



2003

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Meredith Warner Nisse

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Recommended Citation

Meredith W. Nisse, *Pharmacists without Remedies Means Serious Side Effects for Patients: Third Circuit Denies Pennsylvania Pharmacists Standing to Challenge Reimbursement Rates under Medicaid Act*, 48 Vill. L. Rev. 1377 (2003).

Available at: <https://digitalcommons.law.villanova.edu/vlr/vol48/iss5/5>

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PHARMACISTS WITHOUT REMEDIES MEANS SERIOUS SIDE
EFFECTS FOR PATIENTS: THIRD CIRCUIT DENIES PENNSYLVANIA
PHARMACISTS STANDING TO CHALLENGE REIMBURSEMENT
RATES UNDER MEDICAID ACT

I. INTRODUCTION

Providing health care for low-income individuals has always been problematic in the profit-driven health care industry, and it is only getting worse. Medicaid,¹ a joint federal-state health care program, currently covers forty-two million Americans, and that figure is projected to increase in fiscal year 2003.² As a result, states are coming up short in funding for Medicaid and are looking for ways to cut costs.³ Thirty-seven states plan to cut costs by reducing or freezing reimbursement rates to Medicaid providers.⁴ Pharmacies that participate in Medicaid are getting hit hard by the reduction in reimbursement rates and are losing money on Medicaid transactions.⁵

1. See Centers for Medicare & Medicaid Services (CMS), *Overview of the Medicaid Program*, at <http://www.cms.hhs.gov/medicaid/mover.asp> (last visited Jan. 19, 2003) (defining Medicaid as program that "provides medical assistance for certain individuals and families with low incomes and resources. The program . . . became law in 1965 as a jointly funded cooperative venture between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons"). The Medicaid program is codified in Title XIX of the Social Security Act. See 42 U.S.C. §§ 1396a(a)-1396v (2002) (providing codification of Medicaid program); see also 5 WEST FED. ADMIN. PRAC. § 6323 (Christopher Kelley et al. eds., 3d ed. 2002) (distinguishing Medicaid from Medicare).

2. See VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, MEDICAID SPENDING GROWTH: A 50 STATE UPDATE FOR FISCAL YEAR 2003 (Jan. 2003), at <http://www.kff.org/content/2003/20030113/4082.pdf> (surveying all fifty states on individual Medicaid budgets); see also Press Release, Kaiser Comm'n on Medicaid and the Uninsured, 49 States Have Planned or Implemented Medicaid Cuts in FY2003; 32 of Them Have Taken Action Twice (Jan. 13, 2003), at <http://www.kff.org/content/2003/20030113/jan13rls.pdf> (summarizing surveys' findings of impact of state budget constraints on Medicaid programs).

3. See Smith, *supra* note 2, at 9-13 (citing methods states use to cut costs, including: provider rate reductions or freezes, containing prescription drug costs, benefit limits or eliminations, eligibility cuts and restrictions, beneficiary co-payments and long-term care reduction strategies).

4. See *id.* at 9, 21 app. B (exhibiting number of states planning cost containment strategies in Fiscal Year 2003).

5. See, e.g., *Court Stops Indiana Medicaid Rate Cuts*, at http://www.pharmacist.com/articles/h_lr_0002.cfm (last visited Feb. 10, 2003) (noting state court granted injunction blocking state from implementing reductions in Medicaid reimbursement for prescription drugs); Rick Harding, *Massachusetts Ends Medicaid Feud with Chains*, at http://www.pharmacist.com/articles/h_ts_0074.cfm (last visited Feb. 10, 2003) (reporting that state agreed to maintain current reimbursement rates to pharmacies in face of threats from major pharmacies to pull out of Medicaid program); Press Release, Kentucky Pharmacists Association, Kentucky Retail Federation and American Pharmacy Services Corp. (Jan. 21, 2002), at

Pharmacies may elect to participate as Medicaid service providers.⁶ Until the Third Circuit's decision in *Pennsylvania Pharmacists Ass'n v. Houstoun*,⁷ a participating pharmacy had the option to challenge state reimbursement rates by asserting a civil rights claim under 42 U.S.C. § 1983 for violations of the Equal Access provision (§ 30(A)) of the Medicaid Act (hereinafter § 30(A) or Equal Access provision).⁸ Section 30(A) requires states to "assure" that Medicaid recipients have adequate access to Medicaid providers and services and specifies requirements for payments to providers.⁹ Several other circuits have concluded that § 30(A) creates an enforceable right that may be challenged in a § 1983 action by relying on Supreme Court precedent that concluded that another provision of the Medicaid Act, the Boren Amendment, creates an enforceable right.¹⁰ With the repeal of the Boren Amendment in 1997, however, the validity of these circuit court decisions has been called into question.¹¹

<http://www.kphanet.org/Medicaid%20Press%20Release.htm> ("Pharmacies facing increased economic pressures may be forced to close if their reimbursement drops further, ultimately creating a situation in which Medicaid patients may not have access to a pharmacy in their area when a prescription medication is needed."); *Rx for a Medicaid Nightmare?* (Mar. 11, 2002), at <http://www.cbsnews.com/stories/2002/03/11/health/printable503465.shtml> ("Drugstores around the nation are threatening to stop serving Medicaid patients, close or reduce hours if cash-strapped states follow through on plans to cut the amounts paid to pharmacies for filling Medicaid prescriptions."). *But see State Programs Overpaying for Generic Drugs, HHS IG Report Says*, 7 HEALTH CARE DAILY REP. (BNA) (Mar. 15, 2002) (noting that state Medicaid programs "could save hundreds of millions of dollars if they reimbursed generic drugs at a rate closer to the actual acquisition costs of those drugs This formula is causing the Medicaid program to overpay . . . for drugs").

6. See Nancy De Lew, *The First 30 Years of Medicare and Medicaid*, 274 JAMA 262, 266 (1995) (listing prescription drug service as optional service that states can elect to offer).

7. 283 F.3d 531 (3d Cir. 2002).

8. For a discussion of *Pennsylvania Pharmacists Ass'n v. Houstoun* and its implications on Medicaid providers' standing to assert § 1983 actions for violations of § 30(A), see *infra* notes 90-129 and accompanying text.

9. See 42 U.S.C. § 1396a(a)(30)(A) (2002) (requiring adequate access for Medicaid recipients to Medicaid providers and Medicaid services).

10. See, e.g., *Visiting Nurse Ass'n of N. Shore v. Bullen*, 93 F.3d 997 (1st Cir. 1996) (holding Medicaid providers have standing to challenge violations of § 30(A) of Medicaid Act in § 1983 action); *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (same); *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993) (deciding that Section 30(A) creates enforceable right on Medicaid providers); *Minn. Homecare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (allowing Medicaid providers to assert violations of § 30(A) of Medicaid Act). *But see Walgreen Co. v. Hood*, 275 F.3d 475, 478-79 (5th Cir. 2001) ("[As a Medicaid provider], Walgreen does not appear to be an intended beneficiary of § 30(A)."; *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 928 (5th Cir. 2000) ("[Section] 30(A) does not create an 'individual entitlement' for individual providers to a particular level of payment because it does not directly address those providers.")).

11. See, e.g., *Pa. Pharmacists Ass'n*, 283 F.3d at 540 n.15 (stating that one of Congress's objectives in repealing Boren Amendment was to take away Medicaid providers' right to sue under § 1983); Joel M. Hamme, *The Business Environment:*

In *Pennsylvania Pharmacists Ass'n*, the Third Circuit held in a 6-5 decision that pharmacists do not have standing to challenge state reimbursement rates under § 1983 for violations of § 30(A) because pharmacists are not the intended beneficiaries of the Medicaid Act.¹² Additionally, subsequent Supreme Court case law has heightened the standing requirements for asserting a civil rights action under § 1983, indicating that the Third Circuit's holding will remain intact.¹³

This Casebrief explains the Third Circuit's approach to heightening the standing requirements in § 1983 actions for violations of the Medicaid Act in light of its decision in *Pennsylvania Pharmacists Ass'n*. Furthermore, this Casebrief argues that while the Third Circuit's decision was correctly decided under the law, it has adverse policy implications for the Medicaid program.

Part II discusses pertinent aspects of the Medicaid Act, focusing on the similarities between § 30(A) of the Medicaid Act and the Boren Amendment and the effects of the eventual repeal of the Amendment on Medicaid provider rights.¹⁴ Additionally, this section will discuss Medicaid providers' § 1983 remedies under the Act.¹⁵ Part III discusses how other circuits have addressed the issue of Medicaid provider standing under § 1983, comparing circuit court decisions before and after the repeal of the Boren Amendment.¹⁶ Part IV analyzes the Third Circuit's recent construction of the intended beneficiary requirement as applied to Medicaid providers.¹⁷ Moreover, this section critiques the court's decision from a policy perspective and offers advice for practitioners asserting § 1983 actions in the Third Circuit.¹⁸ Part V provides a summary of the issues

Special Legal Concerns—Long-term Care and the Medicaid Program: Past, Present, and Future, in 3 HEALTH LAW PRACTICE GUIDE § 33.8 (2002) (questioning future of Medicaid providers' ability to bring § 1983 action for violations of § 30(A) in other circuits).

12. See *Pa. Pharmacists Ass'n*, 283 F.3d at 541-42 (foreclosing Medicaid provider remedies under § 1983).

13. See *Gonzaga Univ. v. Doe*, 523 U.S. 273, 283 (2002) ("We now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983."); see also *Suter v. Artist M.*, 503 U.S. 347, 364 (1992) (noting that statute "neither confers an enforceable private right . . . nor creates an implied cause of action").

14. For a discussion of the background of the Medicaid program, the Boren Amendment and its eventual repeal, see *infra* notes 19-51 and accompanying text.

