

# Medicaid and the Role of the Courts

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### ABSTRACT

**ISSUE:** By interpreting and enforcing law, courts historically have played a vital role in shaping Medicaid policy. Among the thousands of cases interpreting Medicaid's meaning, numerous decisions have led to further statutory and regulatory reforms.

**GOAL:** To review judicial decisions that have been instrumental in shaping Medicaid policy regarding eligibility, benefits, and provider participation and payment; to review the scope and limits of state and federal powers, including powers granted under Section 1115 to approve Medicaid demonstrations; and to review the critical question of whether courts can intervene, prior to federal agency review, to prevent states from implementing potentially unlawful and harmful policies.

**METHODS:** Review of leading Medicaid cases.

**FINDINGS AND CONCLUSIONS:** The courts have shaped virtually all aspects of Medicaid policy, including eligibility, benefits and coverage, access to care, provider participation and payment, and the scope of federal agency demonstration powers under Section 1115. Furthermore, underlying the cases that focus on what federal law requires of participating states is a key threshold question of importance to lawsuits brought against states by beneficiaries and providers: whether, in advance of federal agency review, federal courts can intervene to prevent potentially unlawful state policies from taking effect before they cause immediate and irreparable injury. This question has commanded the attention of a more conservative judiciary, whose rulings increasingly are narrowing access to the courts.

### KEY TAKEAWAYS

- ▶ The courts have shaped virtually all aspects of Medicaid policy, including eligibility, benefits and coverage, access to care, provider participation and payment, and the scope of federal agency demonstration powers.
- ▶ Because the courts have the final say over what a law means, judicial interpretation of a law as complex as Medicaid is both inevitable and highly influential.
- ▶ The significance of Medicaid cases goes beyond the fact that they give meaning to the federal law on which the program rests: Medicaid is ground zero in an ongoing debate within the judiciary about the proper place of courts in cases involving state-administered public benefit programs.

## INTRODUCTION

Under the U.S. Constitution, the courts have the final power to interpret the law.<sup>1</sup> Because Medicaid is one of the most complex of all health insurance laws, the courts have played a central role in shaping Medicaid policy throughout the program's history. But judicial involvement in Medicaid is not just about complexity. Federal Medicaid law is silent on a question of fundamental importance: when can beneficiaries and providers turn to the courts to enforce the coverage they believe is guaranteed? For this reason, the courts have not only interpreted the meaning of Medicaid law itself but also have been called upon to resolve a critical threshold question: can private individuals seek the help of the courts to enforce states' federal Medicaid obligations, or is enforcement of federal guarantees the sole purview of the U.S. Department of Health and Human Services (HHS) Secretary?

The Medicaid judicial landscape is dominated by cases brought against states by providers and beneficiaries. But many cases also involve disputes between states and the federal government, particularly over matters of federal funding. In addition, numerous cases brought by beneficiaries and providers have involved claims of unlawful action by the HHS Secretary. Several specifically have focused on the question of whether federal approval of Section 1115 Medicaid waivers — which allow states to use Medicaid funds for demonstration projects or experimental pilots — exceeds Secretarial authority.

Judicial decisions have been instrumental in defining states' obligations under Medicaid, including which people must be eligible for coverage and their level of medical assistance.<sup>2</sup> Section 1115 challenges continue to emerge. Most notably, *Stewart v. Azar*,<sup>3</sup> filed in January 2018, challenged the power of the HHS Secretary to approve state 1115 demonstrations that require Medicaid beneficiaries to work as a condition of eligibility, along with other eligibility restrictions.

