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LETTER FROM THE EDITORS

Dear Reader:

On behalf of the Editorial Board and staff, we proudly present Volume 13, Issue 1 of the Health Law & Policy Brief (HLPB). HLPB is an online publication run by law students at American University Washington College of Law (WCL). Since its formation in 2007, HLPB has published articles on a wide variety of emerging topics in the areas of health law, public health law, and food and drug law. Such topics include health care privacy and data security, health care fraud and abuse, medical malpractice, bioethics and regulation of human subjects research, and global health law. HLPB also maintains a blog on emerging health law issues that can be found on our website at www.healthlawpolicy.org.

This issue features two innovative articles on the subjects of the physician-hospital relationship and Medicaid provider agreements. The first, authored by Victoria Hamscho, discusses the historical development of the physician-hospital relationship and argues that the Second Circuit's framework in *Salomon v. Our Lady of Victory Hospital* is the best approach for determining the worker classification of physicians. The second, authored by Morgan Handley, discusses Texas's efforts to remove Planned Parenthood from its Medicaid operations and argues Texas's request to expand family planning benefits with the provider ban in place should be denied.

We would like to thank our authors for their hard work and cooperation in writing, researching, and editing their articles. We would also like to thank HLPB's article editors and staff members who worked diligently on this issue. They are greatly appreciated and should be proud of their work.

For more information about HLPB, or for questions on how to subscribe to our electronic publication, please visit our website at www.healthlawpolicy.org. We also encourage you to visit WCL's Health Law and Policy Program website for more information about health law studies at WCL.

Sincerely,
Samantha and Carolyn

Samantha Schram Carolyn Larcom
Editor-in-Chief *Executive Editor*

REASSESSING THE PHYSICIAN-HOSPITAL RELATIONSHIP

*Victoria Hamscho**

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* *Victoria Hamscho is a J.D. Candidate at NYU School of Law. Victoria hopes to pursue a career at the intersection of public policy and law with a focus on health care. At NYU, Victoria served as a Hermann Biggs Health Policy Fellow, Articles Editor of the NYU Journal of Legislation and Public Policy, and Co-President of the NYU Latinx Law Student Association. Victoria also participated and achieved second place at the University of Maryland School of Law's Health Law Regulatory & Compliance Competition and the L. Edward Bryant, Jr. National Health Law Transactional Competition. Victoria has an M.P.H. in Health Policy and Management from Columbia University and a B.A. in Philosophy from the University of California, Davis.*

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I. INTRODUCTION

Physicians with admitting privileges at hospitals are traditionally considered independent contractors and not hospital employees. The classification of admitting physicians as independent contractors is important because the benefits and protections afforded by most labor and employment laws apply only to employees. Yet these laws tend to provide little guidance as to who qualifies as an employee.¹ Moreover, the courts have failed to articulate a consistent test for distinguishing between employees and independent contractors.² This mixed body of law has resulted in courts frequently dismissing challenges brought by admitting physicians against hospitals under labor and employment laws because the physicians were not deemed employees.

In *Salamon v. Our Lady of Victory Hospital*, the U.S. Court of Appeals for the Second Circuit (Second Circuit) challenged the long-held assumption that admitting physicians are independent contractors for purposes of Title VII of the Civil Rights Act of 1964 (Title VII), which prohibits employment discrimination based on sex, race, color, national origin, and religion.³ Relying on the common-law agency test for distinguishing between employees and independent contractors, the Second Circuit found that a question of fact existed as to whether the admitting physician was an employee of the hospital due to the level of control that the hospital exercised on the physician's medical practice through hospital standards, supervision, and corrective action.

Salamon is the most recent case to analyze the worker classification of admitting physicians for purposes of Title VII. In *Salamon*, the Second Circuit addressed the difficulties of applying the common-law agency test in the medical context and provided an innovative framework for analyzing the physician-hospital relationship that focuses on the level of control the hospital exercises on the physician's practice. This Article argues that the Second Circuit's framework is superior to the approach that other circuits have endorsed for determining the worker classification of physicians and is consistent with the development of the physician-hospital relationship.

¹ See Civil Rights Act of 1964, Title VII § 701, 42 U.S.C. § 2000e(f) (2012) (defining an "employee" as an individual employed by an employer); see also Fair Labor Standards Act, 29 U.S.C. § 203(e)(1) (2012) (stating that "employee" means any individual employed by an employer); see also Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(6) (2012) (expressing that "employee" means any individual employed by an employer); see also Family and Medical Leave Act, 29 U.S.C. § 2611(3) (2012) (articulating that "employee" means any individual employed by an employer); see also Americans with Disabilities Act, 42 U.S.C. § 12111(4) (2012) (referring to an "employee" as an individual employed by an employer); see also Age Discrimination in Employment Act, 29 U.S.C. § 630(f) (2012) (defining "employee" as an individual employed by any employer).

² See Patricia Davidson, Comment, *The Definition of Employee Under Title VII: Distinguishing Between Employees and Independent Contractors*, 53 U. CIN. L. REV. 203, 204-19 (1984) (describing how courts employ three different tests for distinguishing between employees and independent contractors: (1) the common-law agency test, (2) the economic realities test, and (3) a hybrid test that combines elements of both the common-law agency test and the economic realities test).

³ See *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 228-29 (2d Cir. 2008).

II. THE DEVELOPMENT OF THE PHYSICIAN-HOSPITAL RELATIONSHIP

A. Hospitals as Workshops for Independent Physicians

a. *The Reconceptualization of the Hospital in the Early 1900s*

Physicians have traditionally been independent of hospitals.⁴ For most of the nineteenth century, hospitals were primarily religious and charitable institutions for tending the sick, rather than medical institutions intended to cure.⁵ Hospitals evolved from almshouses and other unspecialized institutions that served welfare functions for the elderly and mentally ill.⁶ Even as hospitals began treating the sick, they limited their services to low-income patients.⁷ As a result, physicians performed most services for middle and upper class patients outside of hospitals.⁸

Between 1900 and 1910, hospitals moved to the center of medical practice due to advances in science and technology. Control over infections and improvements in diagnostic tools allowed surgeons to operate earlier.⁹ As surgery became safer and more common, physicians became dependent on the diagnostic and therapeutic facilities hospitals could provide.¹⁰ Hospitals began to charge for their care and permitted physicians practicing in their facilities to charge for their services.¹¹ As the demand for hospital services increased, the number of hospitals increased from 178 in 1873 to 4,349 in 1909.¹² With these changes, the concept of the hospital evolved from “refuges for the homeless poor . . . into doctors’ workshops for all types and classes of patients.”¹³

b. *Physician Dominance Over the Medical Practice and Its Workplace*

The conceptualization of the hospital as a workshop that makes its facilities and equipment available to independent physicians brought important changes to its internal

⁴ See Robert A. Berenson et al., *Hospital-Physician Relations: Cooperation, Competition, or Separation?* 26 HEALTH AFFAIRS w31, w31 (2007) (“Physicians traditionally have been relatively independent of hospitals and have used them as ‘workshops’ in which to carry out their services.”).

⁵ See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 145 (1949).

⁶ *Id.* at 149.

⁷ *Id.* at 150.

⁸ See *id.* at 157; see also Morris J. Vogel, *The Transformation of the American Hospital, 1850-1920*, in *HEALTH CARE IN AMERICA: ESSAYS IN SOCIAL HISTORY* 105, 105-06 (1979) (noting that during the nineteenth century “even the most difficult surgical procedures were performed in the home”).

⁹ See Starr, *supra* note 5, at 156.

¹⁰ *Id.*

¹¹ See *id.* at 163 (noting that while “no American hospital permitted fees” in 1880, “the widely resented rule forbidding physicians to take fees from private patients . . . began to die out at the turn of the century.”).

¹² See Timothy Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 846 (1983) (affirming the increase in the number of hospitals).

¹³ See Starr, *supra* note 5, at 146 (stating that with medical advances, “the conscientious physician became increasingly dependent on the diagnostic and therapeutic facilities which only a hospital could provide.”).

organization and authority distribution. Early hospitals were largely operated by hospital-based staff.¹⁴ Since hospitals relied on charity, trustees decided which physicians were granted privileges, which services were provided, and which patients were admitted.¹⁵ As hospitals came to rely on payments from the patients of physicians, independent physicians replaced the trustees as the chief source of income for hospitals and gained authority over the services available and the patients admitted.¹⁶

Between 1900 and 1917, physicians enjoyed unfettered control over the medical practice and its workplace.¹⁷ Hospitals exercised no control over the work of physicians and were largely insulated from associated liability.¹⁸ As charitable institutions, hospitals were protected from liability for the tortious conduct of physicians by the doctrine of charitable immunity.¹⁹ In 1914, Judge Benjamin Cardozo, writing for the New York Court of Appeals, held in *Schloendorff v. Society of N.Y. Hospital* that a hospital was not liable for the tortious conduct of independent physicians.²⁰ *Schloendorff* concerned an action against a charitable hospital for an unauthorized surgery.²¹ Judge Cardozo concluded that the wrong was that of the physicians who were pursuing an independent calling and not the hospital.²² Judge Cardozo reasoned that the hospital did not intend to act through physicians, but rather for the physicians to act on their own responsibility.²³

B. Quality of Care and Medical Staff Oversight of Physicians

a. The Development of Minimum Standards for Hospitals

As a growing number of physicians gained admitting privileges at hospitals, questions emerged regarding the quality of patient care.²⁴ Surgeons generally believed that hospitals and physicians should meet minimum requirements to ensure quality of care.²⁵

¹⁴ *Id.* at 149.

¹⁵ *Id.*

¹⁶ *See id.* at 162 (“When hospitals relied on donations, the trustees were vital. But as hospitals came to rely on receipts from patients, the doctors who brought in the patients became more important.”).

¹⁷ *See* Mark Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 445 (1988).

¹⁸ *See* MILTON ROEMER & JAY FRIEDMAN, *DOCTORS IN HOSPITALS: MEDICAL STAFF ORGANIZATION AND HOSPITAL PERFORMANCE* 34 (1971) (“There was no systematic policy in voluntary hospitals toward exercise of controls over the work of private physicians.”).

¹⁹ *See* McDonald v. Massachusetts General Hospital, 120 Mass. 432, 436 (1876); *see also* SARA ROSENBAUM ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 789, 790 (2012) (explaining that “[t]he remarkable thing about the charitable immunity doctrine was not that it existed in 1876, but that it continued to exist into the 1950s and 1960s, long after hospitals had transformed themselves into large economic entities serving paying and low-income patients.”).

²⁰ *See* *Schloendorff v. Soc’y of N.Y. Hospital*, 211 N.Y. 125, 130 (1914).

²¹ *Id.*

²² *See id.* at 131 (noting that “the wrong was not that of the hospital; it was that of physicians, who were not the [hospital’s] servants, but were pursuing an independent calling.”).

²³ *Id.*

²⁴ *See* SARA ROSENBAUM ET AL., *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 789, 792 (2012).

²⁵ *See id.* (explaining that surgeons pushed for the standardization of hospitals in part because a “wide-open hospital practice threatened the economic interests and professional status of surgeons.”).

In 1917, the American College of Surgeons (ACS) developed minimum standards for hospitals and a Hospital Standardization Program (HSP) to monitor compliance.²⁶ These standards were meant to organize hospital facilities and clarify the roles of hospitals and physicians in maintaining quality of care.²⁷ The HSP was the predecessor of the Joint Commission on Accreditation of Hospitals (JCAH).²⁸

Adherence to the ACS standards was voluntary and compliance was widely resisted.²⁹ However, compliance with these standards became a requirement for participation in private and public licensing, certification, and financing programs.³⁰ States modeled their licensure statutes after the ACS standards and backed them with enforcement authority.³¹ The Medicare program relied on the ACS standards to certify hospitals for participation in the program.³² In addition, some health plans required compliance with the standards as a condition of participation.³³

b. Medical Staff Oversight of Physicians

The ACS standards solidified the modern organizational structure of a hospital consisting of the governing body, administrative staff, and medical staff.³⁴ The standards provided for the self-regulation of physicians through an organized medical staff charged with adopting, with the consent of the hospital's governing body, medical staff bylaws.³⁵ The bylaws set the organization of the medical staff, defined its relationship with the hospital, and delineated the procedures by which staff privileges would be granted and corrective actions taken against physicians.³⁶

The legal status of the medical staff quickly became subject to debate. Following the characterization of the medical staff as a self-governing body consisting of independent physicians, some courts recognized the medical staff as a legal entity separate from

²⁶ *Id.* at 793.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *See id.* at 793 (“[C]ompliance [to the standards] was widely resisted, not only by the less elite general practitioners, but also by most physicians who wanted to avoid bitter intra-professional disputes.”); *see also* LOYAL DAVIS, FELLOWSHIP OF SURGEONS: A HISTORY OF THE AMERICAN COLLEGE OF SURGEONS 230 (1981) (documenting the opposition to the ACS standards by the American Medical Association, which represented general practitioners).

³⁰ *See Jost, supra* note 12, at 843 (noting that accreditation is a requirement for public and private licensing, certification, and financing programs).

³¹ *See Rosenbaum, supra* note 24, at 793 (explaining that states relied on the ACS standards to draft licensure statutes).

³² *See, e.g.*, 42 C.F.R. § 482.22 (“The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care.”).

³³ *See Jost, supra* note 12, at 845 (noting that accreditation is a condition of participation for Blue Cross plans).

³⁴ *See James R. Wright, The American College of Surgeons, Minimum Standards for Hospitals, and the Provision of High-Quality Laboratory Services*, 141 ARCH. PATHOL. LAB. MED. 704, 708 (2017).

³⁵ *Id.*

³⁶ *Id.*

the hospital.³⁷ However, most courts have declined to recognize the medical staff as a distinct entity, noting that “[the medical staff] has no legal life of its own and is merely one component of the hospital.”³⁸ Courts have reasoned that the governing body must delegate certain authority for the medical staff to exercise self-determination due to state laws barring the corporate practice of medicine.³⁹

c. The Decline of the Traditional Physician-Hospital Relationship

Hospital regulation and medical staff oversight of physicians during this period challenged the initial conceptualization of the hospital as a workshop of independent physicians. The medical staff was a membership in a self-governing organization that afforded physicians rights and responsibilities. Hospitals provided equipment and staff that enabled physicians to provide medical services that they could not provide elsewhere.⁴⁰ In exchange, physicians served on quality and utilization review committees and undertook Emergency Department on-call responsibilities.⁴¹

However, as a new vision of the hospital emerged as a provider of medical care, the idea of the hospital as a “passive charity removed from operational responsibility” faded away.⁴² This shift coincided with court rulings abandoning the doctrines that once protected hospitals from tort liability. In 1957, Judge William Fuld overruled the doctrine of charitable immunity as applied to hospitals, as well as Judge Cardozo’s ruling in *Schloendorff*.⁴³ In *Schloendorff*, which involved an action against a hospital for injuries caused by some of its nurses, Judge Fuld held that “[t]he conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact.”⁴⁴ Judge Fuld noted that hospitals currently provide more than facilities for treatment, which is demonstrated in how hospitals operate.⁴⁵

³⁷ See *St. John’s Hosp. Med. Staff v. St. John Reg’l Med. Ctr.*, 245 N.W.2d 472, 473 (S.D. 1976) (determining the medical staff to be an unincorporated association capable of commencing suit); see also *Corleto v. Shore Mem’l Hosp.*, 350 A.2d 534, 539 (N.J. 1975) (finding the medical staff to be an unincorporated association).

³⁸ See *Exeter Hosp. Med. Staff v. Board of Tr. of Exeter Health Res., Inc.*, 810 A.2d 53, 56 (N.H. 2002); see also *Ramey v. Hosp. Auth. of Habersham Cty.*, 462 S.E.2d 787, 788 (Ga. Ct. App. 1995) (holding that the medical staff is not a separate, independent entity capable of being sued independently of the hospital authority).

³⁹ See Joel Cunningham, Comment, *The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians*, 50 WASH. L. REV. 385, 392 (1975) (noting that most state medical practices acts would be violated by hospital administrators’ attempts to exercise control over medical treatment); see also *Brown v. St. Vincent’s Hosp.*, 222 A.D. 402, 404 (N.Y. App. Div. 1928) (noting that a “hospital corporation may not . . . interfere with the method of treatment”).

⁴⁰ See Berenson, *supra* note 4, at w31.

⁴¹ *Id.*

⁴² See Rosenbaum, *supra* note 24, at 794.

⁴³ See *Bing v. Thunig*, 143 N.E.2d 3, 9 (N.Y. 1957).

⁴⁴ *Id.* at 8.

⁴⁵ *Id.*

This shift was consistent with a growing recognition by the courts that hospitals have direct duties to patients regarding quality of care.⁴⁶ In *Darling v. Charleston Community Memorial Hospital*, where injuries resulted from a hospital's failure to supervise the care provided at its facilities, the Illinois Supreme Court held that hospitals have direct corporate responsibility for the supervision of care.⁴⁷ Following *Darling*, courts have recognized a duty to screen out incompetent physicians and other providers at the time of initial appointment or reappointment to the medical staff.⁴⁸ In *Johnson v. Misericordia Community Hospital*, which involved a medical procedure that was not performed in accord with standard medical practice, the court held a hospital liable for failing to check with previous hospitals where the physician's privileges had been revoked.⁴⁹ Hospitals have also been held liable for failing to monitor the performance of physicians and terminate physicians with a record of mistakes involving patient care.⁵⁰

C. Managed Care and Institutional Control Over Physicians

a. *The Need to Control Health Care Costs*

As hospitals gained greater responsibility over quality of care, greater pressure to contain health care costs ensued. Throughout most of the twentieth century, hospitals and physicians were paid a fee for each service they provided.⁵¹ Patients paid out-of-pocket for the services they received.⁵² However, a new system of third-party payment emerged with the rise of health insurance coverage and the creation of Medicare. Health insurers and Medicare paid hospitals and physicians based on the cost of each service provided and the prevailing fee in their geographic area.⁵³ These payment mechanisms insulated hospitals and physicians from the cost of medical care and created incentives to maximize the volume of services to receive higher payments.⁵⁴

⁴⁶ See B. Abbott Goldberg, *The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care: A Legal Perspective*, 14 PAC. L.J. 55, 77 (1982) (describing the duty of hospitals to regulate quality of care).