15. For a discussion of Medicaid providers' § 1983 remedies, see *infra* notes 52-67 and accompanying text.

16. For a discussion of circuit court cases denying and granting standing to Medicaid providers, including the Third Circuit's precedent prior to *Pennsylvania Pharmacists Ass'n*, see *infra* notes 68-89 and accompanying text.

17. For a discussion of the Third Circuit's reasoning in *Pennsylvania Pharmacists Ass'n*, see *infra* notes 90-129. For a critical discussion of adverse policy implications of the Third Circuit's decision, see *infra* notes 130-43 and accompanying text.

18. For advice to practitioners contemplating § 1983 actions in the Third Circuit, see *infra* notes 144-48.

presented and concludes that the Third Circuit's decision could lead to reduced benefits for Medicaid recipients.

II. BACKGROUND

A. *How Does Medicaid Work?*

In 1965, Congress enacted the Medicaid Act to create a federal and state subsidized public health insurance program for low-income Americans.¹⁹ Under the Act, in exchange for federal funding, participating states agree to comply with the Medicaid Act and applicable federal regulations.²⁰ Medicaid consists of both mandatory services that participating states must offer and optional additional services that states can elect to offer.²¹ One of the options states can elect to offer is a prescription drug service.²²

19. See 42 U.S.C. §§ 1396a(a)-1396v (2002) (outlining procedures for state plans for Medicaid assistance). Because Medicaid is a joint federal and state program, states must elect to participate. See Malcolm J. Harkins III, *Be Careful What You Ask For: The Repeal of the Boren Amendment and Continuing Federal Responsibility to Assure that State Medicaid Programs Pay for Cost Effective Quality Nursing Care*, 4 J. HEALTH CARE L. & POL'Y 159, 162-69 (2001) (providing thorough explanation of how Medicaid program is administered).

20. See Harkins, *supra* note 19, at 162 (explaining requirements of 42 U.S.C. § 1396); see also 42 C.F.R. §§ 447.300-304 (2002) (providing purpose of regulations, definitions, state plan requirements and upper limits of Medicaid reimbursements to Medicaid providers); 42 C.F.R. §§ 447.331-334 (2002) (specifying regulations relating to prescription drugs).

21. See 42 U.S.C. § 1396a(a)(10)(A) (2002) (defining eligible recipients for medical assistance); 42 C.F.R. § 440.210(a) (2001) (describing required services under Medicaid).

22. See 42 U.S.C. § 1396d(a)(12) (listing prescription drugs as one of optional services under Medicaid); 42 C.F.R. § 440.120(a) (2001) (defining prescribed drugs). The majority of states, including Pennsylvania, contract with pharmacies who elect to participate for prescription drug services under a "managed care" program. See Stephen Zuckerman, Alison Evans & John Holahan, Urban Institute, *Questions for States as They Turn to Medicaid Managed Care*, at <http://www.urban.org/template.cfm?Template=/TaggedContent/ViewPublication.cfm&PublicationID=5903&NavMenuID=95> (last visited Feb. 21, 2003) (discussing prevalence of managed care programs among states). The study reports:

The number of Americans enrolled in managed care has grown dramatically during the 1990s, as private and public purchasers of health care turn to managed care as a way of providing more cost-effective delivery of health services The private sector has already achieved substantial savings through managed care. State Medicaid programs are increasing their use of managed care in the hope of achieving similar success.

Id.

The three main types of managed care programs include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Point of Service Plans (POSs). See Health and Human Services (HHS), *Managed Care Terminology*, at <http://cms.hhs.gov/medicaid/managedcare/default.asp> (last visited Feb. 10, 2003) (defining commonly used managed care terms).

Typically, Medicaid has been administered in two ways: (1) through a managed care program or (2) through a “fee for service” program.²³ Managed care programs involve agreements with groups of specific doctors and other providers and require plan members to use only those specified providers.²⁴ In contrast, a fee for service program gives plan members more health care provider choices, but does not reimburse plan members until after they are billed for the health service.²⁵

In the context of Medicaid, the majority of states has switched from a fee for service program to a managed care program in an effort to reduce costs.²⁶ As a result, pharmacies now enter into standard contracts with their state’s Public Welfare Department to provide specific prescription drugs to beneficiaries and set reimbursement rates.²⁷ Historically, when a dispute over the adequacy of reimbursement rates arose, Medicaid providers would assert a § 1983 action for violations of either § 30(A) or the Boren Amendment.²⁸

23. See generally Health Insurance Association of America (HIAA), *Guide to Managed Care: Choosing and Using a Health Plan*, at <http://www.hiaa.org/consumer/choosing.cfm> (last visited Feb. 10, 2003) (explaining differences between managed care program and fee for service program and benefits of both programs). As the HIAA explains: “[i]ndemnity and managed care plans differ in their basic approach. Put broadly, the major differences concern choice of providers, out-of-pocket costs for covered services, and how bills are paid.” See *id.* (outlining health plan choices).

24. See *id.* (noting that under managed care program beneficiaries will have lower out-of-pocket costs).

25. See *id.* (explaining how beneficiary pays for medical services under fee for service program). For example:

You or they send the bill to the insurance company, which pays part of it You have a deductible . . . to pay each year before the insurer starts paying. Once you meet the deductible, most indemnity plans pay a percentage of what they consider the “usual and customary” charge for covered services.

Id.

26. See Zuckerman et al., *supra* note 22, at 1 (“Overall, Medicaid enrollment increased from 28.3 million to 33.2 million between 1991 and 1996, while managed care grew from 9.5 percent to 40.1 percent of total Medicaid enrollment during the period. Forty-nine states now rely on some form of Medicaid managed care plan.”); see also FAMILIES USA AND HEALTH ASSISTANCE P’SHP, FIELD REPORT: MEDICAID MANAGED CARE FINAL REGULATIONS ISSUED (Sept. 2002), at <http://www.familiesusa.org/MMCSept2002.pdf> (explaining regulations that implement patient protections for Medicaid beneficiaries enrolled in managed care). Health Maintenance Organizations (HMOs) contract individually with a state’s department of Public Welfare, and individual pharmacies contract with the HMOs. See *Pa. Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 533 (3d Cir. 2002) (explaining how Medicaid managed care is administered in Pennsylvania).

27. See *Pa. Pharmacists Ass’n*, 283 F.3d at 534 (“The Agreements cover the provision of brand-name and generic prescription drugs to eligible beneficiaries and obligate the Department to reimburse the contracting pharmacies in accordance with state and federal law.”).

28. For a discussion of the development of § 1983 actions for violations of § 30(A) and the Boren Amendment, see *infra* notes 52-89 and accompanying text.

B. *Section 30(A) of the Medicaid Act: The Equal Access Provision*

In asserting a civil rights action under § 1983, Medicaid providers often utilize the Equal Access provision of the Medicaid Act.²⁹ This provision has been cited before and after the repeal of the Boren Amendment.³⁰ Prior to the repeal of the Boren Amendment, courts upheld a provider's right to assert a § 1983 action; after the repeal, courts have declined to uphold such a right.³¹ In the 1981 Amendment to the Medicaid Act, Congress altered § 30(A) in a way that de-emphasized provider benefits, but bolstered its emphasis on recipient benefits.³² This legislative change has been cited to show that Congress intended Medicaid recipients rather than providers to be the intended beneficiaries of the Medicaid Act.³³ Unlike the Boren Amendment, § 30(A) does not include "reasonable cost" language.³⁴ The Boren Amendment specifically re-

29. See 42 U.S.C. § 1396a(a)(30)(A) (2001) (providing Equal Access provision of Medicaid Act). The text of § 30(A) provides in part:

A state plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Id.

30. Compare *Visiting Nurse Ass'n of N. Shore v. Bullen*, 93 F.3d 997, 1003 (1st Cir. 1996) (holding Medicaid providers have right to assert § 1983 action for violations of § 30(A) before repeal of Boren Amendment), *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (same), and *Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993) (same), with *Walgreen Co. v. Hood*, 275 F.3d 475, 477-78 (5th Cir. 2001) (holding § 30(A) does not create enforceable right for purposes of § 1983, after repeal of Boren Amendment), and *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 929 (5th Cir. 2000) (same).

31. For a discussion of Medicaid provider rights prior to the repeal of the Boren Amendment, see *infra* notes 71-79 and accompanying text.

32. See Harkins, *supra* note 19, at 168-72 (explaining intended effects of Boren Amendment). In the 1981 Amendments to the Medicaid Act, § 30(A) was altered in two ways: (1) it was removed from the regulations that accompany the Medicaid Act, and became part of the Medicaid Act itself, and (2) Congress deleted language referring to provider costs and provider benefits and added language referring to Medicaid recipient benefits. See *id.* (same).

33. See, e.g., *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 541 (3d Cir. 2002) ("Nothing in the 1981 amendments suggests that the current version of the statute is intended to benefit providers.").

34. Compare 42 U.S.C. § 1396a(a)(13) (1981) (repealed by Balanced Budget Act of 1997) (providing in relevant part: "A State plan for medical assistance must . . . provide . . . for payment[s] . . . [that] are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services"), with 42 U.S.C. § 1396a(a)(30)(A) (2002) (providing in relevant part: "A state plan for medical assistance must . . . assure that payments are consistent with efficiency, economy, and quality of care

quired that payments to Medicaid providers be reasonable and adequate.³⁵ Opponents of enforcing a private right under § 30(A) argue that Congress's omission of reasonable cost language evinced its intent to eliminate § 30(A) as an enforceable right.³⁶

C. *The Boren Amendment and Its Eventual Repeal*

In 1980, Congress introduced the Boren Amendment³⁷ to the Medicaid Act in response to state concerns that the federal government was usurping too much power and discretion in administering state Medicaid programs.³⁸ The Boren Amendment allowed states to determine on their own whether their Medicaid program complied with federal regulations and required states to adopt payment methods and reimbursement rates that were "reasonable."³⁹ This provision of the Medicaid Act focused on benefiting Medicaid providers, such as participating pharmacists.⁴⁰ Accordingly, courts held that Boren created an enforceable right for provid-

and are sufficient to enlist enough providers so that care and services are available under the plan . . . to the general population in the geographic area").

