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Rate Setting After Douglas

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RATE SETTING AFTER *DOUGLAS*

Daniel J. Sheffner[*]

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I. INTRODUCTION

Section 30(A) of the Medicaid Act mandates that state reimbursement rates for participating Medicaid providers be consistent with (1) efficiency, (2) economy, (3) access to health care, and (4) quality health care.[1] These four nebulous factors have produced discordant interpretations by federal courts reviewing the validity of state Medicaid reimbursement

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[1] 42 U.S.C. § 1396a(a)(30)(A) (2014). The terms "rates" and "reimbursement rates" as used in this Article refer to the payment of Medicaid-participating health care providers. "Rate setting" refers to the states determination of Medicaid reimbursement rates.

rates, resulting in a lack of uniformity in the statute's interpretation.[2] The United States Supreme Court's recent decision in *Douglas v. Independent Living Center of Southern California, Inc.* added a degree of uniformity to rate setting litigation with its suggestion that rate setting plaintiffs challenge rate adjustments under the judicial review procedures of the Administrative Procedure Act (APA).[3] The APA provides litigants with a secure cause of action and consistent standards of review, allowing for more unanimity in judicial assessments of § 30(A).[4]

Douglas, however, did not solve all problems. Section 30(A) requires that states determine their rate adjustments' effects on all four of the statute's factors.[5] Rate setting litigation, however, has focused almost exclusively on § 30(A)'s access requirement.[6] Accordingly, Medicaid providers and beneficiaries argue that rate reductions reduce provider participation in Medicaid, thus lowering beneficiaries' access to care.[7] The statute's first two factors, efficiency and economy, address the need to cap reimbursement rates at economical levels and therefore do not generally interest plaintiffs.[8] The quality of care received by Medicaid beneficiaries is an important health care concern that implicates all provider settings and patient experiences.[9] Notably, however, quality of care has been given scant

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[2] *See infra* note 84 and accompanying text (noting the varying approaches employed by the federal appellate courts in interpreting § 30(A) prior to the Court's decision in *Douglas*).

[3] Douglas v. Indep. Living Ctr. of S. Cal., Inc., 132 S. Ct. 1204, 1210 (2012); Administrative Procedure Act, 5 U.S.C. § 701 (2014) *et seq.* Medicaid providers, including physicians and skilled nursing facilities, and beneficiaries challenge state Medicaid reimbursement rates they believe are too low to adequately compensate providers for their services, and therefore risk affecting provider participation rates in the Medicaid program. *See* Nicole Huberfeld, *Where There is a Right, There Must be a Remedy (Even in Medicaid)*, 102 KY. L. J. 327, 348 (2014) (writing that "[w]hen providers are dissatisfied with the state payment levels and methodologies, they typically will first appeal to the state's Medicaid agency. If that is unsuccessful, then providers will team up with patients to enjoin the state's low payment rates in federal court.").

[4] *See infra* text accompanying notes 79–82 (discussing the consistency provided when actions are brought under the APA).

[5] 42 U.S.C. § 1396a(a)(30)(A).

[6] *See infra* Part II.B.3 (discussing the access-centric approach employed by reviewing courts).

[7] *See, e.g.*, Memisovski ex rel. Memisovski v. Maram, No. 92 C 1982, 2004 WL 1878332, at *41 (N.D. Ill., Aug. 23, 2004) (summarizing the plaintiffs' contentions that "(1) the law requires that Medicaid reimbursement rates paid to health care providers be sufficient to provide Medicaid recipients access to health care equal to that of the generally insured population; (2) the arbitrary and capricious manner in which the defendants set reimbursement rates has resulted in rates that are far too low to result in equal access to care; and (3) plaintiffs endure obstacles to finding care not faced by privately insured patients and, as a result, the health problems they experience are both more acute and more preventable").

[8] *See infra* text accompanying notes 61, 167 (explaining that § 30(A)'s first two factors set the federal ceiling for reimbursement rates to Medicaid providers).

[9] BARRY R. FURROW ET AL., HEALTH LAW CASES, MATERIALS & PROBLEMS 1 (7th ed. 2013) (explaining that "[c]ost, quality, access, and choice are the chief concerns of the health care system").

attention by courts and the state and federal governments in their setting and review of reimbursement rates.[10]

In *Christ the King Manor, Inc. v. Secretary U.S. Department of HHS*, however, the Third Circuit Court of Appeals became the first court to emphasize § 30(A)'s quality prong.[11] In *Christ the King*, the court invalidated nursing home rate adjustments proposed by the Commonwealth of Pennsylvania due to the complete absence of any examination of the rate adjustment's effects on the quality of care produced by the affected institutions.[12] The Third Circuit Court of Appeals was the first post-*Douglas* federal appellate court to invalidate a state's rate setting proposal.

After providing background as to the current state of Medicaid and its reimbursement programs, this article suggests that the Third Circuit Court of Appeals' decision in *Christ the King* indicates that, consistent with § 30(A), quality is a truly independent statutory factor that must be accounted for when setting Medicaid provider reimbursement rates.[13] Furthermore, *Christ the King* delineates helpful guidelines for states, and CMS, in accounting for quality in their rate setting proposals going forward.[14]

II. BACKGROUND

Part II.A provides a brief overview of the Medicaid program and the state rate setting process.[15] Part II.B discusses § 30(A)'s statutory requirements and *Douglas*'s role in providing a measure of uniformity in § 30(A) litigation in order to illuminate the changing direction of Medicaid rate setting law.[16] Part II.B further discusses the access-centric approach that has marked much of rate setting litigation, and the lack of focus states and the Centers for Medicare & Medicaid Services (CMS) have placed on § 30(A)'s quality prong.[17] Part II.C examines the Third Circuit's decision in *Christ the King*, concluding that the decision's importance lies in its emphasis on § 30(A)'s quality of care prong, rather than exclusively access,

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[10] *See infra* Part II.B.3 (illustrating the absence of quality of care analysis that results from the access-centric approach).

[11] Christ the King Manor, Inc. v. Secretary U.S. Department of HHS, 730 F.3d 291 (3d Cir. 2013).

[12] *Id.* at 309–14.

[13] *See infra* text accompanying notes 164–171 (discussing the need to analyze quality after *Christ the King*).

[14] *See infra* Part III.A–C (discussing guidelines provided by *Christ the King* in the assessment of quality as an independent factor in § 30(A)). The reviewing federal agency is the Centers for Medicare & Medicaid Services (CMS), a division of the Department of Health and Human Services (HHS), which is tasked with ensuring that state plans comply with the Medicaid Act. *Christ the King,* 730 F.3d at 297.

[15] *See infra* Part II.A.

[16] *See infra* Part II.B.

[17] *See infra* Part II.B.

indicating that quality of care is a truly independent factor in the § 30(A) calculus that must be considered by states, CMS, and courts.[18]

A. Medicaid and State Rate Setting

The Medicaid program is vital to the provision of medical assistance to many of the nation's disadvantaged.[19] The flexibility provided to states under Medicaid, however, allows states to cut provider reimbursement rates in the face of bulging Medicaid rolls caused by high under- and unemployment.[20] Low reimbursement causes correspondingly low provider participation in Medicaid, which inexorably leads to barriers to accessible and quality health care.[21] This section broadly summarizes the Medicaid program and examines the process of and problems with state Medicaid rate setting.

1. The Medicaid Program

Medicaid is a joint federal-state health insurance program, financed by the federal and state governments, and administered by the states.[22] Codified at Title XIX of the Social Security Act, the Medicaid program provides medical assistance to over 60 million disadvantaged children, pregnant women, disabled individuals, seniors, and individuals newly eligible under the Affordable Care Act's (ACA) Medicaid Expansion.[23] A product of the Spending Clause, the federal government funds a portion of each state's Medicaid program on the condition that each state provide specific medical benefits to mandatory categories of individuals.[24] The

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[18] *See infra* Part II.C.

[19] *Douglas*, 132 S. Ct. at 1208 (noting that "Medicaid is a cooperative federal-state program that provides medical care to needy individuals.").

[20] *See infra* Part II.A.2 (discussing state rate setting generally).

[21] *See infra* Part II.A.2 (discussing state rate adjustments' effects on access and quality).

[22] Kaiser Comm'n on Medicaid and the Uninsured, *Medicaid Moving Forward*, KAISER FAMILY FOUND., at 1 (June 2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/06/7235-07-medicaid-moving-forward2.pdf. (discussing Medicaid generally).

[23] 42 U.S.C. § 1396a *et seq*.; Renee M. Landers & Patrick A. Leeman, *Medicaid Expansion under the 2010 Health Care Reform Legislation: The Continuing Evolution of Medicaid's Central Role in American Health Care*, 7 NAELA J. 143, 143, 146 (2010) (listing the populations covered by Medicaid prior to the ACA's Medicaid Expansion); Sidney D. Watson, *Embracing Justice Roberts' "New Medicaid*,*"* 6 ST. LOUIS U. J. HEALTH L. & POL'Y 247, 255–56 (2013) (discussing newly eligible individuals under the ACA's Medicaid Expansion).