⁴⁷ See *Darling v. Charleston Community Memorial Hospital*, 211 N.E.2d 253, 258 (Ill. 1965) (noting that hospital breached duty of care by failing to respond to apparent errors by physicians as they occur).

⁴⁸ See, e.g., *Johnson v. Misericordia Community Hospital*, 301 N.W.2d 156, 174 (Wis. 1981).

⁴⁹ *Id.*

⁵⁰ See *Elam v. College Park Hosp.*, 183 Cal. Rptr. 156, 161 (Cal. Ct. App. 1982) (embracing that the hospital breached duty of care by failing to monitor the performance of physician); see also *Corleto v. Shore Memorial Hosp.*, 350 A.2d 534, 537-38 (N.J. 1975) (noting that hospital breached duty of care by failing to terminate doctor with a record of mistakes).

⁵¹ See Peter D. Jacobson & Scott D. Pomfret, *Establishing New Legal Doctrine in Managed Care: A Model of Judicial Response to Industrial Change*, 32 U. MICH. J.L. REFORM 813, 839 (1999).

⁵² *Id.*

⁵³ See Starr, *supra* note 5, at 385 (explaining that "Medicare and Medicaid, like Blue Cross, chose to reimburse hospitals on the basis of their costs. Under such a system . . . the greater its costs, the higher its reimbursements.").

⁵⁴ *Id.*

The 1970s opened with a crisis in health care.⁵⁵ By 1980, health care expenditures had reached \$230 billion, up from \$69 billion in 1970.⁵⁶ As pressure to contain health care expenditures increased, third-party payers began to experiment with payment methods that moved away from the traditional fee-for-service system. In 1983, Medicare adopted the diagnosis-related group (DRG) payment system for hospitals, under which hospitals received a fixed amount per patient based on the patient's diagnosis rather than an amount based on the actual treatment costs incurred.⁵⁷ Other payers, including states and self-insured employers, began to steer patients into Health Maintenance Organizations (HMOs), which functioned as an alternative to health insurance plans.⁵⁸ Like the DRG system, HMOs provided patient care for a fixed per capita fee.⁵⁹

b. Institutional Control Over Physicians

Up to eighty percent of health care costs are within the control of physicians.⁶⁰ Even though prospective payment systems did not target physicians directly, the ability of hospitals and HMOs to control health care costs depended on the ability to exert institutional control over physicians, whose practices had been largely unregulated. In designing the DRG payment system, the U.S. Department of Health and Human Services recognized that “prospective payment . . . provides a number of . . . desired incentives by inducing hospitals to control physician services which have associated hospital costs.”⁶¹ Similarly, the purpose of HMOs was to manage costs by working with physicians to provide only medically necessary and cost effective medical services.⁶²

Accordingly, hospitals and HMOs adopted different strategies to influence physician behavior and reduce medical expenditures. Hospitals and HMOs adopted preauthorization review protocols for ordering certain medications and performing certain procedures.⁶³ In an effort to control costs, hospitals adopted rigid standardized treatment protocols aimed at decreasing length of stay or the number of medical

⁵⁵ *Id.* at 381.

⁵⁶ *Id.* at 380.

⁵⁷ See Stuart Altman, *The Lessons Of Medicare's Prospective Payment System Show That The Bundled Payment Program Faces Challenges*, 31 HEALTH AFFAIRS 1923, 1924-25 (2012).

⁵⁸ See Donna Horoshack et al., *State Regulation of Managed Care*, in ESSENTIALS OF MANAGED HEALTH CARE 765, 767 (Peter R. Kongstvedt ed., 2007).

⁵⁹ See Peter D. Fox et al., *The Origins of Managed Health Care*, in ESSENTIALS OF MANAGED HEALTH CARE 3, 6 (Peter R. Kongstvedt ed., 2007).

⁶⁰ See John M. Eisenberg, *Physician Utilization*, 23 MED. CARE 461 (1985); see also John M. Eisenberg & Sankey V. Williams, *Cost Containment and Changing Physicians' Practice Behavior*, 246 JAMA 2195 (1981) (noting that between 50 and 80 percent of health care costs are controlled by physicians).

⁶¹ See U.S. DEP'T OF HEALTH & HUMAN SERVS., PAYING PHYSICIANS: CHOICE FOR MEDICARE E-8 (1988).

⁶² See Peter R. Kongstvedt, ESSENTIALS OF MANAGED HEALTH CARE 6 (2007) (explaining that the cost containment and quality assessment policies by health maintenance organizations are intended to control the inappropriate use of medical services).

⁶³ See John M. Eisenberg, DOCTORS' DECISIONS AND THE COST OF MEDICAL CARE 130 (1986); see also Eisenberg & Williams, *supra* note 60, at 2198 (describing preauthorization review by hospitals).

procedures and diagnostic tests prescribed.⁶⁴ Enforcement of these directives varied from barring physicians from using facilities to refusing to pay for unapproved treatment.⁶⁵ Physician education and feedback from peer review were used to influence physician behavior and control expenditures.

Hospitals and HMOs relied on institutional inducements in the form of sanctions for excessive treatment and rewards for conservative treatment. The Independent Practice Associations, which compensated physicians on a discounted fee-for-service basis, provided bonuses for efficient performance or reduced payment for inefficiency.⁶⁶ Some hospitals paid their medical staff a percentage of profits earned from Medicare patients.⁶⁷ Other hospitals rewarded profitable physicians with in-kind or fringe benefits, such as office space, secretarial services, and malpractice insurance.⁶⁸ These strategies raised concerns regarding federal and state prohibitions on financial dealings between physicians and the hospitals to which they refer patients.⁶⁹

c. The Beginning of New Physician-Hospital Relationships

Managed care drastically changed the nature of the relationship between physicians and hospitals by bringing changes in both reimbursement and contracting for hospital services.⁷⁰ Throughout most of the twentieth century, the economic incentives of physicians and hospitals were aligned and higher reimbursements were associated with providing more services.⁷¹ Prospective payment mechanisms altered this relationship. Because hospitals were paid a fixed sum per patient, administrators were no longer indifferent to resources physicians expended in treatment.⁷² Physicians were incentivized to provide more services to receive higher payment.⁷³

⁶⁴ See Hall, *supra* note 17, at 449-50 (describing treatment protocols); see also William A. Chittenden III, *Malpractice Liability and Managed Care: History and Prognosis*, 26 TORT & INS. L.J. 451, 456 n.28 (1991) (describing standardized diagnosis and treatment protocols by HMOs).

⁶⁵ See Hall, *supra* note 17, at 463-64 (describing enforcement mechanisms with standardized protocols).

⁶⁶ *Id.* at 484.

⁶⁷ See *id.* at 486 (noting, by way of example, that the Paracelsus chain of hospitals in California paid each member of the medical staff a percentage of the profits the hospital earned from that physician's Medicare patients).

⁶⁸ See COMM. ON IMPLICATIONS OF FOR-PROFIT ENTERPRISE IN HEALTH CARE, INST. OF MED., FOR-PROFIT ENTERPRISE IN HEALTH CARE 166 n.7 (1986) (describing different in-kind and fringe physician benefits).

⁶⁹ See Hall, *supra* note 17, at 487-88 (providing an overview of federal and state fee splitting prohibitions).

⁷⁰ See Alison E. Cuellar & Paul J. Gertler, *Strategic Integration of Hospitals and Physicians*, 25 J. HEALTH ECON. 1, 3 (2006) (reasoning that "[m]anaged care brought about a change in hospital contracting and reimbursement").

⁷¹ See Starr, *supra* note 5, at 385 ("Since under fee-for-service, doctors and hospitals make more money the more services they provide, they have an incentive to maximize the volume of services.").

⁷² See Eisenberg & Williams, *supra* note 60, at 2198 (describing hospital cost-containment strategies).

⁷³ *Id.*

At the same time, managed care brought changes in contracting for hospital services. Because HMOs provided care on a capitated basis, HMOs selectively contracted with hospitals to negotiate lower prices and shift payment risk to hospitals.⁷⁴ Hospitals faced pressure to lower costs and gain bargaining power to improve their competitive position for managed care contracts.⁷⁵ In response, hospitals sought more strategic relationships with physicians by acquiring physician practices, including primary care physicians, and employing the physicians.⁷⁶ By 1998, more than 66 percent of hospitals were integrated with a physician practice, up from 33 percent in 1993.⁷⁷

Physician integration with employed physicians was intended to help hospitals lower costs and gain bargaining power. The expectation was that employed physicians would be more cooperative with hospital administration to manage costs and secure more hospital admissions.⁷⁸ Moreover, employing physicians allowed hospitals to negotiate jointly with HMOs. Due to the risk that failure to reach an agreement would result in the loss of both the hospitals and physicians, employing physicians helped hospitals gain bargaining power.⁷⁹ For physicians, hospital employment provided a “shelter from an increasingly complex and unstable market.”⁸⁰

D. Increasing Competition, Quality Expectations, and Physician Employment

a. Physician-Hospital Competition Over Services

Hospitals were under economic pressure to affiliate with physicians, and an adversarial climate with physician-owned facilities ensued. Technological advances enabled more affordable equipment and hospital services to be performed in ambulatory settings. Physicians began to acquire equipment and ambulatory surgical centers, which made physicians direct competitors with hospitals.⁸¹ By owning these facilities, physicians

⁷⁴ See Cuellar & Gertler, *supra* note 70, at 3.

⁷⁵ *Id.*

⁷⁶ See Lawton R. Burns et al., *Impact of HMO Market Structure on Physician-Hospital Strategic Alliance*, 35 HEALTH SERVS. RES. 101, 104 (2000).

⁷⁷ See Cuellar & Gertler, *supra* note 70, at 2 (noting that “hospitals in high-managed care areas, i.e., areas with high managed care penetration rates, are more likely to have vertical relationships with physicians than hospitals in low-managed care areas; only 29 percent of hospitals in low-managed care areas had vertical relationships in 1998, compared to 70 percent of hospitals in high-managed care areas.”).

⁷⁸ See *id.* at 3-4 (arguing that physician integration increases efficiency and quality by allowing physicians and hospitals to achieve economies of scale); see also Lawrence Casalino & James C. Robinson, *Alternative Models of Hospital-Physician Affiliation as the United States Moves Away from Tight Managed Care*, 81 THE MILBANK Q. 331, 338 (2003) (noting that hospitals that employ physicians are more likely to compel cooperation through managerial authority and secure admissions than those with staff physicians).

⁷⁹ See Cuellar & Gertler, *supra* note 70, at 5-6 (observing different theories by which hospital-physician integration may be used to increase hospital market power and bargaining power with health plans).

⁸⁰ See Lawrence P. Casalino et al., *Hospital-Physician Relations: Two-Tracks and the Decline of the Voluntary Medical Staff Model*, 27 HEALTH AFFAIRS 1305, 1309 (2008) (exploring physician motivations for integrating with hospitals).

⁸¹ See Berenson, *supra* note 4, at w35-w36.

were able to capture the facility fee associated with these services that would otherwise go to the hospital, increase consumer expectation of a “one-stop shop” for medical services, and control their work hours and environment.⁸²

b. Patient Safety and Quality of Care Expectations

Hospitals also experienced increasing pressure to improve patient safety and quality of care. In 1999, the Institute of Medicine issued its landmark report, “To Err is Human,” which estimated that as many as 98,000 patients die annually in U.S. hospitals due to preventable medical errors.⁸³ The report put health care quality in the sight of public and private payers, leading to a number of initiatives aimed at improving patient safety and quality of care. One of these initiatives was the publication of comparative quality information. In 2001, the Medicare program launched the Hospital Quality Initiative.⁸⁴ Although participation was voluntary, hospitals participated to receive a payment update.⁸⁵ In 2002, JCAH began requiring hospital quality performance reporting.⁸⁶

“Pay-for-performance” programs, an influential initiative, generally imposed financial penalties on health care providers that failed to meet quality or performance measures.⁸⁷ These measures included process measures that focused on specific activities that contribute to positive health outcomes, the effect of care on patients, and patient satisfaction with the care they received at the hospital.⁸⁸ The Hospital Value-Based Purchasing Program was another initiative where hospitals were paid on the basis of quality measures and performance improvements.⁸⁹

c. The Rise of Physician Employment and its Impact on Admitting Physicians

In response to the increasingly adversarial environment with physician-owned facilities and new pressure to improve patient safety and quality of care, hospitals explored

⁸² See Casalino, *supra* note 78, at 1310 (explaining that ownership of these facilities enables physicians to focus on a more narrow range of procedures, which facilitates efficient scheduling and allows for profitability); see also Berenson, *supra* note 4, at w34 (noting that motivating factors included “seeking additional sources of income, increasing consumers’ expectations of ‘one-stop shopping’ for physician services, and growing physician demand for control over their own work environment”).

⁸³ See INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 31 (2000), <https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system>.

⁸⁴ See CTRS. FOR MEDICARE AND MEDICAID SERVS., HOSPITAL QUALITY INITIATIVE OVERVIEW 1 (2005), <https://www.hsdl.org/?abstract&did=464393>.

⁸⁵ *Id.* at 2.

⁸⁶ See JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, ONGOING ACTIVITIES: 2000 TO 2004 STANDARDIZATION OF METRICS, https://www.jointcommission.org/assets/1/18/SIWG_Vision_paper_ongoing_activities.pdf.

⁸⁷ See Julia James, *Health Policy Brief: Pay-for Performance*, HEALTH AFFAIRS (2012), <https://www.healthaffairs.org/doi/10.1377/hpb20121011.90233/full/>.

⁸⁸ *Id.* at 2.

⁸⁹ See *id.* at 3; see also CTRS. FOR MEDICARE AND MEDICAID SERVS., HOSPITAL VALUE-BASED PURCHASING 1, 3 (2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Hospital_VBPurchasing_Fact_Sheet_ICN907664.pdf.

new relationships with physicians through two main strategies: joint venturing and physician employment.⁹⁰

Hospitals that enter into joint-venture arrangements generally expect to retain some of the revenue the hospital would have otherwise lost to a competing physician-owned entity.⁹¹ For physicians, entering into a joint venture with hospitals allows them to benefit from hospital capital and the hospital's management.⁹² However, since many joint ventures occur between not-for-profit hospitals and for-profit physician entities, such arrangements raise concern regarding Internal Revenue Service rules on tax-exempt status.⁹³ Due to the possibility of service referrals, these joint venture arrangements also raise concern regarding the federal Anti-Kickback Statute, which generally prohibits payment for referral of Medicaid or Medicare business.⁹⁴

Given the regulatory obstacles to establishing joint ventures, hospitals moved to a physician employment model that was focused on employing specialists. Building on earlier trends of employing primary care physicians, the employment of specialists allowed hospitals to preempt competition from physician-owned facilities and increase negotiating leverage with health plans.⁹⁵ Hospitals also employed physicians to staff Emergency Departments.⁹⁶ For years, hospitals reported the unwillingness of medical staff to cover the Emergency Department, which forced hospitals to pay generous per diems for physicians to assume on-call responsibilities.⁹⁷

The employment of specialists threatened hospital relationships with their medical staff. Hospitals have isolated admitting physicians who are members of their medical staff by emphasizing service lines that feature employed specialists.⁹⁸ Although certain hospitals have branded their service lines with participation of employed specialists and medical staff, many have excluded the medical staff to have greater control over how services are provided and marketed.⁹⁹

With the rise in physician employment and its impact on medical staff physicians, the definition of the hospital-physician relationship is underscored.¹⁰⁰ Pressure from third-party payers to control health care costs and improve patient safety urges hospitals to

⁹⁰ See Casalino, *supra* note 77, at 1309 (exploring physician-hospital joint ventures and physician employment).

⁹¹ See Berenson, *supra* note 4, at w38 (exploring hospital motivations for entering into joint ventures).

⁹² See Timothy Lake et al., *Something Old, Something New: Recent Developments in Hospital-Physician Relationships*, 38 HEALTH SERVS. RES. 471, 479 (2003) (exploring physician motivations for entering into joint ventures, such as the ability to purchase costly facilities and technologies).

⁹³ See Berenson, *supra* note 4, at w39 (noting regulatory challenges to establishing joint ventures).

⁹⁴ *Id.*

⁹⁵ See Casalino, *supra* note 77, at 1308 (exploring hospital motivations for employing physicians).

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ See Berenson, *supra* note 4, at w40 (assessing the impact of specialist employment on the medical staff).

⁹⁹ *Id.*

¹⁰⁰ *Id.*

reassess their relationship with employed physicians and admitting physicians, such as the level of control the hospital wishes to exercise over physician behavior.¹⁰¹ Although hospitals may exercise control over the practice of employed physicians, exercising too much control over members of the medical staff can place the hospital at risk of liability.¹⁰² Thus, the general law behind classifying admitting physicians as independent contractors under federal labor and employment law is instructive.

III. GENERAL LAW ON CLASSIFYING PHYSICIANS AS INDEPENDENT CONTRACTORS

A. Worker Classification Under Title VII

Title VII makes it unlawful for employers “to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex, or national origin.”¹⁰³ The statute defines “employee” as “an individual employed by an employer”¹⁰⁴ but does not clearly define “employer.”¹⁰⁵ Given the circularity of this definition, the legislative history of Title VII is instructive to the worker classification of admitting physicians.

B. Legislative History of Worker Classification Under Title VII

The legislative history of Title VII suggests Congress permitted the classification of some physicians as employees.¹⁰⁶ As part of the 1972 amendments to Title VII, Congress considered, but did not include, a proposal to exclude physicians employed by public or private hospitals from Title VII.¹⁰⁷ During Senate debate, Senator Harrison Williams (D-NJ) warned that “[this amendment] would take from a doctor the protection that the Constitution gives him and would protect through [Title VII].”¹⁰⁸ Moreover, Senator Jacob Javits (R-NY) explained:

[T]his amendment would go back beyond decades of struggle and of injustice and reinstate the possibility of discrimination on grounds of ethnic origin, color, sex, religion—just confined to physicians or surgeons, one of the highest rungs

¹⁰¹ See Starr, *supra* note 5, at 385 (describing the pressure to control health care costs); see also INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 31 (2000), <https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system> (describing how improving patient safety is imperative).