35. For a discussion of the Boren Amendment, see *infra* notes 37-51 and accompanying text.

36. See, e.g., *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 929 n.26 (5th Cir. 2000) (citing House reports supporting notion that providers have no right under § 30(A)).

37. See 42 U.S.C. § 1396a(a)(13)(A) (1981) (repealed in 1997 by Balanced Budget Act). The Boren Amendment provided in part:

[A] state plan for medical assistance must . . . provide . . . for payment . . . through the use of rates (determined in accordance with the methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards

Id.

38. See Harkins, *supra* note 19, at 176 ("The states supported Boren primarily because they believed that the Amendment gave them discretion to cut payments without any federal oversight to confirm that their assurances of compliance with federal law were grounded in objective, verifiable facts and not on speculation.").

39. See *id.* at 166 ("[T]he legislative history of the reasonable cost related provision makes explicit Congress' intention that states have freedom both to define reimbursable costs and to determine the reasonable costs of care, services and equipment.").

40. See *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 509-10 (1990). The Court held:

[T]he [Boren Amendment to the Medicaid] Act creates a right enforceable by health care providers under § 1983 to the adoption of reimbursement rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility that provides care to Medicaid patients. The right is not merely a procedural one that rates be accompanied by findings and assurances (however perfunctory) of reasonableness and adequacy; rather the Act provides a substantive right to reasonable and adequate rates as well.

Id.

ers and allowed providers to challenge the adequacy of reimbursement rates through a § 1983 action.⁴¹

As a result, courts were faced with a flood of litigation involving the adequacy of state reimbursement rates.⁴² States again complained that there was too much federal oversight of state Medicaid programs and that states were being forced to spend an "excessive" amount of funding on Medicaid.⁴³ These and other factors led to the repeal of the Boren Amendment.⁴⁴ The Boren Amendment was completely replaced by the Balanced Budget Act of 1997.⁴⁵ The Balanced Budget Act requires that "states use a public process to set rates."⁴⁶ In short, states are no longer

41. See, e.g., *Fla. Ass'n of Rehab. Facilities v. Fla. Dep't. of Health and Rehab. Servs.*, 225 F.3d 1208, 1216 n.5 (11th Cir. 2000) ("Prior to the repeal of the Boren Amendment, it was well settled that health care providers under a state Medicaid program could bring actions pursuant to 42 U.S.C. § 1983 for declaratory and injunctive relief to redress ongoing violations of the Amendment.") (citing *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 704 (11th Cir. 1997)) (allowing Medicaid provider suit under Boren Amendment); *Okla. Nursing Home Ass'n v. Demps*, 792 F. Supp. 721 (W.D. Okla. 1992) (same).

42. See, e.g., *Minn. Homecare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (challenging Minnesota's "rate setting methodology governing reimbursements for home health care providers under the State's Medicaid program violates the statutory mandates of the Federal Medicaid Act"); *Moody Emergency Med. Serv. v. Millbrook*, 967 F. Supp. 488, 491 (M.D. Ala. 1997) (challenging Millbrook's method of assigning emergency 911 calls as creating monopoly by one emergency service provider); *Sobky v. Smoley*, 855 F. Supp. 1123, 1130 (E.D. Cal. 1994) (challenging California's methadone maintenance treatment reimbursement scheme); see also *Harkins*, *supra* note 19, at 193 ("Provider suits brought under the Boren Amendment, 42 U.S.C. § 1396a(13), have been a major factor pressuring states to increase payment rates. . . . Particularly in recent years, states have been dogged by provider lawsuits . . .").

43. See *Harkins*, *supra* note 19, at 186-94 ("The states sought repeal of Boren because they wanted the authority to spend more than two hundred billion federal Medicaid dollars without a concomitant obligation to adhere to any federal standards when doing so.").

44. See *id.* (discussing factors leading to repeal of Boren Amendment). Other factors that led to the repeal of the Boren Amendment included predicted federal Medicaid savings without the Boren Amendment and the deterioration of fiscal conditions after September 11, 2001, that required states to cut Medicaid budgets. See *id.* at 192-94 (explaining reasons for Boren Amendment repeal).

45. See *id.* at 195 ("In short, Boren was replaced by a statute that contained no substantive payment standard and one that did not even require that the state consider the impact of its rate setting decisions on the ability to deliver quality care or to comply with state and federal care standards.").

46. 42 U.S.C. § 1396a(13) (2002). The new text of § 13(A) of the Medicaid Act provides in part:

A state plan for medical assistance must . . . provide (A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

required to meet the federal reasonableness standard with regard to reimbursement rates.⁴⁷ Medicaid providers did not experience the full effect of the repeal until the economy began to decline in late 2001.⁴⁸

In response to poor economic conditions, state Medicaid directors began cutting back Medicaid budgets.⁴⁹ In order to avoid reducing benefits to Medicaid recipients, Medicaid providers were the first target, and states began to reduce provider reimbursement rates.⁵⁰ Some providers were receiving below cost reimbursement rates, and, with the repeal of the Boren Amendment, it remained unclear whether providers would have standing to challenge the adequacy of these rates under other provisions of the Medicaid Act in a § 1983 action.⁵¹

D. *Pharmacists' Remedies Under Section 30(A): Section 1983 and the Intended Beneficiary Requirement*

Section 1983 provides a cause of action for "the deprivation of any rights, privileges, or immunities secured by the Constitution and laws."⁵²

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs . . .

Id.

47. See Mark H. Gallant, *Balanced Budget Act of 1997: Amendments to Medicaid Reimbursement Provisions, Boren Amendment Repeal*, 2 HEALTH L. PRAC. GUIDE § 21:24 (2002) ("[T]he Boren repeal eliminated the states' obligation to render findings and make assurances to the Secretary concerning the reasonableness and adequacy of rates to cover the costs incurred . . . in favor of a 'rate of payment' established pursuant to a loosely defined 'public process.'").

48. See Harkins, *supra* note 19, at 196 (noting that "the economic expansion the United States enjoyed through the 1990s blunted the immediate fiscal impact of the repeal").

49. See *id.* at 160 n.1 (stating between 1995 and 2000, Medicaid expenditures grew, but by beginning of 2001, fiscal year states began cutbacks in Medicaid expenditures) (citing J. GUYER, HENRY J. KAISER FAMILY FOUND., POLICY BRIEF: THE ROLE OF MEDICAID IN STATE BUDGETS (Oct. 2001)).

50. See HEALTH MGMT. ASSOC., MEDICAID BUDGETS UNDER STRESS: SURVEY FINDINGS FOR STATE FISCAL YEAR 2000, 2001 AND 2002 (Oct. 2001) (reporting that "in 2001 roughly one third of states adopted or proposed freezes or actual reductions in provider payments").

51. But see generally Harkins, *supra* note 19, at 213-27 (arguing that after repeal of Boren Amendment, Medicaid providers still have viable cause of action under § 30(A) of Medicaid Act).

52. 42 U.S.C. § 1983 (2002). The full text of the statute provides: 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 States 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, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree

Initially, the Supreme Court interpreted § 1983 narrowly and imposed a strict "implied right of action" standing requirement.⁵³ In applying this test, the Supreme Court specified that a statute must be "phrased in terms of the persons benefited."⁵⁴

Starting in the 1980s, courts interpreted the implied right of action doctrine more expansively.⁵⁵ One such expansion occurred when the Supreme Court declared that a cause of action under § 1983 enforced not

was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

Id.

53. *See, e.g.*, *Cannon v. Univ. of Chi.*, 441 U.S. 677, 688-89 (1979) (applying implied right of action test to determine whether student had enforceable right under Title IX of Education Amendments of 1972); *Cort v. Ash*, 422 U.S. 66, 78 (1975) (applying multi-factored test to determine whether private remedy is implicit in statute). Under this test, the Court looked to four factors to determine whether a private remedy is "implicit" in a statute not expressly providing one. *See id.* at 78-85 (finding no implied right of action under 18 U.S.C. § 610 for shareholders derivative action). These factors included:

[1] Is the plaintiff one of the class for whose especial benefit the statute was enacted . . . ?; [2] is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one?; [3] is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff?; [4] is the cause of action one traditionally relegated to state law . . . so that it would be inappropriate to infer a cause of action based solely on federal law?

Id. at 78 (citations omitted).

Under the first factor, the Court concluded that looking at the legislative purpose of the statute, it was not intended to benefit shareholders, rather, "corporations as a source of aggregated wealth" were the intended beneficiaries. *See id.* at 82 (noting that Court has implied right of action where "there has generally been a clearly articulated federal right in the plaintiff . . . or a pervasive legislative scheme governing the relationship between the plaintiff class and the defendant class in a particular regard"). Under the second factor, the Court found that the legislative history demonstrates no intent to "vest in corporate shareholders a federal right to damages for violation of § 610." *Id.* The Court next held under the third factor that "the remedy sought would not aid the primary congressional goal." *Id.* at 84. Finally, under the fourth factor, the Court determined that state remedies were adequate and state law should govern. *See id.* ("[I]t is entirely appropriate . . . to relegate respondent and others in his situation to whatever remedy is created by state law.").

54. *Cannon*, 441 U.S. at 692 n.13 (noting that "right- or duty-creating language of the statute has generally been the most accurate indicator of the propriety of implication of a cause of action"). Moreover, an implied right of action must "manifest an intent to create not just a private right but also a private remedy." *Alexander v. Sandoval*, 532 U.S. 275, 286-87 (2001) (stating that without statutory intent "a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute").