[24] U.S. CONST. art. I, § 8, cl. 1; Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS. L. REV. 413, 419–20 (2008) [hereinafter Huberfeld, *Bizarre Love Triangle*], (stating that "the federal government promises federal money to the states in exchange for states' promise to fulfill certain conditions on those funds by providing medical assistance to mandatory categories of people"). To help ease the financial burden on the states, the federal government matches a

bedrock of the country's safety net system, Medicaid is necessary for the provision of medical and other health services to the nation's most underprivileged citizens.[25]

States are given wide flexibility in administering and financing their Medicaid programs.[26] This flexibility includes the authority to decide the level of participating Medicaid providers' payments.[27] While federal law requires that each state's program provide for specific mandatory benefits and eligibility categories, states are free to cover certain optional benefits and categories of individuals.[28] States may also seek waivers from federal law to use federal funds for demonstration or other purposes.[29]

States memorialize their Medicaid programs in a state plan, which is submitted to CMS for approval.[30] A state must submit a state plan amendment (SPA) to CMS if it makes any material changes, such as adjusting provider reimbursement rates, to its plan for medical assistance.[31]

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percentage of state Medicaid payments. FURROW, *supra* note 9, at 828 (stating that the federal government funds a portion of each states' Medicaid program). This match, known as the federal medical assistance percentage (FMAP), ranges from 50–74%, depending on each state's per capita income. *Id.* at 836; Landers & Leeman, *supra* note 23, at 147 (stating that federal assistance ranges 50–76%). The FMAP for Medicaid expenditures for the newly eligible population is 100%, as of last January 1, 2014, through 2016, and will decrease incrementally until 2020, in which the FMAP for such newly eligible individuals will remain constant at 90%. *Id*. at 152–54 (explaining the enhanced FMAP under the Medicaid Expansion).

[25] *See* Huberfeld, *Bizarre Love Triangle*, *supra* note 24, at 419 (stating that "Medicaid is not perfect (or philosophically coherent), but it is indispensable as the most consistent device that ensures access to healthcare for underprivileged populations"); Brietta R. Clark, *Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration is Undermining its Own Health Reform Goals*, 55 HOW. L. J. 771, 784–85 (2012) [hereinafter *Rate Setting and Payment Suits*] (discussing the benefits and effectiveness of the Medicaid).

[26] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services,76 Fed. Reg. 26342, 26342 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447) (noting that State Medicaid Programs "have considerable flexibility").

[27] *Id.* (discussing State Medicaid Programs generally).

[28] *See Rate Setting and Payment Suits*, *supra* note 25, at 778 n.16 (noting that "the law gives states the option of covering additional services, such as private nursing, adult dental, and physical, occupational, and speech therapy"). Optional benefits include mental and dental care, and optional categories of individuals include the "medically needy." *Id.*

[29] Watson, *supra* note 23, at 250 n.18 (citing § 1115 of the Social Security Act, which grants "the Secretary of Health and Human Services broad authority to waive statutory and regulatory provisions of health and welfare programs, like Medicaid"). The Secretary of HHS may approve demonstration projects that allow states to provide services or cover individuals otherwise prohibited by federal law. Watson, *supra* note 23, at 250.

[30] 42 C.F.R. § 430.10, *et seq.* (regulating SPAs); *see also* Megan Waugh, *A Broke(n) System: A Comment on the Supreme Court's Decision to Rule on the Equal Access Provision in Douglas v. Independent Living Center*, *and its Potential Impact on the Affordable Care Act*, 32 J. NAT'L ASS'N ADMIN. L. JUDICIARY 855, 859–60 (2012) (discussing the Medicaid Program generally and state plan submissions to HHS).

[31] 42 C.F.R. § 430.12 (providing procedural guidelines for SPA submissions); Waugh, *supra* note 30, at 861 (stating that "[i]f a state makes a material change to the law, organization, policy or operation within the Medicaid program, a state must file an SPA with the CMS") (internal citations and quotation marks omitted).

CMS must review each plan and SPA to determine whether a state's Medicaid program complies with federal law.[32] This process is devoid of any formal procedures, and many SPAs are given only cursory review.[33]

2. State Rate Setting

Each state's Medicaid program relies on the participation of private health care providers to treat Medicaid patients.[34] However, pursuant to the flexibility they enjoy under Medicaid, states frequently reduce provider rates in poor economic times when, due to a rise in unemployment, Medicaid rolls increase.[35] This increase in enrollment strains state budgets, causing them to seek ways to make up for the decrease in tax revenues caused by increased unemployment.[36] Rather than cut eligibility, a politically unpopular move, states instead reduce provider payment rates.[37] A 50-state survey conducted by the Kaiser Commission on Medicaid and the Uninsured reported that in 2013, 38 states cut reimbursement rates of some kind.[38]

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[32] *See* 42 U.S.C. § 1396a(b) ("The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section [delineating SPA requirements]").

[33] Brietta Clark, *The (In)decision of Douglas v. ILC: The Relevance of CMS Approval in Challenges to Medicaid Payment Cuts*, HEALTH CARE JUSTICE BLOG (Feb. 29, 2012), http://healthcarejusticeblog.org/2012/02/us_supreme_cour.html (writing that "[r]eviews of state plans have been cursory, at best, and are often approved by default").

[34] Spectrum Health Continuing Care Grp. v. Anna Marie Bowling Irrecoverable Trust Dated June 27, 2002, 410 F.3d 304, 313 (6th Cir. 2005) (discussing the nature of the Medicaid program, and stating that "[a] health-care provider is not required to participate in the Medicaid program, but rather voluntarily contracts with the state to provide services to Medicaid-eligible patients in return for reimbursement from the state at the specified rates").

[35] *See Rate Setting and Payment Suits*, *supra* note 25, at 774 (discussing the flexibility Congress gave the states in setting rates); Vernon K. Smith et al., *Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014*, KAISER FAMILY FOUND., at 47 (Oct. 2013) [hereinafter Smith, FY 2013–14], http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf. (explaining that states cut rates to control costs during the Great Recession and the 2001–2004 economic downturn).

[36] *See* Vernon K. Smith et al., *Moving Ahead Among Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, KAISER FAMILY FOUND., at 15 (Oct. 2011), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8248.pdf [hereinafter Smith, FY 2011–2012] (writing that "[d]uring an economic downturn, high unemployment puts upward pressure on Medicaid. As individuals lose jobs and their incomes decline, more individuals qualify and enroll in Medicaid which increases program spending.").

[37] Abigail Moncrieff, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 673 (2006) (stating that "[s]tates . . . are hesitant to push for large-scale reductions in eligibility or benefits because excluding needy people from existing welfare programs is politically unattractive and may be financially unwise"); Smith, FY 2011–2012, *supra* note 35, at 31 (explaining that states reduce provider payments during economic downturns).

[38] Smith, FY 2013–2014, *supra* note 35, at 47–48 (discussing state rate cuts in 2013). The ACA temporarily prevented states from decreasing primary care physician rates, beginning in 2013. *Id.* at 48. While 40 states reported increasing rates for some providers in

Rate adjustments that cause low reimbursement levels have a direct impact on access to provider services and quality of care.[39] Nationally, Medicaid physician rates are 66% that of Medicare.[40] Provider participation in Medicaid is voluntary, but is also low: physician participation in Medicaid and the Children's Health Insurance Program (CHIP) is 75% nationally, lower than Medicare, which causes resultant barriers to access to care.[41] One study found that 95% of physicians who did not participate in Medicaid cited low reimbursement as the reason.[42] In 2011, only about 69% of participating physicians accepted new Medicaid patients.[43] The expansion of Medicaid under the ACA may portend further drops in participation.[44]

Low Medicaid reimbursement also has detrimental effects on quality. Low rates lead to low nursing home staffing levels, which lead to concomitant decreases in the quality of nursing home care.[45] Further, there is

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2013 the magnitude of some rate cuts is alarming: California and Maine, for example, cut outpatient reimbursement rates by 10%. *Id.* at 47–49.

[39] *See* Smith, FY 2011–2012, *supra* note 36, at 31 (stating that"[p]rovider rates are an important determinant of provider participation and access to services for Medicaid beneficiaries, so cutting Medicaid rates (which are typically lower than Medicare or commercial insurance) can jeopardize provider participation in the program as well as access"); Brietta R. Clark, *APA Deference after Independent Living Center: Why Informal Adjudicatory Action Needs a Hard Look*, 102 KY. L. J. 211, 217 (2014) [hereinafter *APA Deference after Independent Living Center*] (stating that rate cuts decrease provider participation in Medicaid and therefore endanger beneficiaries' access to Medicaid services).

[40] *Medicaid-to-Medicare Fee Index*, KAISER FAMILY FOUND., http://kff.org /medicaid/state-indicator/medicaid-to-medicare-fee-index/ (last visited March 20, 2014).

[41] State Children's Health Insurance Program, 42 U.S.C. § 1397aa (2014) *et seq.*; Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 15, 20 (2013) (explaining that Medicaid is voluntary for states and providers); FURROW, *supra* note 9, at 850–51 (writing that "Medicaid only pays physicians about 72% of what Medicare pays" and that physician participation in Medicaid and CHIP is about three-quarters nationally); Smith, FY 2011–2012, *supra* note 36, at 31 (noting that "cutting Medicaid rates (which are typically lower than Medicare or commercial insurance) can jeopardize provider participation in the program as well as access"); *Rate Setting and Payment Suits*, *supra* note 25, at 785–86 (stating that low physician participation in Medicaid "impedes access to regular, preventive care").

[42] *Rate Setting and Payment Suits*, *supra* note 25, at 786 (citing U.S. GOV'T ACCOUNTABILITY OFFICE, MEDICAID AND CHIP: MOST PHYSICIANS SERVE COVERED CHILDREN BUT HAVE DIFFICULTY REFERRING THEM FOR SPECIALTY CARE 18 (2011), *available at* http://www.gao.gov/new.items/d11624.pdf.).

[43] 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 (2011) (noting that approximately 69% of participating physicians accepted new Medicaid patients in 2011).

