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Recommended Citation

Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 UC Davis Law Review 413 (2008).

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Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements

Nicole Huberfeld*

The first two terms of the Roberts Court signal a willingness to revisit precedent, even decisions that have been considered long-settled, and the United States Supreme Court may be ready to reinterpret another area of jurisprudence: the private enforcement of conditions on federal spending against states through actions under 42 U.S.C. § 1983. The most recent pre-Roberts Court precedent is Gonzaga University v. Doe, a 2002 decision that made it more difficult for individuals harmed by violations of federal laws to enforce rights through § 1983 actions. Federal courts have inconsistently and confusingly applied the Gonzaga framework, but the Rehnquist Court would not revisit the rule.

Last term, however, the Roberts Court granted a petition for writ of certiorari that would have required reconsidering Gonzaga. Before it could be heard on the merits, the respondents mooted the case, but petitions for certiorari regularly arise in similar Medicaid enforcement cases. Thus, Gonzaga could be revisited in the context of enforcement of Medicaid statutory entitlements. Medicaid does not contain an enforcement mechanism, but the Supreme Court has facilitated enforcement of federal statutory rights against state officers through § 1983. However, this paper highlights recent events that increase the fragility of Medicaid.

The first part of this paper explores the structure of Medicaid and key provisions of the Deficit Reduction Act of 2005 that could change Medicaid from a program of promised care and benefits into one of no enforceable

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promises. The second part of this paper discusses Supreme Court decisions that reveal hostility to enforcement of conditions on spending legislation by beneficiaries under § 1983. This part also explores how changes in the Court's composition may allow this view to become the prevailing rule. Additionally, this section demonstrates the narrowing ability of individuals to enforce Medicaid entitlements through § 1983 due to two distinct but related splits in the circuit courts. The final part of this paper analyzes the Court's hostility to enforcing conditions on spending by § 1983 and proposes legislative responses to the possible demise of the Medicaid entitlement.

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INTRODUCTION

The Roberts Court's first two terms indicate a willingness to revisit precedent, including decisions that have been considered long-settled.¹ The United States Supreme Court can signal intent both by the petitions for certiorari that it grants and those that it denies, but it appears that the Court is poised to reinterpret another area of jurisprudence²: the private enforcement of conditions on federal spending against states through claims under 42 U.S.C. § 1983 ("§ 1983").³ The most recent precedent on point is *Gonzaga University v. Doe*, a 2002 decision that made it more difficult for individuals harmed by violations of federal laws to enforce statutory rights through § 1983 claims.⁴ Federal circuit and district courts have inconsistently and confusingly applied the *Gonzaga* framework,⁵ which was supposed to clarify private causes of action under § 1983. The Rehnquist Court, however, was not interested in revisiting the *Gonzaga* rule.⁶

Last term, in contrast, the Roberts Court granted a petition for writ of certiorari to Arkansas and its Medicaid officials that would have

¹ See *Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 127 S. Ct. 2738, 2765 (2007) (relying on *Brown v. Board of Education* as precedent to prevent grade school integration based in part on racial integration); *Ledbetter v. Goodyear Tire & Rubber Co.*, 127 S. Ct. 2162, 2169 (2007) (providing novel interpretation of starting point for Title VII workplace discrimination claim); *Gonzales v. Carhart*, 127 S. Ct. 1610, 1635-37 (2007) (upholding Partial Birth Abortion Ban Act of 2003 despite lack of exception to ban for health of mother, contrary to all prior expressions of liberty interest at issue in abortion rights cases).

² See *infra* notes 7-12 and accompanying text.

³ 42 U.S.C. § 1983 (2006) [hereinafter "§ 1983"].

⁴ 536 U.S. 273, 283 (2002). Though little-noticed at the time the Court issued its decision, the case has become a source of confusion in the lower federal courts and of controversy among scholars. See Erwin Chemerinsky, *Limiting Suits to Enforce Federal Laws*, 39 JAN. TRIAL 70, 70 (2003) (noting that *Gonzaga* would limit plaintiffs' ability to bring § 1983 actions and that Chief Justice Rehnquist was quoted at conference calling *Gonzaga* important "sleeper decision"); see also TIMOTHY STOLTZFUS JOST, *DISSENTMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 96 (2003) (noting *Gonzaga* Court's skepticism regarding enforcing Spending Clause conditions by § 1983 causes of action).

⁵ See *infra* notes 149-51 and accompanying text.

⁶ See Sasha Samberg-Champion, *How to Read Gonzaga: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 COLUM. L. REV. 1838, 1839 (2003) (noting that Court rejected number of petitions for certiorari that would have facilitated revisiting confusion created by *Gonzaga*).

required the Court to revisit *Gonzaga*.⁷ Before it could be heard on the merits, however, the respondents voluntarily mooted the case after a conversation with the Solicitor General.⁸ Nevertheless, petitions for certiorari regularly arise in similar Medicaid enforcement cases.⁹ Though the Court recently rejected a petition for certiorari from the Ninth Circuit Court of Appeals and two petitions from the Tenth Circuit Court of Appeals,¹⁰ denials that support decisions by the circuits to “close the courthouse doors” to Medicaid enrollees,¹¹ the Court will likely take up the issue again in the near future.¹²

Thus, the context in which the Court could revisit *Gonzaga* is the enforcement of Medicaid statutory entitlements via § 1983.¹³ Medicaid does not contain a federal enforcement mechanism for individuals who do not receive the benefits promised by their states as

⁷ See *Selig v. Pediatric Specialty Care, Inc.*, 127 S. Ct. 3000, 3000 (2007) (granting writ and disposing of case by summary action).

⁸ See generally Petitioners’ Response to Respondents’ Suggestion of Mootness at 2-3, *Selig v. Pediatric Specialty Care, Inc.*, 127 S. Ct. 1356 (June 11, 2007) (No. 06-415) (describing that parties met with Solicitor General’s office after filing their briefs, after which respondents voluntarily dismissed their case); Posting of Lyle Denniston to SCOTUSblog, *Case on Children’s Health Benefits May End*, <http://www.scotusblog.com/wp/> (June 12, 2007, 14:26 EST) (noting that clinics, treatment centers, children and parents decided to dismiss case as moot).

⁹ See generally *Kidd v. Doe*, 501 F.3d 348 (4th Cir. 2007), *cert. denied*, 128 S. Ct. 1483 (2008) (denying writ of certiorari because respondents waived right to file response brief in case).

¹⁰ *Petition for Writ of Certiorari, Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, No. 06-1482 (10th Cir. May 7, 2007), *cert. denied*, 128 S. Ct. 68 (2007).

¹¹ Erwin Chemerinsky, *Closing the Courthouse Doors to Civil Rights Litigants*, 5 U. PA. J. CONST. L. 537, 539 (2003) (describing trend in Rehnquist Court decisions of narrowing civil rights litigants’ access to courts).

¹² A petition for certiorari on the Supreme Court’s 2007-2008 Appellate Docket was not addressed in the 2008 term, but the Court denied the petition early in the 2009 term. See *Equal Access for El Paso, Inc. v. Hawkins*, No. 07-1160 (5th Cir. Mar. 12, 2008), <http://origin.www.supremecourtus.gov/docket/07-1160.htm>.