55. *See, e.g.*, *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 113 (1989) (referring to "broad remedial scope of § 1983"); *Maine v. Thiboutout*, 448 U.S. 1, 4 (1980) (broadly construing phrase "and laws" as used in § 1983).

only constitutional rights, but also federal statutory rights.⁵⁶ The Supreme Court noted two exceptions to this rule, stating that no cause of action will exist: (1) where a statute does not create an “enforceable right” or (2) where Congress has “foreclosed” enforcement of the statute.⁵⁷

In determining whether a particular statute creates an enforceable right, courts have applied a three-prong test.⁵⁸ First, courts ask whether the putative plaintiff is the intended beneficiary of the statutory provision.⁵⁹ Second, courts determine whether the statute creates a “binding obligation,” or more than “merely a ‘congressional preference.’”⁶⁰ Third, courts ensure that the provision is not “too vague or amorphous” to enforce.⁶¹

56. See *Thiboutout*, 448 U.S. at 4 (“[T]he § 1983 remedy broadly encompasses violations of federal statutory as well as constitutional law.”). Prior to this holding, plaintiffs could only assert § 1983 claims of constitutional violations, and additional federal statutory claims were only available as pendant actions. See *id.* (reversing prior cases). But see *Pennhurst State Sch. and Hosp. v. Halderman*, 451 U.S. 1, 27-28 (1981) (applying rationale in *Thiboutout*, but finding no enforceable right under Developmentally Disabled Assistance and Bill of Rights Act).

57. See *Wright v. Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418, 423 (1987) (stating that “if there is a state deprivation of a ‘right’ secured by a federal statute, § 1983 provides a remedial cause of action unless the state actor demonstrates by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement”); see also *Pennhurst*, 451 U.S. at 19 (suggesting § 1983 right is foreclosed because statutory language is ambiguous and does not support rights and obligations “read into it” by lower court); *Middlesex County Sewerage Auth. v. Nat’l Sea Clammers Ass’n*, 453 U.S. 1, 21 (1981) (stating that Congress’s remedial scheme inserted into statute foreclosed availability of privately enforceable right under § 1983).

58. See *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 509 (1990) (holding that Boren Amendment to Medicaid Act creates enforceable right under three-prong analysis); *Golden State*, 493 U.S. at 106 (holding National Labor Relations Act created enforceable right for employers to assert § 1983 action against government interference). But see *Blessing v. Freestone*, 520 U.S. 329, 338 (1997) (finding Title IV-D of Social Security Act does not give individuals federally enforceable right under § 1983 using three-prong analysis).

59. See *Wright*, 479 U.S. at 430 (finding that Brooke Amendment to Housing Act intended to benefit tenants and therefore created enforceable right under § 1983); see also *Wilder*, 496 U.S. at 509 (finding health care providers are intended beneficiaries of Boren Amendment because “provision establishes a system for reimbursement of providers and is phrased in terms benefiting health care providers”).

60. *Pennhurst*, 451 U.S. at 19 (finding that Act “does no more than express a congressional preference for certain kinds of treatment. It is simply a general statement of ‘findings’”). But see *Wilder*, 496 U.S. at 512 (“The Boren Amendment’s language succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or ‘nudge.’”).

61. See *Golden State*, 493 U.S. at 112 (allowing federally enforceable right and concluding that “the violation of a federal right that has been found to be implicit in a statute’s language and structure is as much a ‘direct violation’ of a right as is the violation of a right that is clearly set forth in the text of the statute”); *Wright*, 479 U.S. at 430 (rejecting vague and amorphous argument and finding that “the benefits Congress intended to confer on tenants are sufficiently specific and defi-

In *Wilder v. Virginia Hospital Ass'n*,⁶² the Supreme Court applied the § 1983 three-prong test in an action challenging the administration of Virginia's Medicaid program under the Boren Amendment.⁶³ The issue in *Wilder* was whether a health care provider could bring an action under § 1983 to challenge state reimbursement rates under the Boren Amendment.⁶⁴ In determining whether the Boren Amendment created an enforceable right, the Court first looked to its legislative history and concluded that health care providers are the intended beneficiaries of the Boren Amendment.⁶⁵ Further, because the Boren Amendment is set forth in "mandatory terms," the Court concluded that Boren imposed a binding obligation on states participating in Medicaid to adopt "adequate and reasonable rates."⁶⁶ After *Wilder*, courts continued to apply the three-prong test, but later cases hinted at a return to a stricter standard.⁶⁷

III. OTHER CIRCUITS' POSITIONS ON PHARMACIST STANDING TO ASSERT A § 1983 ACTION: BEFORE AND AFTER THE REPEAL OF THE BOREN AMENDMENT

Other circuit courts have disparate holdings on whether Medicaid providers have standing to assert § 1983 actions for violations of § 30(A).⁶⁸ Looking at circuit court decisions chronologically, the cases may be categorized into two groups: (1) decisions before the repeal of the Boren Amendment and (2) decisions after the repeal that illustrate the effects of Boren's repeal on § 1983 standing.⁶⁹ The Third Circuit case law on the

nite to qualify as enforceable rights under . . . § 1983, rights that are not, as respondent suggests, beyond the competence of the judiciary to enforce").

62. 496 U.S. 498 (1990).

63. *See id.* at 508-20 (finding that Boren Amendment creates enforceable right and Congress did not foreclose enforcement of Act under § 1983).

64. *See id.* at 503 (arguing Virginia's plan for reimbursement violates Medicaid Act "because the rates are not reasonable and adequate to meet the economically and efficiently incurred cost of providing care to Medicaid patients in hospitals and do not assure access to inpatient care").

65. *See id.* at 506 (discussing legislative purpose behind enacting Boren Amendment); *see also* H.R. REP. NO. 97-158, Vol. II, at 293 (1981) (noting that Congress "recognize[d] the inflationary nature of the [then] current cost reimbursement system and intend[ed] to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services").

66. *Wilder*, 496 U.S. at 514 (declining to "adopt an interpretation of the Boren Amendment that would render it a dead letter").

67. *See, e.g.,* *Alexander v. Sandoval*, 532 U.S. 275, 286-87 (2001) (applying implied right of action standard for determining whether statutory provision creates enforceable right); *Suter v. Artist M.*, 503 U.S. 347, 356 (1992) (noting importance of rights creating language). For a discussion of the Supreme Court's most recent decision on the heightened § 1983 standard in *Gonzaga University v. Doe*, *see infra* notes 133-36 and accompanying text.

68. For a discussion of other circuits' holdings, *see infra* notes 71-86 and accompanying text.

69. For a discussion of other circuit courts' holdings before the repeal of the Boren amendment, *see infra* notes 71-79 and accompanying text. For a discussion

issue prior to *Pennsylvania Pharmacists Ass'n* is consistent with the majority of the other circuits.⁷⁰

A. *Decisions Before the Repeal of the Boren Amendment: Medicaid Providers Have Standing Under § 1983*

Initially, courts enforced a private right of action under § 1983 for violations of § 30(A) of the Medicaid Act, likening the Supreme Court's rationale in *Wilder* to cases involving § 30(A) of the Medicaid Act.⁷¹ All of the circuits that addressed this issue prior to the repeal of the Boren Amendment granted a private right of action under § 1983 for violations of § 30(A).⁷² The First, Seventh and Eighth Circuits proposed similar arguments when holding that § 30(A) creates an enforceable right.⁷³

Courts drew similarities between the language in the Boren Amendment and § 30(A), concluding that Medicaid providers are the intended beneficiaries of both provisions.⁷⁴ One court determined the Boren Amendment and § 30(A) contained nearly identical "substantive require-

on other circuit courts' holdings after the repeal of the Boren Amendment, see *infra* notes 80-86.

70. For a discussion of other Third Circuit case law on provider standing, see *infra* notes 87-89 and accompanying text.

71. See, e.g., *Visiting Nurse Ass'n of N. Shore v. Bullen*, 93 F.3d 997, 1003 (1st Cir. 1996) (noting that every circuit that has addressed issue has found that "the *Wilder* rationale likewise applies to the second 'equal access' right described in section 1396(a)(30) . . . health care providers [are] intended beneficiaries under both the Boren Amendment and section 1396(a)(30) since health care providers, as payees, obviously are affected by substantive changes in state reimbursement schemes").

72. See *id.* at 1003-04 (holding that Medicaid providers are intended beneficiaries of § 30(A)); *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (same); *Ark. Med. Soc'y Inc. v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993) (same).

73. For a discussion of arguments advanced by other circuits in support of Medicaid provider standing before the repeal of the Boren Amendment, see *infra* notes 74-79 and accompanying text.