¹⁰² See *Cnty. for Creative Non-Violence v. Reid*, 490 U.S. 730, 751 (1989) (describing the control factor in the common-law agency test for distinguishing between employees and independent contractors).

¹⁰³ 42 U.S.C. § 2000e-2(a)(1) (2018).

¹⁰⁴ 42 U.S.C. § 2000e(f) (2018).

¹⁰⁵ 42 U.S.C. § 2000e(b) (defining a person engaged in an industry affecting commerce who has fifteen or more employees) (2018).

¹⁰⁶ See *Hyland v. New Haven Radiology Assocs.*, 794 F.2d 793, 800 (2d Cir. 1986); see also *Lucido v. Cravath, Swaine & Moore*, 425 F. Supp. 123, 126 (S.D.N.Y. 1977); see also *EEOC v. Rinella & Rinella*, 401 F. Supp. 175, 179 (N.D. Ill. 1975).

¹⁰⁷ See *Rinella & Rinella*, 401 F. Supp. at 179-80 (citing 118 Cong. Rec. 1647 (1972)).

¹⁰⁸ See *id.*

of the ladder that any member of a minority could attain—and thus lock in and fortify the idea that being a doctor or surgeon is just too good for members of a minority, and that they have to be subject to discrimination in respect of it, and the Federal law will not protect them.¹⁰⁹

The proposed exclusion of physicians from the protections of Title VII was ultimately defeated, allowing for the classification of some physicians as employees for purposes of Title VII.¹¹⁰

C. Case Law on Worker Classification for Purposes of Title VII

The uncertainty surrounding worker classification under Title VII charges the courts with making this determination. Courts have employed three different tests for distinguishing between employees and independent contractors: (1) the common-law agency test, (2) the economic realities test, and (3) a hybrid test that combines elements of both the common-law agency test and the economic realities test.¹¹¹ In the medical context, most courts have found that admitting physicians are independent contractors who are not covered by Title VII, but some courts have concluded that physicians may be employees by relying on the common-law agency test.

a. Legal Tests for Distinguishing Employees from Independent Contractors

Prior to 1947, courts distinguished an employee from an independent contractor using the common-law agency test.¹¹² This test focused on the degree of control the employer exercised over the individual's work performance.¹¹³ If the employer controlled not only "what work should be done, but also how it should be done," the worker was deemed an employee.¹¹⁴ In *Community for Creative Non-Violence v. Reid*, which involved the worker classification of an artist, the Supreme Court noted that an important factor is the employer's right to control the "manner and means" of the worker's performance.¹¹⁵ Other factors include the skill required, the source of the instrumentalities and tools, the location of the work, the duration of the parties' relationship, the employer's provision of employee benefits, the tax treatment of the worker, among others.¹¹⁶

In 1947, the Supreme Court held that the common-law agency test was too narrow for determining worker classification for purposes of social legislation.¹¹⁷ The Court

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ See Patricia Davidson, *The Definition of Employee Under Title VII: Distinguishing Between Employees and Independent Contractors*, 53 U. CIN. L. REV. 203, 225 (1984).

¹¹² See *United States v. Silk*, 331 U.S. 704, 713 (1947).

¹¹³ *Id.*

¹¹⁴ See *EEOC v. Zippo Mfg. Co.*, 713 F.2d 32, 36 (3d Cir. 1983).

¹¹⁵ See *Cnty. for Creative Non-Violence v. Reid*, 490 U.S. 730, 751 (1989).

¹¹⁶ See *id.*; see also Restatement of the Law, Agency, § 220 (listing factors to be considered in determining whether an individual is an employee or an independent contractor when performing services for another person or entity).

¹¹⁷ See *Bartels v. Birmingham*, 332 U.S. 126, 130 (1947) (noting that "[c]ontrol is characteristically associated with the employer-employee relationship, but in the application of social legislation

then proposed the “economic realities” test, which focuses on whether the individual is, as a matter of economic reality, dependent upon the business to which she renders her service.¹¹⁸ In applying this test, courts examine the degree of control exercised by the employer, the extent of the relative investments of the worker and the employer, the degree to which the worker’s opportunity for profit or loss is determined by the employer, the skill and initiative required in performing the job, and the permanency of the relationship.¹¹⁹

Notably, the courts have refrained from using the economic realities test for purposes of Title VII. Instead, courts traditionally use the economic realities test only for determining worker status under the Fair Labor Standards Act (FLSA).¹²⁰ Unlike Title VII, the legislative history of the FLSA suggests that the term “employee” be given “the broadest definition that has ever been included in any one act.”¹²¹ Some courts have applied a hybrid of the common-law agency test and the economic realities test to determine worker status under Title VII, through which the worker’s economic dependence on the employer is considered under the common-law principles of agency.¹²² Applying the economic realities test, courts have noted that the extent of the employer’s right to control the worker’s performance is determinative.¹²³ In *Spirides v. Reinhardt*, in which the worker classification of a foreign language broadcaster was considered, the court held that necessary factors that apply to the consideration of worker status under the hybrid test include whether the work performed is under the direction of a supervisor, the skill required for the job, whether the employer furnishes the equipment used and the place of work, and the length of time during which the individual has worked.¹²⁴

b. Case Law on the Worker Classification of Physicians for Purposes of Title VII

Until the mid-1990s, courts applied the hybrid test, concluding that admitting physicians at hospitals were independent contractors for purposes of Title VII. In *Beverly v. Douglas*, where an action against a hospital for denying a physician admitting privileges transpired, the court applied the hybrid test and found that the physician was an independent contractor since the hospital did not exercise control over the manner and means of the physician’s performance.¹²⁵ The court noted that

employees are those who as a matter of economic reality are dependent upon the business to which they render service”).

¹¹⁸ See *id.* (adopting that “in the application of social legislation employees are those who as a matter of economic reality are dependent upon the business to which they render service.”).

¹¹⁹ See *Hopkins v. Cornerstone Am.*, 545 F.3d 338, 343 (5th Cir. 2008).

¹²⁰ See *Cobb v. Sun Papers, Inc.*, 673 F.2d 337, 340 (11th Cir. 1982).

¹²¹ See *id.* (noting that “there is no statement in the [Civil Rights] Act or legislative history of Title VII comparable to one made by Senator Hugo Black (later Justice Black), during the debates on the Fair Labor Standards Act, that the term ‘employee’ in the FLSA was given ‘the broadest definition that has ever been included in any one act.’”).

¹²² *Id.*

¹²³ See *Spirides v. Reinhardt*, 613 F.2d 826, 831-32 (D.C. Cir. 1979).

¹²⁴ See *id.* at 832.

¹²⁵ See *Beverly v. Douglas*, 591 F. Supp. 1321, 1330 (S.D.N.Y. 1984) (accepting the hybrid test and finding the physician to be an independent contractor because the hospital did not exercise control

the physician had a practice outside the hospital, was not paid a salary, received no benefits, and had no office space.¹²⁶ Later cases emphasized that, in addition to these factors, the hospital did not supervise the physician's work and did not control the details of the physician's practice.¹²⁷

The few cases during this time where the court found that physicians were employees for purposes of Title VII identified the ways that the hospital exerted control over the physician. For example, in *Mitchell v. Frank Memorial Hospital*, where an action was brought against a hospital for wrongful termination, the court found that the physician could bring a Title VII action because the hospital controlled the physician's practice.¹²⁸ Moreover, in *Ross v. William Beaumont Hospital*, where a physician brought a sex discrimination action against a hospital, the court found that the physician was an employee because she underwent extensive progressive discipline, including probation and leaves of absence.¹²⁹ Finally, in *Mallare v. St. Lukes Hospital*, where an action against a hospital was brought for denying a physician admitting privileges, the court noted that the hospital exercised control over the physician's practice by retaining the right to withdraw medical staff privileges if his performance did not comport with hospital standards.¹³⁰

Since the mid-1990s, the courts have relied on the common-law agency test and generally classified physicians as independent contractors for purposes of Title VII. The initial switch was guided by the Supreme Court's use of this test in the context of the Copyright Act and Employee Retirement Income Security Act (ERISA).¹³¹ The use of this test was

over the physician's work).

¹²⁶ See *id.* (noting that the physician is an independent contractor in part because staff physicians have practices outside the hospital and staff physicians are not paid a salary).

¹²⁷ See *Diggs v. Harris Hosp. Methodist, Inc.*, 847 F.2d 270, 273 (5th Cir. 1988) (applying the hybrid test and finding the physician to be an independent contractor because the hospital did not direct the manner or means by which the physician rendered medical care and the hospital did not pay salary or licensing fees nor provided benefits); see also *Amro v. St. Luke's Hospital*, 39 F.E.P. 1574, 1576 (E.D. Pa. 1986) (maintaining the hybrid test and finding the physician to be an independent contractor because the hospital did not supervise the physician's work).

¹²⁸ See *Mitchell v. Frank H. Mem'l Hosp.*, 853 F.2d 762, 766 (9th Cir. 1988) (reiterating the hybrid test and finding the physician to be an employee in part because the hospital controlled the means and manner of his performance).

¹²⁹ See *Ross v. William Beaumont Hosp.*, 678 F. Supp. 655, 675 (E.D. Mich. 1988) (assessing the economic realities test and finding physician to be an employee in part because the physician underwent extensive progressive discipline, such as probation and leaves of absence and the physician "based her whole livelihood" on the hospital).

¹³⁰ See *Mallare v. St. Luke's Hosp.*, 699 F. Supp. 1127, 1130 (E.D. Pa. 1988) (applying hybrid test and finding that material issues of fact existed as to whether a hospital was the employer of a physician because "the ultimate question was control of the means and manner of job performance," noting that the hospital exercised control in the sense that staff privileges could be withdrawn if a doctor's performance did not comport with hospital's standards and denial of staff privileges would severely limit his opportunity to develop a full practice).

¹³¹ See *Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 322-23 (1992) (following *Reid* and adopting the common-law agency test for determining who is an employee for purposes of ERISA); see also *Cnty. for Creative Non-Violence v. Reid*, 490 U.S. 730, 739-40 (1989) (holding that when Congress uses the term "employee" without defining it in the context of the Copyright Act,

solidified when the Supreme Court adopted this test for purposes of anti-discrimination laws.¹³² In determining whether the hospital exercised control over the physician's performance, the courts highlighted the physician's ability to provide services according to her medical judgement and determine her working hours, who to work for, and which patients to treat.¹³³ These cases rejected the idea that hospitals exercised control by imposing on-call requirements and hospital standards on physicians.¹³⁴

In 2008, the Second Circuit challenged the traditional classification of admitting physicians as independent contractors for purposes of Title VII.¹³⁵ In *Salamon*, the court examined what it means for a hospital to exercise control over the "manner and means" of a physician's performance in light of the nature of the physician-hospital relationship.¹³⁶ The court focused on the means explored in *Mitchell*, *Ross*, and *Mallare*; namely, the scope of hospital standards and policies, active supervision, and corrective action.¹³⁷ These means had been rejected by sister circuits.¹³⁸

Congress intended to describe the conventional "master-servant" relationship as understood by the common-law agency doctrine).

¹³² See *Clackamas Gastroenterology Assocs., P.C. v. Wells*, 538 U.S. 440, 442-44 (2003) (delineating *Reid/Darden* and adopting the common-law agency test for determining who is an employee for purposes of anti-discrimination laws, stressing that "the common-law element of control is the principal guidepost that should be followed.").

¹³³ See *Shah v. Deaconess Hosp.*, 355 F.3d 496, 500 (6th Cir. 2004) (concluding that the physician was an independent contractor since the hospital could not interfere with the physician's medical discretion or control the manner and means of his performance as a surgeon); see also *Vakharia v. Swedish Covenant Hospital*, 190 F.3d 799, 805 (7th Cir. 1999) (applying the common law agency test and concluding the physician was an independent contractor since the physician provided services according to her professional judgement); see also *Cilecek v. Inova Health Sys. Serv.*, 115 F.3d 256, 259 (4th Cir. 1997) (interpreting the common-law agency test and finding that the physician was an independent contractor since the physician exercised independence in determining his hours, income, and who he worked for); see also *Alexander v. Rush North Shore Med.*, 101 F.3d 487, 493 (7th Cir. 1996) (invoking the common-law agency test and concluding that the physician was an independent contractor because the physician had authority to exercise his independent discretion over his patients care).

¹³⁴ See *Pamintuan v. Nanticoke Mem'l Hosp.*, 192 F.3d 378, 385-86 (3d Cir. 1999) (referring to the common-law agency test and finding the physician to be an independent contractor, while rejecting the idea that being subject to hospital rules and standards made the physician an employee); see also *Alexander*, 101 F.3d at 490 (rejecting the argument that the on-call requirement made the physician an employee because "the details concerning performance remained within his control").

¹³⁵ See *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 220-21 (2d Cir. 2008).

¹³⁶ See *id.* at 228.

¹³⁷ See *Mitchell v. Frank H. Mem'l Hosp.*, 853 F.2d 762, 766 (9th Cir. 1988) (concluding that the hospital controlled the means and manner of physician's performance); see also *Ross v. William Beaumont Hosp.*, 678 F. Supp. 655, 675 (E.D. Mich. 1988) (describing that the physician underwent extensive progressive discipline); see also *Mallare v. St. Luke's Hosp.*, 699 F. Supp. 1127, 1130 (E.D. Pa. 1988) (explaining that the hospital could withdraw staff privileges if physician did not comply with rules).

¹³⁸ See *Shah v. Deaconess Hosp.*, 355 F.3d 496, 500 (6th Cir. 2004) (disagreeing with the idea that being subject to hospital rules and standards made the physician an employee); see also *Vakharia v. Swedish Covenant Hospital*, 190 F.3d 799, 805 (7th Cir. 1999) (rebuffing the idea that suspension of staff privileges is indicative of hospital control); see also *Pamintuan v. Nanticoke Mem'l Hosp.*, 192 F.3d 378, 385-86 (3d Cir. 1999) (objecting to the idea that subjecting physicians to hospital

IV. SALAMON AND HOSPITAL CONTROL OVER THE PRACTICES OF ADMITTING PHYSICIANS

Dr. Barbara Salamon practiced at Our Lady of Victory Hospital (OLV) as a member of its medical staff.¹³⁹ Dr. Salamon filed a lawsuit against OLV claiming violations of Title VII. She alleged that Dr. Michael Moore, Chief of the Gastroenterology Division, sexually harassed her by making inappropriate comments and sexual advances toward her on multiple occasions.¹⁴⁰ Dr. Salamon claimed that Dr. Moore retaliated by using his administrative authority to give her negative performance reviews and subject her practice to excessive scrutiny when she complained about his behavior.¹⁴¹ The district court granted summary judgment in favor of OLV, finding that Dr. Salamon was not an employee under Title VII. The Second Circuit reversed and held that a question of fact existed as to whether Dr. Salamon was an employee.¹⁴² The parties reached a settlement before Dr. Salamon's worker classification could be decided on trial.¹⁴³

A. Salamon's Relationship with OLV

As a member of OLV's medical staff, Dr. Salamon received clinical privileges and was subject to the same duty as staff physicians. Her clinical privileges included the use of hospital facilities and access to OLV's nursing and support staff.¹⁴⁴ Dr. Salamon set her own hours and determined which patients to see and whether to admit them to OLV or a different hospital.¹⁴⁵ However, OLV did not provide Dr. Salamon's salary, benefits, or any other compensation.¹⁴⁶ As a member of OLV's medical staff, Dr. Salamon was required to adhere to medical staff rules and by-laws, participate in staff meetings, and cover the Emergency Department.¹⁴⁷ OLV also required Dr. Salamon's participation in the hospital's Quality Assurance Program (QAP), which required practitioners to examine the procedures that the hospital used during the quarter.¹⁴⁸

rules and standards made physicians employees); *see also* Alexander v. Rush North Shore Med., 101 F.3d 487, 490 (7th Cir. 1996) (rejecting the idea that the on-call requirement made the physician an employee).

¹³⁹ *See* Salamon v. Our Lady of Victory Hosp., 514 F.3d 217, 221 (2d Cir. 2008).

¹⁴⁰ *Id.* at 220

¹⁴¹ *Id.*

¹⁴² *See id.* at 233 (discussing that there was a factual issue regarding Dr. Salamon's status as an employee due to the level of control that the hospital exercised over her medical practice and the methods of her work through hospital standards and policies, active supervision, and corrective action procedures).

¹⁴³ *See* Stipulation and Order of Dismissal, Salamon v. Our Lady of Victory Hosp., 514 F.3d 217 (2d Cir. 2008), (No. 1:99-cv-00048).

¹⁴⁴ *See* Salamon, 514 F.3d at 222.

¹⁴⁵ *See* Salamon v. Our Lady of Victory Hosp., 514 F.3d 217, 222 (2d Cir. 2008).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *See id.* at 222-23 (explaining that cases flagged as problematic were discussed at OLV's mandatory GI division meetings, and the attending physician would be subject to a peer review process if necessary).

