



## *Armstrong v. Exceptional Child Care Center:* Health Care Providers' Access to Court is Blocked

Prepared By: Jane Perkins

Date: April 29, 2015

In *Armstrong v. Exceptional Child Care Center*, 135 S. Ct. 1378 (2015), the Supreme Court held that health care providers do not have a cause of action under the Supremacy Clause or in equity against state Medicaid officials to enjoin Medicaid payment rates that are arguably inconsistent with the Medicaid Act's payment provision.

### **Discussion**

In 2009, the Exceptional Child Center and other in-home habilitation services providers sued the Idaho Medicaid Director, Richard Armstrong, on the grounds that they were not being paid enough. According to the record in the case, the state set the providers' rates based on how much it wanted to spend on the Medicaid program rather than on how much habilitation services actually cost. The providers wanted the Medicaid agency to set the rates according to instructions in the Medicaid Act that require states to set Medicaid payments at a level "sufficient to enlist enough providers so that care and service are available under the [Medicaid] plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A).

To be in federal court, the providers needed a cause of action, and for this, they relied on the Supremacy Clause of the Constitution which says the laws of the United States "shall be the supreme Law of the Land ... any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const. art. VI, cl. 2.

Reliance on the Supremacy Clause was not novel. The underlying rationale for this preemption doctrine, "stated more than a century and a half ago, is that the Supremacy Clause invalidates state laws that 'interfere with or are contrary to, the laws of congress.'" *Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981) (quoting *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 211 (1824)). Indeed, plaintiffs have filed Supremacy Clause actions for hundreds of years, and federal courts have enforced the Supremacy Clause to enjoin state laws that conflict with, and are thus preempted by, the U.S. Constitution or a federal law. In this case, the lower courts had found an implied cause of action under the Supremacy Clause for the health care providers to enforce § (30)(A). See *Inclusion, Inc. v. Armstrong*, 835 F. Supp.2d 960 (D. Idaho 2011), *aff'd*, 567 Fed. App'x 496 (2014).

However, on March 31, 2015, the Supreme Court held that health care providers cannot enforce the Supremacy Clause to make a state comply with the Medicaid Act's payment provision. *Armstrong*, 135 S. Ct. 1378. It comes as no surprise that the case was a close call—a 5-4 decision. The line-up of the justices did not reflect the usual ideological split, however. Justice Breyer voted with the majority; Justice Kennedy, with the dissent.

Justice Antonin Scalia wrote the majority opinion. As noted above, these types of cases have been filed for hundreds of years and, with respect to the Social Security Act (of which Medicaid is a part), since at least the 1970s. See, e.g., *Townsend v. Swank*, 404 U.S. 282,285 (1971) (recognizing that beneficiaries of Social Security Act programs can bring preemption actions to enjoin state laws that conflict with federal law and are, thus, “invalid under the Supremacy Clause”). Forced by the dissent to acknowledge this “long-established practice,” Justice Scalia said that it does not justify a rule that denies the “fairest reading.” *Armstrong*, 135 S. Ct. at 1386.

According to his fairest reading, the health care providers did not have an implied cause of action under the Supremacy Clause because that provision creates a “rule of decision” that merely “instructs courts what to do when state and federal law clash, but is silent regarding who may enforce federal laws in court, and in what circumstances they may do so.” *Id.* at 1383 (citations omitted). The Court gave a couple of examples of how the Supremacy Clause comes into play, notably including: when an “individual claims federal law immunizes him from state regulation, the court may issue an injunction upon finding the state regulatory actions preempted.” *Id.* at 1384 (citing *Ex parte Young*, 209 U.S. 123, 155-156 (1908)).<sup>1</sup>

With hundreds of years of enforcement history, the Court, next, explained how individuals are able to sue to enjoin unconstitutional actions by government officials and found the ability to sue is a “creation of courts of equity.” *Id.* at 1384. While still not explaining the source of the cause of action, the Court turned to whether the plaintiffs could bring their suit against the Idaho Medicaid officials in equity, stating: “The power of federal courts of equity to enjoin unlawful executive action is subject to express and implied statutory limitations.” *Id.* at 1385. In other words, the court must discern congressional intent.