74. See *Minn. Homecare Ass'n v. Gomez*, 108 F.3d 917, 919 (8th Cir. 1997) (Cohen, J., concurring) ("Like the Boren Amendment, section 1396(a)(30) 'requires each state to produce a *result*, not to employ any particular methodology for getting there.'" (emphasis in original)); see also *Visiting Nurse Ass'n*, 93 F.3d at 1004 (explaining that *Wilder* also stands for general proposition that health care providers are intended beneficiaries of Medicaid Act); *Methodist Hosp.*, 91 F.3d at 1029-30 (7th Cir. 1996) (holding *Wilder* decision binding on court because of similarity between Boren Amendment and § 30(A)); *Ark. Med. Soc'y, Inc.*, 6 F.3d at 525 ("[T]he equal access provision is very analogous to the Boren Amendment examined in *Wilder*; they are similar not only in function but also in the specific language employed."); *Moody Emergency Med. Serv. v. Millbrook*, 967 F. Supp. 488, 494 (M.D. Ala. 1997) (noting that because Medicaid providers are intended beneficiaries of Boren Amendment, they are likewise beneficiaries of equal access provision); *Ill. Hosp. Ass'n v. Edgar*, 765 F. Supp. 1343, 1349 (N.D. Ill. 1991) (noting that equal access provision complements Boren Amendment; therefore, it should also be enforceable right).

ments" to determine reimbursement to providers.⁷⁵ Additionally, some courts interpreted the Medicaid Act as having more than one intended beneficiary.⁷⁶

Further, courts pointed to the legislative history of § 30(A) to support their position that Congress intended § 30(A) to be judicially enforced.⁷⁷ Courts determined that when Congress moved § 30(A) from the regulations to the Medicaid Act itself, it intended to confer a right on the Act's beneficiaries.⁷⁸ Moreover, one court noted that, prior to § 30(A)'s inclusion in the Medicaid Act, it was "inadequately enforced."⁷⁹

B. Decisions After the Repeal of the Boren Amendment: Medicaid Providers Do Not Have Standing Under § 1983

After the repeal of the Boren Amendment, courts slowly began to hold that Medicaid providers no longer had standing under § 1983 for violations of § 30(A).⁸⁰ While the Fifth and Third Circuits are the only

75. See *Visiting Nurse Ass'n*, 93 F.3d at 1005 (noting that § 30(A) and Boren Amendment do not create "vague or amorphous" standard for judicial enforcement). The Eighth Circuit similarly reasoned that the Boren Amendment and § 30(A) are "similar not only in function but also in the language employed." *Ark. Med. Soc'y, Inc.*, 6 F.3d at 525 (looking carefully at specific sections of Medicaid Act in light of court's past decisions).

76. See, e.g., *Visiting Nurse Ass'n*, 93 F.3d at 1004 n.7 ("[I]t is well settled that Congress may create more than one class of intended beneficiary."); see also *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 544 (3d Cir. 2002) (Becker, J., dissenting) ("[A] statute can have more than one class of intended beneficiaries and hence the mere fact that Congress intended § 30(A) to benefit Medicaid recipients has no bearing on whether Congress also intended § 30(A) to benefit Medicaid providers.").

77. See *Ark. Med. Soc'y, Inc.*, 6 F.3d at 526 (discussing legislative history of equal access provision).

78. See H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2060, 2115-16 (providing legislative history). The House report provides:

The Committee Bill would codify, with one clarification, the current regulation, 42 C.F.R. 447.204, requiring adequate payment levels. Specifically, the Committee bill would require that Medicaid payments for all practitioners 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.

Id.

79. See *Ark. Med. Soc'y, Inc.*, 6 F.3d at 526 (discussing motivations for codifying equal access provision). District courts in other circuits have also adopted this "inadequate enforcement" rationale as "compelling" evidence that the equal access provision is subject to judicial enforceability. See, e.g., *Moody Emergency Med. Serv. Inc.*, 967 F. Supp. at 495 n.8 (noting that legislative history demonstrates congressional intent to give equal access provision "appropriate enforcement").

80. See *Walgreen Co. v. Hood*, 275 F.3d 475, 478 (5th Cir. 2001) (denying pharmacy, as Medicaid provider, standing to assert § 1983 action for violations of § 30(A)); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 931-32 (5th Cir. 2000) (same); *Burlington United Methodist Family Servs., Inc. v. Atkins*, 227 F. Supp. 2d 593, 596-97 (S.D. W.Va. 2002) (following Supreme Court's heightened standard in *Gonzaga*, stating Medicaid providers have no standing to assert § 1983 action for violations of § 30(A)); *Fla. Pharmacy Ass'n v. Cook*, 17 F. Supp.

circuits that have heard this issue since the repeal of the Boren Amendment, both have concluded that without the Boren Amendment, Medicaid providers lack standing.⁸¹ Courts, therefore, can no longer rely on *Wilder* as their primary authority and are left without a strong basis for finding that § 30(A) is an enforceable right for Medicaid providers.⁸²

Absent reliance on the Boren Amendment, courts determined that Medicaid providers were not the intended beneficiaries of § 30(A) by noting that § 30(A)'s reference to "payment" to providers is not enough to call providers intended beneficiaries.⁸³ The Fifth Circuit stated that the Equal Access provision is not directed to Medicaid providers but rather to recipients, commenting that the benefit to providers is "indirect at best."⁸⁴ Accordingly, an indirect benefit to providers is not sufficient to meet the intended beneficiary requirement.⁸⁵ Additionally, some courts pointed

2d 1293, 1298 (N.D. Fla. 1998) (distinguishing § 30(A) from Boren Amendment and finding no enforceable right under § 30(A)). *But see* Am. Soc'y of Consultant Pharmacists v. Concannon, 214 F. Supp. 2d 23, 29-30 (D. Me. 2002) (upholding First Circuit's holding that Medicaid providers do have standing to assert § 1983 actions under § 30(A), but calling into doubt First Circuit's holding in light of decision in *Gonzaga*); Am. Soc'y of Consultant Pharmacists v. Garner, 180 F. Supp. 2d 953, 971 (N.D. Ill. 2001) (noting that Seventh Circuit's decision is still viable, and repeal of Boren does not necessarily lead to conclusion that there is no longer standing under § 30(A)); Wal-Mart Stores, Inc. v. Knickerman, 101 F. Supp. 2d 749, 752 (E.D. Ark. 2000) (upholding Eighth Circuit's conferral of standing to Medicaid providers).

81. *See, e.g., Pa. Pharmacists Ass'n*, 283 F.3d at 541-42 (determining that Medicaid providers are not intended beneficiaries of § 30(A), therefore, they have no standing under § 1983); *Evergreen Presbyterian Ministries*, 235 F.3d at 931-32 (same).

82. *Cf. Health Care Law—Medicaid—Third Circuit Finds Providers Lack Standing to Enforce the Medicaid Act*, 116 HARV. L. REV. 969, 975-76 (2003) (suggesting that *Wilder* has little remaining vitality after Supreme Court's decision in *Gonzaga* and Boren repeal).

83. *See Evergreen Presbyterian Ministries*, 235 F.3d at 928 (discussing whether providers are intended beneficiaries).

[I]n contrast to the Boren Amendment, section 30(A) does not create an "individual entitlement" for individual providers to a particular level of payment because it does not directly address those providers. Instead, section 30(A) speaks directly to individual recipients, conferring upon them an "individual entitlement" to equal access to medical care.

Id.

84. *See id.* at 929 ("The statute does not confer any direct right upon the individual provider because, . . . even if an individual provider is forced to liquidate, the recipients' right to access is not necessarily violated."). Another district court reasoned that the intended beneficiaries of § 30(A) include "federal and state governments who fund the Medicaid program, taxpayers who ultimately bear the financial burden, and patients." *Fla. Pharmacy Ass'n*, 17 F. Supp. 2d at 1300 (finding that "requirement for 'efficiency, economy and quality of care' is not intended to benefit pharmacies"). Even if the goals of Medicaid are "important" to providers, they are not the intended beneficiaries within the meaning of the three-prong test. *See id.* (explaining why providers have no enforceable right under § 30(A)).

85. Some district courts have declined to deny standing to Medicaid providers in response to the repeal of the Boren Amendment. *See, e.g., Concannon*, 214 F. Supp. 2d at 30 ("At present, Section 30(A) creates a right in Medicaid service providers to rates of reimbursement that are consistent with the goals of economy,

specifically to the repeal of the Boren Amendment as an indication that Congress no longer intended Medicaid providers to have the right to challenge § 30(A) in a § 1983 action.⁸⁶

C. *Third Circuit Precedent: Medicaid Provider Standing Before Pennsylvania Pharmacists Ass'n*

Prior to the court's holding in *Pennsylvania Pharmacists Ass'n*, the Third Circuit had not developed significant case law on Medicaid provider standing for violations of § 30(A).⁸⁷ This issue was mentioned once in a footnote of an opinion that rejected the argument that Medicaid provid-

efficiency, quality of care, and equal access, enforceable via section 1983 actions."); *Garner*, 180 F. Supp. 2d at 972 ("We decline the defendant's invitation to disregard the clear holding of *Methodist Hospitals*, and we thus conclude that plaintiffs have a right to pursue this claim under section 30(A)."). The District Court of Illinois commented that the Boren Amendment repeal "does not inevitably lead to the conclusion that Congress intended to eliminate that right in actions under Section 30(A) because presumably Congress knew that a provider right of action was recognized under section 30(A), but declined to override those precedents." *Id.* at 971 (offering argument that repeal of Boren is not fatal to asserting § 1983 actions for violations of 30(A)); see generally Harkins, *supra* note 19, at 199-203 ("Opponents of the Boren Amendment who believed that the repeal would leave the states with almost unfettered discretion to set payment rates failed to recognize that the Act contained other provisions governing the calculation, and amount, of Medicaid payment."). The author also suggests:

[T]he legislative history of the Boren repeal states that the Committee contemplated that the Act would not support a cause of action to challenge the adequacy under federal law of a state's Medicaid payment rates. Unfortunately for the states, the Committee's language is years too late and far too little to prevent enforcement of [§ 30(A)].

Id. at 203.

Other district courts have granted standing to Medicaid providers simply because they are bound by their respective circuit's decisions on the issue. See, e.g., *Concannon*, 214 F. Supp. 2d at 29-30 (upholding First Circuit's decision that Medicaid providers have standing to assert § 1983 actions under § 30(A), but calling into doubt First Circuit's holding in light of decision in *Gonzaga*); *Garner*, 180 F. Supp. 2d at 972 (upholding Seventh Circuit's action under § 30(A)); *Wal-Mart Stores*, 101 F. Supp. 2d at 752 (upholding Eighth Circuit's decision).

