative” or “sliding scale” test. Under this approach, “a court may grant the injunction if the plaintiff ‘demonstrates either a combination of probable success on the merits and the possibility of irreparable injury or that serious questions are raised and the balance of hardships tips sharply in his favor.’”¹⁰⁸ Despite the long-standing circuit split, the “Supreme Court has not yet articulated a consistent standard for granting or denying a preliminary injunction.”¹⁰⁹

103. Preliminary injunctions only function until the trial has ended. In cases of preemption, the intention is to permanently stop the action. A preliminary injunction should be sought to stop the action as the trial proceeds with a permanent injunction being the actual final award. Therefore, both should be sought.

104. *Lundgrin v. Claytor*, 619 F.2d 61, 63 (10th Cir. 1980).

105. *Force*, 570 F. Supp. at 1031-32.

106. See Morton Denlow, *The Motion for a Preliminary Injunction: Time for a Uniform Federal Standard*, 22 REV. LITIG. 495, 514-30 (2003); but see *Winter v. NRDC, Inc.*, 129 S. Ct. 365, 375-76 (2008).

107. See, e.g., *Narragansett Indian Tribe v. Guilbert*, 934 F.2d 4, 5 (1st Cir. 1991).

108. *Save Our Sonoran, Inc. v. Flowers*, 381 F.3d 905, 912 (9th Cir. 2004) (citing *Johnson v. Cal. St. Bd. of Accountancy*, 72 F.3d 1427, 1430 (9th Cir. 1995)).

109. Denlow, *supra* note 106, at 510.

The second possible remedy is derived from the Declaratory Judgment Act. The Act provides:

In a case of actual controversy within its jurisdiction . . . any court of the United States . . . may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought. Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such.¹¹⁰

Relief under the Act is available if there is an actual controversy and the controversy would allow for “specific relief through a decree of a conclusive character, as distinguished from an opinion.”¹¹¹ This declaration is not a right, but merely “available as a matter of judicial discretion.”¹¹² Declaratory judgments should not be used as a means of circumventing administrative or special tribunal decisions.¹¹³ Finally, courts have long recognized the potential for declaratory relief in preemption actions.¹¹⁴

Section 1983 claims, alternatively, can result in awards of monetary relief, such as attorney’s fees and punitive damages.¹¹⁵ As a result, preemption actions are less attractive than § 1983 claims, especially for Medicaid beneficiaries whose acceptance in the Medicaid program alone indicates a lack of finances. For providers, the lack of monetary relief and paying out of pocket for attorney fees does not diminish the attractiveness of preemption claims, given the impact of *Gonzaga* on § 1983.

B. PREEMPTION AND THE MEDICAID ACT: PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA V. WALSH

Preemption has become an important avenue for Medicaid providers following *Gonzaga*. One reason for the Supremacy Clause’s prominence is that it is not a source of any federal right, ostensibly negating a “*Gonzaga*-like” analysis. This brings the equal access provision back into play so long

110. 28 U.S.C. § 2201(a) (2006).

111. *Calderon v. Ashmus*, 523 U.S. 740, 746 (1998).

112. *Allnet Commc’n Serv., Inc. v. Nat’l Exch. Carrier Ass’n, Inc.*, 965 F.2d 1118, 1121 (D.C. Cir. 1992).

113. *Public Serv. Com. v. Wycoff Co.*, 344 U.S. 237, 246 (1952).

114. *See Verizon Md., Inc. v. Pub. Serv. Comm’n of Md.*, 535 U.S. 635, 645-46 (2002); *Gade v. Nat’l Solid Wastes Mgmt. Ass’n*, 505 U.S. 88, 97 (1992).

115. *Smith v. Wade*, 461 U.S. 30, 56 (1983).

as it has preemptive force. The Medicaid Act contains no general preemption clause; consequently, there exists no claim of express preemption.¹¹⁶ If the Medicaid Act has any preemptive force, it must be implied. However, any implied field preemption claim is likely to fail for several reasons. First, the structure of Medicaid as a voluntary cooperative federal-state program implies that it is not an area where Congress has taken regulatory control of the entire field. Further, the Medicaid Act leaves wide discretion to the states, again negating a field preemption claim.¹¹⁷ There have been successful impossibility preemption claims under the Medicaid Act.¹¹⁸ Providers, however, would have little to no success making such a claim under the equal access provision because their participation, like the states, is purely voluntary.¹¹⁹ This leaves only obstacle preemption as a possible claim.