¹³ See Petitioners’ Response to Respondents’ Suggestion of Mootness at 2-3, *Selig*, 127 S. Ct. 1356 (No. 06-415) (vacating judgment in lower courts and directing dismissal for mootness). Then-Judge Alito, concurring in the decision of *Sabree v. Richman*, a Third Circuit case that allowed Medicaid enrollees to enforce individual federal rights to Medicaid services under § 1983, provided insight into his position on the use of § 1983 to enforce Medicaid entitlements: “While the analysis and decision of the District Court may reflect the direction that future Supreme Court cases in this area will take, currently binding precedent supports the decision of the Court. I therefore concur in the Court’s decision.” 367 F.3d 180, 194 (2004) (emphasis added). Judge Alito was agreeing, indirectly, with the district court judge who found that Medicaid was a cooperative federal-state program that did not provide the kind of rights that are enforceable through § 1983 actions. See *Sabree v. Houston*, 245 F. Supp. 2d 653, 660-61 (E.D. Pa. 2003).

required by federal guidelines.¹⁴ For decades, this omission was not overwhelmingly problematic, as the Supreme Court facilitated enforcement of federal statutory rights against state officers through § 1983.¹⁵ Indeed, the sheer quantity of lower federal court cases might lead the casual observer to believe that Medicaid providers and enrollees have a firm foundation to enforce Medicaid entitlements through § 1983 claims.¹⁶ This paper, however, contends that Medicaid is metamorphosing into a right without a remedy due to federal courts' inconsistent interpretation of § 1983.¹⁷

Recent events reveal the fragility of the § 1983 enforcement mechanism. First, various currently-sitting Justices have displayed skepticism regarding private parties' ability to enforce conditions on spending through § 1983; this doubt appears to be supported by a majority now that Chief Justice Roberts and Justice Alito are on the Court.¹⁸ Second, a circuit divide exists regarding how to apply *Gonzaga* to Medicaid entitlements. This split is exacerbated by a newly popular theory adopted by a few circuits that the phrase "medical assistance" in the Medicaid Act merely requires states to pay,

¹⁴ Though Medicaid does contain an administrative process for simple claims denial, see 42 U.S.C. § 1396a(a)(3) (2006); 42 C.F.R. §§ 431.151-.154, 431.200-.245 (2008), and a notification process for denial of eligibility, see 42 C.F.R. § 435.911 (2008); see also Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement*, 22 HEALTH AFFAIRS 145, 145-46 (2003) (describing lack of access to federal courts for Medicaid enrollees); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 23-24 (2006) (noting that unlike Medicare and ERISA, Medicaid contains no federal cause of action).

¹⁵ See *Maine v. Thiboutot*, 448 U.S. 1, 1 (1980); see also 42 U.S.C. § 1983 (2006). Section 1983 creates the cause of action for violations of federal law under color of state law; *Ex parte Young* allows state officers to be sued for injunctive relief under § 1983 by holding that state officers are not the state for purposes of sovereign immunity, thereby avoiding 11th Amendment issues. See *Ex parte Young*, 209 U.S. 123, 156 (1908).

¹⁶ See *infra* notes 152-54 and accompanying text; see also Jost, *supra* note 14, at 148 n.21. Professor Jost provided statistics regarding Medicaid enrollees' and providers' § 1983 lawsuits for 1999 and 2000: in 1999,

recipients and providers prevailed in 53[%] of the reported federal court cases that they brought against Medicaid programs, while in 2000 they won 48[%] of these cases. Recipients were more successful than providers, prevailing 61[%] of the time in suits in 1999 and 2000, while providers prevailed only 35[%] of the time in 1999 and 38[%] in 2000.

Id. at 148. In the accompanying footnote, Professor Jost notes both enrollees and healthcare providers were less successful upon appeal, "where state Medicaid agencies won 83[%] of the reported cases in 1999 and 81[%] in 2000." *Id.* at 148 n.21.

¹⁷ See Samberg-Champion, *supra* note 6, at 1884.

¹⁸ See discussion *infra* Part III.

not to provide care or services.¹⁹ Finally, the Deficit Reduction Act of 2005 turns long-standing premises of Medicaid upside down by allowing states to provide the “actuarial equivalent” of benefits that heretofore were mandated by federal law.²⁰

This paper will explore the contours of these trends in turn. The first part will review the structure of Medicaid and examine key provisions of the Deficit Reduction Act of 2005 that change Medicaid from a program of promised care and benefits into one of no enforceable promises. The second part of this paper will discuss the trends in federal court decisions regarding enforcement of federal spending statutes through § 1983 that reveal hostility to enforcement by beneficiaries of federal spending. This part also will explore how changes in the Court’s composition may allow this view, previously expressed as dicta, to become the prevailing rule. Additionally, this part will demonstrate the narrowing ability of individuals — both patients and healthcare providers — to enforce Medicaid entitlements through § 1983 due to two distinct but related splits in the circuit courts. The final part of this paper will analyze the Court’s resistance to enforcing § 1983’s conditions on spending, which diminishes both individual rights and federal power. This part will conclude by proposing legislative responses.

I. MEDICAID — A FRAGILE RIGHT WITH A DIMINISHING REMEDY

Congress enacted Medicaid in 1965 as companion legislation to Medicare.²¹ Congress structured Medicaid as a federal welfare program, meaning it was a temporary source of help when people became “medically indigent.” Medicaid augmented the welfare system and eased states’ budgetary issues.²² As such, Medicaid’s funding derives from general tax revenue rather than the payroll tax that helps to fund Medicare, a structural aspect of Medicaid that causes ongoing political vulnerability.²³ Medicaid was never designed to provide assistance to all Americans who could not afford medical care; instead, the program allows only the “deserving poor” to enroll for its

¹⁹ See *infra* Part III.B.

²⁰ Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6044 120 Stat. 4 (2006).

²¹ See ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 47-51 (1974) (describing Medicaid as “ill-designed” compared to Medicare).

²² See *id.* at 53.

²³ See *id.* (describing one of driving forces of Medicaid as desire to help remove people from welfare roles, not to assist those who could not afford healthcare as philosophical matter); see also JOST, *supra* note 4, at 15-17, 271.

benefits.²⁴ Although Medicaid currently covers about fifty-five million Americans, eligibility limitations restrict the program to only about forty percent of the poor and near-poor.²⁵ Medicaid covers people who are blind, disabled, elderly, and pregnant, as well as children (and their families) who meet a certain poverty level set by statutorily-defined percentages of the federal poverty line.²⁶ Courts have traditionally treated Medicaid as a statutory entitlement for those who rely on it.²⁷ Medicaid is not perfect (or philosophically coherent),²⁸ but it is indispensable as the most consistent device that ensures access to healthcare for underprivileged populations.²⁹

Medicaid is a classic example of cooperative federalism;³⁰ in the federal statutory scheme creating the Medicaid program (referred to as the “Medicaid Act”³¹), the federal government promises federal money to the states in exchange for states’ promise to fulfill certain conditions on those funds by providing medical assistance to mandatory categories of people.³² The state must submit a “State plan” to participate in

²⁴ See STEVENS & STEVENS, *supra* note 21, at 57; see also Mary Ann Bobinski & Phyllis Griffin Epps, *Women, Poverty, Access to Health Care, and the Perils of Symbolic Reform*, 5 J. GENDER RACE & JUST. 233, 248 n.92 (2002) (noting that, contrary to popular perception, Medicaid covers only certain categories of poor).

²⁵ See KAISER COMM’N ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER 3 (2005), <http://www.kff.org/medicaid/7334.cfm>. See generally KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE MEDICAID PROGRAM AT A GLANCE (2007), <http://www.kff.org/medicaid/upload/7235-02.pdf> (describing Medicaid program in basic terms and noting limitations that make it so that Medicaid covers less than half of population).

²⁶ 42 U.S.C. § 1396a(10)(A) (2006).

²⁷ Arguing for an entitlement program that covers all Americans, Professor Jost notes that “entitlements to health-care coverage may not guarantee health-care services at all if those rights are not legally enforceable, even if the state provides these services directly” JOST, *supra* note 4, at 270.

²⁸ See STEVENS & STEVENS, *supra* note 21, at 53.

²⁹ See Rosenbaum, *supra* note 14, at 6.

³⁰ See, e.g., *Wis. Dept. of Health & Family Servs. v. Blumer*, 534 U.S. 473, 495 (2002) (citing *Harris v. McRae*, 448 U.S. 297, 308 (1980)) (stating that Medicaid Act fosters cooperative federalism and describing program). Typically, when states are required to spend state government funds to create programs that are co-founded and funded by the federal government within the structure called cooperative federalism, the funds are spent on a program that the state controls according to federal guidelines. If the state does not like the federal government’s guidelines, it need not accept federal money and thus either self-funds or does not institute the program. See also Elizabeth A. Weeks, *Cooperative Federalism and Healthcare Reform: The Medicare Part D “Clawback” Example*, 1 J. HEALTH CARE L. & POL’Y 79, 94 (2007).