B. The Alleged Harassment, Retaliation, and Increased Scrutiny

Dr. Salamon alleged that when she complained about Dr. Moore's conduct to hospital administrators, they told her that her complaints were unfounded.¹⁴⁹ The administrators informed Dr. Salamon that several of her cases would be reviewed for quality concerns.¹⁵⁰ Dr. Salamon claimed that her practice was subjected to additional levels of review, and that increased scrutiny resulted in Dr. Salamon participating in a reeducation and mentoring program.¹⁵¹

C. The Hospital's Control of the Manner and Means of the Physician's Performance

Judge Nancy Gertner, sitting by designation and writing for the Second Circuit, relied on *Reid's* framework in analyzing the law governing the worker classification of Dr. Salamon.¹⁵² The district court found that the first *Reid* factor, which focuses on the level of control over the manner and means of a worker's performance, weighed against Dr. Salamon since she exercised her professional judgment with regard to patient diagnosis and treatment.¹⁵³ Judge Gertner found sufficient evidence to raise an issue about whether the hospital controlled the manner and means by which Dr. Salamon delivered her services.¹⁵⁴ Unlike the district court, Judge Gertner focused not only on Dr. Salamon's judgment regarding diagnosis and treatment, but also on the level of control the hospital exercised through quality standards, supervision, and corrective action.¹⁵⁵

a. Scope of Quality Control Procedures and Policies

Judge Gertner found that OLV exercised significant control over Dr. Salamon's practice through the application of its quality management standards, which mandated certain procedures, indicated the timing of other procedures, and dictated which medications to prescribe.¹⁵⁶ Judge Gertner reasoned that the policies were not quality assurance standards required by health and safety concerns or for ensuring Dr. Salamon's qualifications, but rather designed to dictate details of Dr. Salamon's practice.¹⁵⁷ Furthermore, Judge Gertner noted that the purpose of these requirements was to maximize OLV's revenue.¹⁵⁸

¹⁴⁹ *Id.* at 224.

¹⁵⁰ *Id.*

¹⁵¹ See *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 224-25 (2d Cir. 2008) (noting that the additional review included a review by a five-physician ad-hoc committee and a review by an outside expert).

¹⁵² *Id.* at 226.

¹⁵³ *Id.* at 227.

¹⁵⁴ *Id.* at 228-29.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* at 229.

¹⁵⁷ See *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 230 (2d Cir. 2008).

¹⁵⁸ *Id.*

b. Supervision of Physicians with Admitting Privileges

Judge Gertner found that OLV exercised significant control over Dr. Salamon's practice through active supervision. According to Dr. Salamon, excessive scrutiny began when she declined Dr. Moore's advances.¹⁵⁹ Judge Gertner found that OLV's supervision was not merely the result of negative medical outcomes but for variations from recommended procedures.¹⁶⁰ Dr. Salamon contented that OLV's strict standards resulted in nearly every one of her cases being scrutinized.¹⁶¹

c. Methods for Addressing Admitting Physician Performance

Finally, Judge Gertner found that OLV exercised significant control over Dr. Salamon's practice by subjecting her to a reeducation and mentoring program. Rather than terminate Dr. Salamon's contract, the hospital required her to attend a reeducation program, which was designed to change the method by which Dr. Salamon carried out her practice.¹⁶² Judge Gertner emphasized that OLV exerted control over the manner and means of Dr. Salamon's practice by dictating the appropriate treatment for certain conditions and the length of some medical procedures.¹⁶³

V. REASSESSING THE ADMITTING PHYSICIAN-HOSPITAL RELATIONSHIP AFTER SALAMON

A. The Difficulty in Applying the Common-Law Agency Test in the Medical Context

a. Recognizing the Types of Control Inherent in the Physician-Hospital Relationship

The difficulty of applying the common-law agency test in the medical context rests on the nature of the physician-hospital relationship. As the U.S. Court of Appeals for the Fourth Circuit (Fourth Circuit) recognized, "the ultimate control of doctors performing work at hospitals results from a competition for control that is inherent in the duty of each to discharge properly its professional responsibility."¹⁶⁴ Although a physician must have direct control to make decisions regarding medical care, the hospital must exert conflicting control over the physician's work to discharge its professional responsibility to patients regarding patient safety and quality of care.

¹⁵⁹ *Id.* at 223.

¹⁶⁰ *Id.* at 231.

¹⁶¹ *See id.* (restating that Dr. Salamon claimed that nearly all of her cases from 1996 to 2003 were heavily scrutinized).

¹⁶² *Id.*

¹⁶³ *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 231 (2d Cir. 2008) ("OLV was to dictate (a) indications and treatment of esophagogastroduodenoscopies; (b) appropriate treatment of arteriovenous malformations and removal of polyps found on colonoscopy; (c) use of ph monitoring with esophageal manometry; and (d) length of colonoscopy procedures and level of sedation during colonoscopy").

¹⁶⁴ *See Cilecek v. Inova Health Sys. Serv.*, 115 F.3d 256, 260 (4th Cir. 1997).

b. Failure to Consider the Control Hospitals Can Exert Over Admitting Physicians

The tension in professional control between physicians and hospitals over the discharge of medical services has deterred courts from considering control factors indicative of whether the admitting physician is an employee or an independent contractor. Notably, some courts have concluded that admitting physicians are independent contractors largely due to the assumption that hospitals cannot control a physician's practice.¹⁶⁵ Courts have concluded that hospitals are prohibited from interfering with a physician's obligation to exercise her professional judgment in treating patients.¹⁶⁶

In several cases, courts found the control factor in the common-law agency test to weigh in favor of hospital defendants by emphasizing that the physician provided medical services according to her professional judgment. In *Shah v. Deaconess Hospital*, which involved the revocation of a physician's surgical privileges, the U.S. Court of Appeals for the Sixth Circuit (Sixth Circuit) found that the physician was an independent contractor since the hospital did not have the right to interfere with the physician's medical discretion.¹⁶⁷ Similarly, in *Vakharia v. Swedish Covenant Hospital*, where a physician brought an action for wrongful termination, the U.S. Court of Appeals for the Seventh Circuit (Seventh Circuit) applied the common law agency test and found that the physician was an independent contractor because the physician followed her professional judgment.¹⁶⁸ By overemphasizing the role of a physician's professional judgment, the courts did not consider the possibility that the hospital could be exerting control over the physicians' practices even if the physicians had discretion in treating their patients.

Additionally, the courts have dismissed physicians' allegations regarding the extent to which hospitals exercise control over their practices by emphasizing the role of the physicians' professional judgment in treating patients. For example, in *Alexander v. North Shore Medical*, which involved the revocation of hospital privileges, the Seventh Circuit rejected the argument that the hospital exerted control over the physician through its on-call requirement because "the details concerning performance of the work remained essentially within [the physician's] control."¹⁶⁹ Furthermore, in *Diggs v. Harris Methodist Hospital*, which also concerned the revocation of hospital privileges, the U.S. Court of Appeals for the Fifth Circuit (Fifth Circuit) rejected the argument that the hospital exercised control through active supervision during surgical procedures since

¹⁶⁵ See *Salamon*, 514 F.3d at 228 (noting that some courts have found admitting physicians to be independent contractors because "a physician's professional obligation cannot allow the hospital in which she works to dictate the diagnoses or the manner in which diagnoses are reached").

¹⁶⁶ See *id.*

¹⁶⁷ See *Shah v. Deaconess Hosp.*, 355 F.3d 496, 500 (6th Cir. 2004) (finding the physician to be an independent contractor because there was no evidence that suggested that Deaconess "had the right to interfere with the physician's medical discretion or control the manner and means of his performance as a surgeon").

¹⁶⁸ See *Vakharia v. Swedish Covenant Hosp.*, 987 F. Supp. 633, 636-37 (N.D. Ill. 1997), *aff'd*, 190 F.3d 799 (7th Cir. 1999).

¹⁶⁹ See *Alexander v. Rush North Shore Med.*, 101 F.3d 487, 493 (7th Cir. 1996) (examining the common-law agency test and finding physician to be an independent contractor because he had authority to exercise his own independent discretion).

the hospital did not control the manner and means by which the physician performed the surgical procedure.¹⁷⁰ Although not addressed by the courts, hospitals may exert control over physicians' practices even if the physicians exercised professional discretion.

Physicians have a responsibility to submit themselves to hospital standards and policies in order for the hospitals to exercise its professional responsibility to maintain standards of care. In *Wojewski v. Rapid City Regional Hospital*, which involved the revocation of hospital privileges due to a physician's manic episode, the U.S. Court of Appeals for the Eighth Circuit (Eighth Circuit) noted that "[the hospital] could take reasonable steps to ensure patient safety and avoid professional liability while not attempting to control the manner in which [the doctor] performed operations."¹⁷¹ Accordingly, in *Cilecek v. Inova Health System Services*, where a physician brought an action against a hospital for wrongful termination, the Fourth Circuit noted that the physician was responsible for cooperating with the hospital in maintaining standards of patient care.¹⁷² In both instances, the court found that the physicians were independent contractors without any inquiry as to the level of control the hospitals exercised through such hospital standards.

B. Approaches to the Common-Law Agency Test in the Medical Context

Given the difficulty in applying the common-law agency test in the medical context, courts have adopted different approaches for analyzing the extent to which a hospital exercises control over the manner and means of a physician's performance. In *Cilecek*, the Fourth Circuit proposed instead of focusing on the level of control that hospitals exercise over the discharge of professional services, courts should focus on the level of control the hospital exercises over administrative details incident to the services.¹⁷³ Despite the endorsement of the Fourth Circuit's approach by the Sixth and Eighth Circuit, the Second Circuit rejected the approach in *Salamon*. In doing so, the court emphasized that the issue of control over a physician's performance should focus on the hospital's control over the "details and methods" of the work, which may be influenced by hospital standards and policies, supervision, and corrective action.

a. Fourth Circuit's Emphasis on Administrative Details Incident to Professional Services

In *Cilecek*, the admitting physician argued that the hospital where he practiced exercised control over the manner and means of his practice through its medical staff bylaws, which provided a mechanism for peer review and corrective action for physicians whose practices did not meet hospital rules and regulations.¹⁷⁴ The Fourth Circuit recognized that the physician was required to abide by hospital rules and regulations for the

¹⁷⁰ See *Diggs v. Harris Hosp.-Methodist, Inc.*, 847 F.2d 270, 273 (5th Cir. 1988) (noting that, although the physician had to have supervision during surgical procedures, "the purpose was to have someone attest to her essential qualifications, not to direct the details of the exercise of her skill").

¹⁷¹ See *Wojewski v. Rapid City Reg'l Hosp., Inc.*, 450 F.3d 338, 344 (8th Cir. 2006).

¹⁷² See *Cilecek v. Inova Health Sys. Serv.*, 115 F.3d 256, 262 (4th Cir. 1997) (indicating that the physician retained professional independence).

¹⁷³ See *id.* at 260-61.

¹⁷⁴ See *id.* at 264.

treatment of patients, which regulated his work in substantial detail.¹⁷⁵ These rules and regulations governed “every aspect of patient care,” including medical histories, physical exams, tests and procedures, pre-requisites and post-requisites to surgical procedures, administration of medications, among others.¹⁷⁶ Nevertheless, the Fourth Circuit found that the hospital did not exert control through these rules and regulations since they relate to the standards of care that the hospital and physician must maintain.¹⁷⁷

Due to this dual responsibility, the Fourth Circuit found that focusing on the level of control exercised over the discharge of professional services is less useful in the medical context as it may be in other employer-worker relationships.¹⁷⁸ The court emphasized that the type of control exerted should be viewed in the context of the work itself and the applicable industry.¹⁷⁹ In the medical context, the Fourth Circuit focused on whether the hospital controlled the physician when he performed his services and the number of hours the physician performed services, as well as administrative details incident to the services.¹⁸⁰ The court found the physician was an independent contractor since he determined his hours, income, and which hospital he worked for.¹⁸¹ Applying these principles, both the Sixth and Eighth Circuit have found admitting physicians to be independent contractors under Title VII.¹⁸²

b. Second Circuit’s Emphasis on the Details and Methods of a Physician’s Performance

To date, the Second Circuit has been the only Court of Appeals to challenge the Fourth Circuit’s approach in *Cilecek*. In *Salamon*, the Second Circuit acknowledged the dual responsibility that admitting physicians and hospitals have over the discharge of medical services.¹⁸³ However, the court warned that by overemphasizing the role of professional judgment and minimizing the control factor as the Fourth Circuit did in *Cilecek*, all physicians would be carved out from the protections of the anti-discrimination statutes.¹⁸⁴ Instead, the courts should focus on the control the hospital exercises over the details and methods of a physician’s work.¹⁸⁵

In this case, the Second Circuit focused on the level of control that the hospital exerted on admitting physicians through hospital standards and policies, supervision, and corrective action. While the court acknowledged that hospital standards and policies adopted pursuant to professional and governmental standards generally do not create an

¹⁷⁵ See *id.* at 261.

¹⁷⁶ See *id.* at 261-262.

¹⁷⁷ See *id.* at 262.

¹⁷⁸ See *Cilecek v. Inova Health Sys. Serv.*, 115 F.3d 256, 260 (4th Cir. 1997).

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ See *id.* at 261.

¹⁸² See *Wojewski v. Rapid City Reg’l Hosp., Inc.*, 450 F.3d 338, 345 (8th Cir. 2006); see also *Shah v. Deaconess Hosp.*, 355 F.3d 496, 500 (6th Cir. 2004).

¹⁸³ See *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 231 (2d Cir. 2008).

¹⁸⁴ See *id.* at 228-29.

¹⁸⁵ See *id.* at 229.

employment relationship, the court noted that professional and governmental regulatory standards do not dictate the detailed treatment and peer review requirements that the hospital had implemented in this case.¹⁸⁶ These standards tend to concern health care administration, record keeping, financing, liability, patients' rights, and delegation of responsibilities.¹⁸⁷ Moreover, the court noted that there was evidence in this case that some of the hospital's actions were aimed at maximizing the hospital's revenue.¹⁸⁸

c. The Benefits of Endorsing the Second Circuit's Approach in Salamon

The Fourth Circuit's approach to the common-law agency test focuses on the hospital's control over administrative details incident to the physician's practice.¹⁸⁹ This approach would effectively carve out all admitting physicians from the protections of Title VII and other anti-discrimination laws.¹⁹⁰ By overemphasizing the level of control hospitals exercise over a physician's services, the number of hours worked, and the administrative details incident to the services, courts may find that admitting physicians are independent contractors.¹⁹¹ Carving physicians out of these protections disregards congressional purpose to allow admitting physicians to be classified as hospital employees for purposes of Title VII.¹⁹²

Focusing only on the administrative details incident to a physician's services, the Fourth Circuit's approach disregards the level of control that a hospital can exercise over the outcome of those services through non-administrative means.¹⁹³ As the Supreme Court noted in *Reid*, the proper focus of the control factor in the common-law agency test is on the level of control the employer exercises over the result accomplished and the manner and means by which the worker brings about that result.¹⁹⁴ There is nothing intrinsic to the physician-hospital relationship that prevents a court from assessing the

¹⁸⁶ See *id.* at 230.

¹⁸⁷ See *id.*

¹⁸⁸ See *id.*

¹⁸⁹ See *Cilecek v. Inova Health Sys. Serv.*, 115 F.3d 256, 261 (4th Cir. 1997) (finding that the control inquiry should focus on factors, such as the number of hours the physician worked at the hospital and whether the hospital controlled the physician when rendering services).

¹⁹⁰ See *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 228 (2d Cir. 2008) (noting that overemphasizing the role of professional judgment "would carve out all physicians, as a category, from the protections of the antidiscrimination statutes").

¹⁹¹ See *supra* Part III.C (providing an overview of the case law finding that physicians are independent contractors).

¹⁹² See *supra* Part III.B (explaining that the legislative history of Title VII permits the classification of some physicians as employees).

¹⁹³ *Salamon*, 514 F.3d at 231 ("In *Cilecek*, the court minimized the control factor because of the very nature of the medical profession, in which the doctor and hospital necessarily share control over a doctor's work.").

¹⁹⁴ See *Comty. for Creative Non-Violence v. Reid*, 490 U.S. 730, 751 (1989) (explaining that "whether a hired party is an employee under the general common law of agency, we consider the hiring party's right to control the manner and means by which the product is accomplished.").

level of control that a hospital exercises over the details of a physician's practice and the outcomes of her services through non-administrative means.¹⁹⁵

By disregarding the level of control that a hospital can exercise over the treatment outcomes of a physician's services, the Fourth Circuit's approach ignores the way in which the physician-hospital relationship has evolved.¹⁹⁶ The Fourth Circuit's approach disregards the level of institutional control that hospitals have exerted on physicians through non-administrative means like mandated procedures, supervision, or corrective action.¹⁹⁷ Moreover, this approach is likely to prove increasingly unworkable. As hospitals continue to face pressure to influence physician behavior and experiment with physician employment, it is essential that hospitals define and differentiate the relationships maintained with employed physicians and admitting physicians.¹⁹⁸

By contrast, the Second Circuit's approach considers both the level of control that the hospital exercises over the administrative details related to a physician's services, as well as the level of control over the discharge of such services.¹⁹⁹ Consistent with *Reid*, this approach focuses on the level of control the hospital exercises over both the treatment outcomes of a physician's practice and the details of her work.²⁰⁰ In doing so, the Second Circuit's approach allows some physicians to be classified as employees for purposes of Title VII, as intended by the statute.²⁰¹ This approach recognizes the level of institutional control that hospitals have increasingly exerted over physicians over time.²⁰² As long as health care costs are primarily within the control of physicians, hospitals are incentivized to influence physician's actions to control health care costs.²⁰³

¹⁹⁵ See *supra* Part V.A (describing the difficulty in applying the common-law agency test in the medical context).

¹⁹⁶ See *supra* Part II (providing an overview of the development of the physician-hospital relationship).

¹⁹⁷ See *supra* Part II.C (describing the level of institutional control that hospitals have exercised over physicians through mandated procedures, supervision, and corrective action since the beginning of managed care).

¹⁹⁸ See *supra* Part II.D (discussing the pressure hospitals face to control costs and the rise of physician employment).

¹⁹⁹ See *Salamon v. Our Lady of Victory Hosp.*, 514 F.3d 217, 228-29 (2d Cir. 2008) (finding that the control inquiry in the common-law agency test should consider not only on the physician's judgment regarding her practice, but also the level of control the hospital exercises through quality standards, supervision, and corrective action).

²⁰⁰ See *id.*

²⁰¹ See *supra* Part III.B (explaining that the legislative history of Title VII permits the classification of some physicians as employees).