The Supreme Court, in *Pharmaceutical Research and Manufacturers of America v. Walsh*, a 2003 decision, directly confronted such a claim.¹²⁰ In that case, the Pharmaceutical Research and Manufacturers of America (“PhRMA”) brought suit challenging the constitutionality of Maine’s prescription drug rebate program.¹²¹ PhRMA contended that the Medicaid Act preempted the state program because it stood as an obstacle to the accomplishment and execution of the Act’s full purposes and objectives.¹²² Specifically, the program subjected Medicaid sales to a “prior authorization” procedure, which the state implemented *without* the Secretary’s prior approval and to achieve Medicaid-related goals.¹²³ The district court issued a preliminary injunction enjoining the State of Maine from implementing the program.¹²⁴ The Court of Appeals for the First Circuit reversed the order,

116. 42 U.S.C. § 1396a.

117. See *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (holding that the Medicaid Act “gives the States substantial discretion . . . as long as care and services are provided in the best interest of the recipients”).

118. *Ark. Dep’t. of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 269 (2006).

119. 42 U.S.C. § 1396a(a)(30)(A).

120. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 644 (2003).

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.*

and PhRMA appealed to the Supreme Court.¹²⁵ Justice John Paul Stevens, writing for a plurality of the Court, found that PhRMA failed to adequately establish a likelihood of success on the merits.¹²⁶ The opinion carried the day because of one concurring opinion by Justice Stephen Breyer and Justices Clarence Thomas and Antonin Scalia's separate opinions concurring in result only.¹²⁷

The seven Justices seemingly reaffirmed two other important factors. First, the presumption against preemption is applicable. Justice Stevens, joined by Justices Souter, Ginsberg and Breyer wrote: "[T]he question is whether there is a probability that Maine's program was pre-empted by the mere existence of the federal statute. We start therefore with a presumption that the state statute is valid."¹²⁸ The dissent did not sign on to that part of the decision; however, unlike Part V, the dissent did not take particular issue with the plurality's analysis.¹²⁹ Given other similarly situated preemption cases, it is safe to assume that the presumption against preemption has force.¹³⁰

Second, the seven Justices affirmed, albeit *sub silentio*, that the Supremacy Clause provides an implied right of action. Both the dissent and plurality discussed the issue of preemption on its merits without ever mentioning whether a right existed to bring suit.¹³¹ Only Justices Scalia and Thomas took issue with the viability of PhRMA's claim.¹³² These two points aside, Part V of the plurality opinion inspired the most debate.

125. *Id.*

126. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 668 (2003). This holding is found in Part V of the plurality opinion and is joined by only two other Justices. *Id.* at 649.

127. *Id.* at 649, 674-75. Outside of Part V, seven other Justices joined portions of the decision; excluding Justices Thomas and Scalia.

128. *Id.* at 661.

129. *Id.* at 684 (O'Connor, J., dissenting).

130. *See Hillsborough Cnty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 715-718 (1985); *see also Davies Warehouse Co. v. Bowles*, 321 U.S. 144, 153 (1944).

131. *Walsh*, 538 U.S. at 649, 684 (O'Connor, J., dissenting).

132. *Id.* at 674-75 (Scalia, J., joined by Thomas, J., concurring).

1. Part V of the Plurality: Justice Breyer's Concurrence and the Dissent

Part V of the plurality opinion, written by Justice Stevens and joined by Justices Ginsburg and Souter held that the plaintiff failed to “show that there was no Medicaid-related goal or purpose served” by state statute.¹³³ The fact that Maine’s statute failed to explicitly state a Medicaid-related goal or purpose was not by itself adequate proof because the statute on its face “clearly” served some Medicaid-related goals.¹³⁴ In support of the holding, Justice Stevens listed three specific Medicaid-related goals “plainly present in the Maine Rx Program.”¹³⁵

The plurality’s analysis does not end there. The fact that the program may serve Medicaid-related goals or purposes does “not provide a sufficient basis for upholding the program if it *severely* curtailed Medicaid recipients’ access.”¹³⁶ In further examination of PhRMA’s obstacle preemption claim, Justice Stevens stated, the “mere fact that prior authorization may impose a *modest* impediment to access . . . does not provide a sufficient basis for pre-emption.”¹³⁷ There must be evidence “that a significant number of patients’ medical needs . . . will be adversely affected . . . [Additionally,] the impact on doctors may be significant if it produces an administrative burden that affects the quality of their treatment of patients.”¹³⁸ PhRMA, however, failed to demonstrate such a burden.¹³⁹

The plurality also noted the importance of the Secretary’s opinion. Justice Stevens wrote: “The presumption against federal pre-emption of a state statute designed to foster public health *has special force* when it appears, and the Secretary has not decided to the contrary, that the two governments are pursuing ‘common purposes.’”¹⁴⁰ As addressed above, the Secretary had

133. *Id.* at 662.

134. *Id.* at 662-63.

135. *Id.* at 663-64.

136. *Id.* at 665 (emphasis added).

137. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 667 (2003) (emphasis added).

138. *Id.* at 667-68.