³¹ 42 U.S.C. §§ 1396-1396v (2006).

³² 42 U.S.C. § 1396a. Medicaid is the largest grant of federal funds to the states, by some estimates accounting for nearly 40% of all federal dollars received by states.

Medicaid, which contains mandatory and optional elements.³³ Thus, the Medicaid Act contains language describing medical assistance — a term that refers to Medicaid itself — as an entitlement for enrollees. The entitlement for funds to create medical assistance extends to the state, healthcare providers who treat Medicaid patients, and Medicaid enrollees.³⁴ Importantly, states must provide at least as much as the federal government requires in the conditions on its funds, but states cannot provide less than the federal Medicaid statutes and regulations order.³⁵ States also can fulfill the demands for State plans by obtaining waiver approval from the Secretary of the Department of Health and Human Services (“DHHS”) for a managed care version of Medicaid rather than a fee-for-service format.³⁶

See Bipartisan Comm. on the Medicaid Act of 2005, H.R. 985, 109th Cong. § 2(13) (2005) (stating as part of its findings that: “Medicaid is the single largest Federal grant-in-aid program to the States, accounting for over 40[%] of all Federal grants to States.”).

³³ 42 U.S.C. § 1396a.

³⁴ See, e.g., 42 U.S.C. § 1396b(d) (describing amount of federal funds to which state is “entitled”); 42 U.S.C. § 1396b(k) (describing federal assistance available for calculating managed care benefits for individuals “entitled to” Medicaid); 42 U.S.C. § 1396e (describing guidelines for creating group health plans for individuals “entitled” to Medicaid); see also JOST, *supra* note 4, at 32 and attendant endnotes (conveying list of provisions within 42 U.S.C. § 1396 that contain word “entitle”).

³⁵ 42 U.S.C. § 1396a(a) (“A State plan for medical assistance *must*”) (emphasis added); 42 U.S.C. § 1396a(a)(10)(A)(ii) (stating that “at the option of the State” certain other categories of people can be covered); 42 U.S.C. § 1396a(b) (“The Secretary shall approve any plan which fulfills the conditions specified in subsection (a)”). Additional services also can receive matching funds. See 42 U.S.C. § 1396d(a); see also ANDY SCHNEIDER, RISA ELIAS, RACHEL GARFIELD, DAVID ROUSSEAU & VICTORIA WACHINO, *THE MEDICAID RESOURCE BOOK, KAISER COMMISSION ON MEDICAID AND THE UNINSURED* 57 (2002), <http://www.kff.org/medicaid/2236-index.cfm>.

³⁶ 42 U.S.C. § 1396n. The first version of the Medicaid waiver was § 1915(b) waivers, passed as part of the Omnibus Budget Reconciliation Act of 1981. See 42 U.S.C. § 1396n (Social Security Act § 1915). The second type of waiver, a § 1115 waiver, allowed state experimentation to cover the uninsured without increasing costs to the federal government. See 42 U.S.C. § 1315(a) (2000) (Social Security Act § 1115(a)). The Balanced Budget Act of 1997 allowed states to simply amend their State plans to implement managed care rather than requiring them to seek waivers. See 42 U.S.C. § 1396u-2. Some studies have shown that increased flexibility through waivers for managed care and other programs decreases the level of care for Medicaid enrollees. See, e.g., Dayna Bowen Matthew, *The “New Federalism” Approach to Medicaid: Empirical Evidence That Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 974-75, 982 (2002) (providing evidence that increased state control of Medicaid leads to worse access to and provision of healthcare for poor).

A key defining feature of Medicaid has been the equal coverage that it provides enrollees.³⁷ By federal law, if a person qualifies for Medicaid in terms of poverty level and categorical eligibility, then that person must not only receive relatively prompt Medicaid coverage but also the same medical assistance as every other person in that category of eligibility.³⁸ Accordingly, each pregnant woman who qualifies for Medicaid receives the same services; each blind person who qualifies for Medicaid receives the same services; and each child who qualifies for Medicaid receives the same services. The promised equal benefits have been called, in short form, “comparability” (all enrollees within a category of eligibility must have access to the same items and services),³⁹ “statewideness” (the State plan must be in effect in all political subdivisions of the state),⁴⁰ “freedom of choice” (enrollees must be able to choose which healthcare provider treats them),⁴¹ and “assurance of transportation” to medically necessary services.⁴² The federal statutes and regulations that mandate baseline Medicaid benefits require states to provide minimal medical assistance, a promise of certain specified benefits that is unique.⁴³ This is the “defined benefit approach” of Medicaid.⁴⁴ The equal access, equal coverage aspect of Medicaid has been the basis for enrollees’ enforcement of Medicaid’s entitlements through § 1983, discussed in greater detail below.⁴⁵

States traditionally have had leeway in structuring State plans, but they often seek more flexibility in Medicaid. The latest effort to give

³⁷ 42 U.S.C. § 1396a.

³⁸ 42 U.S.C. §§ 1396a(a)(8), (a)(10).

³⁹ 42 U.S.C. § 1396a(a)(10)(B).

⁴⁰ 42 U.S.C. § 1396a(a)(1).

⁴¹ 42 U.S.C. § 1396a(a)(23).

⁴² See 42 U.S.C. § 1396a(a)(70); 42 C.F.R. § 431.53 (2008); see also CTRS. FOR MEDICARE AND MEDICAID SERVS., MEDICAID AT-A-GLANCE 2005: A MEDICAID INFORMATION SOURCE 11 (2005), <http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf>.

⁴³ See Rosenbaum, *supra* note 14, at 13.

⁴⁴ See *id.* at 40-41. Professor Rosenbaum writes:

Under a defined benefit approach, the [Medicaid] entitlement consists of an entitlement to coverage encompassing a broad array of specified benefits; indeed, the detailed nature of benefit specification is such that much of the Medicaid litigation that has taken place over the past four decades has focused on the enforcement of federal coverage rights in terms of benefit class and amount, duration, and scope.

Id. at 41.

⁴⁵ See *infra* Part III.B.

states more flexibility was encompassed in the Deficit Reduction Act of 2005 (“the DRA”), which begins to morph Medicaid from a defined benefit program into a defined contribution program.⁴⁶ Section 6044 of the DRA, also called the “Benchmark Provision,” allows states to modify their State plans so that they provide what is called “benchmark coverage.”⁴⁷ Benchmark coverage essentially permits states to enroll Medicaid beneficiaries in non-Medicaid managed care plans, which by definition includes the Federal Employee Health Benefit Program, state employee health benefit programs, or any plan already offered by a major health maintenance organization in the state.⁴⁸ Benchmark coverage, according to the Centers for Medicare and Medicaid Services (“CMS”) draft regulations, is intended to afford “[s]tates unprecedented flexibility within Medicaid State Plans to provide health benefits coverage.”⁴⁹ This “unprecedented flexibility” led CMS to draft the interpretive regulations so that comparability, statewideness, freedom of choice, and the assurance of transportation are not required of a state that has amended its State plan to include benchmark coverage.⁵⁰ Also, states can force a large portion of the Medicaid population to enroll in benchmark coverage and can provide different benefits within eligibility categories, though the DRA excepts some of the particularly vulnerable and short-term categories of

⁴⁶ See Rosenbaum, *supra* note 14, at 40-41. President Bush sought to transform Medicaid into a block-grant program as part of the DRA but was not successful. See Jeanne M. Lambrew, *Making Medicaid a Block Grant Program: An Analysis of the Implications of Past Proposals*, 83 MILBANK Q. 41, 46-47 (2005).