In defining the limits of legal entitlement under Medicaid,<sup>4</sup> the judiciary has regularly been asked to interpret the program's enabling statute, which has been characterized as “almost unintelligible to the uninitiated” by one of

the 20th century's most preeminent federal judges.<sup>5</sup> In rare cases, courts have been asked to decide the basic constitutionality of crucial provisions of the statute. Nearly 40 years ago, for example, the United States Supreme Court concluded that it was consistent with the Constitution for Congress to deny federal Medicaid funding for most abortion procedures.<sup>6</sup> More than 30 years later, in *NFIB v. Sebelius*,<sup>7</sup> the Court held that Congress exceeded its constitutional powers by conditioning funding for the “traditional” Medicaid program to state participation in the Affordable Care Act's (ACA) coverage expansion for low-income adults. This decision effectively made the law's mandatory Medicaid expansion optional.

Whether it involves the constitutionality of laws, the legality of federal agency policymaking, or the lawfulness of state actions, Medicaid litigation is wide-ranging. Cases can involve disputes brought by states challenging the power of the federal government to impose certain conditions on federal Medicaid funding. For instance, in *NFIB* states claimed that federal funding could not be withheld from their basic Medicaid programs because they failed to implement the ACA Medicaid expansion. More typically, beneficiaries and providers bring claims against states over questions of eligibility, coverage, procedural due-process safeguards, provider qualification standards, and provider payment. Recent cases involving state efforts to exclude Planned Parenthood from Medicaid offer a particularly vivid example. To date, four federal appellate courts have ruled that states cannot arbitrarily exclude qualified providers from their Medicaid program; three of these cases involve the attempted exclusion of Planned Parenthood from treating Medicaid patients.<sup>8</sup> However one appeals court, concluding that the free-choice-of-provider provision cannot be privately enforced by providers and beneficiaries, has refused to even consider the legality of excluding Planned Parenthood from a state's program.<sup>9</sup> The Trump administration has sought to influence the direction of these cases by using its own administrative powers to set aside earlier agency rulings by the Obama administration that prevented such state exclusionary practices.<sup>10</sup>

In some cases, Congress responds to judicial rulings. In 1990, the Supreme Court held in *Wilder v. Virginia Hospital Association* that the Medicaid statute entitles hospitals to reimbursement rates that are “reasonable and adequate” and that hospitals have the right to sue state Medicaid officials to enforce this requirement.<sup>11</sup> Several years later, Congress eventually repealed the reasonable and adequate hospital payment protection (known as the Boren Amendment), thereby simply eliminating the basis of the lawsuit. In another instance, after a major appellate court decision held the HHS Secretary accountable for defining and enforcing nursing home standards,<sup>12</sup> Congress strengthened federal law to make these duties clear.<sup>15</sup>

The most significant Medicaid cases are usually brought in federal court. As with any lawsuit, Medicaid cases must first deal with the preliminary questions applicable to litigation generally. For example, before having the opportunity to present the merits of their claims, plaintiffs first must demonstrate that they have suffered the type of legal injury that allows them to be in court — this is known as standing. In addition, because there are policies designed to temper judicial overreach, plaintiffs must also convince the court that their case is a timely and appropriate use of judicial powers.

Another preliminary matter increasingly critical in Medicaid cases is whether private individuals can even bring certain types of lawsuits at all, or whether there are provisions of the Medicaid statute that can only be enforced by the HHS Secretary. These cases, known as right-of-action cases, arise from the fact that the same provisions of the Medicaid statute serve a dual purpose; that is, they create individual protections and guarantees while also imposing legal requirements on participating states. The Supreme Court has begun to signal that some of these most important dual-purpose provisions, which guarantee protections for individuals while imposing requirements on participating states, can be enforced only by the HHS Secretary. As discussed below, in 2015 the Court placed Medicaid’s “equal access” guarantee off limits to private enforcement against states. With the Court now poised to consider whether to resolve the split among the lower courts over whether Medicaid’s free-choice-of-provider provision can be privately enforced,

additional key provisions of federal Medicaid law that establish crucial protections may be placed off limits to private litigants.