86. See *Evergreen Presbyterian Ministries*, 235 F.3d at 929 n.26 ("[O]ur conclusion that providers are not intended beneficiaries of section 30(A) is consistent with Congress' concern in its repeal of the Boren Amendment to preclude further lawsuits by providers to contest the adequacy of their reimbursement rates."); *Burlington United Methodist Family Servs., Inc. v. Atkins*, 227 F. Supp. 2d 593, 596 n.3 (S.D. W. Va. 2002) ("Congress' concern in repeal of the Boren Amendment is consistent with the conclusion, based on statutory analysis, that § 30(A) is not intended to benefit providers."). One court noted, "[w]ith the repeal of the Boren Amendment nothing remains that remotely resembles a federal right to reasonable and adequate rates." *HCMF v. Gilmore*, 26 F. Supp. 2d 873, 880 (W.D. Va. 1998) (explaining impact of repeal of Boren Amendment).

87. See, e.g., *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 850-51 (3d Cir. 1999) (assuming that Medicaid providers had standing to assert § 1983 action and addressing merits of § 30(A) violation), *superseded by* *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531 (3d Cir. 2002), *cert. denied*, 123 S.Ct. 100 (2002).

ers do not have “a private cause of action” under § 30(A).⁸⁸ Considering Medicaid providers previously had a right to sue for violations of the Boren Amendment, one can infer that prior to *Pennsylvania Pharmacists Ass’n*, Medicaid providers had standing to sue for violations of § 30(A) in the Third Circuit.⁸⁹

IV. THE THIRD CIRCUIT’S REASONING IN *PENNSYLVANIA PHARMACISTS ASS’N*

This section details the reasoning of the majority and dissenting opinions in *Pennsylvania Pharmacists Ass’n*. In this six to five decision, Judge Alito wrote the majority opinion and was joined by five other judges.⁹⁰ Chief Judge Becker wrote the dissenting opinion and was joined by four other judges.⁹¹ Additionally, Judge Rendell wrote a dissenting opinion that was joined by Chief Judge Becker.⁹²

A. *Facts and Procedural Background*

In 1997, the Pennsylvania Department of Public Welfare (hereinafter PA Department) implemented a mandatory managed care program, “HealthChoices,” to provide health care for needy Pennsylvania citizens covered by Medicaid.⁹³ In January 1999, a group of sixteen Pennsylvania pharmacists and the Pennsylvania Pharmacists Association brought a class action against the PA Department under § 1983 for violations of § 30(A)

88. See *Rite Aid*, 171 F.3d at 850 n.7 (rejecting Pennsylvania Department of Public Welfare’s argument that pharmacists may not sue to enforce § 30(A)); see also *Rite Aid of Pa. v. Houstoun*, 998 F. Supp. 522, 525-26 (E.D. Pa. 1997) (explaining that pharmacists had standing under § 1983).

89. For further discussion of Medicaid providers’ right to sue under the Boren Amendment, see *supra* notes 37-51 and accompanying text.

90. See *Pa. Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 531 (3d Cir. 2002) (stating that Judge Alito wrote majority opinion joined by Judges Nygaard, Roth, Barry, Ambro and Fuentes).

91. See *id.* (stating that Judge Becker wrote main dissenting opinion joined by Judges Mansmann, Scirica, McKee and Rendell).

92. See *id.* (stating that Judge Rendell also wrote separate dissenting opinion joined by Chief Judge Becker). For purposes of this section, the text will focus on Chief Judge Becker’s dissenting opinion, unless specifically referring to Judge Rendell’s separate opinion.

93. See *Pa. Pharmacists Ass’n*, 283 F.3d at 533 (noting that under prior fee for service program pharmacies were reimbursed for brand-name drugs based on “estimated acquisition cost” of the drugs plus a “reasonable” dispensing fee). Under HealthChoices, pharmacists entered into “Medical Assistance Provider Agreements” with the Pennsylvania Department of Public Welfare (PA Department), which covered brand name and generic prescription drugs that were eligible to Medicaid recipients, and also covered the rate at which pharmacies would be reimbursed for the cost of these drugs. See *id.* at 533-34 (noting that Pennsylvania agreed to participate in mandatory managed care pursuant to waiver from certain provisions of Medicaid Act). The court noted that the “waiver applies to 42 U.S.C. § 1396a(a)(1) (statewide scope), § 1396a(a)(10)(B) (comparability of services), and § 1396a(a)(23) (freedom of choice).” *Id.* at 533 n.3.

of the Medicaid Act.⁹⁴ The pharmacists alleged that the new reimbursement rates to pharmacies for prescription drug coverage were below the cost of acquiring and dispensing the drugs.⁹⁵

The district court certified the class of pharmacists and denied the PA Department's motion to dismiss, holding that the pharmacists had standing under § 1983.⁹⁶ Additionally, the district court granted the PA Department's motion for summary judgment, finding that the Department's determination of the reimbursement rates did not violate § 30(A).⁹⁷ The pharmacists appealed to the Third Circuit, but before the panel issued its decision, the court granted a rehearing en banc because other circuits were split on the issue of Medicaid provider standing under § 30(A).⁹⁸ In an en banc panel of eleven judges, the Third Circuit held that the pharmacists did not have a private right to enforce § 30(A) and affirmed the district court's order in favor of the PA Department.⁹⁹

B. *Majority Opinion*

The Third Circuit first determined that § 1983 requires plaintiffs to be the intended beneficiaries of the federal statute, regardless of whether the statute "in fact" benefits them.¹⁰⁰ The court acknowledged that § 30(A) in fact benefits pharmacies in some states by increasing drug sales, which then has a "ripple effect," benefiting other businesses such as drug manufacturers and drug wholesalers.¹⁰¹ Nonetheless, the court concluded that it was not Congress's intent to create an enforceable federal right for all entities who are in fact benefited by § 30(A).¹⁰²

In determining that § 30(A) was not intended to benefit Medicaid providers, the court returned to the implied right of action test from early

94. *See id.* at 534 (explaining procedural posture of case).

95. *See id.* (pointing to pharmacy benefits managers who, "without oversight from Department, had decreased the outpatient pharmacy benefit rates").

96. *See id.* (quoting *Pa. Pharmacists Ass'n v. Houstoun*, No. CIV.A.99-491, 1999 U.S. Dist. LEXIS 23011 (E.D. Pa. Oct. 21, 1999)).

97. *Pa. Pharmacists Ass'n v. Houstoun*, No. CIV.A.99-491, 2000 U.S. Dist. LEXIS 7807, at *3-5 (E.D. Pa. June 7, 2000) (granting summary judgment on merits of § 30(A) claim).

98. *See Pa. Pharmacists Ass'n*, 283 F.3d at 534 (explaining how case arrived at eleven judge en banc panel).

99. *See id.* at 541-42 (holding in 6-5 decision that Medicaid providers are not intended beneficiaries of the Medicaid Act).

100. *See id.* at 535-36 (noting distinction between "intended to benefit" and "in fact benefits").

101. *See id.* at 536 (illustrating why "in fact" beneficiaries have no enforceable right to assert § 1983 actions).

102. *See id.* ("[I]t would be outlandish to argue that the *Wilder/Blessing* intended-to-benefit requirement permits all of these businesses and individuals to assert § 30(A) claims in federal court.").

§ 1983 jurisprudence.¹⁰³ The court reiterated the importance of looking at the language of the statute itself, scrutinizing the way in which the statutory provision is framed and determining whether there is any “right- or duty-creating language” in the statute.¹⁰⁴

In an effort to distinguish *Pennsylvania Pharmacists Ass’n* from the Supreme Court’s decision in *Wilder*, the Third Circuit pointed to the “critical” differences between the Boren Amendment and § 30(A). First, unlike the Boren Amendment, § 30(A) manifests no direct concern for the economic situation of providers.¹⁰⁵ Instead § 30(A) is concerned with benefits to recipients.¹⁰⁶ Unlike the congressional intent behind the Boren Amendment, the legislative history of § 30(A) focuses solely on benefiting Medicaid recipients.¹⁰⁷

The court additionally rejected plaintiffs’ argument that the Health and Human Services (HHS) regulations that accompany the Medicaid Act evince intent to benefit providers.¹⁰⁸ The court discounted this argument, reasoning that the regulations merely set a ceiling for reimburse-

103. *See id.* (quoting *Cannon v. Univ. of Chi.* and *Alexander v. Sandoval*). For a discussion of the implied right of action test under § 1983, see *supra* notes 53-61 and accompanying text.

104. *See Pa. Pharmacists Ass’n*, 283 F.3d at 536 (requiring courts to “pay careful attention to the way in which the statutory provision at issue is framed”). Using this reasoning, the court separated the language of § 30(A) into four main components: “A state must provide methods and procedures . . . [that] assure that payments to providers produce four outcomes: (1) ‘efficiency,’ (2) ‘economy,’ (3) ‘quality of care,’ and (4) adequate access to providers by Medicaid beneficiaries.” *Id.* at 537 (looking first at statutory language). The court first dismissed outcomes (1) and (2) as not intending to benefit providers, but rather assuring that payments to pharmacists are not too high, thereby benefiting the state. *See id.* at 538 n.9 (discussing how unprofitability of pharmacy does not make Medicaid program inefficient and uneconomical). Additionally, it held that outcomes (3) and (4) are also not intended to benefit Medicaid providers because they have an “‘unmistakable focus on’ Medicaid beneficiaries, not providers.” *See id.* at 538 (suggesting that “[i]f Congress had wanted to look after pharmacies, it would hardly have framed section 30(A) in the terms it chose”). Further, the language of section 30(A) is phrased in terms of benefiting Medicaid recipients. *See id.* (citing *Wilder* for support).

105. *See Pa. Pharmacists Ass’n*, 283 F.3d at 538 (“Section 30(A), unlike the Boren Amendment, does not demand that payments be set at levels that are sufficient to cover provider costs.”).

106. *See id.* (noting that dissent disagrees with this proposition, arguing that Boren and § 30(A) confer “nearly identical rights on providers”).