⁴⁷ Section 6044, “State flexibility in benefit packages,” provides the following regarding modification of State plans:

Notwithstanding any other provision of this title, a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through enrollment in coverage that provides — (i) benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and (ii) for any child under 19 years of age who is covered under the State plan under section 1902(a)(10)(A), wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r).

42 U.S.C. § 1396u-7(a)(1)(A) (2006).

⁴⁸ *Id.* § 1396u-7(b)(1).

⁴⁹ 73 Fed. Reg. 9714, 9715 (Feb. 22, 2008).

⁵⁰ See *id.* at 9715, 9718, 9721, 9727.

enrollees, such as those eligible for both Medicare and Medicaid (“dual eligibles”).⁵¹

In addition, states now have the option to provide “benchmark equivalent coverage,” which also relieves the states of traditional mandatory services, comparability, statewideness, freedom of choice, and the assurance of transportation requirements.⁵² Benchmark equivalent coverage is defined minimally compared to the lists of services and items traditionally required by the Medicaid Act. States must cover inpatient and outpatient hospital care, physician services, laboratory and x-ray services, well-baby care, and immunizations,⁵³ and those services must be supplied by the “actuarial equivalent” of the listed benchmark coverage providers.⁵⁴ Benchmark equivalent coverage

⁵¹ The statute provides:

Except as provided in subparagraph (B), a State may require that a full-benefit eligible individual . . . within a group obtain benefits under this title through enrollment in coverage A State may apply the previous sentence to individuals within [one] or more groups of such individuals. . . . A State may not require . . . an individual to obtain benefits through enrollment . . . if the individual is within one of the following categories of individuals: (i) Mandatory pregnant women . . . , (ii) Blind or disabled individuals . . . , (iii) Dual eligibles . . . , (iv) Terminally ill hospice patients . . . , (v) Eligible on basis of institutionalization . . . , (vi) Medically frail and special medical needs individuals . . . , (vii) Beneficiaries qualifying for long-term care services . . . , (viii) Children in foster care receiving child welfare services and children receiving foster care or adoption assistance . . . , (ix) TANF and section 1396u-1 parents . . . , (x) Women in the breast or cervical cancer program . . . , [or] (xi) Limited services beneficiaries. . . .

42 U.S.C. § 1396u-7(a)(2) (emphasis added).

⁵² See *id.*; see also *id.* § 1396u-7(a)(1), (b)(2). The statute defines benchmark equivalent coverage as:

The coverage includes benefits for items and services within each of the following categories of basic services:

- (i) Inpatient and outpatient hospital services.
- (ii) Physicians’ surgical and medical services.
- (iii) Laboratory and x-ray services.
- (iv) Well-baby and well-child care, including age-appropriate immunizations.
- (v) Other appropriate preventive services, as designated by the Secretary.

Id. § 1396u-7(b)(2).

⁵³ See 42 U.S.C. § 1396u-7(b)(2).

⁵⁴ The statute provides that a benchmark equivalent

essentially allows states to supply money for payment of premiums rather than a well-defined healthcare program. Instead of carefully planned, statutorily-designed care and services, states can pay a private insurer who does not have to comply with the Medicaid Act.⁵⁵

Thus, the federal government has given states “unprecedented flexibility”⁵⁶ that holds them to a monetary standard rather than a benefit requirement, thereby rendering Medicaid a “premium support” program that gives private insurers control over access to both benefits and providers, without attendant accountability.⁵⁷ In addition, for the first time, states can treat Medicaid enrollees within a category of eligibility differently.⁵⁸ Although the states also sought to close off

has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages described in paragraph [b](1).

(C) Substantial actuarial value for additional services included in benchmark package. With respect to each of the following categories of additional services for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75[%] of the actuarial value of the coverage of that category of services in such package:

- (i) Coverage of prescription drugs.
- (ii) Mental health services.
- (iii) Vision services.
- (iv) Hearing services.

Id. § 1396u-7(b)(2)(B)-(C). A qualified actuary must make the determination of actuarial equivalency, taking into account certain factors. *See id.* § 1396u-7(b)(3).

⁵⁵ 42 U.S.C. § 1396u-7.

⁵⁶ *See* Sidney D. Watson, *The View from the Bottom: Consumer Directed Medicaid and Cost Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 404 (2007).

⁵⁷ Rosenbaum, *supra* note 14, at 41. Professor Rosenbaum defines “premium support” as a monetary contribution toward paying for health coverage, which would reduce the Medicaid entitlement to a certain promised contribution rather than a defined set of benefits. *Id.*

⁵⁸ *Id.* at 33. For example, Kentucky’s DRA program has four different plans and is one of the first states to implement the DRA Benchmark Provision. *See* KyHealth Choices, Member Section, <https://kentucky.fhsc.com/kmaa/sectionMains/MembersMain.asp> (click “benefit packages”) (last visited Oct. 12, 2007). The four plans are dubbed Global Choices, Family Choices, Optimum Choices, and Comprehensive Choices. *Id.* Global Choices is the plan for most Medicaid enrollees (which the state calls “members”), and it covers what the state calls basic medical services, mental health services, and hearing and vision services for people under 18. *Id.* Global Choices does not promise more than the Benchmark Coverage Equivalent requires. *Id.* Family Choices is the Kentucky Medicaid plan for most children, and it covers checkups and screenings, prescriptions, shots, doctor visits, eye exams and

court access to Medicaid enrollees, they were not successful incorporating this element into the DRA.⁵⁹ At the time of this writing, eleven states had taken advantage of DRA flexibility.⁶⁰

The DRA Benchmark Provision, as discussed below, exacerbates a trend in the circuit courts that defines Medicaid as mere payments to the states rather than a system of medical care and services for enrollees.⁶¹ This provision alone could thwart enrollees' and providers' private enforcement actions against states,⁶² but the prospect is underlined by a double circuit court split pertaining to enforcement of conditions on federal spending by private parties through § 1983. Combined, these developments make it so that some provisions of the Medicaid Act are now enforceable by § 1983 and some are not, depending on the statutory provision, the State plan, and the circuit's interpretation of § 1983 jurisprudence.

glasses, hearing services, dental care, hospital care, and mental health services. *Id.* This closely follows EPSTD requirements. 42 U.S.C. §§ 1396d(a)(4) (2006), 1396r (2006). Optimum Choices covers enrollees who have mental retardation or developmental disabilities, and it articulates the goal of "keep[ing] a member out of an institution and in the community." KyHealth Choices, Member Section. Though logistically separate, Optimum Choices has all the same benefits as Global Choices. *Id.* The fourth part of Kentucky's Medicaid DRA program is Comprehensive Choices, which covers enrollees in nursing homes and those who are ventilator-dependent or who have an acquired brain injury. *Id.* This part has the same benefits as Global Choices. *Id.* CMS explains in the draft regulations that it has interpreted Congress's intent to give the states room to be creative as quite far-reaching. *See generally* 73 Fed. Reg. 9714, 9715 (Feb. 22, 2008) (asserting that Congress intended to provide States with "unprecedented flexibility"). However, subsequent administrative interpretations have clarified that EPSDT benefits must still be provided, even in benchmark plans. *See* 42 U.S.C. §§ 1396a(a)(10), 1396d(a) (2006); *see also* JANE PERKINS, THE DRA BENEFIT PROVISIONS AND EPSDT, NATIONAL HEALTH LAW PROGRAM 3-4 (2006), <http://www.healthlaw.org/library/attachment.81954>.

⁵⁹ *See* NAT'L GOVERNORS' ASS'N, POLICY POSITION EC-16. MEDICAID REFORM § 16.2.5 (2005), <http://www.nga.org> (follow "Policy Positions" hyperlink; then follow "EC-16. Medicaid Reform" hyperlink).

⁶⁰ *See* CTRS. FOR MEDICARE AND MEDICAID SERVS., DEFICIT REDUCTION ACT (DRA) RELATED MEDICAID STATE PLAN AMENDMENTS (2008), http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp#TopOfPage.