139. *Id.*

140. *Id.* at 666 (citation omitted) (emphasis added).

not approved Maine's action, but CMS had sent a letter to all Medicaid directors on behalf of the Secretary indicating that a program such as Maine's would be considered a significant component of a state plan.¹⁴¹ Furthermore, CMS had approved at least one similar program.¹⁴²

Justice Breyer did not sign on with this portion of the opinion. Instead, he wrote a concurrence with similar force. Justice Breyer opined, "[t]o prevail, petitioner ultimately must demonstrate that Maine's program would 'seriously compromise important federal interests.'"¹⁴³ He also noted that the Secretary's "views are highly relevant to the question . . ."¹⁴⁴ Justices Thomas and Scalia – concurring solely in *Walsh's* outcome – reaffirmed the authority accorded to the Secretary in the plurality opinion, which emphasized the importance of the Secretary's views. The dissent, however, did not discuss any weight it afforded the Secretary's opinions.

Justice Sandra Day O'Connor, joined by Chief Justice William Rehnquist and Justice Anthony Kennedy, wrote for the dissent.¹⁴⁵ The dissent found that "a limit on States' authority is inherent in the purpose and structure of the Medicaid Act."¹⁴⁶ Justice O'Connor also cited the importance of § 1396a(a)(30):

[A] state plan must "safeguard against unnecessary utilization" of services and ensure that "payments are consistent with efficiency, economy, and quality of care." These provisions confirm Congress' intent that state Medicaid initiatives not burden Medicaid beneficiaries without serving a Medicaid goal such as stretching available resources to the greatest effect.¹⁴⁷

Thus, Justice O'Connor opposed the plurality's "*post-hoc* justifications" that Medicaid goals were served by the state action as such arguments were never raised by Maine.¹⁴⁸ The dissent would have upheld the injunction,

141. *Id.* at 661 n.30.

142. *Id.* at 672 (Breyer, J., concurring).

143. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 671 (2003) (Breyer, J., concurring) (emphasis added).

144. *Id.* at 672.

145. *Id.* at 684.

146. *Id.* at 685-86.

147. *Id.* at 686-87 (quoting § 1396a (a)(30)(A)).

148. *Id.* at 688.

because the petitioners presented “concrete evidence of the burdens” and there was “no evidence or argument” that Medicaid-related goals were served.¹⁴⁹ Although agreeing in part with the plurality’s analysis, the dissent found that the state’s action created an obstacle to the accomplishment of the Medicaid Act’s goals and purposes.¹⁵⁰ In reaching this conclusion there was no mention of the Secretary’s opinion and what impact, if any, it had on the dissenting Justices’ rationale. As the district court stated on remand, “[t]he dissenters apparently did not view the role of HHS as central to the determination of whether the Plan served a Medicaid purpose, believing the District Court could (and did) properly make that assessment.”¹⁵¹

2. *Separate Concurrences, in Result Only: Justices Scalia and Thomas*

Justices Scalia and Thomas, unlike the other seven Justices, did not reach the preemption issue on its merits, but in somewhat different fashions, they both dismissed the claim on procedural grounds. Justice Thomas wrote: “[t]he Medicaid Act grants States broad discretion to impose prior authorization and proper consideration of the Secretary of the Department of Health and Human Services’ role in administering the Medicaid Act forecloses petitioner’s pre-emption claim.”¹⁵² Further, Justice Thomas asserted that the Secretary “is delegated a type of pre-emptive authority” because he must approve all state plans.¹⁵³ Accordingly, he would give the Secretary the highest level of deference – *Chevron* deference.¹⁵⁴ A *Chevron* analysis, however, would impose “a perhaps-insurmountable barrier to a claim of obstacle pre-emption.”¹⁵⁵

In his final observation, Justice Thomas cited *Gonzaga* for the proposition that the “unambiguously conferred right” standard applied not only to §

149. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 668-90 (2003) (2003).

150. *Id.*

151. *Pharm. Research & Mfrs. of Am. v. Nicholas*, No. CIVA 00-157-BH, 2005 WL 4677368 at *5 (D. Me. Jan. 27, 2005).

152. *Walsh*, 538 U.S. at 676.

153. *Id.* at 679.

154. *Id.* at 680.

155. *Id.* at 681.

1983 claims but also to an implied private right of action.¹⁵⁶ In closing, he stated, “I would give careful consideration to whether Spending Clause legislation can be enforced by third parties in the absence of a private right of action.”¹⁵⁷ Justice Thomas’s position has been uniformly dismissed by a majority of the Court, as time and time again the Court has decided issues of preemption without ever discussing if a right to bring such an action even exists.¹⁵⁸ Similarly, it has also been dismissed at the circuit court level.¹⁵⁹ For example, in *Lankford v. Sherman*, a notable Eighth Circuit case, the court stated: “Preemption claims are analyzed under a different test than § 1983 claims, affording plaintiffs an alternative theory for relief when a state law conflicts with a federal statute or regulation.”¹⁶⁰ Every circuit court that has since examined this issue has held likewise.¹⁶¹

Finally, Justice Scalia penned a short, two-paragraph concurrence opining that he “would reject petitioner’s statutory claim on the ground that the remedy for the State’s failure to comply . . . [is limited] . . . under the

156. *Id.* at 683 (2003) (Thomas, J., concurring).