107. *See id.* at 540-41 (finding nothing in legislative history inconsistent with court’s interpretation of statute). The court noted that in the 1981 Amendments to § 30(A), Congress removed language concerning providers’ reasonable charges and added language providing further protection for Medicaid recipients. *See id.* at 541 (“[T]he effect of the 1981 amendments was to sharpen the focus on Medicaid beneficiaries.”).

108. *See id.* (quoting federal regulations that set price ceiling on what providers must be paid); *see also generally* 42 C.F.R. §§ 447.300-304 (2001) (providing purpose of regulations, definitions, state plan requirements and upper limits of Medicaid reimbursements to Medicaid providers); 42 C.F.R. §§ 447.331-334 (2001) (specifying regulations relating to prescription drugs).

ment rates, not a floor above which providers must be paid.¹⁰⁹ Moreover, these regulations protect states from overpaying providers.¹¹⁰

Finally, the court discussed the significance of the repeal of the Boren Amendment.¹¹¹ The Third Circuit stated that one of Congress's objectives in repealing the Boren Amendment was to take away Medicaid providers' right to sue under § 1983.¹¹² Accordingly, Congress did not intend § 30(A) to create an enforceable right for Medicaid providers, otherwise § 30(A) also would have been repealed.¹¹³ The court concluded its analysis by adopting the Fifth Circuit's holding that § 30(A) was not intended to benefit Medicaid providers and rejected the First, Seventh and Eighth Circuit approaches.¹¹⁴

C. *Dissenting Opinion*

The dissent acknowledged that Medicaid recipients are one of the intended beneficiaries of § 30(A), but emphasized that it was possible that the statute could have more than one class of intended beneficiaries.¹¹⁵ Moreover, § 30(A) targets both Medicaid providers and Medicaid recipi-

109. See 42 C.F.R. § 447.331(b) (2001) (requiring that state agency's payment for drugs not exceed, in aggregate, payment levels determined by Health and Human Services).

110. See *Pa. Pharmacists Ass'n*, 283 F.3d at 541 (suggesting that regulation would allow any payments below ceiling).

111. See *id.* at 539 (reporting that repeal of Boren Amendment would save \$1.2 billion over four years).

112. See generally *Governors' Perspective on Medicaid: Hearing Before the Subcomm. on Health and Env't of the House Comm. on Commerce*, 105th Cong. 18-23 (1997) (statement of Governors Miller and Leavitt) ("The Boren Amendment and other Boren-like statutory provisions must be repealed. 'One hundred percent reasonable cost reimbursement' must be phased out."). For further discussion of the purpose behind the repeal of the Boren Amendment, see *supra* notes 44-51 and accompanying text.

113. See *Pa. Pharmacists Ass'n*, 283 F.3d at 540 (noting critical differences between Boren Amendment and § 30(A)).

114. See *id.* at 542-44 (discussing other circuit court cases). The majority declined to enter into a policy debate regarding the adequacy of Medicaid provider reimbursement rates, but criticized the dissent's portrayal of the inadequacy of pharmacist reimbursement rates in Pennsylvania. See *id.* at 539 (noting that inclusion of cost-reimbursement language in Boren Amendment was unmistakable sign of congressional desire to benefit providers). The majority noted that the dissent relied solely on plaintiffs' evidence about the effect of new rates on access to pharmacies, even though this evidence is disputed. See *id.* at 539 n.10 (stating that district court held that plaintiffs had not shown sufficient evidence that access requirement was not being met). The majority found that the dissent's characterization of the "real world of health care" was unconvincing. *Id.*

115. See *id.* at 544-45 (Becker, J., dissenting) (explaining possibility of more than one class of intended beneficiaries). The dissent stressed that the mere fact that Congress intended § 30(A) to benefit Medicaid recipients did not mean that Medicaid providers could not also benefit from § 30(A). See *id.* (explaining similarities between providers and beneficiaries).

ents by requiring adequate reimbursement for providers and access to care for recipients.¹¹⁶

Next, the dissent questioned the majority's return to the heightened implied right of action test for creating an enforceable right under § 1983.¹¹⁷ The dissent argued that the intended beneficiary requirement does not require a provision to be "drafted with an unmistakable focus on the benefited class."¹¹⁸ Rather, the dissent suggested a looser standard for determining whether a statute creates an enforceable right under § 1983.¹¹⁹

In applying *Wilder*, the dissent advocated that § 30(A) and the Boren Amendment confer "nearly identical rights" on Medicaid providers.¹²⁰ Looking at the language of both provisions, the dissent claimed that the text of § 30(A) is "strikingly similar" to the Boren Amendment because both require states to reimburse providers for services rendered and both require states to reimburse providers at rates that are sufficient to ensure quality of care.¹²¹ Additionally, the dissent emphasized the similarity of the two "quality of care" provisions found in § 30(A) and the Boren Amendment as further evidence that § 30(A) creates an enforceable right.¹²²

116. See *id.* at 546 (Becker, J., dissenting) (finding § 30(A) "expressly requires states to establish a scheme for provider reimbursement and mandates minimum reimbursement rates defined by reference to recipients' quality of care and access to care and services"). Additionally, in looking at the plain language of § 30(A), in a separate dissenting opinion, Judge Rendell also suggested that there can be two classes of intended beneficiaries: if the statute is designed to "benefit one (the providers) in order to provide the desired level of services to the other (the recipients)." *Id.* at 561 (Rendell, J., dissenting) (focusing on statutory language).

117. See *id.* at 548 n.1 (Becker, J., dissenting) (arguing that § 1983 only requires showing that provision intended to benefit plaintiff instead of returning to stricter implied right of action cases).

118. See *id.* (Becker, J., dissenting) (distinguishing intended to benefit requirement from implied right of action inquiry).

119. See *id.* (Becker, J., dissenting) (citing *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989)) ("[I]n the § 1983 context, a plaintiff must simply show that the provision in question was 'intended to benefit' the plaintiff.").

120. See *id.* at 550 (Becker, J., dissenting) (suggesting that *Wilder* is appropriate standard).

121. See *id.* at 549 (Becker, J., dissenting) ("I can find no principled basis for holding that providers are intended beneficiaries of the Boren Amendment . . . but are not intended beneficiaries of section 30(A) as the majority holds today.").

122. See *id.* (comparing Boren Amendment provisions on quality of care to section 30(A) provision on same). Compare 42 U.S.C. § 1396a(13) (1981) (repealed in 1997) (noting that reimbursement rates must be "reasonable and adequate to meet the costs which must be incurred . . . in order to provide care and services in conformity with . . . quality and safety standards"), with 42 U.S.C. § 1396a(30)(A) (2002) (noting that states must "assure that payments 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"). The dissent argued that the Boren Amendment did not create an individual right to pursue a § 1983 action as part of

Finally, the dissent contended that the majority opinion was flawed from a policy standpoint in that it ignored the "dynamic of the real world of health care."¹²³ The dissent argued that on a practical level HMOs set provider reimbursement rates too low.¹²⁴ If Medicaid providers are unable to challenge the adequacy of these reimbursement rates through a § 1983 action, providers will simply refuse to render services to recipients and Medicaid recipients will ultimately suffer from reduced access to Medicaid providers.¹²⁵ Further, the dissent provided data that suggested that provider pharmacies have already started dropping out of the Medicaid program.¹²⁶

Although the majority held that Medicaid *recipients* have an enforceable right under § 30(A) and can sue under § 1983, the dissent noted that Medicaid recipients are ill-equipped for such lawsuits and Medicaid providers are in a better position to vindicate both recipient and provider rights.¹²⁷ Financially, Medicaid recipients are extremely limited in their

Boren's "cost reimbursement" provision; rather the court's holding is dependent upon its interpretation of the quality of care provision. *See Pa. Pharmacists Ass'n*, 283 F.3d at 551 (Becker, J., dissenting) (suggesting that "the reference to providers' costs in the Boren Amendment and the absence of such a reference in Section 30(A) are immaterial for purposes of determining whether providers are among the intended beneficiaries of Section 30(A)"). The dissent next argued that the majority misinterpreted *Wilder's* determination as to which specific Boren Amendment language was "phrased in terms of benefiting providers." *See id.* (Becker, J., dissenting) (explaining different interpretations of *Wilder*). The dissent contended that *Wilder's* holding relied on the portion of the Boren Amendment that required a state plan to "provide for payment of the hospital services" rather than Boren's requirement that states "establish a scheme to reimburse providers for services rendered." *See id.* at 553 n.3 (Becker, J., dissenting) (arguing that majority mischaracterized statutory interpretation as redundant). Under the dissent's interpretation of *Wilder*, § 30(A) similarly is phrased in terms of benefiting providers because it requires "a state plan to provide for payment for [] care and services available under the plan." *See id.* at 555 (quoting § 30(A)).

123. *See Pa. Pharmacists Ass'n*, 283 F.3d at 545 (Becker, J., dissenting) (noting that majority failed to put case in context of health care crisis).

124. *See id.* (Becker, J., dissenting) ("The plaintiffs have adduced evidence designed to demonstrate that the HMOs, in administering Medicaid, have squeezed the pharmacies and reduced provider reimbursement rates to levels that, according to the plaintiffs, are below any reasonable measure of the cost of providing care and services.").

125. *See id.* (Becker, J., dissenting) (arguing that providers withdrawing from Medicaid is a natural consequence of majority's decision).

126. *See id.* (Becker, J., dissenting) ("[Fifty percent] of the pharmacies that participated in Medicaid in the five county area have dropped out since 1997 . . . no pharmacy within fifteen contiguous zip codes in Bucks and Montgomery counties participates in Medicaid."). The data further suggested that of those pharmacies that remain, quality of care has suffered. *See id.* (Becker, J., dissenting) ("[A]mong those pharmacies in the five-county area that continue to participate in Medicaid, quality of care has suffered as a result of inadequate reimbursement rates.").