[44] Abby Goodnough, *Medicaid Growth Could Aggravate Doctor Shortage*, N.Y. TIMES, Nov. 28, 2013, at A1 (reporting that many physicians may refuse to accept new patients under the Medicaid Expansion due to low reimbursement rates).

[45] *See* Charlene Harrington et al., *Nurse Staffing Levels and Medicaid Reimbursement Rates in Nursing Facilities*, 42 HEALTH SERV. RESEARCH 1105, 1124 (2011) (reporting the results of a study that were consistent with earlier findings in which nursing "facilities with higher proportions of Medicaid residents had fewer nurses and consequently . . . appeared to have lower quality of care").

evidence that some of the participating Medicaid providers provide a degree of care lower than that provided by those who primarily treat Medicare and privately insured patients.[46]

B. Section 30(A) and State Rate Setting Litigation

Section 30(A) of the Medicaid program provides the authority by which Medicaid providers and beneficiaries challenge state Medicaid rate adjustments.[47] Bereft of a private right of action, plaintiffs have traditionally enforced the Medicaid Act's provisions, including § 30(A), with 42 U.S.C. § 1983, a civil rights statute, or the Supremacy Clause of the U.S. Constitution.[48] The Supreme Court, in *Douglas*, suggested an alternative vehicle through which to enforce § 30(A)—the judicial review provisions of the APA.[49] The APA allows for a degree of uniformity that had been absent in rate setting litigation.[50] Decisions both before and after *Douglas* have focused mainly on the access requirement imposed by § 30(A), giving less weight to the provision's quality prong.[51] This access-centric trend, however, has been upset by the *Christ the King* decision's focus on quality.[52] This section contains an overview of § 30(A) litigation, the *Douglas* decision, and rate setting litigation's predominate focus on access.[53]

1. Section 30(A)

Congress enacted § 30(A) of the Medicaid Act in 1989 to prevent states from arbitrarily reducing Medicaid reimbursement rates.[54] Since the 1997 repeal of a similar rate setting provision, the Boren Amendment, Medicaid providers and beneficiaries have challenged Medicaid rate adjustments under § 30(A), first through 42 U.S.C. § 1983, and following the

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[46] *See* FURROW, *supra* note 9, at 851 (noting that many Medicaid beneficiaries receive substandard physician services).

[47] *See infra* Part II.B.1 (discussing § 30(A) generally).

[48] *See infra* Part II.B.1 (explaining that § 1983 and the Supremacy Clause have historically served as the basis for rate setting litigation).

[49] *See infra* text accompany notes 79–82 (discussing the Court's suggestion in *Douglas* that aggrieved plaintiffs proceed under the APA).

[50] *See infra* text accompanying note 82 (discussing the consistency provided when actions are brought under the APA).

[51] *See infra* Part II.B.3 (discussing the access-centric approach employed by reviewing courts).

[52] *See infra* Part II.C (discussing the Third Circuit Court of Appeals decision in *Christ the King*).

[53] *See infra* Parts II.A–C.

[54] 42 U.S.C. § 1396a(a)(30)(A); *Rate Setting and Payment Suits*, *supra* note 25, at 800–01 (noting that § 30(A) was enacted "to ensure that state flexibility in rate-setting did not result in state disregard for federal protections with respect to the adequacy of rates, and their impact on access and quality").

Supreme Court's near-foreclosure of § 1983,[55] the Supremacy Clause[56] and the APA.[57] While CMS may withhold funds from states for violating § 30(A), the agency is deservedly reluctant to impose a penalty that would most affect individuals dependent on governmental funding for their medical care.[58] Therefore, litigation is a crucial tool through which to enforce the Medicaid Acts' requirements.

Section 30(A) mandates that a state's Medicaid plan:

> [P]rovide such methods and procedures relating to the utilization of, and payment for, care and services available

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55 *Rate Setting and Payment Suits*, *supra* note 25, at 802–03 (discussing the repeal of the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A) (1982)). 42 U.S.C. § 1983 states:

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

Section 1983 is a particularly attractive statute through which to enforce civil rights because a companion statute provides winning plaintiffs reasonable attorneys' fees. *See* 42 U.S.C. § 1988(b) (2014). However, in 2002, the United States Supreme Court's decision in *Gonzaga University v. Doe* impeded the ability to bring § 1983 claims under the Spending Clause. 536 U.S. 273, 280 (2001) (holding that § 1983 confers a right to privately enforce a Spending Clause statute only where the statute in question "manifests an 'unambiguous' intent to confer individual rights"). *See also infra* note 87 and accompanying text (discussing the federal circuit court split on this issue).

56 U.S. CONST. art. VI, cl. 2; Martina Brendel, *When a Door Closes, a Window Opens Up: Using Preemption to Challenge State Medicaid Cutbacks*, 86 CHI.-KENT L. REV. 925, 926–27 (2011) (discussing the Supremacy Clause as an alternative means to enforce § 30(A) in absence of § 1983).

57 *See, e.g.*, Managed Pharmacy Care v. Sebelius, 716 F.3d 1235, 1240 (9th Cir. 2013) (plaintiffs challenging reimbursement rate reductions under the APA and the Supremacy Clause); *Christ the King*, 730 F.3d at 296 (3d Cir. 2013) (plaintiff challenging reimbursement rate reductions under the APA and the Supremacy Clause).

58 *See* Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 52 (1981) (White, J., dissenting) (noting that, despite the ability to cut off funds, the judicial "reluctance is founded on the perception that a funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act"). CMS's authority to cut off fund is derived from 42 U.S.C. § 1396c (2014), which states:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> > (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
> >
> > (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State . . . . until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State . . . .

> under the plan . . . as may be necessary . . . to assure that payments are consistent with [1] *efficiency*, [2] *economy*, and [3] *quality of care* and [4] 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 . . . .[59]

Section 30(A) sets a federal floor and ceiling for provider rates, guaranteeing that Medicaid beneficiaries receive accessible, quality medical care of the same degree as privately insured individuals in an economical and efficient manner.[60]

Section 30(A)'s first two factors, efficiency and economy, serve as the federal ceiling for Medicaid payment rates by mandating that payments be no more than "necessary . . . to assure" consistency "with efficiency [and] economy," and are commonly evaluated together.[61] The Ninth Circuit Court of Appeals historically focused on these two factors in interpreting § 30(A).[62] As such, the Ninth Circuit's approach required, until recently, that states examine cost studies prior to cutting rates in order to assess how the cuts compared to the costs of providing Medicaid services.[63] The cost studies approach included a procedural requirement that ensured a relatively searching level of judicial review.[64] However, since the Supreme Court's decision in *Douglas*, patients and providers have brought § 30(A) claims in the Ninth Circuit against CMS under the APA, instead of merely against the state.[65] Accordingly, the Ninth Circuit has deferred to the Department of Health and Human Services' (HHS) interpretation of § 30(A), resulting in

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[59] 42 U.S.C. § 1396a(a)(30)(A) (emphasis added).

[60] Moncrieff, *supra* note 37, at 676–77 (writing that "[a]lthough the states have flexibility in setting the amount that they are willing to pay for healthcare services or for managed care coverage, Title XIX sets a ceiling and a floor on payments").

[61] 42 U.S.C. § 1396a(a)(30)(A); Ariz. Hosp. & Health Care Ass'n v. Betlach, 865 F. Supp. 2d 984, 995 (D. Ariz. 2012) (analyzing efficiency and economy together). *See also* Moncrieff, *supra* note 37, at 676–77 (implying that the efficiency and economy factors are the federal ceiling); *APA Deference after Independent Living Center*, *supra* note 39, at 217 (writing that "economy and efficiency . . . are typically understood to reflect federal concerns about payments being too high").

[62] *See* Moncrieff, *supra* note 37, at 678 (writing that "the Ninth Circuit has focused primarily on the 'efficiency' and 'economy' requirements of § 30(A), holding that rates violate the Medicaid statute if they do not reflect the costs of providing care, even if the rates are sufficient to sustain equal access").

[63] Orthopaedic Hosp. v. Belshe, 103 F.3d 1491, 1499 (9th Cir. 1997) (holding that rates comply with § 30(A) if they "bear a reasonable relationship to provider costs").

[64] *APA Deference after Independent Living Center*, *supra* note 39, at 213 (commenting that the Ninth Circuit historically applied "robust judicial review" to rate cuts).

[65] *See, e.g.*, *Managed Pharmacy Care*, 716 F.3d at 1235; *Ariz. Hosp. & Health Care Ass'n*, 865 F. Supp. 2d at 984.

the abandonment of the cost studies requirement, and a near-singular focus on access.[66]

Section 30(A)'s last two factors, access and quality of care, serve as the federal floor for payment rates.[67] These factors require that each state's Medicaid program provide patients access to quality care.[68] Access to care in the United States is predominately based on access to health insurance.[69] The provision of Medicaid services ensures that many Americans receive health care services that they would otherwise not receive.[70] However, access to care is also implicated by the availability of provider services.[71] Costs that are *too* efficient and economical deter many providers from participating in Medicaid, thus limiting the avenues through which beneficiaries may attain health services.[72]

"Quality" health care is difficult to define. The Institute of Medicine defines quality care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[73] Other definitions abound, but quality care at base must embody care that adequately advances patient welfare.[74] Perhaps as difficult a task as defining quality is selecting the "correct" approach to measuring the quality of any given patient's care. Should quality be measured by outcome? Patient satisfaction? Structural or "process" standards?[75] Does quality depend on whether the provider at issue is an individual or an institution?