It is hard to overstate the importance of this threshold matter, a subject of intense focus in an increasingly conservative judicial environment. It is a crucial one, because unlike HHS, courts have the power to preliminarily halt potentially unlawful state action while litigation is in process to avoid immediate and irreparable injury. In contrast, HHS review can take years and typically happens long after a challenged state policy — such as changes in eligibility, coverage, provider participation, or payment — has already taken effect.

Given the low-income status of beneficiaries, Medicaid cases fundamentally are about access to health care itself. As a practical matter, they can be won or lost on this preliminary issue. Since the Supreme Court’s decision in *Wilder*, which not only recognized hospitals’ claim to cost-based payment but also their right to seek judicial intervention to alter state payment rules, the question of who has a right of action to bring a suit has been front and center in social welfare policy.

This report aims to illuminate the role of courts in the evolution of federal Medicaid policy. This includes the question of when private parties — in this case, beneficiaries and providers — can enlist the help of the courts to defend provisions of federal Medicaid law that both set minimum requirements for states while also guaranteeing coverage and access to care for individuals.

## FINDINGS

### Section 1115 Cases

Section 1115 of the Social Security Act allows states to request waivers to conduct experimental demonstrations with their Medicaid programs to further the objectives of Medicaid. *Stewart v. Azar* raises the question of whether Section 1115 permits the HHS Secretary to authorize Medicaid demonstrations that reduce eligibility through work requirements, premium payments, increased reporting requirements, and lengthy lock-out periods for failure to comply with new rules.

In deciding the case, the court will exercise its power under federal law to review the legality of federal agency action under the Administrative Procedure Act, which ensures a fair process for agency decision-making and decisions that rest on a sound record. This is something the courts have done when evaluating 1115 waivers since the early 1970s,<sup>14</sup> and since at least 1976 in the case of 1115 demonstrations under Medicaid.<sup>15</sup> In *Stewart*, the court will decide first whether state regulations that put benefits at risk of loss can be authorized as demonstrations promoting the objectives of the Medicaid program, which are the only type of Medicaid demonstrations that 1115 permits. This will turn on the court's reading of the Medicaid statute itself, as well as consideration of Section 1115's underlying history and context.

Assuming the court concludes that work demonstrations carrying an exclusively downside risk of Medicaid coverage loss are legally permissible, the next question will be whether the administrative record shows that the Secretary's actions were reasonable. This assessment will turn on whether the administrative record: 1) supports the demonstration in concept; 2) supports its central underlying hypothesis that work requirements, premiums, added reporting, and lock-out periods improve health by encouraging employment, wage gains, and access to private health insurance coverage; and 3) shows there is a sound research design and evaluation plan.

### Eligibility Cases

Medicaid contains more than 60 distinct eligibility categories, some mandatory and others optional. All eligibility categories rest on complex financial and nonfinancial criteria that can trigger disputes. In addition, federal procedural due-process safeguards aimed at ensuring fair state agency conduct in making determinations apply to mandatory and optional eligibility groups alike. Beyond the constitutional protections that apply to governmental decisions to grant, deny, or reduce public assistance,<sup>16</sup> federal Medicaid law establishes a right to a fair hearing and requires states to determine eligibility and furnish medical assistance with "reasonable promptness."<sup>17</sup>

Not surprisingly, numerous cases have challenged state actions that deny or terminate eligibility. These cases frequently involve plaintiffs in need of expensive long-term institutional care. Several of the most significant cases upheld restrictive eligibility criteria. In *Friedman v. Berger*, a federal appeals court upheld New York's standards restricting eligibility for medically needy nursing home residents, arguably below levels required under federal law.<sup>18</sup> Similarly, in *Schweiker v. Gray Panthers*,<sup>19</sup> the Supreme Court upheld Medicaid eligibility regulations issued by HHS that litigants had argued unlawfully narrowed the eligibility criteria contained in the Medicaid statute itself.