²⁰² See *supra* Part II.C (describing the level of institutional control that hospitals have exercised over physicians through mandated procedures, supervision, and corrective action since the beginning of managed care).

²⁰³ See *supra* Part II.C (describing that the ability of a hospital to control costs depends on physician behavior).

VI. CONCLUSION

Salamon is the most recent case to analyze the worker classification of admitting physicians for purposes of Title VII. The Second Circuit's decision in *Salamon* has elevated the fact-specific nature of the common-law agency test as applied in the medical context and redefined how courts assess the physician-hospital relationship. As hospitals continue to face pressure from third-party payers to control costs, it is incumbent on hospitals to define and differentiate the relationships maintained with employed physicians and admitting physicians. To minimize risk of liability, hospitals must ensure that the standards and policies, peer review programs, and corrective action procedures they impose on admitting physicians are aligned with government standards and not aimed at influencing physician behavior or maximizing revenue.

QUALIFIED: MEDICAID PROVIDER AGREEMENTS, WAIVERS, AND THE POLITICS OF PLANNED PARENTHOOD

Morgan Handley*

ABSTRACT

Over the last decade, a growing minority of Americans have come to favor “defunding” Planned Parenthood, which provides family planning care to millions of Americans through Medicaid at over 800 locations. Planned Parenthood also provides abortions with private funds. Following budget fights in 2011 and two rounds of doctored “undercover sting” videos in 2011 and 2015, several states have undertaken to bar entities that provide abortion care, including Planned Parenthood, from contracting as Medicaid providers. In 2012, Texas chose to forego \$35 million annually in federal Medicaid funds in order to advance its agenda to “defund” Planned Parenthood. With the Department of Health and Human Services under new political management, the state now requests that federal funding be restored on the very terms that caused it to be terminated in 2012: the exclusion of abortion providers.

This note examines the permissibility of categorical bars on certain types of family planning providers under existing federal Medicaid law in both traditional Medicaid and discretionary expanded family planning programs, with a case-specific examination of Texas’s efforts to remove Planned Parenthood from its Medicaid operations. This note argues that it is illegal to enforce abortion provider contract bans within traditional Medicaid, and the violation of federal law may not be waived. As a result, Texas’s pending request to expand family planning benefits with the provider ban in place should be denied.

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I. INTRODUCTION

The Social Security Act (SSA), which contains federal Medicaid law, provides that Medicaid beneficiaries may access covered services from any provider who is qualified and willing to offer the necessary care.¹ This mandate is commonly known as the free choice of provider provision.² As the participation of Planned Parenthood affiliated clinics as providers of government-financed health care, such as Medicaid family planning services, became increasingly controversial, several states sought to bar entities providing abortion care and their affiliates from contracting with and receiving funds from the state governments.³ In effect, these states are attempting to bar politically disfavored providers from contracting as Medicaid providers, which reduces patient choice.⁴ The states urge that their contract bans do not violate the free choice provision, but are a proper exercise of state authority to define the term “qualified” for the purposes Medicaid to exclude abortion providers and their affiliates.⁵ However, the Department of Health and Human Services (HHS), which supervises Medicaid at the federal level, has historically viewed these laws as in direct conflict with the free choice provision.⁶ Every court to reach the merits of a challenge to the state law contract bans or terminations of provider contracts for similar reasons under traditional Medicaid has enjoined the removal of providers on the grounds that they run afoul of free choice.⁷

¹ Social Security Act, 42 U.S.C. § 1396a(a)(23) (2012).

² See Letter from Ctrs. For Medicare & Medicaid Servs. Director Vikki Wachino to State Medicaid Directors, Re: Clarifying Free Choice of Provider Requirement in Conjunction with State Authority to Take Action Against Medicaid Providers, State Medicaid Director Letter # 16-005 (Apr. 19, 2016) [hereinafter *Clarifying Free Choice*] <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf>.

³ See Tex. Hum. Res. Code § 32.024(c-1) (2017) (instructing the Commissioner of the Texas Health and Human Services Commission to ensure that no funds from a family planning demonstration project are dispensed to entities that provide abortions or their affiliates); see also Burns Ind. Code Ann. § 5-22-17-5.5 (2011) (prohibiting all state agencies from entering into contracts with or awarding grants to any entity that provides abortions); see also Fla. Stat. § 390.0111(15) (2018) (prohibiting state and local agencies and managed care entities from contracting with or making payments to clinics licensed to perform abortions); see also Ariz. Rev. Stat. § 35-196.05 (2012) (forbidding state agencies from entering into contracts with or awarding grants to abortion providers); see also Alexandra Zavis, *Defund Planned Parenthood Has Gained Momentum: Texas Shows How Extensive the Effects Can Be*, L.A. TIMES (May 30, 2017), <https://www.latimes.com/nation/la-na-texas-planned-parenthood-20170530-story.html>.

⁴ See *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 969 (9th Cir. 2013), *Planned Parenthood of Ind., Inc. v. Comm’r of the Ind. State Dep’t of Health*, 699 F.3d 962, 978 (7th Cir. 2012), Complaint at ¶ 19, *Texas v. Sebelius* (W.D. Tex. 2012) (No. 6:12-cv-62).

⁵ See *Planned Parenthood of Kan. & Mid-Missouri v. Andersen*, 882 F.3d 1205, 1230 (10th Cir. 2018), *cert. denied*, 2018 WL 1456394 (2018); see also *Planned Parenthood of Gulf Coast v. Gee*, 862 F.3d 445, 465 (5th Cir. 2017), *cert. denied*, 139 S. Ct. 408 (2018); *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 969 (9th Cir. 2013); *Planned Parenthood of Ind., Inc. v. Comm’r of the Ind. State Dep’t of Health*, 699 F.3d 962, 980 (7th Cir. 2012).

⁶ See *Clarifying Free Choice*, *supra* note 2.

⁷ See *Andersen*, 882 F.3d at 1230; see also *Gee*, 862 F.3d at 465; *Betlach*, 727 F.3d at 969; *Planned Parenthood Ind.*, 699 F.3d at 980.

In 2012, the Centers for Medicare and Medicaid Services (CMS) ended an expanded discretionary family planning program in Texas after the state insisted on enforcing its contract ban in the event of renewal.⁸ CMS took the position that allowing Texas to enforce the ban would be inconsistent with the requirements of the expanded programs, and subsequently terminated similar programs for the same reasons.⁹ These expanded family planning programs, or “Waivers,” were an exercise of the Secretary’s authority under § 1115 of the SSA to waive certain provisions of the law and create demonstration projects when the Waivers are considered likely to promote the objectives of the Act.¹⁰

After self-funding a replacement program on its own terms, Texas seeks authorization to create a new Waiver under § 1115 that is substantially similar to the terminated Waiver and would enforce the contract ban.¹¹ While federal law on this issue remains unchanged since the termination of Texas’s first Waiver, CMS rescinded guidance interpreting the free choice provision to bar the contract bans in 2018.¹² The letter advised that “qualified” could not be construed to exclude providers on political grounds “unrelated to their fitness to perform covered services or the adequacy of their billing practices.”¹³

This Note argues that states may not use laws purporting to limit contract eligibility to redefine the term “qualified” to suit their political purposes and that such contract bans are a violation of the free choice provision that may not be waived under the Secretary’s § 1115 authority.¹⁴ Part II of this Note explores Texas’s ongoing efforts to remove Planned Parenthood from its Medicaid operations.¹⁵ Part III provides a global review of Medicaid family planning policy, and Part IV explores the parameters of the

⁸ See Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., U.S. Dep’t of Health & Human Servs., to Kay Ghahremani, Comm’r, Tex. Medicaid & CHIP (Nov. 7, 2012).

⁹ See Ctrs. for Medicare & Medicaid Servs., Missouri Section 1115 Demonstration Fact Sheet, Missouri Women’s Health Services (Oct. 6, 2017) (stating that the program was terminated effective March 6, 2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mo/mo-health-services-program-fs.pdf>; see also Ctrs. for Medicare & Medicaid Servs., Medicaid Section 1115 Demonstration Fact Sheet, Iowa Family Planning Network (Jan. 2, 2018) (announcing that the program was terminated effective June 30, 2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-family-planning-network-fs.pdf>.

¹⁰ See 42 U.S.C. § 1315 (2012); see also *State Waivers List*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html> (last visited Nov. 30, 2018) (stating that programs authorized under §§ 1915(b) and 1915(c) are also known as Waivers).

¹¹ Marissa Evans, *Texas Wants to Renew Federal Women’s Health Funding It Lost Over Planned Parenthood*, THE TEXAS TRIBUNE (May 16, 2017), <https://www.texastribune.org/2017/05/16/womens-health-programs-saw-sharp-decline-clients/>.

¹² See Centers for Medicare and Medicaid Services, State Medicaid Director Letter # 18-003, Re: Rescinding SMD #16-005 (Jan. 19, 2018) [hereinafter *Rescinding SMD*] <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18003.pdf>.

¹³ *Id.*

¹⁴ See *infra* Part VI (outlining limits on § 1115 authority and arguing that free choice may not be waived to exclude politically disfavored providers).

¹⁵ See *infra* Part II (explaining Texas’ history of efforts to remove abortion providers from Medicaid family planning programs and state equivalents).

free choice provision in depth.¹⁶ Part V asserts that barring Planned Parenthood from holding Medicaid provider contracts or terminating Planned Parenthood contracts on political grounds is a violation of the free choice provision.¹⁷ Finally, Part VI concludes that the violation described in Part V may not be waived by the Secretary under his § 1115 authority.¹⁸

II. PROVIDER POLITICS: A TEXAN CASE STUDY IN PUTTING IDEOLOGY OVER CARE

From 2007 to 2012, Texas operated a family planning Waiver, which offered Medicaid family planning benefits to those not otherwise eligible for Medicaid pursuant to § 1115(a)(2).¹⁹ Texas offers Medicaid to pregnant women up to 203% of the federal poverty level, which is an annual calculation of the highest income at which the federal government considers a person or family to be living in poverty; however, childless adults without a qualifying disability are not eligible for Medicaid.²⁰ Parents of minor children enrolled in the Children’s Health Insurance Program (CHIP) must have incomes below 18% of the federal poverty level to receive benefits.²¹ The terminated Waiver, entitled the Texas Women’s Health Waiver, offered family planning benefits to individuals up to 185% of the federal poverty line.²² The Waiver program provided family planning benefits, but not the full spectrum of Medicaid benefits.²³ The Expenditure Authority, which authorizes states to claim federal reimbursement under Medicaid for the costs of their Waiver programs, was set to expire on December 31, 2011.²⁴ The Expenditure Authority was briefly extended to allow for renewal negotiations and to facilitate the transition from the federally-funded program under Medicaid to an independent state-

¹⁶ See *infra* Part III (describing the three modalities of Medicaid family planning).

¹⁷ See *infra* Part V (arguing that excluding abortion providers from Medicaid is a violation of the free choice provision)

¹⁸ See *infra* Part VI (concluding that the violation of free choice is not within the discretionary waiver authority of the Secretary)

¹⁹ Ctrs. for Medicare & Medicaid Servs., Expenditure Authority No. 11-W-00232/6, Texas Women’s Health Waiver (2006) [hereinafter *Texas Expenditure Authority*] <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Womens-Health-Waiver/tx-womens-health-waiver-expnditure-auth-12302006-12312011.pdf>.

²⁰ See *Medicaid and CHIP Coverage for Pregnant Women and Medicaid Family Planning Programs*, KAISER FAM. FOUND. (Jan. 12, 2017), <http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017-Table-4>.

²¹ See *id.*

²² See *id.*; see also Ctrs. For Medicare & Medicaid Servs., 1115(a) Research and Demonstration Waiver, Texas Women’s Health Program 1, 3 (2011) [hereinafter *Texas Women’s Health Waiver*] <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Womens-Health-Waiver/tx-womens-health-waiver-research-demo-waiver.pdf>.

²³ See *Texas Women’s Health Waiver*, *supra* note 22, at 3.

²⁴ See *Texas Expenditure Authority*, *supra* note 19.

funded program.²⁵ As a result, federal funding ended on December 31, 2012, and the state began an entirely self-funded replacement.²⁶

Texas initially sought to renew the waiver for an additional year rather than allow the Expenditure Authority to expire.²⁷ However, the extension requests sought to alter the Waiver by requesting that the Secretary also waive the free choice provision to allow the state to ban abortion providers from holding contracts under the Waiver.²⁸ Though Texas requested a waiver of the provision “to the extent necessary,” the state maintained that its proposal did not violate the provision, and therefore waiver was unnecessary.²⁹ Texas sought to implement Human Resources Code § 32.024(c-1), which targeted entities contracting to provide care under family planning Waivers.³⁰ Under the provision, providers were ineligible to participate in the Waiver if their practice included abortion care.³¹ Accordingly, the Secretary of HHS would not authorize the waiver renewal because the free choice provision was not likely to promote the objectives of the Act as required under § 1115.³²

a. The Texas Human Resources Code and Abortion-Providing Entities

When Texas applied for the 2007 Waiver, the state law that authorized Texas Health and Human Services Commission to seek the Waiver dictated that “money spent under the demonstration project, regardless of the funding source, [may] not [be] used to perform or promote elective abortions. The department . . . may not contract with entities that perform or promote elective abortions or are affiliates of entities that perform or promote elective abortions.”³³ The previously proposed language only barred Waiver funds from being used to perform elective abortions, which was consistent with federal

²⁵ See Letter from Cindy Mann, Dir. of the Ctr. for Medicaid & CHIP Servs., to Billy Millwee, Assoc. Comm’r for Medicaid & CHIP, Health & Human Servs. Comm’n (Mar. 15, 2012) [hereinafter *March Letter from Mann to Millwee*]; see also Letter from Cindy Mann, Dir. of the Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicare Servs., to Billy Millwee, Assoc. Comm’r for Medicaid & CHIP, Health & Human Servs. Comm’n (Dec. 12, 2011) [hereinafter *December Letter from Mann to Millwee*] <https://senatorjoserodriguez.com/wp-content/uploads/2012/03/CMS-Letter-to-HHSC-re-WHP.12.12.2011.pdf>.

²⁶ See Letter from Cindy Mann, Dir., Ctr. for Medicaid & CHIP Servs., U.S. Dep’t of Health & Human Servs., to Kay Ghahremani, Comm’r, Tex. Medicaid & CHIP (Nov. 7, 2012) [hereinafter *November Letter from Mann to Millwee*].

²⁷ See Texas Health and Human Services Commission, 1115(a) Research and Demonstration Waiver: Texas Women’s Health Program (2011) (requesting renewal of the expenditure authority through December 31, 2013), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Womens-Health-Waiver/tx-womens-health-waiver-research-demo-waiver.pdf>.

²⁸ *Id.*

²⁹ *Id.*

³⁰ Tex. Hum. Res. Code § 32.024(c-1) (2017).

³¹ *Id.*

³² See *supra*, *December Letter from Mann to Millwee*.

³³ See S. 747, 79th Leg., R.S. (Tex. 2005), <https://capitol.texas.gov/tlodocs/79R/billtext/pdf/SB00747F.pdf#navpanes=0>.

Medicaid policy restricting the use of federal funds to pay for abortions.³⁴ This policy takes form in an annual appropriations rider, known as the Hyde Amendment, which is an amendment to the appropriations bill that restricts the use of the appropriated funds.³⁵ The legislation now exists in renewed form as § 32.024(c-1) of the Human Resources Code.³⁶

While the contract ban was part of Texas law and the Waiver applications at both initial authorization and renewal application, Planned Parenthood clinics not performing abortions participated in the Waiver despite being legally affiliated with Planned Parenthood Federation of America.³⁷ Planned Parenthood clinics participated in the Waiver with the understanding that clinics remained eligible as long as the participating clinic did not recommend elective abortion to Waiver patients and maintained a separate legal identity from the Planned Parenthood clinics that provide or recommend abortion.³⁸ By 2011, when the Waiver was due to expire, Planned Parenthood clinics were providing nearly half of the care covered by the Waiver.³⁹ During that time, Planned Parenthood was amidst the first of two “undercover” video campaigns and budget fights on Capitol Hill, which drew a critical eye to the organization’s participation in public health care programs.⁴⁰

b. Texas v. Sebelius

When negotiations to renew the Waiver with the contract ban resulted in the termination of the Waiver by CMS, Texas filed suit.⁴¹ Texas claimed that the 2007 waiver had identical restrictions on participation of abortion providers despite Planned Parenthood affiliates holding contracts to provide care under the Waiver.⁴² The 2007 application included a statement that abortion providers and affiliates would not be permitted to obtain provider contracts.⁴³ Contrary to the state’s position, the Waiver Expenditure

³⁴ *Id.*

³⁵ See Neal Devins, *Appropriation Riders*, WM. & MARY 66-67 (1994), <https://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=2679&context=facpubs>; see also *The Hyde Amendment and Coverage for Abortion Services*, KAISER FAM. FOUND. (Oct. 16, 2017), <https://www.kff.org/womens-health-policy/perspective/the-hyde-amendment-and-coverage-for-abortion-services/>.

³⁶ See Tex. Hum. Res. Code § 32.024(c-1) (2017).

³⁷ See *Planned Parenthood Ass’n of Hidalgo County Tex., Inc. v. Suehs*, 692 F.3d 343, 347 (5th Cir. 2012) (explaining that Planned Parenthood Federation of America operates clinics that provide abortion services and engage in abortion rights advocacy).

³⁸ See *id.*

³⁹ See generally *Texas v. Sebelius* (W.D. Tex. 2012) (Case No. 6:12-cv-62); see also Peter Shin et al., *An Early Assessment of the Potential Impact of Texas’s “Affiliation” Regulation on Access to Care for Low-income Women*, RCHN COMMUNITY HEALTH FOUNDATION RESEARCH COLLABORATIVE (May 4, 2012), <https://publichealth.gwu.edu/departments/healthpolicy/publications/TexasWHP.pdf>.