The *Armstrong* majority found that the Medicaid Act “implicitly precludes private enforcement of § (30)(A),” and the health care providers could not invoke the court’s equitable powers to “circumvent Congress’s exclusion of private enforcement.” *Id.* at 1385. The Court found two indications of congressional intent. First, the “sole remedy” Congress provided in the Medicaid Act authorities the Secretary of Health and Human Services (HHS) to terminate federal funding to all or parts of the state Medicaid program

---

<sup>1</sup> This recognition was critical because most Medicaid and Social Security Act cases seek prospective injunctive relief under *Ex parte Young*.

until the state stops violating the federal law. *Id.* (citing 42 U.S.C. § 1396c). The *Armstrong* majority found that this “express provision of one method of enforcing a statute suggests that Congress intended to preclude others.” *Id.* (quoting *Alexander v. Sandoval*, 532 U.S. 275, 290 (2001)).

There are a couple of problems with this reading. This is supposed to be about congressional intent. When Congress enacted Medicaid, it was working under Supreme Court precedent that recognized a remedial imperative—the right of individuals to claim protection of the law and the duty of courts to accord an appropriate remedy in the absence of any express statutory authorization of a federal cause of action. So, the enacting Congress would not have thought it necessary to insert provisions about private enforcement. Second, a statutory enforcement scheme either substitutes for private enforcement or it does not. In *Wilder v. Virginia Hospital Association*, the Court had already held that the Medicaid Act does not contain a statutory scheme that would replace private enforcement. 496 U.S. 498, 521-22 (1990). Interestingly, in a 2005 case, Justice Scalia listed Medicaid as a statute whose private judicial enforcement is not foreclosed based on a statutory enforcement scheme. See *City of Rancho Palo Verdes v. Abrams*, 544 U.S. 113, 121-22 (2005).<sup>2</sup>

The *Armstrong* majority’s second major point is that, while the termination of funding provision might not, by itself, preclude the provider’s lawsuit, the Medicaid payment provision does because it is so broad and non-specific as to be “judicially unadministrable.” 135 S. Ct. at 1385. But this rationale also is problematic. The Medicaid payment provision does require significant evidentiary proof, but it is certainly not beyond the competency of a court to administer.<sup>3</sup> Indeed, prior to this opinion, courts had enforced the Medicaid payment provision dozens of times. These courts were well-able to discern the statutory demands and weigh the evidence regarding Medicaid and private pay provider participation and Medicaid insured and privately insured access to care. In fact, when my organization, the National Health Law Program, litigated one of these cases in California, the federal agency filed a brief with the court setting forth the various standards that courts could use to measure whether the state’s Medicaid payments ensured that the services in question were available to Medicaid beneficiaries at least to the extent they were available to the general population.

---

<sup>2</sup> The *Armstrong* majority addressed *Wilder* in a footnote as follows: “Respondents do not claim that *Wilder* establishes precedent for a private cause of action in this case. They do not assert a § 1983 action, since our later opinions plainly repudiate the ready implication of a § 1983 action that *Wilder* exemplified. See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002) (expressly ‘reject[ing] the notion,’ implicit in *Wilder*, that our cases permit anything short of an unambiguously conferred right to support a cause of action under § 1983.’).”

<sup>3</sup> Admittedly, the Medicaid payment provision does require a court to engage in a complex balancing test. It must consider whether rates are consistent with efficiency, economy, and quality of care and, at the same time, requires a determination as to whether they are sufficient to afford beneficiaries equal access to necessary services.

According to the Supreme Court majority, the Medicaid providers' remedy is to get the Secretary of Health and Human Services to take action against the state. 135 S Ct. at 1387. As noted, the action that the Medicaid Act authorizes the Secretary to take is the termination of all or part of the state's federal Medicaid funding. In other words, health care providers, who are not being paid enough by the state Medicaid agency, can ask the federal government to deny the state the federal funding that the state needs to operate its Medicaid program. That does not seem fair; in fact, it seems nonsensical that Congress would have ever expected a health care provider to seek such a "remedy." Indeed, former HHS officials submitted a brief to the Supreme Court in this case stating:

Every aspect of [HHS's] administration of the Medicaid program—from its regulations to its annual budget—is premised on the understanding that private parties will shoulder much of the enforcement burden. CMS [the part of HHS in charge of Medicaid] lacks the logistical and financial resources necessary to be the exclusive enforcer of the equal access mandate, and it is highly unlikely to receive the necessary resources in the future.

Brief for Former HHS Officials as *Amici Curiae* in Support of Respondents at 6, *Armstrong v. Exceptional Child*, 135 S. Ct. 1378 (2015) (No. 14-15).