Court challenges have also frequently addressed procedural due-process protections as part of the Medicaid application and renewal process, even in states that have not adopted the ACA's Medicaid expansion. Even states that have not expanded eligibility are bound by the ACA's procedural requirements that streamline and simplify the eligibility determination process for Medicaid applicants. As noted above, these cases may involve questions of agency adherence to federal legal protections. In *Wilson v. Gordon*,<sup>20</sup> a federal appeals court ruled against the state of Tennessee after it failed to process Medicaid applications and provide fair hearings to those whose applications were delayed.

### Coverage Cases

Perhaps the most common type of Medicaid litigation has involved claims that states have wrongfully denied coverage for medically necessary care. The statute, along with federal implementing regulations, requires that a determination of "medical necessity" be based on reasonable and nondiscriminatory criteria. Furthermore, federal laws aimed at protecting persons with disabilities, including Section 504 of the Rehabilitation Act of 1973 (known as Section 504) and the Americans with Disabilities Act, apply to state Medicaid programs.

Despite these considerable protections, lawsuits involving Medicaid coverage have had mixed success. Applying federal Medicaid policies as well as Section 504, courts have held that, like private insurers, state agencies may apply

across-the-board treatment limits to coverage for adults, even when treatment limits result in coverage that is less than all medically necessary care for specific individuals<sup>21</sup> and reduce the effectiveness of coverage for persons with disabilities who need more care than the treatment limits permit. In *Alexander v. Choate*,<sup>22</sup> for example, the Supreme Court ruled that a 14-day annual limit on hospital coverage did not violate Section 504, even though coverage was inadequate for people with disabilities who needed additional care. But where plaintiffs can show that a state has discriminatorily withheld coverage of necessary medical and hospital care because of their medical condition (something that occurred in early transgender discrimination treatment cases brought by Medicaid beneficiaries), they have prevailed.<sup>23</sup>

Judicial enforcement of civil rights guarantees for people with disabilities have powered Medicaid's remarkable evolution in terms of long-term services. In its landmark decision in *Olmstead v. L.C. by Zimring*,<sup>24</sup> the Supreme Court held that the Americans with Disabilities Act (ADA) (which parallels Section 504 where public programs are concerned) bars state Medicaid programs from limiting coverage for disabled patients solely to institutional settings, requires that they administer their programs in a nondiscriminatory fashion ("with an even hand" in the words of the Court), and cannot discriminate against people with disabilities by withholding covered services in community settings when necessary and appropriate. *Olmstead* became a catalyst for the extraordinary reconfiguration of Medicaid policy away from institutional care and toward home- and community-based care.<sup>25</sup>

Although courts permit across-the-board coverage limits for adults (as long as those limits do not discriminate against people with specific health conditions), the law has been interpreted quite differently as it pertains to children. Under the Medicaid statute, all children and adolescents up to age 21 are entitled to Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefits. The EPSDT statute provides extensive detail regarding the screening, diagnostic, and treatment services it encompasses. Extensive case law<sup>26</sup> interpreting the scope of the EPSDT entitlement has established that the Medicaid

statute prohibits coverage limits other than those based on medical necessity as decided based on the facts in individual cases. In other words, while flat, across-the-board coverage limits (e.g., four physician visits annually) are legal where adults are concerned as long as the limits are based on reasonable norms, they are not permissible for children under EPSDT; an individual child would be entitled to as many visits as are necessary. This recognition of EPSDT as imposing a unique coverage standard has been a hallmark of Medicaid since the benefit was added in 1967. Amendments made to EPSDT in 1989 further broadened the scope of the entitlement to include all federal medical assistance classes even if not covered for adults, leading to even more far-reaching court decisions.<sup>27</sup>

The courts have also clarified how other federal civil rights laws affect state Medicaid coverage obligations. For example, a landmark decision found that Title VI of the 1964 Civil Rights Act, which bars discrimination based on race or national origin by recipients of federal financial assistance, prohibits state Medicaid agencies from paying for nursing home care in institutions that maintain segregated Medicaid wings because of the disproportionate impact that such practices have on minority patients.<sup>28</sup> Similarly, under Title VI, Medicaid agencies must ensure that they and participating providers comply with federal requirements aimed at ensuring that benefits and services are accessible to people whose first language is not English.<sup>29</sup> As *Olmstead* underscores, similar access protections for people with disabilities also apply to Medicaid programs and services under federal disability laws.