⁴⁰ See Erik Eckholm, *Planned Parenthood Financing is Caught in Budget Feud*, N.Y. TIMES (Feb. 2, 2011), <https://www.nytimes.com/2011/02/18/us/politics/18parenthood.html>.

⁴¹ See *Complaint at 1, Texas v. Sebelius* (W.D. Tex. 2012) (No. 6:12-cv-62).

⁴² See *id.* at ¶ 11; see also Shin, *supra* note 39.

⁴³ See Ctrs. for Medicare & Medicaid Servs., *Texas Women’s Health Section 1115 Demonstration Waiver Application* (Dec. 28, 2005) (explaining that Texas’s 2005 Waiver application references

Authority was not the blanket grant Texas requested, but instead an itemized list of waived requirements that did not include the free choice provision.⁴⁴

Texas's complaint asserted the state did not need CMS to waive compliance with the free choice provision because federal law only required that a state guarantee choice among qualified providers, and the effect of the Texas provision was that abortion providers were not qualified to provide care financed by Medicaid.⁴⁵ The state also argued that barring abortion providers from providing Medicaid services only furthered federal Medicaid policy objectives. Since Congress had long forbidden the use of federal funds to pay for abortions except in narrow circumstances, the provision only promoted the objectives of the act.⁴⁶ The state claimed that neither Texas nor the federal government should indirectly subsidize abortion providers with Medicaid funds.⁴⁷ Finally, the state argued that the Secretary's refusal to waive the free choice provision and subsequent termination of the Waiver was an unlawful attempt to coerce Texas into repealing or not enforcing Human Resources Code § 32.024(c-1), therefore violating the Tenth Amendment.⁴⁸ Following a denial of Texas's request for preliminary injunction, the suit was dismissed without prejudice.⁴⁹ When federal funding ended in December 2012, Texas began implementing a fully state funded program.

c. Texas's Self-Funded "Fix"

Following the expiration of Texas's waiver, the state began to self-fund an equivalent family planning program on its own terms.⁵⁰ Since federal funding ended in December

the contract ban, in the "Eligible Providers" section, but does not request the waiver of any specific provisions in order to effectuate the ban).

⁴⁴ See *Texas Expenditure Authority*, *supra* note 19, at 11 (explaining that the expenditure authority denotes subsections of § 1902 as opposed to § 1396a, and that § 1902 is the section number within the Social Security Act that correlates to the same provisions as codified at 42 U.S.C. § 1396a).

⁴⁵ See Complaint at 6, *Texas v. Sebelius* (W.D. Tex. 2012) (No. 6:12-cv-62).

⁴⁶ See *id.*

⁴⁷ See *id.* at ¶ 31; see also Alina Salganicoff et al., *The Hyde Amendment and Coverage for Abortion Services*, KAISER FAM. FOUND. (Oct. 16, 2017) (explaining that states may use their own funds to provide abortion coverage through Medicaid without federal fund matching; nineteen states currently do so), <https://www.kff.org/womens-health-policy/perspective/the-hyde-amendment-and-coverage-for-abortion-services>.

⁴⁸ See P. Mot. Sum. J. at 27, *Texas v. Sebelius* (W.D. Tex. 2012) (Case No. 6:12-cv-62). *But see* *Beno v. Shalala*, 30 F.3d 1057, 1068 (9th Cir. 1994) (stating that the "legislative scheme, with its mandatory language and detailed requirements, evidences a clear Congressional intent to take certain decisions away from state officials . . . federalism arguments have less weight in the context of a waiver of a congressional requirement. We are not examining the Secretary's authority to interfere with state official's discretion, but rather her authority to waive compliance with federal statutes.") (citing *Rosado v. Wyman*, 397 U.S. 397, 417 (1970)).

⁴⁹ See Order of Dismissal, *Texas v. Sebelius* (W.D. Tex. 2013) (Case No. 6:12-cv-62); see also Jordan Smith, *State Cannot Ban Planned Parenthood and Keep Federal Funds for Women's Health Program*, THE AUSTIN CHRONICLE, (Dec. 22, 2012), <https://www.austinchronicle.com/daily/news/2012-12-22/state-cannot-ban-planned-parenthood-and-keep-federal-funds-for-whp/>.

⁵⁰ See Stacey Pogue, *Excluding Planned Parenthood Has Been Terrible for Texas Women*, Center for Public Policy Priorities 1, 2 (2017), https://forabettertexas.org/images/HW_2017_08_PlannedParenthoodExclusion.pdf.

2012, the program has been funded by a variety of sources under several different names.⁵¹ There have been two major obstacles in addition to the exclusion of abortion providers: first, the state severely underfunded the program in its first years; second, it implemented a tiered provider system that strongly disfavored provider practices that were dedicated to reproductive health care.⁵² Since federal funding was terminated, enrollment across equivalent programs in Texas has reduced by 29% with a 39% reduction in access to care and a 41% decrease in access to contraception as compared to the end of the federally funded program.⁵³

The self-funded programs reduced utilization of highly effective long-acting reversible contraceptives (LARCs) and injectable contraceptives, which resulted in higher rates of unintended pregnancy among beneficiaries.⁵⁴ Researchers found the decrease in LARC utilization was not correlated with the longer effective-life of these contraceptives, which indicates that decreased usage correlates with decreased availability.⁵⁵ Unintended pregnancy rates increased in the areas that lost coverage through Planned Parenthood affiliates, but continued to decline in the areas that never had a Planned Parenthood affiliate.⁵⁶ This disruption indicates that the removal of Planned Parenthood was a cause of decreased access to and continuity of services, especially in communities without family planning providers.⁵⁷ Texas published inaccurate information and data about providers in the state funded program.⁵⁸ Texas claimed to have had 4,012 unique

⁵¹ See MaryBeth Musumeci et al., *Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers*, KAISER FAM. FOUND. (Sept. 20, 2018), <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-a-look-at-the-current-landscape-of-approved-and-pending-waivers/>.

⁵² See Kinsey Hasstedt & Adam Sonfield, *At It Again: Texas Continues to Undercut Access to Reproductive Health Care*, GUTTMACHER INST. 1 (July 18, 2017), <https://www.guttmacher.org/article/2017/07/at-it-again-texas-continues-undercut-access-reproductive-health-care>.

⁵³ See Stacey Pogue, *Excluding Planned Parenthood has been Terrible for Texas Women*, Center for Public Policy Priorities (2017), https://forabettertexas.org/images/HW_2017_08_PlannedParenthoodExclusion.pdf.

⁵⁴ See Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 AM. J. PUB. HEALTH 851, 851 (2015) (explaining that before federal funding ended in 2011, 71% of participating providers offered LARCs, and in 2013 only 46% of participating providers offered LARCs, since decreased funding made the high up-front costs of LARCs prohibitive); see also Amanda J. Stevenson et al., *Effect of Removal of Planned Parenthood from the Texas Women's Health Program*, 374 N. ENGL. J. MED. 853, 853 (2016) (showing a relative reduction of 35.5% in long-acting reversible contraceptives and 31.3% for injectable contraceptives).

⁵⁵ See White et al., *supra* note 54, at 854 (discussing that decreased availability seems to be affected by both provider exclusion and tiering and the high up-front costs of LARCs, exacerbated by the fact that disfavored providers lost eligibility for rebated pharmaceutical prices. Excluded and lower-tier providers are also more likely to have experience in administering LARCs, and therefore the exclusions and tiering not only decreased availability of the pharmaceuticals themselves, but of participating providers who can administer them).

⁵⁶ See Stevenson et al., *supra* note 54, at 858

⁵⁷ See Stevenson et al., *supra* note 54, at 853-860.

⁵⁸ See NARAL Pro-Choice Texas, 2015 TEXAS WOMEN'S HEALTH PROGRAM REPORT (2015), <https://www.scribd.com/document/260127216/2015-NARAL-TX-TWHP-Study>.

providers enrolled in the self-funded program at the end of Fiscal Year 2014.⁵⁹ However, a spot-check investigation by NARAL Pro-Choice Texas of 681 listings revealed only 236 unique “providers,” and only 17% of those listings were practices that provided routine genealogical preventative services.⁶⁰

In October 2018, the Texas Health and Human Services Commission terminated the contracts of an organization called the Heidi Group, which repeatedly received among the largest contracts in the program while repeatedly failing to meet service goals.⁶¹ The Heidi Group estimated that it could serve 50,000 beneficiaries of the state-funded program in fiscal year 2017, but ended up serving less than 2,500.⁶² Even though the group also failed to meet service goals in 2018, its contracts were renewed for fiscal year 2019 before being terminated.⁶³

d. Healthy Texas Women

In June 2017, Texas filed a new request for a § 1115 Waiver with CMS entitled “Healthy Texas Women.”⁶⁴ The new Waiver request is substantively the same as the terminated waiver, and references the provider ban, which is now permanent state law.⁶⁵ The proposed Waiver would increase the income cutoff from 185% of the federal poverty line to 200%.⁶⁶ Minors were not eligible to receive benefits under the terminated Waiver, but the new Waiver would allow minors fifteen and older to receive benefits if a parent applies on her behalf.⁶⁷ The new Waiver would cover the same benefits as the terminated Waiver.⁶⁸ If the Waiver is granted, beneficiaries will automatically transfer into the Waiver population.⁶⁹ Texas proposed that the Waiver become effective September 1, 2018, for a five year period ending August 31, 2023.⁷⁰ Though this start date has passed,

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ See Marissa Evans, *State Cancels Health Contracts With Anti-Abortion Heidi Group*, THE TEXAS TRIBUNE (Oct. 12, 2018), <https://www.texastribune.org/2018/10/12/texas-cancels-health-contracts-anti-abortion-heidi-group/>; see also Sophie Novack, *Texas Anti-Abortion Family Planning Group Promised to Serve 70,000 Women: It Served 3,300*, THE TEXAS OBSERVER (Sep. 26, 2018), <https://www.texasobserver.org/texas-anti-abortion-family-planning-group-promised-to-serve-70000-women-it-served-3300>.

⁶² See Novack, *supra* note 61.

⁶³ See *id.*

⁶⁴ *Healthy Texas Women Section 1115 Demonstration Waiver Application*, Texas Health and Human Services Commission (June 30, 2017) [hereinafter *Texas Waiver Application 2017*].

⁶⁵ Compare *Texas Waiver Application 2017*, *supra* note 64, with *Texas Women’s Health Waiver § 1115 Research and Demonstration Waiver*, Texas Health and Human Services Commission (Dec. 28, 2005) [hereinafter *Texas Demonstration Waiver 2005*].

⁶⁶ See *Texas Waiver Application 2017*, *supra* note 64, at 10.

⁶⁷ *Id.*

⁶⁸ Compare *Texas Waiver Application 2017*, *supra* note 64, with *Texas Demonstration Waiver 2005*, *supra* note 65.

⁶⁹ See *Texas Waiver Application 2017*, *supra* note 64.

⁷⁰ *Id.*

CMS has not denied the Waiver and it could potentially be approved with a later start date agreed upon by Texas and CMS.⁷¹

III. A BRIEF OVERVIEW OF MEDICAID FAMILY PLANNING POLICY

States offer Medicaid family planning benefits in three modalities to serve several population groups. Full Medicaid beneficiaries receive family planning benefits as part of their mandatory benefits package.⁷² States may also expand the eligibility for family planning benefits in one of two ways: through either a § 1115 Waiver program or a State Plan Amendment (SPA).⁷³

a. Mandatory Benefits

Shortly after the Supreme Court held that all adults had a right to privacy in their use of contraceptives in *Eisenstadt v. Baird*, the SSA was amended in 1972 to make family planning services a standard Medicaid benefit.⁷⁴ The federal government pays 90% of the costs of family planning benefits instead of the regular Federal Medical Assistance Percentage (FMAP) rate for the jurisdiction, which distributes Medicaid costs between the state and federal governments according to a formula that compares per capita income in the state to nationwide per capita income.⁷⁵ FMAP rates currently vary from 50%, the minimum set by federal law, to 76%.⁷⁶ For the beneficiaries who receive full Medicaid, family planning benefits are just one of the many categories of coverage they have access to as members of a traditional coverage population. Benefit design, which describes what services are covered and eligibility by age and gender, varies from state to state.⁷⁷

⁷¹ See *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Jan. 9, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state>.

⁷² 42 U.S.C. § 1396d(a)(4)(C) (2012).

⁷³ See Patient Protection and Affordable Care Act, 124 Stat. 119, § 2303 (2010); see also *Usha Ranji et al., Medicaid and Family Planning: Background and Implications of the ACA*, KAISER FAM. FOUND. (Feb. 3, 2016), <https://www.kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy>.

⁷⁴ See Social Security Act, Pub. Law No. 92-603, § 299E, 86 Stat. 1329, 1462-63 (1972), codified at 42 U.S.C. § 1396d(a)(4)(C) (2012); see also *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (holding that the privacy interest in the use of contraceptives protected by the Court's decision in *Griswold v. Connecticut*, 381 U.S. 479 (1965), could not be limited to married couples under the Equal Protection Clause of the Fourteenth Amendment).

⁷⁵ See 42 U.S.C. § 1396b(a)(5) (2012) (showing the federal government pays 90% of costs of care and 50% of administrative costs); see also Federal Financial Participation in State Assistance Expenditures, 80 Fed. Reg. 73779 (proposed Nov. 25, 2015).

⁷⁶ See *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, KAISER FAM. FOUND. (2018), <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁷⁷ See *Minors' Access to Contraceptive Services*, GUTTMACHER INST. 1 (2018), <https://www.guttmacher.org/state-policy/explore/minors-access-contraceptive-services>; see also *Payment and Coverage for the Prevention of Sexually Transmitted Infections (STIs)*, KAISER FAM. FOUND.

b. Section 1115 Waivers

For over twenty years, CMS has allowed states to extend family planning benefits to individuals who do not qualify for Medicaid, but whose incomes would make them categorically eligible if they were pregnant.⁷⁸ To create these programs, the Secretary authorizes discretionary waivers of Medicaid requirements under § 1115 of the SSA. Waived provisions typically include the amount, duration, the scope of services requirement,⁷⁹ the EPSDT requirement,⁸⁰ the retroactive coverage provision,⁸¹ and the prospective payment provisions.⁸² Expenditure Authorities for Waiver programs dictate that for a specified period, expenditures under the Waiver will be regarded as regular expenditures under the state's Medicaid plan and unwaived provisions of the SSA still apply.⁸³

Section 1115 allows the Secretary to waive compliance with various requirements of the Social Security Act, including federal Medicaid law, for the purposes of “experimental, pilot, or demonstration project[s]” when the Secretary believes authorizing a waiver “is likely to assist in promoting the objectives” of the Act.⁸⁴ Section 1115 has also been used to promote a variety of Medicaid objectives including delivery system reform and authorizing modified Medicaid expansions under the Affordable Care Act (ACA). Additionally, Waivers authorize coverage for services not authorized by the SSA, such as behavioral health and long-term care.⁸⁵

CMS's longstanding policy is that Waiver programs are budget neutral, meaning they do not increase federal expenditures when compared to the state's Medicaid program

1 (2017), <https://www.kff.org/womens-health-policy/fact-sheet/payment-and-coverage-for-the-prevention-of-sexually-transmitted-infections-stis/>.

⁷⁸ See Usha Ranji et al., *Medicaid and Family Planning: Background and Implications of the ACA*, KAISER FAM. FOUND. (Feb. 3, 2016), <https://www.kff.org/report-section/medicaid-and-family-planning-medicaid-family-planning-policy>.

⁷⁹ 42 U.S.C. § 1396a(a)(10)(B) (2012) (providing that all Medicaid beneficiaries shall be eligible for the same amount, duration, and scope of services).

⁸⁰ 42 U.S.C. § 1396a(a)(43)(A) (stating that early and periodic screening, diagnostic, and treatment benefits are targeted at Medicaid beneficiaries under the age of twenty-one to screen for and treat physical, mental, developmental, dental, hearing, and vision problems and delays).

⁸¹ 42 U.S.C. § 1396a(a)(34) (stating that retroactive coverage allows for coverage of services rendered up to three months before the beneficiary submits an application for Medicaid and is generally intended to ensure that providers administer medically necessary care when a Medicaid-eligible patient presents for it, even if the patient does not currently have Medicaid).

⁸² 42 U.S.C. § 1396a(a)(15) (requiring that the Prospective Payment system establishes reimbursement levels and systems that apply to traditional Medicaid, which are waived to allow the states to compensate family planning providers solely for those services).

⁸³ See *Texas Expenditure Authority*, *supra* note 19.

⁸⁴ 42 U.S.C. § 1315(a).

⁸⁵ See MaryBeth Musumeci et al., *Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers*, KAISER FAM. FOUND. (Sept. 20, 2018), <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-a-look-at-the-current-landscape-of-approved-and-pending-waivers/>.

without the Waiver.⁸⁶ Family planning waivers are approved and funded on the principle that providing contraceptive coverage to women who would be eligible for Medicaid pregnancy coverage reduces Medicaid-covered pregnancies and births, which are more costly than family planning programs.⁸⁷

c. State Plan Amendments

The ACA allowed states to amend their state Medicaid plans to permanently incorporate expanded family planning programs.⁸⁸ Instead of using the Waiver authority, which requires evaluation as demonstrations and periodic renewal, states can create a permanent eligibility category for the population served through the Waivers.⁸⁹ Fifteen states have obtained SPAs, ten states continue to operate expanded family planning benefits as § 1115 demonstrations, and the remaining twenty-five states do not have expanded family planning benefits.⁹⁰ Only beneficiaries fully enrolled in Medicaid have access to Medicaid family planning coverage.⁹¹

IV. FREEDOM OF CHOICE: THE PROVISION PROTECTING ABORTION PROVIDERS AND THEIR MEDICAID PATIENTS

The SSA requires states to allow Medicaid beneficiaries to access covered benefits from any qualified provider willing to administer care.⁹² Both the SSA and federal regulations pertaining to the provision show an intent to protect free choice in the family planning context, specifically beyond free choice for other medical care.⁹³ The free choice provision exempts family planning from managed care and beneficiaries must be allowed to obtain their family planning benefits from outside the network at no extra cost.⁹⁴ While free choice can be waived to implement a managed care system, family planning benefits continue to operate outside of the managed care framework.⁹⁵

Enforceability of individual Medicaid provisions by recipients is uncertain following the Supreme Court's 2002 ruling in *Gonzaga Univ. v. Doe*, which narrowed the

⁸⁶ See Ctrs. for Medicare & Medicaid Servs., Budget Neutrality Form, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/interim1115-budget-neutrality-form.pdf>.