⁶¹ *See* Bruggeman v. Blagojevich, 324 F.3d 906, 910 (7th Cir. 2003). As one of the first states to amend its state plan to create a Benchmark Program, Kentucky will be important to watch, as it also sits in the Sixth Circuit, which has adopted the limiting definition of "medical assistance." *See* Westside Mothers v. Olszewski, 454 F.3d 532, 539-41 (6th Cir. 2006).

⁶² *See* Rosenbaum, *supra* note 14, at 33-34 (noting that this is long-standing goal of National Governors' Association).

II. THE TRIANGLE — § 1983, SPENDING, AND BENEFICIARIES

That the federal government can place conditions on the receipt of funds by the states is well established.⁶³ Indeed, the Spending Clause provides one of the broadest enumerated powers of Congress, though the clause has generated relatively little guidance from the Supreme Court.⁶⁴ Generally the federal government enforces its own conditions on federal funds against the states.⁶⁵ However, beneficiaries of federal funding, when not receiving the promised benefits, can enforce the undelivered conditions against states by suing state officers through § 1983 claims pursuant to the holding in *Maine v. Thiboutot*.⁶⁶

⁶³ The idea that Congress can place conditions on spending to legislate behavior that may not otherwise be regulable dates back to *Oklahoma v. Civil Service Commission*, 330 U.S. 127, 137 (1947).

⁶⁴ See David Freeman Engstrom, *Drawing Lines Between Chevron and Pennhurst: A Functional Analysis of the Spending Power, Federalism, and the Administrative State*, 82 TEX. L. REV. 1197, 1198-99 (2004) (noting that expansive Spending Clause power was little touched by Rehnquist Court's federalism revolution). Though two decades old, Professor Rosenthal's observations still ring true:

The Supreme Court has seldom dealt directly with the validity of conditional federal spending, and its opinions in this area have not been especially helpful. Although what is decided with respect to such spending could render irrelevant many generally accepted doctrines concerning the powers of and limitations upon the federal government, remarkably little scholarly attention has been paid to the problem as an aspect of constitutional law.

Albert J. Rosenthal, *Conditional Federal Spending and the Constitution*, 39 STAN. L. REV. 1103, 1106 (1987). Professor Rosenthal further noted that even when the Supreme Court engaged in a Spending Clause analysis and reiterated that the spending power is not unlimited, the Court never found limits on spending to actually exist. *Id.* at 1110. But see generally Ilya Somin, *Closing the Pandora's Box of Federalism: The Case for Judicial Restriction of Federal Subsidies to State Governments*, 90 GEO. L.J. 461 (2002) (positing that conditions are more pernicious than outlawed commandeering and thus should not be placed on federal funds because they impose even greater burdens on state autonomy and because they distort horizontal competition between states and vertical competition between state and federal governments).

⁶⁵ See *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981). Justice Rehnquist wrote: "In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the state." *Id.* The certitude of the statement is belied by the reality that the federal agencies in charge of enforcing conditions on spending are reluctant to enforce by withdrawing funds. See Lisa E. Key, *Private Enforcement of Federal Funding Conditions under Section 1983: The Supreme Court's Failure to Adhere to the Doctrine of Separation of Powers*, 29 UC DAVIS L. REV. 283, 292-93 (1996).

⁶⁶ See 448 U.S. 1, 3-4 (1980) (holding that § 1983 provides causes of action for both constitutional and statutory violations and allowing award of attorney's fees against state under § 1988 in state court action). In *Will v. Michigan Department of*

Three converging trends will likely have a profound impact on § 1983 litigation, especially as it relates to Medicaid. First, a majority of Justices on the Roberts Court appear to believe that conditions on spending are not enforceable by beneficiaries of federal spending through § 1983 actions.⁶⁷ Second, the circuits have been confused as to the application of the most recent § 1983 case, *Gonzaga*, and the Rehnquist majority's dicta regarding private enforceability of conditions on federal spending.⁶⁸ Third, some circuits are interpreting the foundational Medicaid statute and its "medical assistance" language to impose lesser conditions on the states than have been traditionally understood.⁶⁹ Since the landmark decision in *Thiboutot*, the Court has chipped away at the precedent that has allowed private enforcement of federal laws in addition to constitutional rights.⁷⁰ This movement will be important for both Spending Clause jurisprudence and for private enforcement of federal rights through § 1983.

A. *Private Enforcement of Federal Spending Laws and the Roberts Court*

The language of § 1983, a federal civil rights statute Congress enacted in 1871, provides:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution *and laws*, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress⁷¹

State Police, the Court held that a state is not a "person" that can be held liable for damages under § 1983, narrowing the scope of *Maine v. Thiboutot* but not foreclosing equitable actions against state officers through § 1983 for violations of federal law. See *Will v. Mich. Dep't of State Police*, 491 U.S. 58, 71 n.10 (1989) (noting that state officers qualified as "persons" under § 1983).

⁶⁷ See *infra* Part III.A.2.

⁶⁸ See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 279-80 (2002).

⁶⁹ See *infra* Part III.B.2.

⁷⁰ See *Thiboutot*, 448 U.S. at 1. *King v. Smith*, in which the Court allowed private causes of action for welfare recipients, foreshadowed *Thiboutot*. See *King v. Smith*, 392 U.S. 309, 311-12 (1968). It was not until *Thiboutot*, however, that the Court held specifically that § 1983 was available to enforce federal statutory rights in addition to constitutional protections. *Thiboutot*, 448 U.S. at 5-7.

⁷¹ 42 U.S.C. § 1983 (2006) (emphasis added). Congress passed § 1983 as part of the Civil Rights Act of 1871, which was intended to protect freed slaves' constitutional

This verbiage has facilitated private lawsuits to enforce federal statutes when their language does not provide a cause of action.⁷²

1. Spending Clause Legislation and § 1983 Enforcement Actions

Maine v. Thiboutot and *Pennhurst State School and Hospital v. Halderman* created the foundation of modern § 1983 doctrine.⁷³ Although *Thiboutot* was the first case to explicitly articulate the rule allowing enforcement of federal statutory rights through § 1983 (rather than constitutional rights),⁷⁴ *Pennhurst* is the favored decision of the Court's federalism-minded Justices, who appear interested in returning to its holding and analysis.⁷⁵ The Justices' reliance on *Pennhurst* is ominous, as Medicaid contains provisions that are quite similar to the federal statute at issue in that case.⁷⁶

rights in the "lawless and racist" South after the Civil War; later, the language of § 1983 deliberately included the phrase "and laws" pursuant to a statutory amendment passed in 1874. See Theodore Eisenberg, *Section 1983: Doctrinal Foundations and an Empirical Study*, 67 CORNELL L. REV. 482, 483 n.6 (1982) (describing tension that exists in § 1983 interpretation and noting that it derives in part from Congress's lack of guidance). See generally Jack M. Beermann, *A Critical Approach to Section 1983 with Special Attention to Sources of Law*, 42 STAN. L. REV. 51, 86 (1989) (describing widely varying approaches to interpretation of § 1983 and proposing more openly political discourse surrounding its interpretation).

⁷² See *Thiboutot*, 448 U.S. at 4.

⁷³ *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981).

⁷⁴ Other cases related to the Social Security Act implied that § 1983 was available for private causes of action, but none had set forth the rule expressed by Justice Brennan in *Thiboutot*. See generally *King*, 392 U.S. at 311 (allowing private causes of action for welfare recipients).

⁷⁵ In fact, stricter standards for conditions on spending, recently enunciated in *Arlington Central School District Board of Education v. Murphy*, were partially founded on *Pennhurst*. See *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (setting forth "clear notice" test that states' rights justices had long desired). On May 21, 2007, the Court announced a decision that was noted for its interpretation of the rights of parents to represent themselves and their children in IDEA cases. See *Winkelman ex rel. Winkelman v. Parma City Sch. Dist.*, 127 S. Ct. 1994, 2004-05 (2007). That decision also contained an affirmation of *Arlington's* clear notice standard. See *id.* at 2006. For a discussion of the line of dissents that became the majority in *Arlington*, see Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. REV. 441, 453-56 (2008). *Arlington* is likely to narrow Congress's ability to place conditions on federal funds, and the Court in *Winkelman* confirmed that interpretation of *Arlington*. *Winkelman*, 127 S. Ct. at 2006. *Arlington* and *Winkelman* can be seen as part of a larger trend in the Roberts Court — a willingness to revisit Spending Clause doctrine. See *Arlington*, 548 U.S. at 297.