157. *Id.*

158. *See, e.g.,* Verizon Md., Inc. v. Pub. Serv. Comm’n of Md., 535 U.S. 635, 635 (2002); Gade v. Nat’l Solid Wastes Mgmt. Ass’n, 505 U.S. 88, 88 (1992); Lawrence Cnty. v. Lead-Deadwood Sch. Dist. No. 40-1, 469 U.S. 256 (1985); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 85 (1983); Ray v. Atl. Richfield Co., 435 U.S. 151 (1978); Burbank v. Lockheed Air Terminal, Inc., 411 U.S. 624 (1973); Fla. Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132 (1963).

159. *See* Indep. Living Ctr. v. Shewry, 543 F.3d 1050, 1066 (9th Cir. 2008); *Lankford v. Sherman*, 451 F.3d 496, 513 (8th Cir. 2006); *Qwest Corp. v. Santa Fe*, 380 F.3d 1258, 1266 (10th Cir. 2004); *Local Union No. 12004 v. Mass.*, 377 F.3d 64, 75 (1st Cir. 2004); *Ill. Ass’n of Mortg. Brokers v. Office of Banks & Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002); *St. Thomas-St. John Hotel & Tourism Ass’n v. V.I.*, 218 F.3d 232, 241 (3d Cir. 2000) (holding that “a state or territorial law can be unenforceable as preempted by federal law even when the federal law secures no individual substantive rights for the party arguing preemption”); *Westfield v. Welch’s*, 170 F.3d 116, 124 n. 4 (2d Cir. 1999) (holding that a cause of action under the Supremacy Clause “do[es] not depend on the existence of a private right of action under the [preempting statute]”); *Burgio & Campofelice, Inc. v. N.Y. State Dep’t of Labor*, 107 F.3d 1000, 1005-07 (2d Cir. 1997); *First Nat’l Bank of E. Ark. v. Taylor*, 907 F.2d 775, 776 n. 3 (8th Cir. 1990).

160. *Lankford*, 451 F.3d at 509.

161. *See* sources cited *supra* note 158.

Medicaid Act.”¹⁶² Namely, petitioners may seek only the termination of funding by the Secretary under § 1396c.¹⁶³ Justice Scalia would dismiss any preemption claim under the Medicaid Act; and only examine a claim if petitioners were seeking review of a denial to terminate funding.¹⁶⁴ This analysis holds little weight for several reasons. First, the Secretary’s approval of a State Plan is illustrative of the Secretary’s decision to terminate funding, and second, the Secretary in *Walsh* had not formally approved the state’s action. Additionally, § 1396c is rarely used and if used it would serve only to further harm Medicaid providers and beneficiaries.¹⁶⁵

Justice Scalia’s approach of limiting petitioner’s remedy to termination of funding would require overruling *Wilder*, which the Court has explicitly rejected. This position has also been rejected by the lower courts. In *Harris v. Olszewski*, the Sixth Circuit found “that the Federal Government may withhold federal funds to non-complying States is not inconsistent with private enforcement.”¹⁶⁶ The most apropos argument originated in the Fifth Circuit, which rejected arguments based on the opinions of both Justices Scalia and Thomas, stating, “their persuasive force is wasted on the inferior courts. Rather, they must persuade at least three other Justices.”¹⁶⁷

C. *The Circuit Court’s Analysis of Preemption and § 1396a(a)(30)*

The subsequent circuit court decisions in this arena can be broken down into two subgroups that fall in line with either the plurality or dissent in *Walsh*. The first subgroup involves preemption claims where the Secretary was given substantial deference. The second subgroup comes solely from the Ninth Circuit where no discussion of deference is involved and the state has been required to show that it affirmatively does not conflict with the Medicaid Act’s goals and purposes.

162. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 675 (2003).

163. *Id.*

164. *Id.*

165. See 42 U.S.C. § 1396c; see also Lisa E. Key, *Private Enforcement of Federal Funding Conditions under § 1983: The Supreme Court’s Failure to Adhere to the Doctrine of Separation of Powers*, 29 U.C. DAVIS L. REV. 283, 292-293 (1996) (arguing § 1396c is an ineffective means of securing state compliance).

166. *Harris v. Olszewski*, 442 F.3d 456, 463 (6th Cir. 2006).

167. *Planned Parenthood of Hous. v. Sanchez*, 403 F.3d 324, 332 n.34 (5th Cir. 2005).