### Provider Participation and Payment

The Planned Parenthood cases discussed earlier focus on the scope of state powers over setting standards for health care providers; they also show the kind of standoff that can develop between the Executive Branch and the federal circuit appeals courts, a situation that can prompt Supreme Court intervention. Federal law requires that states determine who is a qualified provider and set provider qualification standards as long as they are reasonable and not discriminatory. To date, every



federal appeals court that has agreed to review the legality of state policies excluding Planned Parenthood clinics (because the organization also furnishes abortions that Medicaid does not pay for) has overturned such policies as discriminatory and unrelated to Planned Parenthood's qualification to provide family planning and preventive care. In their rulings, courts relied on previous Obama administration policies interpreting the law as barring such an exclusion. The Trump administration has now scrapped its predecessor's interpretation on procedural grounds, claiming that such an interpretation requires a formal rulemaking with a notice and comment period. Whether the current administration's decision to set aside its predecessor's policy on procedural grounds is enough to cause future courts to decide that such practices are in fact legal remains to be seen. Ultimately, it may be up to the Supreme Court to decide this matter. Until that happens, the Trump administration could permit states in circuits not covered by prior rulings to exclude Planned Parenthood, effectively pushing matters to the Supreme Court for an ultimate determination.

Free choice of providers is not the only matter of provider concern under Medicaid. The sufficiency of payment is also important. Since the demise of the Boren Amendment's reasonable payment requirement, discussed earlier, Medicaid's provider payment protections are far more limited. A notable exception has been Medicaid's special payment requirements for community health centers, known under Medicaid as federally qualified health centers (FQHCs). Courts repeatedly have concluded that federal FQHC payment rules operate both as a state requirement and as a guarantee for individual health centers, thereby giving them the ability to privately enforce the payment guarantee when states arguably have failed to honor it.<sup>50</sup> Yet just because health centers can get their claims heard in court rather than waiting for the HHS Secretary to act does not mean they win. After concluding that a health center has the right to privately enforce the FQHC payment protection, one appeals court nonetheless recently ruled in a Texas case that a state has flexibility in how it administers the payment rule and furthermore,

that it has no obligation to ensure that managed care organizations pay FQHCs for covered services furnished on an out-of-network basis.<sup>51</sup>

### Can Private Parties Enforce Federal Medicaid Law Against State Agencies?

The Administrative Procedure Act allows beneficiaries and providers to challenge HHS Secretarial approval of state Medicaid plans. But unlike Medicare and the Employee Retirement Income Security Act, the Medicaid statute itself is silent on the question of whether, in advance of Secretarial action, beneficiaries and providers can sue to prevent potentially harmful state actions that threaten to cause irreparable injury.

This silence is consistent with prevailing legal understanding at the time of Medicaid's original enactment. When Medicaid was established more than a half century ago, judicial tradition recognized the right of people on whose behalf a program was created to seek the aid of the courts when state action threatened program guarantees. As Justice Sotomayor along with Justices Kennedy, Kagan, and Ginsburg noted in their dissent in *Armstrong v. Exceptional Child Center Inc.*,<sup>52</sup> decided in 2015, "since the early days of the Republic" the courts recognized suits in federal court to stop state officials from implementing laws that conflict with federal law in violation of the Constitution's Supremacy Clause. This recognition was formalized in *Ex parte Young*,<sup>53</sup> a landmark case challenging the right of individuals to sue state officials in federal court, despite the Constitution's guarantee of state sovereign immunity, when their actions threatened to violate federal law.