⁷⁶ See *Pennhurst*, 451 U.S. at 5-6 (citing 42 U.S.C. § 6000 *et seq.* (1976)).

The 1980 holding in *Thiboutot* permitted citizens to bring actions against states for violations of all federal laws.⁷⁷ Justice Brennan determined that the historical modifications that resulted in the language “and laws” in the recodification effort of 1874 were deliberate and that the provision was expanded, intentionally, to provide remedies for violations of the laws of the United States in addition to violations of the United States Constitution.⁷⁸ In other words, Justice Brennan read the phrase “and laws” to provide a statutory cause of action that was not limited to just those actions traditionally considered civil rights actions.⁷⁹ Justice Brennan’s interpretation also avoided applying *Cort v. Ash*, which set forth a limiting test for finding implied causes of action in federal statutes.⁸⁰ Justice Rehnquist joined Justice Powell’s dissent, which found that the history of § 1983’s recodification dictated the opposite result from Justice Brennan’s conclusion. Justice Powell was also deeply skeptical about the “dramatic[.]” expansion of litigation that could result from the Court’s decision.⁸¹

Almost as soon as the Court read § 1983 to apply to all federal laws, then-Associate Justice Rehnquist began to narrow that construal in the holding and analysis of *Pennhurst*. *Pennhurst* marked the beginning of a line of Supreme Court cases that declined to find a substantive right enforceable through § 1983.⁸² Thus, *Pennhurst* often is cited as support for the intertwined ideas that the federal government alone enforces conditions on spending through withdrawal of funds and that the ability to use § 1983 to privately enforce conditions on spending is limited, if not non-existent.⁸³ Justice Rehnquist noted that the “typical remedy” for state noncompliance with conditions on spending

⁷⁷ See *Thiboutot*, 448 U.S. at 4.

⁷⁸ *Id.* at 7. The plaintiffs sued Maine for violations of the Social Security Act, specifically the welfare provisions that would have permitted the family to receive credit for child-support payments. See *id.* at 2-3. At the time, welfare was a cooperative federal-state program, much like Medicaid. See 42 U.S.C. § 603 (1991) (amended 1996).

⁷⁹ See *Thiboutot*, 448 U.S. at 4.

⁸⁰ See *Cort v. Ash*, 422 U.S. 66, 78 (1975).

⁸¹ See *Thiboutot*, 448 U.S. at 12 (Powell, J., dissenting).

⁸² See generally *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981) (holding that statutory bill of rights could not confer privately enforceable rights for purposes of § 1983 claims). As the Court noted in *Gonzaga*: “Since *Pennhurst*, only twice have we found spending legislation to give rise to enforceable rights. In *Wright v. Roanoke Redevelopment and Housing Authority* ... [and] in *Wilder v. Virginia Hospital Association*.” *Gonzaga University v. Doe*, 536 U.S. 273, 280 (2002).

⁸³ See *id.* at 28. *Pennhurst* is also the progenitor of the requirement for “clear notice” for placing conditions on spending. See Huberfeld, *supra* note 75, at 455.

potentially conflicted with the holding in *Thiboutot* allowing private causes of action against the offending state.⁸⁴ However, because the Court found that the Bill of Rights section of the Developmentally Disabled Assistance and Bill of Rights Act was merely precatory and conferred no substantive rights on the plaintiffs, the Court did not analyze further whether beneficiaries of federal spending can use § 1983 to privately enforce conditions on spending.⁸⁵ In other words, the majority avoided interpretation of *Thiboutot* because it construed the Bill of Rights as hortatory rather than mandatory.⁸⁶ The Court in *Pennhurst* also endorsed what has become a favorite theme for judges who would limit the power to spend in general: the contract analogy.⁸⁷ As will be discussed below, federal courts cite the *Pennhurst* contract analogy to support limitations on § 1983 causes of action and to limit remedies for beneficiaries of federal spending in general. In addition, an increasing number of federal judges cite *Pennhurst* to support their decisions that Medicaid provisions are not privately enforceable.⁸⁸

Nine years after *Pennhurst*, the Court detoured briefly (yet importantly) from the course of narrowing *Thiboutot* by allowing healthcare providers who participated in Medicaid to challenge Virginia's reimbursement rates in *Wilder v. Virginia Hospital Ass'n*.⁸⁹ The majority allowed an association of hospitals to enforce the Boren Amendment requirement for reasonable and adequate payment rates through a § 1983 action because the provision specifically required states to pay reasonable rates.⁹⁰ The Court read the Boren Amendment

⁸⁴ See *Pennhurst*, 451 U.S. at 28. Lower federal courts, in limiting or explaining the extent to which § 1983 actions are available to enforce federal statutes, often cite this dicta. See *Ball v. Rodgers*, 492 F.3d 1094, 1104 (9th Cir. 2007); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 183 (3d Cir. 2004).

⁸⁵ *Pennhurst*, 451 U.S. at 28 n.21.

⁸⁶ Justice White's dissent, joined by Justices Brennan and Marshall, would have found that the Bill of Rights was mandatory and thus enforceable through § 1983. See *id.* at 39-53 (White, J., dissenting).

⁸⁷ See *id.* at 17.

⁸⁸ See *Doe v. Kidd*, 501 F.3d 348, 366 (4th Cir. 2007); *Ball*, 492 F.3d at 1104; *Sanchez v. Johnson*, 416 F.3d 1051, 1056 (9th Cir. 2005).

⁸⁹ *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498 (1990). *Wilder* was influenced by two intervening § 1983 decisions. *Id.* at 512. *Wright v. City of Roanoke Redevelopment and Housing Authority* allowed tenants to enforce rent-ceilings created in the Brooke Amendment to the Fair Housing Act by § 1983. See 479 U.S. 418, 439 (1987). The second was the § 1983-limiting holding in *Golden State Transit Corp. v. City of Los Angeles*. 493 U.S. 103 (1989).

⁹⁰ See *Wilder*, 496 U.S. at 509-20; see also 42 U.S.C. § 1396a(a)(13)(A) (1980) (consisting of now-repealed element of Medicaid Act that permitted healthcare

to be mandatory, not precatory, which conferred a substantive and specific federal right on Medicaid-participating healthcare providers that was enforceable under § 1983.⁹¹ Justice Brennan echoed Justice Rehnquist's analysis in *Pennhurst* but found that, consistent with Justice Rehnquist's call for more than congressional expressions of preference, Congress had created a definite right for healthcare providers by requiring states to adopt reasonable and adequate rates for hospitals.⁹² Justice Brennan opened the door to enforcement claims by both providers and Medicaid enrollees, arguably ensuring that the Medicaid program was not excluded from § 1983 enforcement actions.⁹³

The *Wilder* dissent, authored by Chief Justice Rehnquist and joined by Justices O'Connor, Scalia, and Kennedy, described *Thiboutot* as eliminating implied cause of action standards, disapproving of the decision while buttressing Justice Rehnquist's narrow statutory interpretation in *Pennhurst* (which had precluded a § 1983 cause of action).⁹⁴ The dissent read *Pennhurst* to prevent a § 1983 cause of action because Congress did not intend the Boren Amendment to create an enforceable right.⁹⁵ The dissent's analysis parallels the amicus brief on behalf of the United States as written by then-Deputy Solicitor General John G. Roberts. That amicus brief not only read the Boren Amendment narrowly in concluding that it conferred no enforceable rights but also opined that individual interests that arise as a result of federal spending may not be enforceable as rights under § 1983.⁹⁶

In 1997, the Court appeared to settle the scope of plaintiffs' ability to privately enforce federal laws using § 1983.⁹⁷ Justice O'Connor's majority opinion in *Blessing v. Freestone* articulated a three-part test to determine when § 1983 actions are permitted to enforce federal laws⁹⁸: First, the opinion instructed that Congress must intend that the provision benefit the plaintiff. "Second, the plaintiff must demonstrate that the right . . . protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence.

providers to contest payment rates states set for their Medicaid reimbursement).