1. *Chevron-Level Deference and Preemption Decisions*

Less than a year following the Supreme Court's decision in *PhRMA v. Walsh*, PhRMA raised similar claims in D.C. Circuit.¹⁶⁸ In *Pharmaceutical Research and Manufacturers of America v. Thompson*, the Court of Appeals for the D.C. Circuit held that the Secretary's interpretations when approving state's Medicaid plan were afforded *Chevron*-level deference.¹⁶⁹ In doing so, the court found that the state's actions did not violate the Supremacy Clause.¹⁷⁰ The court relied heavily on *Walsh* in making its determination,¹⁷¹ despite the fact that only Justice Thomas explicitly stated that *Chevron* was applicable.¹⁷²

The D.C. Circuit laid out the appropriate analysis for determining when an agency is afforded such deference, stating:

Under the *Chevron* framework, “[i]f . . . ‘Congress has directly spoken to the precise question at issue,’ we must give effect to Congress’s ‘unambiguously expressed intent’” but “[i]f ‘the statute is silent or ambiguous with respect to the specific issue,’ we ask whether the agency’s position rests on a ‘permissible construction of the statute.’”¹⁷³

PhRMA argued that *Chevron* deference was not applicable in the preemption context, and that at best the Secretary's interpretation should only be afforded *Skidmore* deference.¹⁷⁴ Under *Skidmore*, the weight accorded to the Secretary's interpretation “depend[s] upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power

168. *Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 819 (D.C. Cir. 2004).

169. *Id.* at 821.

170. *Id.* at 824-25.

171. *Id.* at 821.

172. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 680 (2003) (Thomas, J., concurring). Justice Breyer was the only other Justice to cite *Chevron*; he also cited *Skidmore*. *Id.* at 673 (Breyer, J., concurring) (citing *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944)).

173. *Thompson*, 362 F.3d at 823.

174. *Id.* at 819.

to persuade, if lacking power to control.”¹⁷⁵ The D.C. Circuit disagreed with this assertion, reasoning that “Congress manifested its intent that the Secretary’s determinations, based on interpretation of the relevant statutory provisions, should have the force of law.”¹⁷⁶

Without ever laying the ground work for the proper preemption analysis, the court concluded that under *Chevron* the “Secretary’s statutory interpretation is permissible.”¹⁷⁷ After finding a “permissible” interpretation, the court then considered “whether [the Secretary’s] specific determination that the Initiative serves valid Medicaid goals is ‘arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.’”¹⁷⁸ Notwithstanding the minimal amount of evidence presented by the state, the court found it “sufficient to [show that] the Secretary’s determination of Medicaid-related benefit [was] not arbitrary.”¹⁷⁹ Thus, the Medicaid Act did not preempt the state’s actions.¹⁸⁰ The D.C. Circuit Court noted that a majority of the Justices in *Walsh* did not invoke *Chevron* “presumably because the Secretary had not reviewed Maine’s program and participated in the case only as amicus curiae.”¹⁸¹ *Thompson* has been cited in other circuits as well.

On February 10, 2010, a Minnesota district court ruled on *Minnesota Pharmacists Association v. Pawlenty*.¹⁸² In *Pawlenty*, Medicaid providers sued for declaratory and injunctive relief, alleging that a Minnesota law reducing reimbursement rates was preempted by 42 U.S.C. § 1396a(a)(30).¹⁸³ The court held that any interpretation of the Secretary

175. Skidmore, 323 U.S. at 140.

176. *Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 822 (D.C. Cir. 2004).

177. *Id.* at 825.

178. *Id.*

179. *Id.* at 826.

180. *Id.*

181. *Id.* at 825 n.10.

182. *Minn. Pharmacists Ass’n v. Pawlenty*, 690 F.Supp. 2d 809 (D. Minn. 2010).

183. *Id.* at 811–12.

would be afforded *Chevron*-level deference.¹⁸⁴ Relying on *Thompson*, the court stated that “as the D.C. Circuit has ruled, the Secretary’s interpretation of § 1396a is reviewed ‘under the familiar and deferential two-part framework of *Chevron U.S.A., Inc. v. Natural Resources Defense Council.*’”¹⁸⁵ According to the *Pawlenty* court, the Secretary is afforded such deference because “Congress ‘expressly conferred on the Secretary authority to review and approve state Medicaid plans as a condition to disbursing federal Medicaid payments.’”¹⁸⁶ The court went on to dismiss the provider’s preliminary injunction motion.¹⁸⁷

2. *The Ninth Circuit’s Approach*

It has long been a rule in the Ninth Circuit that § 1396a(a)(30) contains procedural requirements, which the state must consider before passing Medicaid-related legislation. The Ninth Circuit, like the dissent in *Walsh*, focuses not on the actions of the Secretary, but on the actions of the state, to which it did not extend *Chevron* deference.¹⁸⁸ In *Orthopaedic Hospital v. Belshe*, several hospitals sued the director of California’s Medicaid program, known as Medi-Cal, for reducing reimbursement rates to a level that violated § 1396a(a)(30).¹⁸⁹ Although *Orthopaedic* centered on a § 1983 claim, the Ninth Circuit’s analysis of § 1396a(a)(30) has been subsequently applied in preemption claims.¹⁹⁰ The *Orthopaedic* court held that the state “must satisfy the requirement that the payments themselves be consistent with quality care.”¹⁹¹

184. *Id.* at 826.