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[66] *See Managed Pharmacy Care*, 716 F.3d at 1249–51 (holding that the cost study's methodology is not required by § 30(A) and providing deference to CMS's approval of California's rate cuts).

[67] 42 U.S.C. § 1396a(a)(30)(A).

[68] *Id.*

[69] *See* FURROW, *supra* note 9, at 3 (noting that, unlike many other systems in the developed world that provide universal health care to citizens, the United States' health care system is based on a mix of private and public insurance).

[70] *See supra* text accompanying notes 23–25 (noting that Medicaid is necessary to millions of the nation's most underprivileged citizens).

[71] *See supra* text accompanying notes 39–42 (explaining that low Medicaid reimbursement rates cause low physician-participation in Medicaid).

[72] *See supra* text accompanying notes 39–42, 61 (noting the ceiling on federal reimbursement rates).

[73] INSTITUTE OF MEDICINE, MEDICARE: A STRATEGY FOR QUALITY ASSURANCE, Vol. I, 21 (K. Lohr, ed. 1990) (noting the Institute of Medicine's definition for "quality of care").

[74] *See, e.g.*, Avedis Donabedian, *The Quality of Care: How Can it be Assessed?*, 260 JAMA 1743, 1743 (1988) (writing that "the goodness of technical performance," one element of quality care, "is judged in comparison with the best in practice," which is in turn defined as that practice "that is known or believed to produce the greatest improvement in health.").

[75] *See* FURROW, *supra* note 9, at 144–45 (describing Avedis Donabedian's explanation of the three approaches to quality assessment: "structure," "process," and "outcome").

Analyzing and measuring efficiency, economy, access, and quality is not always easy; however, states are required to take all four factors into consideration when proposing adjustments to provider payment rates.[76]

2. Douglas v. Independent Living Center of Southern California, Inc.

In its 2012 decision of *Douglas v. Independent Living Center of Southern California, Inc.*, the Supreme Court remanded to the Ninth Circuit a series of challenges to rate cuts imposed by the State of California after CMS belatedly approved the state's SPAs.[77] The Court originally granted certiorari to determine whether the Supremacy Clause provides a private right of action to enforce § 30(A).[78] In remanding, however, the Court emphasized the benefits of judicial review under the APA, writing that CMS's actions "may require [the plaintiffs] now to proceed by seeking review of the agency determination under the [APA] . . . rather than in an action against California under the Supremacy Clause."[79] The Court favored review under the APA primarily for reasons of certainty, agency expertise, and consistency.[80] Specifically, the Court noted that the APA provides plaintiffs with "an authoritative judicial determination of the merits of their legal claim" and is uniquely equipped to guide the court in evaluating agency action under the Medicaid Act's complex statutory scheme.[81] The Court also wrote that review under the APA promotes judicial-agency consistency and uniformity by preventing discordant judicial and administrative decisions concerning the same issue.[82]

Rate setting litigation had previously been marked by a degree of inconsistency due to the lack of agency guidance in interpreting § 30(A)'s factors.[83] Uncertainty regarding the proper vehicle through which to

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[76] *See* 42 U.S.C. § 1396a(a)(30)(A) (including (1) efficiency, (2) economy, (3) access to health care, and (4) quality health care).

[77] *Douglas*, 132 S. Ct. at 1207–08.

[78] *Id.* at 1208–10.

[79] *Id.* at 1210.

[80] *See id.* at 1210–11.

[81] *Id.* Writing for the Supreme Court, Justice Breyer stated:

> The Act provides for judicial review of final agency action. It permits any person adversely affected or aggrieved by agency action to obtain judicial review of the lawfulness of that action. And it requires a reviewing court to set aside agency action found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

Id. (citing 5 U.S.C. §§ 702, 704, 706(2)(A) (2014)).

[82] *Douglas*, 132 S. Ct. at 1211.

[83] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342, 26344 (proposed May 6, 2011) ("We are not aware of any standardized, transparent methodology that is broadly accepted to definitively measure access to health care services. Partly as a result, there has been no prior Federal rulemaking or guidance previously on this subject. As a consequence, in implementing their programs, States lack the guidance that they need to understand the types of information that they are expected to analyze and monitor in determining compliance with statutory access requirements. This

challenge state rate adjustments also contributed to inconsistencies.[84] Plaintiffs have historically been forced to use other means to challenge alleged violations of § 30(A) because the Medicaid Act does not contain a private right of action.[85] Initially, plaintiffs challenged rate cuts under § 1983, a civil rights statute used to vindicate state violations of federal constitutional and certain statutory rights.[86] The Supreme Court's narrow, and relatively recent, construction of § 1983 relating to its use as a vehicle to enforce Spending Clause statutes, however, has greatly limited use of that avenue.[87] Plaintiffs then turned to the Supremacy Clause to vindicate their rights, arguing that § 30(A) preempts state rate reductions that fall below the floor instituted by that provision.[88] The preemption strategy has achieved success in some Medicaid suits, but the Court has not yet determined its constitutionality.[89]

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issue has come to light recently, both in litigation and in our review of proposed Medicaid . . . state plan amendments (SPAs) that would reduce provider payment rates.").

[84] *See, e.g.*, Huberfeld, *Bizarre Love Triangle*, *supra* note 24, at 447–50 (describing the discordant judicial interpretations of § 1983 and its viability as a vehicle to enforce § 30(A)). Moreover, the federal circuit courts utilized various approaches in interpreting the statute before *Douglas*. *See, e.g.*, *Belshe*, 103 F.3d at 1499 (applying the cost studies approach); Methodist Hosp., Inc. v. Sullivan, 91 F.3d 1026, 1029 (7th Cir. 1996) (focusing on the access prong of § 30(A)); Ark. Med. Soc., Inc. v. Reynolds, 6 F.3d 519, 529 (8th Cir.1993) (applying the "arbitrary and capricious" test). *See also* Moncrieff, *supra* note 37, at 677–691 (providing further discussion on the judicial inconsistencies in interpreting § 30(A)).

[85] *See* Timothy Stoltzfus Jost, *The Tenuous Nature Of The Medicaid Entitlement*, 22 HEALTH AFF. 145, 146 (2003) (noting the absence of a private right of action in the Medicaid Act).

[86] 42 U.S.C § 1983. *See, e.g.*, Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 512 (1990) (holding that the Boren Amendment was enforceable under § 1983); Jost, *supra* note 85, at 146 (writing that from the late 1960s to the mid-1970s, the Supreme Court firmly recognized the right to enforce certain provisions of the Medicaid Act under § 1983).

[87] *See Gonzaga Univ.*, 536 U.S. at 280 (holding that § 1983 confers a right to privately enforce a Spending Clause statute only where the statute in question "manifests an unambiguous intent to confer individual rights"). Since *Gonzaga Univ.*, the federal circuit courts have split on whether patients or providers, or either, may enforce § 30(A) pursuant to a § 1983 action. Andrew R. Gardella, *The Equal Access Illusion: A Growing Majority of Federal Courts Erroneously Foreclose Private Enforcement of § 1396a(a)(30) of the Medicaid Act using 42 U.S.C. § 1983*, 38 U. MEM. L. REV. 697, 733–36 (2008) (discussing the federal circuit court split that emerged after *Gonzaga*). Only the Eighth Circuit has interpreted such a right in both beneficiaries and providers. *See* Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Serv., 443 F.3d 1005, 1016 (8th Cir. 2006) (holding that § 1983 may be used by both providers and patients to enforce § 30(A)).

[88] *See* Matthew McKennan, *Medicaid Access after Health Reform: The Shifting Legal Basis for Equal Access,* 7 SETON HALL CIRCUIT REV. 477, 499–503 (2011) (discussing use of the Supremacy Clause to enforce § 30(A)).

[89] *See, e.g.*, Lankford v. Sherman, 451 F.3d 496, 509–13 (8th Cir. 2006) (holding that the Supremacy Clause likely preempted a state regulation that limited the provision of durable medical equipment to most categorically-needy Medicaid beneficiaries). The Ninth Circuit, in an early decision in the *Douglas* litigation, became the first federal circuit court to recognize a right of action under the Supremacy Clause to enforce § 30(A). *See* Living Ctr. of

The Supreme Court's decision in *Douglas* went a long way to resolve the foregoing inconsistencies in the judicial arena because, consistent with principles of administrative law, CMS's reasonable interpretation of § 30(A)'s factors will govern the courts' review of state rate adjustments under the APA.[90] Further, the APA provides a stable means through which to challenge agency review of SPAs, in contrast to the present state of flux in which § 1983 and Supremacy Clause actions reside.[91] However, the APA's standard of review is not as searching as was the Ninth Circuit's cost studies test because judicial review of informal agency adjudications (which include CMS SPA approvals)[92] is governed by the deferential "arbitrary and capricious" standard of review.[93] Furthermore, federal agency actions are

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S. Cal., Inc. v. Shewry, 543 F.3d 1050, 1065–66 (9th Cir. 2008) (holding that the Supremacy Clause may be used to enforce § 30(A)).

[90] *See infra* note 93 and accompanying text (explaining the "arbitrary and capricious" standard of review).

[91] *Douglas*, 132 S. Ct. at 1210 (discussing the consistency of review under the APA).