127. *See id.* (Becker, J., dissenting) (providing reasons why Medicaid providers are in better position to bring suits for violations of § 30(A)).

ability to afford and to access legal services.¹²⁸ Providers have easier access to information about reimbursement rates and to statistical data about the availability of health care to the general public.¹²⁹ Accordingly, Medicaid providers are in a better position to challenge provider reimbursement rates under § 30(A).

D. *Critical Analysis of the Majority Opinion: Adverse Implications for Medicaid Recipients*

Based on the repeal of the Boren Amendment, the majority properly followed the law in denying Medicaid providers standing to challenge Medicaid reimbursement rates. The majority's decision, however, has adverse public policy implications. Congressional reports indicate that one of the motivating factors behind the repeal of the Boren Amendment was to preclude Medicaid provider § 1983 actions.¹³⁰ Although the Third Circuit's holding contravenes three other circuits' decisions, these three decisions were issued before the repeal of the Boren Amendment.¹³¹ Therefore, the significance of Boren's repeal is clear: without the Amendment, Medicaid providers have no cause of action.¹³² Additionally, by looking at the recent Supreme Court precedent on § 1983 actions, the Third Circuit properly anticipated a heightened intended beneficiary requirement.¹³³ Three months after the Third Circuit's decision, the Su-

128. See *id.* (Becker, J., dissenting) (focusing on financial constraints of Medicaid recipients). But see *id.* at 559 n.5 (Becker, J., dissenting) (noting that attorneys' fees are available to successful § 1983 claimant).

129. See *id.* at 559-60 (Becker, J., dissenting) (noting that "professional associations such as the pharmacists association plaintiff in this case are more likely to possess the market data necessary to determine whether a colorable claim under § 30(A) exists").

130. For a discussion of the purpose behind the repeal of the Boren Amendment, see *supra* notes 44-51 and accompanying text.

131. See *Visiting Nurse Ass'n of N. Shore v. Bullen*, 93 F.3d 997, 1004-05 (1st Cir. 1996) (finding standing based on analogy to Boren Amendment); *Methodist Hosp., Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (same); *Ark. Med. Soc'y, Inc., v. Reynolds*, 6 F.3d 519, 528 (8th Cir. 1993) (same).

132. But see *Harkins*, *supra* note 19, at 217-27 (suggesting that even after repeal of Boren, providers can still enforce other provisions of Medicaid Act, including § 30(A)).

133. See, e.g., *Gonzaga Univ. v. Doe*, 536 U.S. 273, 284-85 (2002) (quoting *California v. Sierra Club*, 451 U.S. 287, 294 (1981)) (suggesting that "initial inquiry—determining whether a statute confers any right at all—is no different from the initial inquiry in an implied right of action case, the express purpose of which is to determine whether or not a statute 'confer[s] rights on a particular class of persons'"). The Court in *Gonzaga* also stated that recent decisions have rejected attempts to infer "enforceable rights" from Spending Clause statutes. *Id.* at 281; see also *Alexander v. Sandoval*, 532 U.S. 275, 288 (2001) (looking for "rights-creating" language as set forth in implied right of action cases); *Suter v. Artist M.*, 503 U.S. 347, 357 (1992) (questioning whether Adoption Act "unambiguously confer[s]" rights upon child beneficiaries of Act).

preme Court held that in order to bring an action under § 1983, there must be evidence of a violation of an “unambiguously conferred right.”¹³⁴

In *Gonzaga University v. Doe*, a former university student sued the school under § 1983 for violations of the Family Educational Rights and Privacy Act (FERPA).¹³⁵ The Court held that the student did not have standing to sue under § 1983 because the challenged provision of FERPA did not contain any “rights-creating language.”¹³⁶ The Court’s holding indicates that the Third Circuit’s strict interpretation of the intended beneficiary requirement properly anticipated a trend in § 1983 jurisprudence.¹³⁷

The Third Circuit’s decision indirectly undercuts some of the policy objectives behind Medicaid. Congress’s main objective in developing Medicaid was to provide access to health care services for the neediest Americans.¹³⁸ Pharmacies have a legitimate objective of running a profitable business.¹³⁹ Necessarily, these two objectives clash.

If pharmacies have no way to challenge their reimbursement rates and lose money on each Medicaid prescription, they have no incentive to participate in the Medicaid program.¹⁴⁰ The pharmacies that withdraw from Medicaid first are likely to be the pharmacies that proportionately serve the most Medicaid recipients.¹⁴¹ Pharmacies that service a large proportion of Medicaid recipients are usually located in an area where Medicaid services are utilized the most.¹⁴² If these pharmacies withdraw from

134. See *Gonzaga*, 536 U.S. at 283 (“[I]t is *rights*, not the broader or vaguer ‘benefits’ or ‘interests’ that may be enforced under the authority of that section.”) (emphasis in original).

135. See *id.* at 276-77 (alleging pendent violation of § 1983 for “release of personal information to an ‘unauthorized person’” in violation of Family Educational Rights and Privacy Act of 1974 (FERPA)).

136. *Id.* at 286-90 (suggesting that FERPA does not “confer the sort of ‘individual entitlement’ that is enforceable under § 1983”) (emphasis in original).

137. For a discussion of the Third Circuit’s application of the § 1983 enforceable rights test, see *supra* notes 100-14 and accompanying text.

138. See generally Dayna Bowen Matthew, *The “New Federalism” Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health*, 90 Ky. L.J. 973, 978-79 (2002) (noting historical significance of Medicaid as providing access to better quality healthcare for poor, elderly and disabled Americans).

139. See, e.g., *Rx for a Medicaid Nightmare?*, *supra* note 5 (“We believe everyone should have access to medical care. It’s just hard to do it below your costs.”) (quoting Rite Aid pharmacy spokeswoman).

140. See *Pa. Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 547 (3d Cir. 2002), *cert. denied*, 123 S. Ct. 100 (2002) (Becker, J., dissenting) (commenting that “Medicaid recipients’ access to healthcare will suffer if provider reimbursement rates are too low to induce a sufficient number of providers to participate in Medicaid”).

141. See *id.* at 546 (Becker, J., dissenting) (noting “a precipitous drop in the number of pharmacies in the five-county area who participate in Medicaid since the inception of HealthChoices”).

142. See *id.* (Becker, J., dissenting) (referencing plaintiffs’ data that due to low reimbursement rates pharmacies are shutting down and Medicaid recipients “lack access to pharmacies to the same extent as the general population”).

Medicaid, the neediest Medicaid recipients will suffer the most. Ultimately, this pattern could reduce access to Medicaid services for those who need it the most, a result contrary to Congress's objective in developing the Medicaid program.

The consequence of denying pharmacists § 1983 standing is that Medicaid recipients will be denied access to health care services.¹⁴³ Thus, Congress must decide how to solve this problem. Under current Medicaid law, and trends in § 1983 law, the Third Circuit's opinion will likely become the prevailing view.

E. *Advice to Practitioners: Implications Beyond Medicaid*

The Third Circuit's holding in *Pennsylvania Pharmacists Ass'n* sets forth new guidelines for practitioners for actions under § 1983 and challenges to reimbursement rates under the Medicaid Act.¹⁴⁴ Practitioners representing providers are precluded from challenging reimbursement rates under § 30(A) in the Third Circuit.¹⁴⁵ This case, however, has broader implications for other § 1983 actions in the Third Circuit.

The court's reference to early implied right of action cases indicates a move towards a heightened standard for determining whether a federal statute confers an enforceable right under § 1983 and whether an individual or class of individuals are the intended beneficiaries of a statute.¹⁴⁶ The Supreme Court has recently confirmed this heightened standard, holding that in order for a right to be enforceable, it must be "unambiguously conferred."¹⁴⁷ Accordingly, practitioners who argue that a statute is enforceable under § 1983 must point to specific statutory language conferring a benefit on an individual or a class of individuals; the statute must also contain "rights-creating language."¹⁴⁸

143. See *Pa. Pharmacists Ass'n*, 283 F.3d at 547 (Becker, J., dissenting) (noting congressional concern for adequate reimbursement to providers); see also Press Release, Kentucky Pharmacists Association, *supra* note 5 (suggesting that Medicaid patients might not have access to pharmacies if low reimbursement rates force pharmacies to close).

144. See *Pa. Pharmacists Ass'n*, 283 F.3d at 541-42 (holding that § 30(A) is not intended to benefit providers and therefore that providers may not assert § 30(A) claim under § 1983).

145. See *id.* (eliminating § 1983 remedy for providers).

146. See *Gonzaga Univ. v. Doe*, 122 S. Ct. 2268, 2275 (2002) (adopting implied right of action standard similarly used in Third Circuit's decision).

147. See *id.* at 2279 ("[I]f Congress wishes to create new rights enforceable under § 1983, it must do so in clear and unambiguous terms—no less and no more than what is required for Congress to create new rights enforceable under an implied private right of action.").

148. See, e.g., *id.* (refusing to find FERPA created enforceable right because it lacked "rights creating language"). Specific legislative history demonstrating congressional intent is also important under this heightened standard. See *id.* at 2277 (looking closely at statutory language).

V. CONCLUSION

The Third Circuit's holding in *Pennsylvania Pharmacists Ass'n* forecloses the ability of Medicaid providers to assert a § 1983 action for violations of § 30(A) of the Medicaid Act. The court's action follows logically from Congress's repeal of the Boren Amendment. Given that prior case law allowing Medicaid provider suits for violations of § 30(A) relied primarily on analogies to the Boren Amendment, the court acted properly in modifying this doctrine in light of Boren's repeal. The practical consequences of this decision, however, raise larger concerns. The court's decision may have adverse policy implications in that providers might decide to withdraw from Medicaid due to inadequate reimbursement, resulting in reduced Medicaid benefits to recipients.

Meredith Warner Nissen