185. *Id.* at 825.

186. *Id.* at 826 (citing *Pharm. Research & Mfrs. of Am. v. Thompson*, 362 F.3d 817, 821-22 (D.C. Cir. 2004)).

187. *Minn. Pharmacists Ass’n*, 690 F.Supp. 2d at 829.

188. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1495 (9th Cir. 1997).

189. *Id.* at 1492.

190. See, e.g., *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009). A Petition for a Writ of Certiorari with the Supreme Court of the United States is pending at the time this Article goes to press.

191. *Orthopaedic*, 103 F.3d at 1497.

Further, “Congress intended payments to be flexible within a range; payments should be no higher than what is required to provide efficient and economical care, but still high enough to provide for quality care and to ensure access to services.”¹⁹² To set rates without establishing evidence that the rates are consistent with efficiency, economy, quality of care, and access would make the rates arbitrary.¹⁹³ Therefore, the state “must undertake to determine what it costs an efficient hospital economically to provide quality care” and the final rates “must ultimately bear a reasonable relationship to those costs.”¹⁹⁴ The state “need not follow a rigid formula,” but in *Orthopaedic*, the state failed to make any such findings prior to the rate reduction and thus, the rates failed to meet the burdens of § 1396a(a)(30).¹⁹⁵

The analysis set forth in *Orthopaedic* has recently been applied in obstacle preemption claims. In *Independent Living Center v. Maxwell-Jolly*, a group of health care providers brought suit claiming that a ten percent rate reduction based solely on budgetary issues created an obstacle to the goals and purposes of the Medicaid Act.¹⁹⁶ In its review, the court found that the state “failed to provide any evidence that the Department had considered the impact of the ten percent rate reduction on quality and access to care, as required by § 30(A).”¹⁹⁷ The providers, however, established sufficient evidence of the burdens the reimbursement rates placed on both them and the beneficiaries.¹⁹⁸ Based on these facts the court found a likelihood of success on the merits of the preemption claim and granted the providers’ motion for preliminary injunction.¹⁹⁹

In response to the court’s decision in *Independent Living Center*, the California legislature adjusted payment rates again, only this time reducing

192. *Id.*

193. *Id.* at 1500.

194. *Id.* at 1498.

195. *Id.*

196. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 649 (9th Cir. 2009).

197. *Id.* at 650, 652.

198. *Id.*

199. *Id.* at 663.

them by five percent as opposed to ten percent.²⁰⁰ This too spawned several provider suits claiming that § 1396a(a)(30) preempted the reduction. In March of 2010, the Ninth Circuit reaffirmed the application of *Orthopaedic* to those cases. In *California Pharmacists Association v. Maxwell-Jolly*, the court reiterated that in “setting Medicaid reimbursement rates [the state] must study the impact of the contemplated rate reduction on the statutory factors of efficiency, economy, quality of care, and access to care *prior* to setting or adjusting payment rates.”²⁰¹ In enacting the five percent rate reduction, the legislature did not once even mention efficiency, economy, quality of care, and access to care.²⁰² Instead, the court found that, as with the ten percent rate reduction, the state based the five percent rate reduction solely on budgetary concerns.²⁰³

The state argued that the providers failed to establish that the rate reduction did not further Medicaid-related goals or purposes.²⁰⁴ The court dismissed this argument stating, “it is fair to assume that a rate that is set arbitrarily, without reference to the Section 30(A) requirements, is unlikely to meet the equal access and quality requirements.”²⁰⁵ The court upheld the injunction.²⁰⁶ Likewise, in *Dominguez v. Schwarzenegger*, delivered the same day as *California Pharmacists*, the court found that a reduction in hourly wages of in-home health care providers was also preempted by § 1396a(a)(30).²⁰⁷ Again the court emphasized that the “State should have studied the impact of its decreased contribution to provider’s wages and benefits *prior* to passing [the wage reduction legislation].”²⁰⁸

200. CAL. WELF. & INST. CODE § 14105.191(b)(2) (2010); *see also* CAL. ASSEMBLY BILL NO. 1183 (2008); CAL. LEGIS. SERV. CH. 758 (2008).

201. *Cal. Pharmacists Ass’n v. Maxwell-Jolly*, 596 F.3d 1098, 1107 (9th Cir. 2010). A Petition for a Writ of Certiorari with the Supreme Court of the United States is pending at the time this Article goes to press.

202. *Id.* at 1109.

203. *Id.*

204. *Id.* at 1113.

205. *Id.*

206. *Id.* at 1115.

207. *Dominguez v. Schwarzenegger*, 596 F.3d 1087, 1089-90 (9th Cir. 2010).