[92] Substantive agency action is divided into formal and informal rulemaking and adjudication. Formal rulemaking and adjudicatory proceedings resemble trial-type proceedings. *See* 5 U.S.C. § 554(a) (2014) ("This section applies, according to the provisions thereof, in every case of adjudication required by statute to be determined on the record after opportunity for an agency hearing"). Informal rulemaking is governed by the notice-and-comment provisions contained in § 553 of the APA and is typified by the promulgation of codified regulations. *Id.* § 553(b)(3), (c), (d). Informal adjudications consist of all particularized orders that are not subject to the APA's formal adjudicatory provisions. *See, e.g.*, Londoner v. City & Cnty. of Denver, 210 U.S. 373 (1908) (a tax assessment imposed on one neighborhood was an adjudicatory order, not a legislative rule, and so notice and a hearing was required prior to its imposition). *See also* Thomas Moore, *Abandoning Mead*: *Why Informal Adjudications Should Only Receive Minimal Deference in Federal Courts*, 2008 UTAH L. REV. 719, 724–25 (deducing that "adjudications target individuals or 'a few people' whereas rulemaking has a broader aim"). As such, informal adjudications, such as U.S. Customs Service tariff classification rulings, licensing suspensions, deportation decisions, and approvals of Medicaid SPAs, take varying and multifarious forms. United States v. Mead Corp., 533 U.S. 218 (2001) (tariff classification ruling); Butz v. Glover Livestock Comm'n Co., 411 U.S. 182 (1973) (licensing suspension); Salameda v. Immigration & Naturalization Serv., 70 F.3d 447 (7th Cir. 1995) (deportation ruling); *Managed Pharmacy Care*, 716 F.3d 1235 (Medicaid SPA approval).

[93] *See* 5 U.S.C. § 706(2)(A) (2014) (providing that a court on review shall "hold unlawful and set aside agency action, findings, and conclusions" it determines to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"). The arbitrary and capricious standard of review governs judicial review of, among other actions, the discretionary elements of informal administrative adjudications. *See* MICHAEL ASIMOW & RONALD M. LEVIN, STATE AND FEDERAL ADMINISTRATIVE LAW 567 (3d ed. 2009) (discussing the arbitrary and capricious standard of review). Section 706(2)(A) Under the arbitrary and capricious test, if the court finds that the agency's action was not reasonable, it generally must remand the issue back to the agency "for additional investigation or explanation." Fla. Power & Light Co. v. Lorion, 470 U.S. 729, 744 (1985). The court's review of an agency's decision-making process may only be based on those issues that the agency actually considered. SEC v. Chenery Corp., 318 U.S. 80, 88 (1943) (stating that "[i]f an order is valid only as a determination of policy or judgment which the agency alone is authorized to make and which it has not made, a judicial judgment cannot be made to do service for an administrative

afforded significant deference pursuant to the doctrine set out by *Chevron, USA, Inc. v. NRDC, Inc.* and its progeny.[94] Some commentators have expressed concern that the APA's judicial review framework will provide defendants too much flexibility and deference in rate setting litigation, to the detriment of Medicaid beneficiaries and providers.[95] Given the recency of the decision, it is too early to say whether such fears will materialize. Nevertheless, plaintiffs are taking the Supreme Court's advice in *Douglas*

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judgment. For purposes of affirming no less than reversing its orders, an appellate court cannot intrude upon the domain which Congress has exclusively entrusted to an administrative agency."). The test is intended to be deferential, while requiring that the agency exhibit rational decision-making. *See* ASIMOW & LEVIN, *supra* note 93, at 576–77. The Supreme Court famously articulated the arbitrary and capricious test in informal agency actions in *Citizens to Preserve Overton Park, Inc. v. Volpe*, stating:

> [T]he court must consider whether the [agency's] decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment. Although this inquiry into the facts is to be searching and careful, the ultimate standard of review is a narrow one. The court is not empowered to substitute its judgment for that of the agency.

401 U.S. 402, 416–17 (1971) (internal citations omitted). An important consideration is whether the agency considered the "relevant factors" required by the applicable statute or other source of law in making its decision. Therefore, judicial review of CMS's approval of state rate reductions turns on whether CMS reasonably determined that the state assessed the specific rate adjustments' impact on § 30(A)'s "relevant factors" of efficiency, economy, quality, and access. As long as there is evidence in the administrative record sufficient to allow CMS to determine whether the state considered such factors, and CMS reasonably considered the state's evidence, approval of the rate adjustments is not arbitrary and capricious.

[94] *See* Chevron, USA, Inc. v. NRDC, Inc., 467 U.S. 837 (1984) (holding that courts must give deference to agency interpretations of ambiguous statutes); *Mead Corp.*, 533 U.S. at 226–27 (holding that *Chevron* deference only applies to interpretations "promulgated in the exercise of" the agency's congressionally delegated authority to issue rules carrying the force of law); Barnhart v. Walton, 535 U.S. 212, 222 (2002) (expanding the contours of *Mead*'s analysis by advising courts to consider the following factors before applying *Chevron* deference: (1) the legal question's interstitial nature; the agency's expertise; (2) the importance of the question to the administration of the statute; (3) the level of complexity of administration; and (4) the careful consideration the agency has given the question over a long period of time). The D.C. Circuit Court of Appeals has determined that CMS SPA approvals are entitled to *Chevron* deference. *See* PhRMA v. Thompson, 362 F.3d 817, 821–22 (D.C. Cir. 2004) (holding that Congress's express delegation to HHS to review state Medicaid plans and amendments indicates congress's intent that such case-by-case adjudications carry the force of law).

[95] *See* Lindsey Gabrielsen, *California Medicaid Amendments: Supreme Court Vacates and Remands Supremacy Clause Private Right of Action Issue Based on Changed Conditions – Douglas v. Independent Living Center of Southern California*, 38 AM. J. L. & MED. 751, 753 (2012) (speculating that APA § 706(2)(A) and *Chevron* will render future rate setting litigation challenging for plaintiffs); David M. Dirr, *High Court Decision Leaves Medicaid Providers Feeling Uneasy*, 24 NO. 5 HEALTH LAW. 34, 37–38 (2012) (suggesting that future plaintiffs find alternative ways, aside from litigation, to challenge Medicaid rate cuts).

and challenging CMS's review of state rate adjustments under the judicial review provisions of the APA.[96]

3. Access, Access, Access

Section 30(A)'s analytical framework is conjunctive: rate adjustments must be consistent with efficiency, economy, quality, *and* access.[97] The quality prong, however, has rarely been the focus of litigation, with most rate setting lawsuits predominately concerning access to care.[98] In fact, § 30(A) is commonly referred to as the "equal access provision."[99] Whether a given lawsuit primarily concerns access is, of course, dependent on the plaintiffs' complaint. Even so, § 30(A) does not, given its grammatical structure, give states, agencies, and reviewing courts the option to ignore one or most of its factors.[100] Therefore, the predominant focus on access, as opposed to efficiency, economy, and quality, seemingly violates Congress's directive.

The access-centric focus has not abated after *Douglas*. The Ninth Circuit considered a § 30(A) claim in *Managed Pharmacy Care v. Sebelius*.[101] *Managed Pharmacy Care* concerned California's latest foray into Medicaid rate cutting.[102] While the court determined that CMS adequately considered § 30(A)'s requirements, its discussion mainly concerned the "[h]undreds of pages of analysis submitted by [California] . . . [concerning] beneficiary access," including a report issued by the Medicaid and CHIP Payment and Access Commission (MACPAC), which proposed the use of a § 30(A) "access framework" in evaluating compliance with the statute, and which was cited approvingly by the court.[103] Similarly, in *Arizona Hospital & Healthcare Ass'n v. Betlach*, the United States District

[96] *See, e.g.*, *Managed Pharmacy Care*, 716 F.3d at 1240 (plaintiffs challenging reimbursement rate reductions under the APA and the Supremacy Clause); *Christ the King*, 730 F.3d at 296 (plaintiff challenging reimbursement rate reductions under the APA and the Supremacy Clause).

[97] 42 U.S.C. § 1396a(a)(30)(A) (emphasis added).

[98] *See, e.g.*, *Ariz. Hosp. & Health Care Ass'n*, 865 F. Supp. 2d at 993–94; (focusing on access) Presbyterian Ministries Inc. v. Hood, 235 F.3d 908, 927 n.24 (5th Cir. 2000) (focusing on access); *Sullivan*, 91 F.3d at 1029 (focusing on access).

[99] *See Rate Setting and Payment Suits*, *supra* note 25, at 800 (referring to the "equal access provision" under § 30(A)); Moncrieff, *supra* note 37, at 674 n.11 (noting that many authorities refer to § 30(A) in its entirety as the "equal access provision," although that title actually only applies to that section's access language).

[100] *See* 42 U.S.C. § 1396a(a)(30)(A) (requiring that state plans "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") (emphasis added).

[101] *Managed Pharmacy Care,* 716 F.3d 1235.

[102] *Id.* at 1239–40.

[103] *Id.* at 1250–51 (citing the MACPAC 2011 Report, which established a three-part test for studying access).