For many years, in the absence of an express law to the contrary, the federal courts permitted beneficiaries of public assistance to seek the help of the courts in situations in which pending state actions could unlawfully harm their interests (known as an "implied right of action").<sup>54</sup> The Supreme Court recognized that access to the courts was particularly appropriate because beneficiaries had no right under federal welfare law to appeal to the federal reviewing agency for intervention.<sup>55</sup>

By the early 1980s, the Court had moved away from the implied right of action theory, instead requiring that plaintiffs in state-administered public benefit cases be able to show the existence of “enforceable rights”<sup>56</sup> guaranteed by federal law.

Today, the Court applies an especially rigorous test in measuring when federal law creates enforceable rights. It requires that plaintiffs be able to point to unequivocal statutory text conferring a special benefit on individuals; this test is particularly difficult in a law such as Medicaid, where so many provisions are interpreted by the Court as establishing general conditions of federal funding, not a specific right to specific benefits. A previous Supreme Court decision involving federal education funding established this modern judicial principle,<sup>57</sup> setting an extremely high bar for laws such as Medicaid that similarly establish standards applicable to participating states rather than conferring a right to benefits on specific people. Medicaid still is interpreted by the courts as creating such rights, but the number of provisions viewed as privately enforceable appear to be shrinking in number. At any time, the Supreme Court can decide that provisions thought to be privately enforceable are instead general rules governing federal payment to states that only the HHS Secretary can enforce. In cases where individual rights are found to exist, plaintiffs can enforce these rights directly using a special legislative guarantee established as part of the Civil War Amendments (42 U.S.C. section 1983). But section 1983 allows people to go to court only if they can point to express rights-creating language.

This restrictive principle led an appellate court to block a challenge to a state’s exclusion of Planned Parenthood as a qualified provider under Medicaid. In this case — decided differently from four others — the Court of Appeals for the 8th Circuit held that Medicaid’s free choice of provider protections created no individually enforceable rights. Plaintiffs, therefore, could not seek the aid of the courts to stop Arkansas from barring Planned Parenthood from its program.<sup>58</sup>

One provision that the Court concluded simply imposes a general duty on states rather than creating individual rights is Medicaid’s “equal access” guarantee. This provision is a rate-setting requirement; it requires that state payment rates be “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.” In the *Armstrong* case, a closely divided Supreme Court held that this requirement did not create rights on the part of either beneficiaries or providers. The Court further held that in drafting the provision, Congress had intended to preclude judicial review in advance of HHS review. The Court adopted this reasoning even though nothing in Medicaid law prohibited advance judicial review, and even in a case in which real harm could be shown, in this situation by a provider of care to seriously disabled children that argued that the rates were so low that care itself was threatened. The proper remedy, according to the majority, was to await ultimate resolution by the HHS Secretary, which would occur only long after the fact, and to then challenge the Secretary’s decision as incorrect.

In *Armstrong*, Justice Scalia went beyond the immediate holding, suggesting that he would substantially narrow the Court’s previous holdings that Medicaid is the kind of law that ever can be interpreted by the courts as creating rights actionable under section 1983. Although a majority would not go this far, there appeared to be four votes for this view. If adopted, this shift in judicial philosophy could mean that beneficiaries would lose access to the equitable powers of the federal courts when state actions challenge coverage itself. Justice Scalia’s position would apply even to those Medicaid provisions that appear unequivocally to create rights, such as the right to medical assistance for individuals eligible under a state plan. Should this happen, some 75 million beneficiaries would be completely dependent on the willingness of the HHS Secretary to take immediate and decisive action against states that fail to honor the law’s eligibility and coverage guarantees.

## CONCLUSION

For a half century, judicial decisions have shaped virtually every aspect of Medicaid policy, from benefits for children to the deinstitutionalization of persons with disabilities and the desegregation of long-term care institutions. Because the courts have the final say over what a law means, judicial interpretation of a law as complex as Medicaid is both inevitable and highly influential.