⁹¹ See *Wilder*, 496 U.S. at 512.

⁹² See *id.*

⁹³ The petitioners argued that the Medicaid Act precluded private causes of action, even though no private cause of action exists in the Medicaid statutory or regulatory provisions and Congress had not directly addressed the issue. See *id.* at 520-21.

⁹⁴ See *id.* at 525-26 (Rehnquist, C.J., dissenting).

⁹⁵ See *id.* at 525.

⁹⁶ See Brief for the United States as Amicus Curiae Supporting Petitioners at 11, *Wilder*, 496 U.S. 498 (No. 88-2043) (relying on *Pennhurst*).

⁹⁷ See *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997).

⁹⁸ See *id.*

Third, the statute must unambiguously impose a binding obligation on the States,” meaning it “must be couched in mandatory . . . terms.”⁹⁹ Justice O’Connor’s analysis relied in part on *Wilder* and *Pennhurst*; ultimately the aggregate nature of the welfare provision at issue defeated the plaintiffs’ claims because no individual right existed in the statutory language.¹⁰⁰ The Court, however, preserved plaintiffs’ ability to bring § 1983 claims to enforce federal statutes, including other aspects of the welfare statute, which were connected to Medicaid through statutory structure and benefits.

Justice Scalia, joined by Justice Kennedy, agreed with the *Blessing* majority that no private cause of action existed given the generalized relief sought, but his concurrence openly questioned the use of § 1983 to authorize beneficiaries of federal-state Spending Clause legislation to bring suit.¹⁰¹ Justice Scalia relied on the *Pennhurst* contract analogy¹⁰² and compared enrollees in welfare programs to third-party beneficiaries of contracts.¹⁰³ According to the concurrence, the relationship between

⁹⁹ *Id.* (internal citations omitted). The Court denied mothers the right to enforce child support provisions within the Aid to Families with Dependent Children statutory scheme against Arizona because the newly articulated three-part test, which drew upon *Wilder*, was not met. *See id.* at 345-46.

¹⁰⁰ *See id.* at 341-48.

¹⁰¹ *See id.* at 349 (Scalia, J., concurring). Justice Scalia wrote:

I agree with the Court that under the test set forth in *Wright v. Roanoke Redevelopment and Housing Authority* and *Wilder v. Virginia Hospital Assn.*, 42 U.S.C. § 1983 does not permit individual beneficiaries of Title IV-D of the Social Security Act to bring suit challenging a State’s failure to achieve “substantial compliance” with the requirements of Title IV-D. *That conclusion makes it unnecessary to reach the question whether § 1983 ever authorizes the beneficiaries of a federal-state funding and spending agreement — such as Title IV-D — to bring suit.*

See id. (emphasis added) (internal citations omitted).

¹⁰² The *Pennhurst* Court stated:

[L]egislation enacted pursuant to the spending power is much in the nature of a contract; in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress’[s] power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the “contract”

Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17 (1981).

¹⁰³ *See Blessing*, 520 U.S. at 349 (Scalia, J., concurring). Justice Scalia wrote:

Until relatively recent times, the third-party beneficiary was generally regarded as a stranger to the contract, and could not sue upon it; . . . the only person who could enforce the promise in court was the other party to the contract This appears to have been the law at the time § 1983 was

the federal government and the state did not provide an opportunity to privately enforce breaches of the conditions the federal government placed on the state because, at the time Congress passed § 1983 in 1871, third-party beneficiaries to contracts had no ability to enforce or challenge the contract that benefited them.¹⁰⁴ Thus, Justices Scalia and Kennedy would have narrowed significantly private parties' ability to bring § 1983 actions, stating that "the ability of persons in respondents' situation to compel a State to make good on its promise to the Federal Government was not a 'righ[t] . . . secured by the . . . laws' under § 1983."¹⁰⁵ Acknowledging that the Court had thus far permitted beneficiaries' private causes of action, Justice Scalia welcomed future cases that challenged, in essence, any beneficiary suing to enforce conditions on federal spending.¹⁰⁶

Given the Scalia-Kennedy concurrence in *Blessing*, and the Court's ongoing narrowing of the § 1983 cause of action, the 2002 decision in *Gonzaga University v. Doe* could have been more drastic.¹⁰⁷ Chief

enacted. . . .

. . . I am not prepared without further consideration to reject the possibility that third-party-beneficiary suits simply do not lie.

Id. at 349-50 (citation omitted). Justices Scalia and Kennedy appear to have found persuasive the amicus brief of the Council of State Governments, National Governors' Association, and other related parties, as the concurrence echoes many of the brief's points regarding whether federal spending statutes should be enforceable against states by private parties. See Brief for the Council of State Governments, National Governors' Ass'n, National Conference of State Legislatures, National Ass'n of Counties, International City/County Management Ass'n, and International Municipal Lawyers Ass'n as Amici Curiae Supporting Petitioner at 8-15, *Blessing*, 520 U.S. 329 (No. 95-1441), 1996 WL 422135. The amicus brief drew on the dissents in *Wilder* and the *Pennhurst* majority as support for the proposition that no private cause of action should exist. *Id.* at 13-14.

¹⁰⁴ See *Blessing*, 520 U.S. at 349-50 (Scalia, J., concurring). Justice Scalia's point may not be as unassailable as asserted in the concurrence. For example, as early as 1859, New York courts applied trust principles to facilitate a suit by a third-party beneficiary against the party breaching a contract. See *Lawrence v. Fox*, 20 N.Y. 268, 274-75 (1859); see also E. ALLAN FARNSWORTH, *CONTRACTS* 653-57 (4th ed. 2004) (describing historical development of third-party beneficiary doctrine). The briefs in *Gonzaga* also bring this point to the fore, as John G. Roberts, then in private practice, represented the university and articulated the same arguments that Justices Scalia and Kennedy advanced in *Blessing*. See Brief for Petitioners at 39-43, *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002) (No. 01-679); see also Brief for Respondent at 46-49, *Gonzaga*, 536 U.S. 273 (No. 01-679) (analyzing third-party beneficiary analogy and describing why it is invalid method of interpreting § 1983 causes of action).

¹⁰⁵ *Blessing*, 520 U.S. at 350 (Scalia, J., concurring).

¹⁰⁶ See *id.*

¹⁰⁷ See *Gonzaga*, 536 U.S. at 273. The Court held that a student could not sue

Justice Rehnquist authored the majority opinion that narrowed, and attempted to clarify, the *Blessing* test but did not absolutely reject private enforcement of conditions on spending. However, the majority expressed deep skepticism regarding private parties enforcing federal conditions on spending against states. Citing *Pennhurst*, the Court wrote: “unless Congress ‘speak[s] with a clear voice’ and manifests an ‘unambiguous’ intent to confer individual rights, federal funding provisions provide no basis for private enforcement by § 1983.”¹⁰⁸ The majority reiterated the observation from *Blessing* that only twice since *Thiboutot* had the Court found that Spending Clause legislation could give rise to privately enforceable rights.¹⁰⁹ Emphasizing that more recent cases had rejected private causes of action, the majority announced that § 1983 only provides a remedy for deprivations of rights as conferred by a federal statute, not mere benefits or interests — effectively limiting the nexus between § 1983 and Spending Clause legislation.¹¹⁰ Ultimately, the Court constructed a new test that appears to replace part one of the *Blessing* test (though the Court was not clear on the use or breadth of its clarifying language). The test asks whether the statute in question confers individual rights with the kind of language that is found in, by example, Title VI of the Civil Rights Act of 1964 — “no person . . . shall . . . be subjected to”¹¹¹ In other words, Congress must create new rights that are to be enforced by § 1983 in “clear and unambiguous terms.”¹¹²

The concurrence and the dissent in *Gonzaga* expressed varying degrees of skepticism regarding the Court’s narrowed view of the § 1983 cause of action. Justice Breyer’s concurrence disagreed with the slender window of opportunity delineated by the majority and noted that the majority would only find a right that allows a private party to

using § 1983 for a privacy breach under the Family Educational Rights and Privacy Act (“FERPA”), a federal spending statute that ties funds for education to privacy of student records. *See id.* at 276.