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Court for the District of Arizona upheld Arizona's proposed rate cuts.[104] While Arizona did not entirely ignore § 30(A)'s quality prong, the state, CMS, and the court devoted most of its attention to access.[105] Arizona's quality findings were brief, consisting almost entirely of a reiteration of the effects its new access monitoring system would have on quality, its willingness to transport geographically-isolated beneficiaries to accessible providers, and a declaration that its overall mission was to provide "comprehensive, quality health care for all of its members."[106] The court found that the federal agency's consideration complied with § 30(A) merely because "there [was] evidence in the record that CMS addressed quality."[107]

HHS recently issued administrative guidance that further illustrates the near-singular focus on access in rate setting. In 2011, HHS issued a proposed rule in response to the lack of agency guidance on Medicaid rate setting and § 30(A).[108] The proposed rule, however, is based on the MACPAC report that California relied on in *Managed Pharmacy Care*.[109] As such, the proposal is entirely concerned with access.[110] To ensure compliance with § 30(A), it proposes that prior to reducing reimbursement rates, states must submit to CMS "access reviews" that take into account (1) enrollee needs, (2) provider availability, and (3) utilization of services.[111] The proposed rule eschews methodologies that focus primarily on providers' costs, "recogniz[ing] that access to covered services is affected by multiple factors," including demographic differences and local market conditions.[112] As such, HHS's proposed rule allows states to evaluate access levels using a wide variety of data measures, thus permitting "State and Federal review of beneficiary access to evolve over time and for States to implement effective and efficient approaches and solutions that are appropriate to their local and perhaps changing circumstances."[113] The proposed regulation, therefore, is

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[104] *Ariz. Hosp. & Health Care Ass'n*, 865 F. Supp. 2d at 986.

[105] *See id.*at 993–94 (exhibiting the state and CMS's, as well as the reviewing court's, concentration on access).

[106] *Id.* at 995 (internal quotation marks and citations omitted).

[107] *Id.*

[108] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342 (proposing a framework addressing access due to the lack of agency guidance in interpreting § 30(A)).

[109] *Id.* at 26344–45; MACPAC, MARCH 2011 REPORT TO THE CONGRESS ON MEDICAID AND CHIP, at 125–27 (Mar. 2011), http://www.macpac.gov/reports (follow March 2011 Report) (discussing the framework proposed for examining Medicaid beneficiaries' access to care).

[110] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342 (proposing an access-focused framework to interpreting § 30(A)'s requirements).

[111] *Id.* at 26344–45; MACPAC, MARCH 2011 REPORT TO THE CONGRESS ON MEDICAID AND CHIP, at 125–27 (delineating the factors associated with the proposed access reviews).

[112] Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. at 26344.

[113] *Id.* at 26344–47.

not a bright line rule, and has been criticized for its narrow scope, ambiguity, and insufficient lack of focus on providers' costs.[114] Whether effective or not, however, the proposed rule is consistent with the access-centric approach to rate setting.

C. Christ the King Manor, Inc. v. Secretary U.S. Department of HHS

In *Christ the King*, the Third Circuit analyzed Pennsylvania's nursing home rate adjustment under the quality prong of § 30(A), in marked contrast to the access-centric approach employed by courts both pre- and post-*Douglas*.[115] *Christ the King* correctly recognizes quality is, as the statutory language clearly indicates, a standalone factor that CMS must assess independent of access.[116] As such, it provides guidance to states, CMS, and plaintiffs regarding the state and federal agencies' obligation to independently assess the quality prong of § 30(A) in rate suits initiated under the APA. This section discusses the factual and procedural history of the case and the Third Circuit Court of Appeals' opinion.

1. Factual and Procedural History

Pennsylvania reimburses public and private Medicaid-participating nursing facilities under the so-called "case-mix" prospective payment system.[117] Under this system, the Pennsylvania Department of Public Welfare (PDPW) determines each facility's per diem rate based on a calculation that takes into account the costs necessary to run a Medicaid nursing facility.[118] Because the costs of providing care to Medicaid patients have continuously risen, payments to such facilities under the case-mix system have risen as well.[119] In an effort to curb rising costs, since 2005, Pennsylvania has consistently applied a budget adjustment factor (BAF) to

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[114] *See* Peter Nozicka, *The Equal Access Provision: A Destiny of Ambiguity*, 21 ANNALS HEALTH L. ADVANCE DIRECTIVE 22, 33 (2011) (noting that the proposed rule is narrow in scope because it only applies to fee-for-service pricing arrangements, not managed care, and that, while the equal access provision of § 30(A) focuses on access as regards other populations in the same geographic locations, the proposed rule focuses on beneficiaries' needs and provider availability); *Rate Setting and Payment Suits*, *supra* note 25, at 840 (lamenting that "[n]owhere in the three-part MACPAC framework adopted by HHS does it explicitly include provider cost studies or data as a measure of access or payment sufficiency").

[115] *Christ the King*, 730 F.3d 291. *See supra* Part II.B.3 (discussing the access-centric approach exhibited by most courts pre- and post-*Douglas*).

[116] *Id.* at 309–14 (analyzing Pennsylvania's failure to examine of the rate adjustment's effect on quality of care).

[117] *Christ the King,* 730 F.3d at 298; Christ the King Manor v. Com., Dep't of Pub. Welfare, 911 A.2d 624, 630 (Pa. Commw. Ct. 2006) (discussing the case-mix system). The case-mix system has been in place since 1996. *Id.*

[118] *Christ the King*, 730 F.3d at 298. PDPW takes into account such factors as "the acuity level of residents" and the "allowable costs" that facilities incur. *Id.*

[119] *Id.* at 298–99.

the case-mix rates that decreases reimbursement rates by a certain percentage.[120] As explained by the Third Circuit, "if a case-mix rate of $100 was multiplied by a BAF of 0.900, the resulting reimbursement rate would be $90, or 10% less than what was called for by the case-mix calculation."[121] Using the BAF, reimbursement rates declined by nearly 2% from 2005 to 2007.[122]

In 2008, PDPW submitted an SPA to CMS, seeking federal approval to apply a BAF for 2008–2009 because the BAF for 2007–2008 was set to expire soon.[123] The new BAF decreased the case-mix rate for private nursing homes by 9.109%.[124] However, because the costs of providing care to Medicaid patients under the case-mix methodology continued to rise, total payments to such facilities were estimated to increase by 1% after application of the BAF.[125] While the SPA was under review, the CMS employee responsible for evaluating the state's SPAs contacted PDPW, inquiring as to whether the new BAF would decrease overall nursing facility rates, as he believed the SPA indicated.[126] PDPW assured the employee that any such indication was incorrect.[127] Thereafter convinced, based on a spreadsheet provided by PDPW, that implementation of the proposed SPA would actually result in higher nursing home rates than if it were not approved, the employee recommended approval of the SPA, which CMS gave in December of 2008.[128]

Nursing homes brought suit against HHS and PDPW in 2009 under the APA and the Supremacy Clause, alleging that the state violated § 30(A) because it did not provide CMS with any evidence indicating the BAF's effect on nursing home residents' quality of care.[129] The district court disagreed and upheld CMS's approval, "[a]ccording significant deference to [CMS's] interpretation of the Medicaid Act."[130] On appeal, the Third Circuit

[120] *Id.*

[121] *Id.* at 298.

[122] *Id.* at 299 (noting that reimbursement rates to participating nursing home facilities decreased by cutting 4.878% in 2005 and 6.806% by 2007).

[123] *Id.* at 300. PDPW submitted two SPAs, one concerning public nursing facilities, the other concerning private nursing facilities. *Christ the King*, 730 F.3d at 300 n.8. However, the Third Circuit only discussed the private nursing facilities SPA because plaintiffs waived their ability to argue the validity of the other SPA when they failed to issue a specific objection to that SPA at trial and on appeal. *Id.*

[124] *Id.* at 301–02.

[125] *Id.*

[126] *Id.* at 301.

[127] *Id.*

[128] *Christ the King*, 730 F.3d at 301–02. This belief was a misunderstanding for, if CMS failed to approve the SPA, the current BAF would expire and the case-mix rate would go unreduced. *Id.* at 301 n.12.

[129] *Id.* at 302; Opening Brief of Appellants at 28, Christ the King Manor v. Baldock Assoc., 2012 WL 5986894 (3d Cir. 2013).

[130] *Christ the King*, 730 F.3d at 304–05 (citing Christ the King Manor, Inc. v. Sebelius, 2012 WL 3027543, at *8–9 (M.D. Pa. 2012)).

Court of Appeals reversed, finding CMS's review of Pennsylvania's SPA "arbitrary and capricious" under the APA.[131]

2. Third Circuit Court of Appeals Opinion

The Third Circuit Court of Appeals held that CMS's approval of PDPW's SPA violated § 30(A) because the state agency did not specify in its SPA application how it settled on the specific BAF at issue.[132] The court also held that the state failed to specify how the new BAF "allows for rates 'consistent with'" § 30(A), specifically concentrating on quality of care.[133] Whereas prior Third Circuit § 30(A) state defendants had supplied CMS with data from studies analyzing proposed rate adjustments' effects, stakeholder input, comparative data from other states, and other evidence in support of their SPAs, the administrative record here was "remarkably thin."[134] The state's submission to CMS consisted of a cover letter, an SPA submittal form, notices published in the *Pennsylvania Bulletin* announcing the proposed BAF, a chart indicating the state's Medicaid costs, a description of the proposed BAF, and the calculation used to determine it.[135] Nowhere in its application did PDPW explain how the rates would affect quality of care.[136]

CMS maintained that its approval of Pennsylvania's SPA was not arbitrary and capricious.[137] CMS supported this argument by citing (1) the lack of any quality concerns associated with previous BAFs, (2) the projected 1% increase in reimbursement rates under the proposed BAF, (3) other statutory sources that assure adequate quality of nursing home care, and (4) assurances by the state agency that the proposed BAF complied with § 30(A).[138]

The court was not persuaded by CMS's reliance on the state's past use of the BAF methodology:

> The obvious flaw in that argument is that earlier adjustments do not reveal how a later and different adjustment may change a system already affected by the earlier adjustments. The fifth blow to a boxer's chin may be no more forceful than the previous four, but still be forceful enough to shatter a weakened jaw. And if the fifth blow is more forceful, a "no worries" mindset is even less warranted. The [proposed]

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[131] *Id.* at 305.
[132] *Id.* at 309.
[133] *Id*.
[134] *Id.*
[135] *Id.* at 309, 301.
[136] In fact, the Third Circuit's description of the record as "thin" may have been too generous given that the phrase "quality of care" appeared nowhere in the administrative record. *See* Opening Brief of Appellants, *supra* note 129, at 28.
[137] *Christ the King*, 730 F.3d at 309.
[138] *Id.* at 309, 312.