But the significance of Medicaid cases goes beyond the fact that they give meaning to the federal law on which the program rests. Today Medicaid is essentially ground zero in an ongoing and profound philosophical debate within the judiciary about the proper place of courts in cases involving state-administered public benefit programs. Unlike other laws governing public and private insurance, Medicaid is silent on the question of judicial review of state agency actions. This silence may be traceable to the judicial philosophical principles that held sway at the time of Medicaid's enactment, when the courts' ability to intervene to block unlawful state practices was a bedrock assumption.

These principles no longer hold as much sway. Today the Supreme Court looks for unequivocal rights and clear evidence in the text of laws themselves indicating congressional intent to allow federal courts to intervene to protect private interests in state-administered public welfare programs.

As with other public welfare laws, Medicaid's provisions were designed before this modern judicial philosophy took hold. The authority of the federal courts to intervene to protect benefits for the poor when threatened by state actions of questionable legality is now severely constrained. Even so, the future of judicial intervention powers will ultimately depend on an increasingly conservative Court's willingness to adhere to decades-old principles to support beneficiaries' abilities to enforce their rights in court.

## ABOUT THIS STUDY

This report focused on Medicaid decisions issued by federal courts and involving interpretation of federal law. Experts consider these cases to be influential in shaping Medicaid law. Decisions issued by state courts and involving interpretation of state Medicaid law were omitted; although these cases can be highly important, their impact typically is confined to the state in which they are decided.<sup>39</sup>

Except for cases exploring the threshold "right of action" question — that is, whether private litigants can sue to halt potentially unlawful state actions in advance of federal review and before they take effect — the cases discussed all addressed substantive questions of how to interpret the Medicaid law.



## NOTES

- <sup>1</sup> *Marbury v. Madison* 5 U.S. (1 Cranch) 137 (1803); see, generally, Erwin Chemerinsky, *Constitutional Law: Principles and Politics* (Aspen Publishers, 2002).
- <sup>2</sup> Sara Rosenbaum, “How the Courts Created the Medicaid Entitlement,” in *Medicare and Medicaid at 50: America’s Entitlement Programs in the Age of Affordable Care*, ed. Alan B. Cohen et al. (Oxford University Press, 2017).
- <sup>3</sup> D.D.C., No. 1:18-cv-152 (filed Jan. 24, 2018).
- <sup>4</sup> Sara Rosenbaum, “Medicaid at Fifty,” in *The Oxford Handbook of U.S. Health Law*, ed. I. Glenn Cohen, Allison K. Hoffman, and William M. Sage (Oxford University Press, 2016).
- <sup>5</sup> Judge Henry Friendly, *Friedman v. Berger* 547 F. 2d 724, note 7 (1976).
- <sup>6</sup> *Harris v. McRae*, 448 U.S. 297 (1980).
- <sup>7</sup> 567 U.S. 519 (2012).
- <sup>8</sup> See *Planned Parenthood of Kansas v. Andersen*, \_\_ F. 3d \_\_\_ 2018 WL 991502 (10th Cir., 2018); *Planned Parenthood v. Betlach* 727 F. 3d 960 (9th Cir., 2013), cert. den. \_\_\_ U.S. \_\_\_ 134 S. Ct. 1283 (2014); *Planned Parenthood of Indiana v. Commissioner of Indiana State Department of Health*, 699 F. 3d 962, cert. den. 133 S. Ct. 2736; *Harris v. Olszewski*, 442 F. 3d. 456 (6th Cir., 2006); and *Does v. Gillespie*, 867 F. 3d 1034 (8th Cir., 2017).
- <sup>9</sup> Sara Rosenbaum, “Medicaid Coverage for Family Planning — Can the Courts Stop the States from Excluding Planned Parenthood?,” *New England Journal of Medicine* 377, no. 23 (Dec. 7, 2017): 2205–7, <https://www.nejm.org/doi/full/10.1056/NEJMp1711490>.
- <sup>10</sup> Sara Rosenbaum, “The Trump Administration’s Newest Strategy for Excluding Planned Parenthood from Medicaid,” *Health Affairs Blog*, Jan. 28, 2015, <https://www.healthaffairs.org/doi/10.1377/hblog20180125.480978/full/>.
- <sup>11</sup> *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990).
- <sup>12</sup> *Estate of Smith v. Heckler*, 742 F. 2d 583 (10th Cir., 1984).
- <sup>13</sup> Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203.
- <sup>14</sup> 473 F. 2d 1090 (2d Cir., 1973).
- <sup>15</sup> 417 F. Supp 532 (N.D. Ga., 1976).
- <sup>16</sup> See *Goldberg v. Kelly* 379 U.S. 254 (1970).
- <sup>17</sup> 42 U.S.C. § 1396a(a)(8).
- <sup>18</sup> 547 F. 2d 724 (1976).
- <sup>19</sup> 453 U.S. 34 (1981).
- <sup>20</sup> 822 F. 3d 934 (6th Cir., 2016 (Rehearing en banc den.)).
- <sup>21</sup> *Curtis v. Taylor*, 625 F. 2d 635 (5th Cir., 1980) reh. den.
- <sup>22</sup> 469 U.S. 287 (1985).
- <sup>23</sup> See, *Pinneke v Preiser*, 643 F. 2d 546 (8<sup>th</sup> Cir.,1980).
- <sup>24</sup> 527 U.S. 581 (1999).
- <sup>25</sup> Marybeth Musumeci and Henry Claypool, *Olmstead’s Role in Community Integration for People with Disabilities Under Medicaid: 15 Years After the Supreme Court’s Olmstead Decision* (Kaiser Family Foundation, 2014), <https://www.kff.org/medicaid/issue-brief/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicare-15-years-after-the-supreme-courts-olmstead-decision/view/print/>.
- <sup>26</sup> Jane Perkins, Fact Sheet: *Medicaid EPSDT Litigation — Case Trends* (National Health Law Program, updated June 2, 2016), <http://www.healthlaw.org/issues/litigation/EPST-Litigation-Fact-Sheet#.WxiiAEgvzIU>.
- <sup>27</sup> Rosenbaum, “How the Courts,” 2017.