208. *Id.* at 1096.

IV. CONCLUSION

A. *Chevron* or *Skidmore*?

Since the decision in *Walsh*, the dissent has lost two of its three members, leaving only Justice Kennedy. It is likely that the dissent will have very little sway on future Medicaid preemption claims that reach the Supreme Court. The opinions penned by the remaining Justices leave us with one major point of emphasis—the Secretary’s opinion is highly relevant. As detailed above, this concept did not fall on deaf ears. That is, a few lower courts have gone as far as to apply *Chevron*-level deference to matters of preemption. However, the Supreme Court has further reviewed this issue and decided to the contrary; making the analysis followed by *Thompson* and *Pawlenty* incorrect.

First, *Thompson* and *Pawlenty* represent a misinterpretation of the *Walsh* decision. Although both claim to be consistent with the plurality decision in *Walsh*, their results are more akin to Justice Thomas’s opinion, the only Justice specifically finding *Chevron* applicable.²⁰⁹ If any other Justice had thought *Chevron* should be applied they had the argument before them and choose not to address it. In fact, Justice Breyer, in opining that some level of deference should be applied the Secretary’s interpretations, cited both *Chevron* and *Skidmore*,²¹⁰ indicating that Justice Breyer himself could not determine with certainty which would apply.

Second, subsequent Supreme Court decisions have determined that the agency’s interpretation as to preemption is only entitled to *Skidmore* deference.²¹¹ In 2008, the Supreme Court decided *Riegel v. Medtronic Inc.*²¹² The Court noted that if the federal statute at issue is ambiguous and the agency’s position accorded deference, “mere *Skidmore* deference would seemingly be at issue.”²¹³ Further, in 2009 the Supreme Court stated:

In prior cases, we have given “*some weight*” to an agency’s views . . . Even in such cases, however, we have not deferred to an agency’s *conclusion* that state law is pre-empted. Rather, we have

209. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 680-81 (2003) (Thomas, J., concurring).

210. *Id.* at 672–73 (Breyer, J., concurring).

211. *See Wyeth v. Levine* 129 S. Ct. 1187, 1201 (2009).

212. *Riegel v. Medtronic, Inc.*, 552 U.S. 312, 312 (2008).

213. *Id.* at 326.

attended to an agency's explanation of how state law affects the regulatory scheme. While agencies have no special authority to pronounce on pre-emption absent delegation by Congress, they do have a unique understanding of the statutes they administer and an attendant ability to make informed determinations about how state requirements may pose an "obstacle to the accomplishment and execution of the full purposes and objectives of Congress." The weight we accord the agency's explanation of state law's impact on the federal scheme *depends on its thoroughness, consistency, and persuasiveness*.²¹⁴

Despite what seems to be the clear intent of the court, indicating that *Skidmore*, not *Chevron*, deference should apply, *Pawlenty* still found that *Chevron* reflected the appropriate test. Perhaps Justice Thomas said it most succinctly when he opined, "Where an agency is charged with administering a federal statute as the Secretary is here, *Chevron* imposes a perhaps-insurmountable barrier to a claim of obstacle preemption."²¹⁵ There is little doubt that if other courts follow *Thompson*, as did *Pawlenty*, and ignore recent Supreme Court precedence, Medicaid providers would face an "insurmountable barrier."

Even further, Justice Thomas's line of analysis in *Walsh* not only conflicts with subsequent Supreme Court decisions, but also directly conflicts with Congressional intent. The opinion of Justice Thomas rests on the powers the Secretary has over State Plans. However, 42 U.S.C. § 1320a-2 states, in pertinent part: "In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan."²¹⁶ Section 1320a-2 is referred to as the "Suter fix", as Congress added the provision following the Supreme Court's decision in *Suter v. Artist M.*²¹⁷ In *Suter*, the Supreme Court held that a provision contained in a State Plan is not enforceable under § 1983.²¹⁸ Congress reacted with § 1320a-2. Although § 1320a-2 has received much criticism for

214. *Wyeth*, 129 S.Ct. at 1201 (emphasis added) (citations omitted).

215. *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 681 (2003) (Thomas, J., concurring).

216. 42 U.S.C. § 1320a-2 (2003).

217. *Id.*

218. *Suter v. Artist M.*, 503 U.S. 347 (1992).

being “very poorly drafted,”²¹⁹ it still indicates Congressional intent that the State Plans are enforceable and should not be deemed unenforceable solely because they are required to be included in State Plans. Justice Thomas’s opinion accomplishes just that.

Providers bringing obstacle preemption claims under § 1396a(a)(30) should argue that interpretations by the Secretary, if any exist, are afforded only *Skidmore* deference. To be sure, *Chevron*-level deference is applicable under claims against the Secretary for approval or disapproval of a state plan. However, no such deference should be afforded when determining whether a state action is preempted by federal law. If the D.C. and Eighth Circuit’s application of *Chevron* becomes the rule, rather than the exception, it may spell the end to all provider initiated preemption claims.