⁸⁷ See Texas Women's Health Program Application (Dec. 28, 2005).

⁸⁸ Patient Protection and Affordable Care Act, 124 Stat. 119, § 2303 (2010).

⁸⁹ Compare *Texas Expenditure Authority*, *supra* note 19, with California Medicaid State Plan, State Plan Amendment 10-014 (approved Mar. 24, 2011) (making permanent change to state's Medicaid Plan allowing certain beneficiaries to access family planning benefits only).

⁹⁰ See Usha Ranji et al., *State Medicaid Coverage for Family Planning Services: A Summary of State Survey Findings*, KAISER FAM. FOUND. (2009) (stating that in the year preceding the passage of the Affordable Care Act, 24 states were operating family planning waivers), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8015.pdf>.

⁹¹ See *id.*

⁹² 42 U.S.C. § 1396a(a)(23)(A) (2012).

⁹³ 42 U.S.C. § 1396a(a)(23)(B); 42 C.F.R. § 431.51 (2012).

⁹⁴ 42 U.S.C. § 1396n(b)(4) (2012).

⁹⁵ See 42 U.S.C. § 1396n (2012) (providing the legal authority for the establishment of MCOs, followed by subsection (b)(4), which exempts family planning benefits from the waiver of free choice inherent in MCO arrangements).

circumstances under which a federal statute confers a private right of action under 42 U.S.C. § 1983.⁹⁶ In narrowing these circumstances, the Court declined to overturn previous precedent in *Wilder v. Virginia Hospital Association*, which vested a §1983 action in Medicaid beneficiaries to enforce rate-setting provisions, and left untouched the precedent in *O’Bannon v. Town Court Nursing Center*, which held the free choice provision enforceable.⁹⁷

In 2017, following *Gonzaga*, the Eighth Circuit held in *Does v. Gillespie* that the free choice provision does not vest a § 1983 cause of action in Medicaid beneficiaries.⁹⁸ This holding allowed Arkansas to terminate Planned Parenthood of Arkansas and Eastern Oklahoma’s Medicaid contracts without deciding whether the action violated the free choice provision. The court read the *O’Bannon* holding as a denial of any right vested in the free choice provision, but ultimately decided that the right had not been violated.⁹⁹ Additionally, the holding in *Doe v. Gillespie* departed from four other circuit courts and created the first significant circuit split since *Gonzaga* on the enforceability of a provision of Medicaid via a § 1983 action.¹⁰⁰

V. ELIMINATING ABORTION-PROVIDING FAMILY PLANNING PROVIDERS VIOLATES THE SOCIAL SECURITY ACT

Drawing on jurisprudence from the four circuit courts to substantively consider the state’s power to define “qualified,” Texas’s state law contract ban violates the free choice provision and is therefore unenforceable in traditional Medicaid. States may not use the term “qualified” to make abortion providers categorically ineligible to participate in Medicaid. Although Texas claims it has an absolute power to do so without Waiver, its efforts to remove Planned Parenthood from traditional Medicaid counsel show otherwise.

a. Defining “Qualified”

In *Texas v. Sebelius*, Texas asserted the free choice provision did not conflict with the state’s contract ban because the free choice provision protects beneficiaries’ access to qualified providers and the contract ban merely dictated which providers are qualified, and were therefore eligible to enter into provider contracts.¹⁰¹ Texas renewed these arguments in a pending application to obtain a new Waiver under substantially the same

⁹⁶ See *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002).

⁹⁷ See *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 524 (1990); see also *O’Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785 (1980).

⁹⁸ See *Does v. Gillespie*, 867 F.3d 1034, 1046 (8th Cir. 2017).

⁹⁹ See *O’Bannon*, 447 U.S. at 785 (finding that the plaintiffs’ rights in the free choice provision did not entitle them to remain in a nursing home that had been completely decertified by the state but did not hold that the plaintiffs were foreclosed from judicial enforcement of the provision at all).

¹⁰⁰ See Jane Perkins, *Update on Private Enforcement of the Medicaid Act: The Supremacy Clause and 42 U.S.C. §1983*, NAT’L HEALTH L. PROGRAM (Oct. 13, 2014), https://9kqpw4dcaw91s37kozim5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2014/10/2014_10_14_NHeLP_Issue_Brief.pdf.

¹⁰¹ See Complaint at ¶ 19, *Texas v. Sebelius* (W.D. Tex. 2012) (Case No. 6:12-cv-62).

conditions as the proposal that resulted in termination in 2012, anticipated by the change in administration.¹⁰²

Appellate courts have repeatedly dismissed this argument, including in the Fifth Circuit.¹⁰³ In *Rosado v. Wyman*, the Supreme Court explicitly disapproved of states redefining terms that appear in the SSA by state legislative fiat to avoid an unsatisfactory application of federal law.¹⁰⁴ States have the power to set provider qualifications, and federal regulations allow states to set “reasonable standards” for providers.¹⁰⁵ However, this authority may not be used to transform the term “qualified” into “a Medicaid-specific term of art conferring upon the states plenary authority to withhold Medicaid funds on any policy grounds they prefer to pursue.”¹⁰⁶ “Qualified” must be given its plain meaning. The states’ power to set qualifications in the Medicaid context is tied to the traditional power to police the practice of medicine within their borders.¹⁰⁷ Furthermore, the term is modified by the language immediately following: “to perform the service or services required.”¹⁰⁸ The Seventh Circuit found that the term “qualified” in this context unambiguously relates to the professional and clinical competence of providers.¹⁰⁹

Both the Seventh and Ninth Circuits considered and found invalid contract bans mirroring Texas’s.¹¹⁰ In *Betlach*, Arizona claimed that the free choice provision enabled states to exclude providers “for any reason supplied by state law,” thus allowing the legislature to pass a state law excluding any provider for any reason.¹¹¹ Texas’s defense of its contract ban in *Texas v. Sebelius* likewise makes this argument.¹¹² The *Betlach*

¹⁰² See *Healthy Texas Women Section 1115 Demonstration Waiver Application*, TEX. HEALTH AND HUMAN SERVS. COMM’N (Jun. 30, 2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-healthy-women-pa.pdf>.

¹⁰³ See *Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445 (5th Cir. 2017) (per curiam).

¹⁰⁴ See *Rosado v. Wyman*, 397 U.S. 397, 457 (1970) (holding that New York “may not redefine its standard of need in such a way that it skirts the requirement of re-evaluating its existing standard;” it was impermissible to define standard of need to avoid the responsibility to adjust it to changing costs of living).

¹⁰⁵ 42 C.F.R. § 431.51(c)(2); see also *Planned Parenthood of Kan. & Mid-Missouri v. Andersen*, 882 F.3d 1205, 1230 (10th Cir. 2018).

¹⁰⁶ See *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 969-70 (9th Cir. 2013).

¹⁰⁷ See *Andersen*, 882 F.3d at 1230; see also *Gee*, 862 F.3d at 465; *Betlach*, 727 F.3d at 969; see also *Planned Parenthood of Ind., Inc. v. Comm’r of the Ind. State Dep’t of Health*, 699 F.3d 962, 980 (7th Cir. 2012).

¹⁰⁸ See 42 U.S.C. § 1396a(a)(23); see also *Indiana*, 699 F.3d at 978 (holding that the use of the term “reasonable” limits state power to define qualified to “permissible variations in the ordinary concept” of the term); see also *Betlach*, 727 F.3d at 969 (finding that “to perform the service or services required” modified “qualified”).

¹⁰⁹ *Indiana*, 699 F.3d at 978.

¹¹⁰ See *Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 969-70 (9th Cir. 2013); see also *Planned Parenthood Ind., Inc. v. Comm’r Ind. State Dep’t Health*, 699 F.3d 962, 980 (7th Cir. 2012).

¹¹¹ *Betlach*, 727 F.3d at 969.

¹¹² See P. Mot. Preliminary Inj. at 14-18, *Texas v. Sebelius* (W.D. Tex. 2012) (No. 6:12-cv-62-WSS) (citing *First Med. Health Plan, Inc. v. Vega-Ramos*, 479 F.3d 46, 53 (1st Cir. 2007) (allowing Puerto Rico to exclude from Medicare an insurer eligible to participate under federal law because their

Court found that in addition to defying the ordinary meaning of the term, to hold that Arizona could exclude providers for any reason at all would abrogate the duty to give meaning to every word of a statute and allow for the production of absurd results.¹¹³ Such a decision would permit states to undermine Medicaid beneficiaries' statutory rights by moving the term away from its meaning grounded in quality and competency of care and towards a mere dictate of contract eligibility.

In *Indiana*, the state narrowed the claimed state power slightly, arguing that the state could exclude providers for any reason that furthers a legitimate state interest, and that preventing the "indirect subsidization of abortion" is a legitimate state interest, but the Seventh Circuit ultimately found this argument unpersuasive.¹¹⁴ While the state suggested that a state law could not define qualified merely in order to target choice of providers, an interpretation of the statute that permits diminishing free choice for reasons unrelated to ability to provide care "inverts what the statute says."¹¹⁵ The court interpreted the state's action as an attempt to fashion a loophole in the law by labeling exclusionary rules "qualifications."¹¹⁶ The free choice provision does not protect beneficiaries' ability to choose between providers that the state finds politically unobjectionable, rather it protects the ability of beneficiaries to choose from all providers capable of and willing to provide care.¹¹⁷ The Fifth Circuit, Seventh Circuit, Ninth Circuit, and the Tenth Circuit have held the state's power to qualify providers cannot be used to exclude clinics performing abortion when the practitioners are licensed to administer the covered care.¹¹⁸

b. Texas's Blocked Enforcement Action Against Texas Planned Parenthood Affiliates

The Human Resources Code only imposes the provider restrictions on providers under the Waiver, but does not interfere with the ability of those entities to enter into provider contracts to provide care to beneficiaries in traditional Medicaid.¹¹⁹ Texas initiated enforcement actions against Planned Parenthood of Greater Texas (PPGT) to invalidate contracts held under traditional Medicaid, but the Health and Human Services Commission was enjoined by the District Court for the Western District of Texas from

participation would violate a Puerto Rico anti-kickback law since the free choice provision does not apply in Puerto Rico).

¹¹³ See *Betlach*, 727 F.3d at 970 (quoting *United States v. Menasche*, 348 U.S. 528 (1955)).

¹¹⁴ See *Planned Parenthood of Ind. v. Comm'r Ind. State Dep't Health*, 699 F.3d 962, 978 (7th Cir. 2012).

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ See *id.* at 980.

¹¹⁸ See *Planned Parenthood of Kan. & Mid-Missouri v. Andersen*, 882 F.3d 1205, 1229, 1246 (10th Cir. 2018); see also *Planned Parenthood Golf Coast, Inc., v. Gee*, 862 F.3d 445, 465 (5th Cir. 2017); see also *Planned Parenthood of Ariz., Inc. v. Betlach*, 727 F.3d 960, 974 (9th Cir. 2013); see also *Planned Parenthood of Ind. v. Comm'r Ind. State Dep't Health*, 699 F.3d 962, 980 (7th Cir. 2012).

¹¹⁹ TEX. HUMAN RES. CODE § 32.024(c-1).

terminating the provider agreements held by PPGT affiliate clinics.¹²⁰ Although Texas claims that it does not violate the free choice provision to bar abortion providers and their affiliates from Medicaid, it has not attempted to pass a law paralleling Human Resources Code § 32.024(c-1).¹²¹

In *Betlach*, the Ninth Circuit emphasized the difference between excluding an individual provider on account of improper or illegal conduct and banning an entire class of providers “on the ground that their scope of practice includes certain perfectly legal medical procedures.”¹²² The Fifth Circuit applied this principle in *Gee*, and while Louisiana argued Planned Parenthood was unqualified to provide care covered by Medicaid, the state conceded that the terminated clinics were clinically competent.¹²³

The Inspector General of the Commission for Texas initially sent a letter to PPGT in October 2015 informing PPGT that their provider agreements were being terminated for alleged crimes and program violations.¹²⁴ No action was taken until over a year later, when the state sent out another termination notice in December 2016.¹²⁵ The termination letter alleged that an investigation revealed Planned Parenthood received illegal payments for fetal tissue and altered procedures for the purpose of obtaining tissue to sell, which was a practice that violated generally accepted medical standards.¹²⁶ The district court, however, found that the Inspector General had no factual basis for terminating the provider agreements.¹²⁷ As a result, the court concluded that PPGT could not lawfully be excluded from Medicaid, because the Inspector General had not proven that PPGT clinics were unqualified to provide the covered services.¹²⁸

Although Texas alleges that § 32.024(c-1) is compatible with the free choice provision, and that federal law does not bar the state from removing Planned Parenthood from Medicaid, the law Texas has passed to that effect applies only to programs requiring additional federal approval.¹²⁹ Instead of passing a state law that would de facto disqualify Planned Parenthood across all Medicaid programing, the state brought an enforcement action against one of the Planned Parenthood entities that provides care to

¹²⁰ *Planned Parenthood Greater Tex. Family Planning & Preventative Health Servs. v. Smith*, 236 F. Supp. 3d 974, 1000 (W.D. Tex. 2017).

¹²¹ *See Texas Women’s Health Waiver Renewal Application*, TEX. HEALTH AND HUMAN SERVS. COMM’N (2011); *see also Healthy Texas Women Section 1115 Demonstration Waiver Application*, TEX. HEALTH AND HUMAN SERVS. COMM’N (Jun. 30, 2017) (stating that Texas maintained that their contract ban does not run afoul of the free choice provision and therefore does not require the waiver).

¹²² *See Planned Parenthood Ariz., Inc. v. Betlach*, 727 F.3d 960, 973 (9th Cir. 2013).

¹²³ *See Planned Parenthood of Gulf Coast, Inc. v. Gee*, 862 F.3d 445, 460, 466 (5th Cir. 2017).

¹²⁴ *See Smith*, 236 F. Supp. 3d at 984-86.

¹²⁵ *See id.*

¹²⁶ *Id.*

¹²⁷ *Id.* at 990.

¹²⁸ *See Planned Parenthood Greater Tex. Family Planning & Preventative Health Servs. v. Smith*, 236 F. Supp. 3d 974, 990 (W.D. Tex. 2017).

¹²⁹ *See* TEX. HUMAN RES. CODE § 32.024(c-1).

traditional Medicaid beneficiaries.¹³⁰ The state did not claim the power to debar Planned Parenthood on the mere basis of policy, but rather attempted to make a case out of affirmative wrongdoing by the clinic.¹³¹

VI. FREE CHOICE MAY NOT BE WAIVED FOR THE PURPOSE OF EXCLUDING ABORTION PROVIDERS

a. Restrictions on Section 1115 Authority

Texas's proposed action, if permitted by HHS, would be reviewed under the APA, because it would be an action by a federal administrative agency.¹³² Administrative decisions by departments of the federal government are subject to judicial review under the APA, except where review has been proscribed by statute or the action is "committed to agency discretion."¹³³ The APA provides that a court shall set aside any agency action that is "arbitrary and capricious, an abuse of discretion . . . or not in accordance with law."¹³⁴ While administrative decisions are entitled to a "presumption of regularity," a court considering an APA challenge must engage in a "substantial inquiry" that goes beyond whether the administrative action was within the scope of statutory authority.¹³⁵ A substantial inquiry includes determining whether the decision gave due consideration to the relevant factors and screening for clear errors in judgement.¹³⁶ As a result, a decision would be held to violate the APA if the agency:

relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs contrary to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.¹³⁷

The Supreme Court has never considered an APA challenge to the grant of a § 1115 Waiver, but several Circuit Court of Appeals and U.S. District Courts have interpreted the Court's APA jurisprudence in reviewing the Secretary's authority to authorize Waivers.¹³⁸ Some courts have explicitly held that review of experimental programs is inherently narrower than the administrative actions at issue in the Supreme Court's APA

¹³⁰ See *Smith*, 236 F. Supp. 3d at 984-86.

¹³¹ See *id.*

¹³² See e.g., *Beno v. Shalala*, 30 F.3d 1057, 1066 (9th Cir. 1994) (reviewing approval of the § 1115 Waiver under the APA); see also *C.K. v. New Jersey Dep't of Health & Human Servs.*, 92 F.3d 171 (3d Cir. 1996); see also *Aguayo v. Richardson*, 473 F.2d 1090, 1101 (2d Cir. 1973).

¹³³ *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 408 (1971) (citing Section 701 of the APA, 5 U.S.C. § 701 (1964 ed., Supp. V)).

¹³⁴ APA, 5 U.S.C. § 706(2)(A).

¹³⁵ See *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 415. (1971).

¹³⁶ *Id.*

¹³⁷ See *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42 (1983).