<sup>28</sup> See *Linton v. Carney*, 779 F. Supp. 925 (M.D. Tenn, 1990).

<sup>29</sup> See U.S. Department of Health and Human Services, Office of the Inspector General, *Guidance and Standards on Language Access Services: Medicare Plans* (HHS OIG, July 2010), <https://oig.hhs.gov/oei/reports/oei-05-10-00051.pdf>.

<sup>30</sup> See National Association of Community Health Centers, *Emerging Issues in the FQHC Prospective Payment System* (NACHC, Sept. 2015), <http://www.nachc.org/wp-content/uploads/2015/11/SPR38-Emerging-Issues-in-PPS-September-20111.pdf>.

<sup>31</sup> *Legacy Community Health Services v. Smith*, 881 F. 3d 358 (5<sup>th</sup> Cir., 2018), reh. den.

<sup>32</sup> 135 S. Ct 1378 (2015).

<sup>33</sup> 209 U.S. 123 ( 1908)

<sup>34</sup> *King v. Smith*, 392 U.S. 376 (1968); see *Holding Health Insurance Marketplaces Accountable*, op. cit.

<sup>35</sup> *Rosado v. Wyman* 397 U.S. 397 (1970).

<sup>36</sup> Rosenbaum, “How the Courts,” 2017.

<sup>37</sup> *Gonzaga University v. Doe*, 536 U.S. 273 (2002).

<sup>38</sup> *Does v. Gillespie*, 867 F. 3d 1034 (8th Cir., 2017).

<sup>39</sup> See, for example, *Rivera v. Douglas*, decided by California courts, which used state law protections to prevent the Medi-Cal agency from unreasonably delaying Medicaid eligibility determinations.

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*Editorial support was provided by Deborah Lorber.*

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