> adjustment of 9.109% is not necessarily the same in its impact as the 6.806% adjustment [previously adopted].[139]

Therefore, previous rates' effects on quality do not provide sufficient evidence of currently proposed rates' effects on quality because "[i]t is simply not reasonable to conclude that, because prior cuts did not seem too painful, a deeper cut would not hurt."[140]

Regarding the second argument, the court found CMS's assertion that the proposed BAF's projected 1% increase evidenced a lack of any decrease in nursing home quality misguided.[141] CMS approved the SPA based, in part, on its conclusion that the proposed BAF was responsible for the projected rate increase.[142] The court found this conclusion exhibited a fundamental misunderstanding of the state's ratemaking methodology.[143] The BAF would not cause an overall rate increase, but rather would stymie an otherwise larger increase under the case-mix rate absent a cap on growth.[144] Were the SPA not implemented after the then-current BAF expired, the case-mix rate would not be adjusted.[145]

The court was similarly unimpressed with CMS's reliance on other statutory assurances of quality.[146] The state contended that the federal Nursing Home Reform Act's conditions for certification, and nursing homes' duties under state law to provide quality care, were sufficient to ensure PDPW's SPA would not negatively affect quality.[147] The court, however, wrote that depending on other statutory sources to ensure quality would "nullif[y] [CMS's] review process under [§ 30(A)]," and "ignores fiscal realities by implying that a state can continue to assure quality of care by holding nursing homes to high standards while simultaneously underfunding them."[148]

Finally, the Third Circuit rejected CMS's "unsupported assertion that its [SPA] meets [§] 30(A)'s requirements . . . ."[149] Noting that states have flexibility under the Medicaid Act in adjusting provider rates, the court reminded the agency that such flexibility is not limitless.[150] Section 30(A) "gives teeth to the [SPA] approval process," requiring something more than

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139 *Id.* at 311.
140 *Id.*
141 *Id.* at 310
142 *Id.*
143 *Christ the King*, 730 F.3d at 310.
144 *Id*.
145 *Id.*
146 *Id.* at 311–12.
147 *Id.*
148 *Id.* at 312.
149 *Christ the King*, 730 F.3d at 312
150 *Id.*

unsupported, conclusory statements.[151] Any contrary interpretation would render the statute "a dead letter."[152]

CMS's reliance on past rate adjustments and other statutory provisions, misunderstanding of the state's rate setting methodology, and conclusory statements in support of the SPA's positive effects on quality ultimately failed to convince the Third Circuit that CMS complied with the quality prong of § 30(A) when it approved Pennsylvania's SPA.[153] In *Christ the King*, the Third Circuit Court of Appeals issued the first post-*Douglas* decision that invalidated rate adjustments under the APA. The opinion, however, is even more significant in that its discussion focused almost exclusively on quality, as opposed to access.[154] *Christ the King* indicates that § 30(A)'s quality prong is an independent factor in rate reviews going forward, especially when the affected providers consist of institutions that, like nursing homes, are not at risk of leaving the Medicaid program due to their favorable status under the Medicaid Act.[155]

III. ANALYSIS

Christ the King stands for the proposition that states and CMS must treat quality as the truly independent factor of § 30(A) that it is.[156] Anomalous in its focus on quality, the Third Circuit's discussion provides helpful guidelines for states and CMS going forward.[157] While *Christ the King* is unlikely to bring an end to litigants' access arguments, especially when the plaintiffs consist of providers other than, for example, nursing homes, states and CMS should keep in mind its emphasis on quality of care

[151] *Id.* at 312–13.

[152] *Id.* at 313.

[153] *Id.* at 309–14.

[154] *See supra* Part II.B.3 (discussing the pre- and post-*Douglas* access-centric approach to § 30(A)).

[155] *See* Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History*, 26 GA. ST. U. L. REV. 937, 938–40 (explaining the Medicaid Act's institutional bias towards nursing homes exhibited by the fact that Medicaid substantially funds nursing homes and was intended by Congress to direct beneficiaries into nursing homes for the provision of long-term care). One million out of 1.5 million nursing home residents receive Medicaid. FURROW, *supra* note 9, at 140. About half of all national expenditures concerning long-term care stem from Medicaid. William Pipal, *You Don't Have to Go Home, But You Can't Stay Here: The Current State of Federal Nursing Home Involuntary Discharge Laws*, 20 ELDER L. J. 235, 244 (2012).

[156] *See supra* text accompanying note 155 (explaining that *Christ the King*'s focus on quality indicates that reviewing agencies and courts must account for quality of care when analyzing compliance with § 30(A)).

[157] *See infra* Part III.A–C (discussing the guidelines provided by the *Christ the King* decision).

in the event that *Christ the King* spurs more active judicial inquiry into defendants' assessments of quality.[158]

Pennsylvania's rate adjustments were not upheld despite the deferential review afforded rate decisions under the APA.[159] This should provide warning to states and CMS to seriously consider all of § 30(A)'s factors when making and reviewing changes to Medicaid provider payments.[160] *Christ the King*, however, also provides specific guidance concerning state assessments of quality.[161] Finding CMS's reliance on an SPA that did not discuss the quality prong of § 30(A) "arbitrary and capricious," the Third Circuit emphasized the need for independent examination of state rate adjustments' effects on quality by the state, and a concomitant duty on the part of CMS to require such an examination.[162] This overall theme is embedded in the court's discrete responses to CMS's blatant disregard for the lack of any quality assessment by Pennsylvania, and the agency's reliance on independent assurances of, and past rate adjustments' effects on, quality.[163]

A. *Quality Analysis*

One of *Christ the King*'s most important, and perhaps obvious, guidelines is that states must include an assessment of quality in their SPA submissions.[164] Issues of access may more directly affect providers that do not receive as substantial funding from Medicaid as do nursing homes; however, issues regarding the quality of health care provided obviously concern more than simply nursing homes.[165] In any event, Pennsylvania's

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158 *See infra* text accompanying and note 165 (explaining that nursing homes' beneficial status under the Medicaid Act renders them at low risk of leaving the Medicaid program).

159 *See Christ the King*, 730 F.3d at 314 (stating that "from the record there was no reasoned basis for the agency's decision" and therefore the approval of PDPW's SPA was "arbitrary and capricious").

160 *See supra* Part II.C.2 (illustrating that the *Christ the King* decision indicates that *all* of § 30(A)'s factors, including quality, must be assessed by states and the federal government in reviewing rate adjustments) (emphasis added).

161 *See infra* Part III.A–C (discussing the guidelines provided by the *Christ the King* decision).

162 *See supra* text accompanying note 153 (explaining that the Third Circuit in *Christ the King* held that reliance on past rate adjustments and other statutory provisions and conclusory statements in support of the SPA's positive effects on quality are no substitutes for actual review of an SPA's effects on quality of care).

163 *See supra* II.C.2 (discussing the court's disapproval of the state's quality analysis demanded by § 30(A) in *Christ the King*).

164 *See supra* Part II.C.2 (stating that the *Christ the King* court held that CMS's review of Pennsylvania's SPA was arbitrary and capricious because it did not discuss how the adjustment affected quality of care).

165 *See supra* text accompanying note 9 (noting that quality of care implicates all provider settings and patient experiences).

SPA provided no individual examination of quality.[166] Plaintiffs are not generally concerned with issues of economy and efficiency, factors that impose a nebulous federal ceiling on Medicaid reimbursement rates.[167] Therefore, the effects on quality of care in nursing homes was the only § 30(A) issue implicated by Pennsylvania's SPA.[168] Even so, the state did not discuss quality, and CMS approved the state's SPA regardless.[169]

The obvious lesson for states and reviewing agencies is, then, to include, and require, an assessment of quality in SPAs. Measuring quality, of course, is not an easy task.[170] The Third Circuit made clear, however, that conclusory, unsupported assurances of quality will not suffice.[171] In the nursing home context, institutions regularly collect data measuring resident satisfaction.[172] Also, CMS provides nursing home quality ratings on its *Nursing Home Compare* website.[173] The website reviews nursing homes based on a "Five-Star Quality Rating System" both as to a nursing home's overall score, and as to health inspections, staffing, and "quality measures" (QMs).[174] The website contains general "nursing home information" for each institution that indicates whether the nursing home participates in Medicaid.[175]

States should use data from, or of the sort compiled on, *Nursing Home Compare* to measure the quality levels of its nursing homes and other

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[166] *See supra* Part II.C.2 (explaining that Pennsylvania's SPA contained an inadequate examination of quality of care as required by § 30(A)).

[167] *See supra* text accompanying note 61(explaining that § 30(A)'s first two factors set the federal ceiling).

[168] *See supra* Part II.C.1 (writing that the plaintiffs in *Christ the King* brought suit due to the state and federal agencies' lack of assessment of the adjustment's effects on quality).

[169] *See supra* Part II.C.1 (explaining that CMS approved Pennsylvania's SPA even though the submission did not discuss quality).

[170] *See supra* text accompanying notes 73–75 (explaining that quality is a difficult concept to define and measure).