## Conclusion

*Armstrong v. Exceptional Child Care Center* answers a single question. It holds simply that health care providers cannot enforce the Medicaid payment provision against states in federal court. This is a narrow ruling that concerns the rights of health care providers with regard to one rate setting provision of one federal statute.<sup>4</sup> For example, *Armstrong* does not make a holding regarding private enforcement under the other traditional avenue into federal court, 42 U.S.C. § 1983, which provides an express cause of action against a state that is acting to deny an individual a right under the Constitution or a federal law.<sup>5</sup>

---

<sup>4</sup> Notably, Justice Breyer's concurring opinion focused almost exclusively on the rate-setting nature of the provision and his concern that the health care providers were asking the court to engage in "direct rate-setting" as opposed to first asking the federal agency to address the rates and then seeking judicial review of the agency action or inaction as arbitrary or capricious under the Administrative Procedure Act. *Id.* at 1389-90 (citing 5 U.S.C. § 553(e)).

<sup>5</sup> The Court restricted private parties reliance upon § 1983 in *Gonzaga University v. Doe*, 536 U.S. 273 (2002) (regarding a provision of the Federal Education Rights and Privacy Act). After *Gonzaga*, the courts of appeals to have reviewed the question (the First, Second, Fifth, Sixth, Ninth, and Tenth) have held that § (30)(A) does *not* create a privately enforceable right under § 1983. A decision from the Eighth Circuit that allowed private enforcement based on previously controlling circuit precedent was vacated by the Supreme Court. *See Ped. Specialty Care v. Ark. Dep't of Human Servs.*, 443 F.3d 1015 (8th Cir. 2006), *vacated on other grounds by Selig v. Ped. Specialty Care*, 551 U.S. 142 (2007). A decision from the Third Circuit slightly ahead of *Gonzaga* applied analysis quite similar to that in *Gonzaga*. *See Pa. Pharm. Ass'n v. Houstoun*, 283 F.3d 551 (3d Cir. 2002). For in-depth discussion of § 1983 enforcement, see Jane Perkins, National Health Law Program, *Update on Private Enforcement of the Medicaid Act: The*

Nevertheless, some states will seek to stretch the boundaries of *Armstrong* to further limit the relief that is available to private parties from a court sitting in equity. And, the narrowness of the holding will not keep some states from citing *Armstrong* as the grounds for dismissing claims brought under § 1983. This has already occurred in a pending Florida case. See Defendants' Memorandum of law Addressing the Impact of *Armstrong v. Exceptional Child Care Center, Inc., Florida Pediatric Society et al. v. Dudek*, No. 05-23037 (Apr. 17, 2015) (ECF No. 1326).<sup>6</sup>

It remains to be seen whether and how *Armstrong* will affect other private plaintiffs (e.g., Medicaid beneficiaries, health care providers participating in other federal programs, beneficiaries of other federal programs); other defendants (e.g., the Secretary of the US Department of Health and Human Services); and other federal provisions (e.g. other Medicaid provisions, other federal laws).

Finally, *Armstrong* should have administrative repercussions. Over the years, the US Department of Health and Human Services (DHHS) has relied on private health care providers to "shoulder much of the enforcement burden." Brief for Former HHS Officials as *Amici Curiae* in Support of Respondents at 6, *Armstrong v. Exceptional Child*, 135 S. Ct. 1378 (2015) (No. 14-15). After this ruling, however, the federal agency will need to engage in meaningful oversight and enforcement to ensure that health care providers are paid enough to make Medicaid participation economically feasible. DHHS promulgated regulations to enforce § (30)(A) nearly five years ago. See *Medicaid Program: Methods for Assuring Access to Covered Medicaid Services*, 76 Fed. Reg. 26,342 (May 6, 2011). It is time for DHHS to respond to the comments received and finalize these regulations.

---

*Supremacy Clause and 42 U.S.C. § 1983* (Oct. 13, 2014), at <http://www.healthlaw.org/publications/browse-all-publications/issue-brief-medicaid-supremacy-clause#.VT1jSZPK6Vo>.

<sup>6</sup> For in-depth discussion of this case, see Jane Perkins, National Health Law Program, *Q&A-Summary of Florida Pediatric Society v. Dudek Findings & Conclusions* (Jan. 26, 2015) (available from NHeLP).