B. *Who has the Burden of Production?*

Representing one of the remaining disputes apparent in *Walsh*, courts appear uncertain whether the provider or the state bears the burden of production regarding whether a legislature enacted a statute in furtherance of a Medicaid-related goal or purpose. The Ninth Circuit’s analysis, starting with *Orthopaedic*, and its subsequent application in *Independent Living Center*, *California Pharmacists Association*, and *Dominguez* is akin to that of the dissent in *Walsh*. The *Walsh* dissent seems to require the state to demonstrate that its legislature acted in furtherance of Medicaid-related goals and purposes.²²⁰ The lack of such evidence in the face of a demonstrated burden would warrant a finding of preemption.²²¹ Given those same circumstances, the Ninth Circuit found a likelihood of success for providers claiming preemption under § 1396a(a)(30).

The Ninth Circuit’s interpretation of § 1396a(a)(30) has not received much acceptance. For example, the Third Circuit, in *Rite Aid v. Houstoun*, refused to adopt the *Orthopaedic* analysis.²²² Instead, the court held that “Section 30(A) requires the state to achieve a certain result but does not

219. Timothy Stoltzfus Jost, *Health Care Rationing in the Courts: A Comparative Study*, 21 HASTINGS INTL. & COMP. L. REV. 639, 698 (1998); see also Brian D. Ledahl, *Congress Overruling the Courts: Legislative Changes to the Scope of Section 1983*, 29 COLUM. J. L. SOC. PROBS. 411, 412, 434 (1996) (considering § 1320a-2 “confusing”).

220. *Walsh*, 538 U.S. at 684 (O’Connor, J., dissenting).

221. *Id.* at 690.

222. *Rite Aid of Pa. v. Hous.*, 171 F.3d 842, 851 (3d Cir. 1999).

impose any particular method or process for getting to that result.”²²³ The Third Circuit is not alone in this “result” oriented analysis of § 1396a(a)(30).

The Seventh Circuit has held that “[n]othing in the language of § 1396a(a)(30) . . . requires a state to conduct studies in advance of every modification;” rather, the statute “requires each state to produce a *result*.”²²⁴ But as the a Ninth Circuit Court explained, “[t]hose courts that have criticized *Orthopaedic’s* reasoning have not simply rubber-stamped rate reductions imposed by state agencies; rather, reviewing courts typically subject state rate-making to something akin to ‘arbitrary and capricious’ review.”²²⁵

Unlike the D.C. and Eighth Circuit’s approach, outlined above, the Third and Seventh Circuit’s analysis of § 1396a(a)(30) might actually be more in line with the plurality’s opinion in *Walsh*. A “result” oriented analysis would require some affirmative proof on the plaintiff’s part that the state’s actions were not in furtherance of Medicaid’s goals and purposes. Additionally, “result” like evidence may demonstrate more clearly the obstacle the state’s action creates, which presumably would be more likely to satisfy the plurality’s significant and serious obstruction language. However, the “results” approach creates quite an impediment to provider appeals; essentially forcing them to wait until they can no longer accept Medicaid beneficiaries as patients or go out of business. This is similar to Scalia’s approach of limiting providers’ remedies only to removal of federal funding, only instead of the federal government pulling out of Medicaid, it requires providers to do so.

Despite the spilt at both the circuit level and within the Supreme Court, providers should assume they have the burden of production. In this regard, providers should present evidence that the state did not consider economy, efficiency, quality of care, and equal access of care. Providers, however, should be prepared to argue and present evidence that the state’s action results in a failure to meet economy, efficiency, quality of care, and equal access of care. Although the “result” oriented approach as stated above will cause greater hardships on both providers and beneficiaries, it may be the only route to success outside of the Ninth Circuit.

Given the lack of precedence of any real value on § 1396a(a)(30), preemptive force providers raising such claims do so in uncharted territory, which is nothing new for anyone who has ever litigated in the Medicaid

223. *Id.* (emphasis added).

224. *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1029-30 (7th Cir. 1996).

225. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 656 (9th Cir. 2009).

arena. It is clear that providers, for now, can sue for preemption under the Medicaid Act. But if there is to be any true success on these claims, providers must press that *Skidmore*, not *Chevron*, is the appropriate framework for an agency's determination concerning preemption. Further, providers must be prepared to produce evidence not only of the potential harm, but at least of some quantifiable actual harm. Accomplishing both items will be crucial to provider success.

The Medicaid Act's preemptive qualities will likely be tested in the coming year. With further budgetary shortfalls projected and the sun setting on the ARRA, some, if not most, states will be cutting back their Medicaid funding. Providers should be prepared, not only to lobby their respective legislatures, but also to raise claims of preemption. Engaging the courts and making successful preemption claims will keep states honest and providers afloat.