[171] *See supra* Part II.C.2 (reviewing the *Christ the King* court's rejection of CMS's unsupported assertions that the SPA comported with § 30(A)).

[172] *See, e.g.*, Ctr. for Medicare & Medicaid Serv., *Nursing Home Quality Initiative*, CMS.GOV, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/NursingHomeQualityInits (last updated Apr. 4, 2014) (providing "consumer and provider information regarding the quality of care in nursing homes").

[173] *Nursing Home Compare*, MEDICARE.GOV, http://www.medicare.gov/nursinghomecompare (last visited Nov. 22, 2014).

[174] Ctr. for Medicare & Medicaid Serv., *Five-Star Quality Rating System*, CMS.GOV, http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html (last updated Apr. 20, 2014) (describing the "Five-Star Quality Rating System"). QMs consist of "physical and clinical measures for nursing home residents" collected by nursing homes. *Id*

[175] *See, e.g.*, *Nursing Home Compare*, MEDICARE.GOV, http://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=265672&loc=63109&lat=38.5844193&lng=-90.2948797 (last visited May 12, 2014) (providing general information on a nursing home located in St. Louis, Missouri).

similarly situated long-term care institutions and services. *Nursing Home Compare* evaluates nursing homes' staffing levels by assessing the number of residents in each respective institution and the number of nurse and physical therapist (PT) staff hours expended per resident per day.[176] The number of hours expended by registered nurses, licensed practical and licensed vocational nurses, certified nursing assistants, and PTs per resident per day is calculated by dividing the number of hours worked by professionals in each respective group two weeks before inspection by the number of residents.[177]

Each nursing home's recent health inspection information is posted on *Nursing Home Compare*.[178] Inspection results are divided into the following categories: health deficiencies, fire safety deficiencies, and complaints and facility-reported incidents.[179] Health deficiencies are further categorized by mistreatment deficiencies, quality care deficiencies, resident right deficiencies, nutrition and dietary deficiencies, pharmacy services deficiencies, and environmental deficiencies. The data for an institution's health deficiencies includes the date of the last health inspection and a copy of the full inspection report, the dates of complaint inspections, the total number of health deficiencies found in the institution, and the average number of health deficiencies found in the state in which the institution is located, as well of the entire country.[180]

QMs are divided into those measures affecting long-term ("long stay") residents, and those affecting short-term ("short stay") residents.[181] There are thirteen long stay resident QMs, including the percentage of long-term residents who: (1) have experienced one or more falls resulting in major injury; (2) were physically restrained; (3) lost too much weight; (4) have depressive symptoms; and (5) have or had a catheter inserted and left in their bladder.[182] Short-stay QMs consist of the percentage of short-term residents who: (1) self-report moderate to severe pain; (2) have new or worsened pressure ulcers; (3) were appropriately given seasonal influenza vaccination; (4) were appropriately given pneumococcal vaccination; and (5) have been recently prescribed antipsychotic medication.[183]

The foregoing data metrics could prove useful to states in assessing the present quality levels of institutional providers, or at the very least of

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[176] *See, e.g.*, *id.* (providing staffing analysis on a nursing home located in St. Louis, Missouri).

[177] *Id.*

[178] *Id.*

[179] *Id.*

[180] *Nursing Home Compare*, MEDICARE.GOV, http://www.medicare.gov/nursinghomecompare/profile.html#profTab=1&ID=265600&loc=63109&lat=38.5844193&lng=-90.2948797 (last visited May 12, 2014).

[181] *Nursing Home Compare*, MEDICARE.GOV, http://www.medicare.gov/NursingHomeCompare/About/Quality-Measures-Info.html (last visited May 12, 2014).

[182] *Id.*

[183] *Id.*

nursing homes, and in predicting future rate adjustments' effects on such levels. Due to its focus on nursing homes, information of this nature may not prove as useful in evaluating the quality of care provided by individual providers. In any event, it is likely, given their favorable treatment under the Medicaid Act, that institutional long-term care providers will be the most likely to bring quality of care claims.[184]

States may also measure quality by patient satisfaction or outcome data, or other measurements. Regardless of the data gathered and assessed, however, the submission of studies and analyses on quality is necessary.[185] Therefore, states would do well to formulate quality assessment procedures and guidelines in order to prevent judicial invalidation of CMS's approval of rate adjustments.[186] A website like *Nursing Home Compare* would have provided Pennsylvania useful information in studying and assessing its rate adjustment's effects on the quality levels of its nursing homes.

B. Independent Assurances of Quality

Christ the King also provided that, whatever data states use to analyze rate reductions' effects on quality of care, quality standards imposed by other sources are not sufficient substitutes for independent assessment.[187] Pennsylvania relied, in part, on the Nursing Home Reform Act's survey and certification provisions, and comparative state monitoring requirements, in arguing that its SPA would not have a negative impact on quality.[188] The Third Circuit's opinion, however, indicates that § 30(A) requires an independent analysis on the part of the state into each specific rate adjustment's impact on quality of care.[189] This implies that the whole range of quality improvement mechanisms used by states and providers in achieving quality of care, such as regulations, credentialing actions, risk management procedures, market competition, and other tools are not enough, alone, to satisfy compliance with § 30(A)'s quality prong.

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[184] *See supra* text accompanying note 155 (noting that nursing homes receive favorable treatment under Medicaid).

[185] *See supra* Part II.C.2 (discussing the finding in *Christ the King* that Pennsylvania's SPA was arbitrary and capricious because it did not contain a discussion of its effect on quality of care).

[186] *See* text accompanying notes 146–148 (discussing the court's rejection of CMS's reliance on other statutory assurances of quality in *Christ the King*).

[187] *See* text accompanying notes 146–148 (discussing *Christ the King*'s rejection of CMS's reliance on statutory assurances of quality other than § 30(A)).

[188] *See* text accompanying notes 146–148 (discussing CMS's statutory arguments in *Christ the King*).

[189] *See* text accompanying notes 146–148 (discussing *Christ the King*'s rejection of CMS's reliance on statutory assurances of quality other than § 30(A)).

C. Past Quality Rates

Lastly, *Christ the King* indicates that the lack of evidence of prior rate adjustments' negative effects on quality does not satisfy § 30(A), even if the current rate adjustments are devised by the same methodology and prompted by the same concerns as were those implemented previously.[190] The past effects of rate adjustments are certainly helpful in assessing the possible effects of future rates, just as the efficacy rates of independent quality improvement mechanisms are helpful in assessing the current state of a patient's quality of care. As with reliance on independent quality tools, however, a lack of decline in quality rates from prior adjustments does not indicate that a new round of adjustments will *not* have a detrimental effect.[191] Citing a history of a lack of detrimental effects on quality is no substitute for a responsible degree of investigation and analysis by the state.[192]

Christ the King indicates that § 30(A) requires independent assessment of quality.[193] It implies that, of the hundreds of pages submitted by California in support of the rate cuts upheld in *Managed Pharmacy Care*, some pages should have explicitly discussed the cuts' effects on quality of care.[194] *Christ the King* also implies that Arizona, in *Arizona Hospital & Healthcare Ass'n v. Betlach*, should have focused more of its resources on evaluating the independent effects of its cuts on quality.[195] Further, *Christ the King* indicates that, instead of promulgating a regulation that focuses exclusively on access, HHS should consider providing guidance as to how states should assess quality as well.[196] States need to gather and assess data metrics that allow them to determine the extent to which quality of care will be affected by the imposition of rate changes. This requires that states rely on up-to-date, not past, data, and something more than independent or unsupported assurances of quality.

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[190] *See* text accompanying notes 139–140 (discussing *Christ the King*'s rejection of CMS's argument that past rate adjustments' effects on quality are sufficient to satisfy § 30(A)'s mandate).

[191] *See* text accompanying notes 139–140. (discussing *Christ the King*'s assessment that previous rates' effects on quality do not sufficiently evidence current rate proposals' effects on quality).

[192] *See* text accompanying notes 139–140.

[193] *See supra* text accompanying notes 164–171 (discussing the need to analyze quality after *Christ the King*).

[194] *See supra* text accompanying notes 101–103 (discussing the *Managed Pharmacy Care* case).

[195] *See supra* text accompanying notes 104–107 (discussing *Ariz. Hosp. & Health Care Ass'n*).

[196] *See supra* text accompanying notes 108–114 (discussing the proposed regulation based on the MACPAC report).

IV. CONCLUSION

Since the United States Supreme Court's decision in *Douglas*, Medicaid providers and beneficiaries have pursued alleged § 30(A) violations under the APA's judicial review provisions.[197] *Christ the King*, a product of *Douglas*, stands for the proposition that courts reviewing § 30(A) APA claims must inquire into the state and federal agencies' assessments of quality.[198] Measuring quality of care is a complicated issue that would benefit from guidance by CMS or the utilization of tools such as *Nursing Home Compare*.[199] No matter the metrics used, states must analyze and report on quality, lest they risk invalidation of their SPAs as Pennsylvania did in *Christ the King*.[200] Quality is an independent factor of § 30(A), and it appears that the courts may be beginning to acknowledge this fact.

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[197] *See supra* Part II.B (discussing the current state of rate setting litigation).

[198] *See supra* text accompanying notes 164–171 (discussing the need for analyzing quality after *Christ the King*).

[199] *See supra* texts accompanying notes 172–175 (discussing Medicaid.gov's *Nursing Home Compare* website).

[200] *See supra* Part III.A (discussing the need to analyze quality of care to comply with § 30(A) after *Christ the King*).