¹³⁸ See *C.K. v. New Jersey Dep't of Health & Human Servs.*, 92 F.3d 171, 181 (3d Cir. 1996); see also *Beno v. Shalala*, 30 F.3d 1057, 1076 (9th Cir. 1994). *But see* *Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973).

jurisprudence.¹³⁹ Each reviewing court has found that § 1115 Waivers are subject to APA review, but the circuit courts have diverging analyses and there is no binding § 1115 jurisprudence in the Fifth Circuit, which has jurisdiction over Texas. However, assuming the Fifth Circuit would find the grant of § 1115 Waivers subject to APA review, Texas's Waiver request would not withstand APA review since it does not meet any of the three elements of § 1115. The Ninth Circuit in *Beno v. Shalala* took the most expansive reading of the Waiver provision, finding each of the three elements of § 1115 as binding on the Secretary to grant or deny waiver requests.¹⁴⁰ Two other Circuits interpreting the law found some, but not all, of these requirements binding.¹⁴¹ The U.S. District Courts are similarly mixed.¹⁴²

The Second, Third, and Ninth Circuits found the “likely to assist in promoting the objectives of the [Social Security] Act” language (“objectives requirement”) binding upon the Secretary.¹⁴³ This language requires that the Secretary consider the impact of the project on the people whom the underlying program was intended to benefit, and is the element most likely to be found binding on the Secretary in the event that a grant of Texas's request is reviewed in federal court.¹⁴⁴

Courts are not empowered to substitute their judgement for that of the agencies in APA review of decision-making and should refrain from “comment[ing] on the wisdom of” agency decision-making.¹⁴⁵ However, the Secretary must have a rational basis for determining that the approved Waiver is likely to assist in promoting the objectives of the Act.¹⁴⁶ Medicaid's stated objectives are

to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.¹⁴⁷

While the Secretary has argued that Medicaid has more nuanced objectives that afford him more discretion, the District Court for the District of Columbia (D.D.C.) has held that these objectives are considered primary.¹⁴⁸ The Secretary may not pursue other

¹³⁹ See *Aguayo*, 473 F.2d at 1103; see also *C.K.*, 92 F.3d at 182 (citing *Overton* as an example of how difficult it is to exercise judicial review outside of traditional review of administrative action).

¹⁴⁰ See *Beno*, 30 F.3d at 1066.

¹⁴¹ See *C.K.*, 92 F.3d at 183; see also *Aguayo*, 473 F.2d at 1105.

¹⁴² See *Stewart v. Azar*, 313 F. Supp. 3d 237, 271 (D.D.C. 2018) (finding all three elements binding); see also *Crane v. Matthews*, 417 F. Supp. 532, 539 (N.D. Ga. 1976) (finding only the objectives requirement binding).

¹⁴³ See *C.K.*, 92 F.3d at 184; see also *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994); see also *Aguayo v. Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973).

¹⁴⁴ See *Beno*, 30 F.3d at 1070.

¹⁴⁵ See *C.K.*, 92 F.3d at 180-81.

¹⁴⁶ *Id.* at 181.

¹⁴⁷ 42 U.S.C. § 1396-1 (2018) (authorizing appropriations for the Medicaid program).

¹⁴⁸ See *Stewart v. Azar*, 313 F. Supp. 3d 237, 271 (D.D.C. 2018).

objectives of the program at the expense of the coverage goals explicitly set out in the statutory language.¹⁴⁹ The Ninth Circuit also found binding the “to the extent and for the period she finds necessary” language (hereafter “extent and period requirement”).¹⁵⁰ However, objections to the Waiver in *Beno* did not address the extent and period requirement, and thus the court did not resolve the “precise meaning” of the extent and period language.¹⁵¹

The Third Circuit and the D.D.C. found the extent and period requirement binding, unlike the Second Circuit.¹⁵² In *C.K.*, the Third Circuit considered a challenge to the extent of the waiver where plaintiffs alleged that it was unnecessary to incorporate nearly the entire population of beneficiaries into the experimental waiver and that it failed to make certain exceptions in applying the waiver to individual beneficiaries.¹⁵³ The plaintiffs in *C.K.* alleged that the Secretary should only have allowed the state to apply the terms of the Waiver to a small group of beneficiaries, while leaving others with standard benefits.¹⁵⁴ While the *Aguayo* and *Beno* courts held that the Secretary does not have to grant the Waiver request exactly as she receives it and that alterations of the Waiver are within her discretion, the court in *C.K.* found that the Secretary did not abuse her discretion by granting the proposed Waiver statewide.¹⁵⁵

The D.D.C. held that Kentucky could not “piggyback” waivers onto a project where those waivers were not necessary to achieve the program’s goals.¹⁵⁶ Kentucky proposed a program targeting the Medicaid expansion population by adding eligibility requirements and cost-sharing provisions.¹⁵⁷ The D.D.C. held that the eligibility and cost-sharing elements were not necessary to the functioning of the substance abuse program, and therefore those elements were struck down while the substance abuse program remained intact.¹⁵⁸

Lastly, examining the “experimental, pilot, or demonstration project” language (“demonstration requirement”), the Ninth Circuit in *Beno* held that § 1115 Waivers may simply to “enable states to save money or to evade federal requirements” but must “test out new ideas and ways of dealing with the problems of public welfare recipients.”¹⁵⁹ On this theory, a “simple benefits cut” to reduce spending on cash welfare recipients did

¹⁴⁹ *Id.*

¹⁵⁰ *Beno v. Shalala*, 30 F.3d 1057, 1071 (9th Cir. 1994).

¹⁵¹ *See id.* at 1072.

¹⁵² *See Stewart v. Azar*, 313 F. Supp. 3d 237, 245 (D.D.C. 2018); *see also C.K. v. New Jersey Dep’t of Health & Human Servs.*, 92 F.3d 171, 183 (3d Cir. 1996); *see also Aguayo v. Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973).

¹⁵³ *See C.K.*, 92 F.3d at 186.

¹⁵⁴ *Id.*

¹⁵⁵ *See C.K. v. New Jersey Dep’t of Health & Human Servs.*, 92 F.3d 171, 186-87 (3d Cir. 1996); *see also Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994); *Aguayo*, 473 F.2d at 1103 n.21.

¹⁵⁶ *See Stewart v. Azar*, 313 F. Supp. 3d 237, 258 (D.D.C. 2018).

¹⁵⁷ *See id.* at 243.

¹⁵⁸ *See id.* at 274.

¹⁵⁹ *See Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994).

not satisfy the demonstration requirement.¹⁶⁰ Neither the Third Circuit in *C.K.* nor the Second Circuit in *Aguayo* found the demonstration requirement binding.¹⁶¹ The D.D.C. adopted *Beno*'s analysis on the demonstration requirement, but noted an incidental loss of coverage for some beneficiaries is not enough to violate the requirement.¹⁶² The objectives requirement is the element of § 1115 most likely to be considered controlling if Texas's proposed Waiver were granted and challenged in federal court. The extent and period and demonstration requirements have found less broad acceptance in the courts but may still be binding.

b. The Proposed Waiver of Section 1396a is Beyond the Scope of the Secretary's Discretionary Authority

Not only does Texas's proposed Waiver fail to meet the requirements of § 1115 on its face, but Texas's self-funded program also undermines its claim to the contrary. The proposed Waiver would not meet any of the binding requirements set out by the court in *Beno* and would therefore also fail the tests set forth by both *C.K.* and *Aguayo*. To grant the Waiver would be beyond the scope of the Secretary's authority, and such action would be subject to reversal as a violation of the APA.¹⁶³

Significantly, the Waiver request fails the objectives requirement, which every reviewing circuit court has found binding.¹⁶⁴ The Waiver does not further the objectives of the act to ban the targeted providers from Medicaid, since reducing the "indirect subsidization of abortion" is not an objective of Medicaid.¹⁶⁵ There is no rational connection between furthering the actual objectives of the Act and barring politically disfavored providers from the program.¹⁶⁶

While there may be other objectives found in the statutory text establishing the Medicaid program, such as improving health outcomes for beneficiaries, the furnishing of covered services to the beneficiary population is the primary objective.¹⁶⁷ To the extent that

¹⁶⁰ See generally U.S. Department of Health and Human Services, *Aid to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF): Overview* (Nov. 30, 2009), <https://aspe.hhs.gov/aid-families-dependent-children-afdc-and-temporary-assistance-needy-families-tanf-overview-0>.

¹⁶¹ See *C.K. v. New Jersey Dep't of Health & Human Servs.*, 92 F.3d 171, 183 (3d Cir. 1996) ("the central question before us is whether the record disclosed that the Secretary rationally could have determined that (1) New Jersey's program was 'likely to assist in promoting the objectives' of AFDC, and (2) it was necessary to waive compliance to the extent and for the period she did to enable New Jersey to carry out its experiment."); see also *Aguayo v. Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973) ("The limitation, and the only limitation imposed on the Secretary was that he must judge the project to be 'likely to assist in promoting the objectives' of the designated parts of the [SSA].").

¹⁶² See *Stewart v. Azar*, 313 F. Supp. 3d 237, 270 (D.D.C. 2018).

¹⁶³ See APA, 5 U.S.C. § 706 (2012).

¹⁶⁴ See *C.K.*, 92 F.3d at 183; see also *Aguayo*, 473 F.2d at 1105.

¹⁶⁵ See *Planned Parenthood of Ind. v. Comm'r Ind. State Dep't Health*, 699 F.3d 962, 978 (7th Cir. 2012).

¹⁶⁶ 42 U.S.C. § 1396-1 (2012).

¹⁶⁷ See *Stewart v. Azar*, 313 F. Supp. 3d 237, 260-61 (D.D.C. June 29, 2018) (rejecting the Secretary's argument that a Waiver expected to result in substantial coverage loss still furthered the

Texas's anti-abortion policy goals and the Hyde Amendment result in reducing public funding available to abortion providers, the goal is null if it runs contrary to the explicit statutory purpose of providing coverage.

Further, Texas's program proves not only the failure to meet the objectives requirement, but an abdication of those objectives in the name of political priorities. While waiving free choice may not affect the objectives, the Waiver itself could not be authorized under the statute because § 1115 requires programs to improve Medicaid.¹⁶⁸ Beyond any impact-neutral façade lies the results of the experiment that Texas has conducted on its own dime. The provider ban undermines the ability of Medicaid family planning to achieve its goals by impeding not just choice, but access, leading to outcomes worse than those of the program in which the free choice provision did apply.¹⁶⁹ Texas's state-funded program performs poorly across all meaningful measures: enrollment numbers are down, fewer services are being administered, some beneficiaries are unable to access their preferred contraceptive method, and the rate of unintended pregnancy in the beneficiary population has increased.¹⁷⁰ These effects are concentrated in areas that have lost access to care from providers who also perform elective abortions.¹⁷¹

A waiver of free choice that has no effect on programmatic integrity would not meet the objective requirements of Medicaid. Likewise, it does not follow that approving the Waiver would increase access to Medicaid family planning. The Waiver request would automatically further the objectives of the Act and the evidence from Texas's self-funded program suggests the request would undermine those objectives. Texas's Waiver request also does not meet the extent and period requirement. Because expanded family planning programs can operate with the free choice provision intact, the Waiver exceeds the requirements for a demonstration project to waive the provision. The D.D.C. held this requirement prevents the Secretary from "piggybacking" unacceptable waivers by attaching them to acceptable ones.¹⁷²

When Texas filed suit to prevent the termination of federal funding under the Waiver, Texas alleged that the Secretary must find that the request promotes the objectives on a program-wide level, without parsing whether each element of the Waiver is necessary.¹⁷³ Therefore, refusal to grant the entire waiver on the basis of finding that one part of the request was improper when the waiver on the whole might promote the objectives was an abuse of discretion.¹⁷⁴ However, the Second Circuit accepted, and the Ninth Circuit

objectives because health outcomes were expected to improve and similarly rejecting the argument that the objectives of Medicaid differed for the traditional and expansion populations).

¹⁶⁸ See *C.K. v. New Jersey Dep't of Health & Human Servs.*, 92 F.3d 171, 184 (3d Cir. 1996); see also *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (holding that a § 1115 Waiver must promote the objectives of the Act); see also *Aguayo v. Richardson*, 473 F.2d 1090, 1105 (2d Cir. 1973).

¹⁶⁹ See *supra* Part II.C.

¹⁷⁰ See *supra* notes 54-59.

¹⁷¹ *Stevenson et al.*, *supra* note 54, at 853, 857.

¹⁷² *Stewart v. Azar*, 313 F. Supp. 3d 237, 258 (D.D.C. June 29, 2018)

¹⁷³ See P. Mot. Sum. J. at 19-20, *Texas v. Sebelius*, No. 6:12-cv-62 (W.D. Tex. 2012).

¹⁷⁴ *Id.*

expanded upon the ability of the Secretary to grant Waivers in part or make certain parts of the grant conditional.¹⁷⁵ The Ninth Circuit in *Beno* held that the Secretary may reject a project or require a project to be modified for consistency with federal requirements, to mitigate potential harms, and to be more likely to further Medicaid's goals.¹⁷⁶

The Secretary exercised this modification power when Texas requested a waiver of free choice in its application for renewal of the Texas Women's Health Waiver.¹⁷⁷ The Secretary notified the state Medicaid commissioner that waiver of the free choice provision did not meet the objectives requirement and therefore would not be granted.¹⁷⁸ However, the Secretary did not outright deny renewal and terminate the Waiver. Instead, the Secretary granted an extension to allow CMS and the state to reach an agreement that only waived Medicaid requirements to the extent necessary to carry out the project, which Texas rejected.¹⁷⁹ Interpreting the extent and period requirement, the Second Circuit explicitly disapproved of shoehorning unnecessary and harmful Waiver criteria into an otherwise beneficial program.¹⁸⁰ If it is within the Secretary's power to "require the states to modify projects" it must be within his discretion to reject a proposal if the state refuses to modify their demonstration project.¹⁸¹

Additionally, family planning waivers lack demonstration or experimental value, given that § 1115 has been used to expand family planning benefits for over twenty years.¹⁸² The ACA authorized states to make expanded family planning benefits a part of their permanent state Medicaid plans through a state plan amendment, and therefore the Waiver authority is no longer necessary to offer these benefits.¹⁸³ Even if family planning Waivers retain experimental value to pass the demonstration requirement, Texas has

¹⁷⁵ See *Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir 1994); see also *Aguayo v. Richardson*, 473 F.2d 1090, 1103 n.21 (2d Cir. 1973).

¹⁷⁶ See *Beno*, 30 F.3d at 1069.

¹⁷⁷ See Letter from Cindy Mann, Dir. of the Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicare Servs., to Billy Millwee, Assoc. Comm'r for Medicaid & CHIP, Health & Human Servs. Comm'n (Dec. 12, 2011), <https://senatorjoserodriguez.com/wp-content/uploads/2012/03/CMS-Letter-to-HHSC-re-WHP.12.12.2011.pdf>.

¹⁷⁸ See *id.*

¹⁷⁹ See Letter from Cindy Mann, Dir. of the Ctr. for Medicaid & CHIP Servs., Ctrs. for Medicare & Medicare Servs., to Billy Millwee, Assoc. Comm'r for Medicaid & CHIP, Health & Human Servs. Comm'n (Mar. 15, 2012), <https://lrl.texas.gov/scanned/archive/2012/17970.pdf>.

¹⁸⁰ See *Beno v. Shalala*, 30 F.3d 1057, 1071-72 (9th Cir 1994).

¹⁸¹ See *id.* at 1068-69.

¹⁸² See Usha Ranji et al., *Medicaid and Family Planning: Background and Implications of the ACA*, KAISER FAM. FOUND., at 4 (Feb. 3, 2016), <https://www.kff.org/report-section/medicaid-and-family-planning-medicare-family-planning-policy/>.

¹⁸³ See Patient Protection and Affordable Care Act, 124 Stat. 119, § 2303 (2010); see also *Medicaid Family Planning Eligibility Expansions*, GUTTMACHER INST. 1 (2017) (stating that in the year preceding the passage of the ACA, twenty-four states were operating family planning waivers; currently, fifteen states have adopted state plan amendments and ten states are operating waivers), <https://www.guttmacher.org/state-policy/explore/medicaid-family-planning-eligibility-expansions>; see also *State Medicaid Coverage for Family Planning Services: A Summary of State Survey Findings*, KAISER FAM. FOUND., at 5 (2009), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8015.pdf>.

operated a self-funded program since 2013 that performs significantly worse than the Waiver program that preceded it. The experiment has been conducted on Texas's own dime and has failed.¹⁸⁴ There is no demonstrative value in supplying federal funding to a poorly performing program to allow the state to avoid complying with federal law. Texas's Waiver request fails to meet the legal criteria of a § 1115 Waiver under any test that could be applied by any combination of the potentially binding elements since it does not meet any of the three binding requirements. The requests following Texas's, made by Tennessee and South Carolina, would also fail any level of review for consistency with the requirements of § 1115.

VII. CONCLUSION

Although Texas alleges that it is within its authority to bar abortion providers from its Medicaid program, Texas's attempts to effectuate this goal in traditional Medicaid and in expanded family planning services is to the contrary. Texas has been enjoined from terminating Planned Parenthood from participating in traditional Medicaid yet seeks a Waiver to enable the same result in expanded family planning services. CMS recently revoked guidance issued in 2016 emphasizing the effects of the free choice provision in the family planning context.¹⁸⁵ Regardless of the rescinded guidance, the free choice provision and related federal regulations remain in full force.

Since the state cannot prove a programmatic violation that warrants barring abortion providers writ large from Medicaid and since states may not label abortion providers de facto unqualified to be Medicaid, Texas may not exclude providers absent a Waiver from CMS. Texas's proposal to obtain such a Waiver cannot meet the criteria for approval. Accordingly, the state may not use a law purporting to limit contract eligibility to limit beneficiary rights for political purposes either in traditional Medicaid or by Waiver. Texas's Waiver request must be denied, and if granted cannot surpass scrutiny under the APA.

¹⁸⁴ See Kari White et al., *The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas*, 105 AM. J. PUB. HEALTH 851, 1179-80 (2015) (documenting the effects of the Texas legislation such as clinics having waiting lists to implement long-acting reversible contraceptives, providing patients with fewer packs of birth control pills per visit, and requiring patients to pay fees for those who do not qualify for the WHP).

¹⁸⁵ See Letter from CMS Director Brian Neale to State Medicaid Directors, Re: Rescinding SMD #16-005 (Jan. 19, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18003.pdf>; see also Letter from CMS Director Vikki Wachino to State Medicaid Directors, Re: Clarifying Free Choice of Provider Requirement in Conjunction with State Authority to Take Action against Medicaid Providers (Apr. 19, 2016), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf>.



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W A S H I N G T O N , D C

American University Washington College of Law

4300 Nebraska Avenue, NW

Washington, D.C. 20016



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