¹⁰⁸ *Id.* at 280 (citing *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 28 n.21 (1981)).

¹⁰⁹ *See id.* (citing *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498 (1990); *Wright v. City of Roanoke Redev. & Hous. Auth.*, 479 U.S. 418 (1987)).

¹¹⁰ *See id.* at 283 (citing *Blessing* as example of narrowing of § 1983 causes of action since *Thiboutot*).

¹¹¹ *Id.* at 284. The Title VI example is strange given that the Court rejected private enforcement of § 602 of that provision by implied cause of action in *Alexander v. Sandoval* just a year before *Gonzaga*. *See Alexander v. Sandoval*, 532 U.S. 275, 287-89 (2001).

¹¹² *Gonzaga*, 536 U.S. at 290.

sue “if set forth ‘unambiguously’ in the statute’s ‘text and structure.’”¹¹³ Justice Stevens’s dissent noted that that majority conflated causes of action under § 1983 and implied causes of action generally (as delineated by *Cort v. Ash*), thus imposing a more stringent test on plaintiffs seeking to vindicate rights under § 1983 and a greater burden on Congress to include rights-creating language in federal laws.¹¹⁴ Justice Stevens also noted that it is virtually impossible to reconcile *Gonzaga* with *Wilder* and *Wright v. City of Roanoke Redevelopment & Housing Authority*, accusing the majority of silently overruling the two precedents.¹¹⁵

Three days before the decision in *Gonzaga*, the Court issued an opinion in another Spending Clause case, *Barnes v. Gorman*.¹¹⁶ Writing for the majority, Justice Scalia reiterated the analysis articulated in his *Blessing* concurrence and, relying on *Pennhurst*’s contract analogy, determined that because punitive damages are not available for breach of contract, they are not available for violations of federal conditions on spending.¹¹⁷ More specifically, the Court held that the contract analogy does not allow for punitive damages because the funding recipient must be “on notice that, by accepting federal funding, it exposes itself to liability of that nature.”¹¹⁸ The majority concluded that states would not accept federal funding if they knew at the time they accepted the funding that punitive damages would be available for violations of the conditions on spending.¹¹⁹ The majority also emphasized that the federal government and/or the funding

¹¹³ *Id.* at 291 (Breyer, J., concurring). Justices Breyer and Souter agreed with the majority, however, that the precise language of FERPA does not confer an individual cause of action. *See id.* at 291-92.

¹¹⁴ *See id.* at 300-01 (Stevens, J., dissenting).

¹¹⁵ *Id.* at 300 n.8; *see supra* note 89.

¹¹⁶ *See Barnes v. Gorman*, 536 U.S. 181, 185-86 (2002). The plaintiff in this case (respondent) was a paraplegic who was injured when he was transported in a police van that was not equipped to transport people with such disabilities. *Id.* at 183-84. He successfully sued the local police under the Americans with Disabilities Act and section 504 of the Rehabilitation Act, and the jury awarded compensatory and punitive damages. *See id.* The issue confronting the Court was whether punitive damages could be awarded to a private plaintiff under the ADA or section 504, both of which contain Spending Clause elements. *See id.* at 185-86.

¹¹⁷ *See id.* at 187.

¹¹⁸ *Id.* The majority relied on the dissenting language in a series of Title IX cases beginning with Justice Kennedy’s dissent in *Davis v. Monroe County Board of Education*, 526 U.S. 629, 654 (1999). Justice Kennedy’s dissent became the majority view in *Arlington Central School District Board of Education v. Murphy*, 548 U.S. 291, 304 (2006).

¹¹⁹ *See Barnes*, 536 U.S. at 188.

recipient are made whole when the state's contractual obligation is fulfilled.¹²⁰ Thus, the 2001-2002 term produced two cases that continued the movement toward limited remedies for private parties injured by states' failure to meet conditions placed on federal funds. These two cases were part of the Rehnquist Court's quest for clear statement rules in federal legislation.¹²¹

Gonzaga allowed *Thiboutot* to remain good, albeit hobbled, precedent. On the other hand, *Arlington Central School District Board of Education v. Murphy*, a first-term Roberts Court case, furthered the Rehnquist Court's goal of reining in individuals' ability to enforce conditions on spending against the states. In *Arlington*, Justice Alito articulated a narrowed standard for conditions on spending by requiring Congress to give the states "clear notice" of all conditions on spending before they accept federal funds.¹²² *Arlington* seems to render the *Gonzaga* modification of the *Blessing* test even narrower, refusing any inference that § 1983 would allow private causes of action without explicit statutory language.¹²³

¹²⁰ See *id.* at 188-89.

¹²¹ See Thomas M. Merrill, *Rescuing Federalism after Raich: The Case for Clear Statement Rules*, 9 LEWIS & CLARK L. REV. 823, 825 (2005). Professor Merrill set forth examples of the Rehnquist Court's search for clear statement rules:

Thus, in cases involving the States' immunity from lawsuits under the [11th] Amendment, the Court held that such suits were permitted only if authorized by Congress in "clear and unmistakable" language in the statute. The Court similarly held that conditions attached to grants of federal monies could be enforced against the States only if set forth "unambiguously" in the grant. And in *Gregory v. Ashcroft*, the Court said it would interpret a federal regulatory statute to apply to traditional state functions, such as the appointment of state judges, only if there was a "plain statement" from Congress requiring this result.

Id. (citations omitted).

¹²² See *Arlington*, 548 U.S. at 296; see also Denise C. Morgan & Rebecca E. Zeitlow, *The New Parity Debate: Congress and Rights of Belonging*, 73 U. CIN. L. REV. 1347, 1364-66 (2005) (enumerating ways in which Rehnquist federalism revolution narrowed avenues of enforcing individual rights and noting then-unexecuted interest of conservative justices in containing individuals' ability to enforce conditions on spending and Spending Clause power in general).

¹²³ A 2003 preemption case, *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644 (2003), also provided a platform for Justices Scalia and Thomas to articulate skepticism regarding private causes of action to enforce conditions on spending. See *id.* at 675 (Scalia, J., concurring); *id.* at 682-83 (Thomas, J., concurring). Justice Thomas noted his doubt that beneficiaries of cooperative federalism programs can sue to enforce their benefits, stating: "[W]ere the issue to be raised, I would give careful consideration to whether Spending Clause legislation can be enforced by third parties in the absence of a private right of action." *Id.* at 683.

Despite Justices Scalia, Thomas, and Kennedy's leeriness to allow private enforcement of conditions on spending by § 1983 claims,¹²⁴ legislation created under the Spending Clause is still the law of the land. The contract analogy cannot be more than that — an analogy, perhaps a model for analysis, but not the law. Otherwise, conditions placed on state acceptance of federal funds pursuant to the Spending Clause would have less influence than other federal laws, and states could take federal money with less fear of enforcement or penalty.¹²⁵ Surely the Court does not intend to indicate that spending legislation is not underpinned by the Supremacy Clause.¹²⁶ Furthermore, third-party beneficiaries in the modern era can enforce contractual provisions intended to benefit them.¹²⁷ States participate in Medicaid to benefit their poorest, neediest citizens, and they cannot be surprised that enrollees are the intended beneficiaries of the partnership between the federal and state governments.

¹²⁴ For a more extreme position on this issue, see David E. Engdahl, *The Spending Power*, 44 DUKE L.J. 1, 49-53 (1994), which argues that the "Taxing Clause" does not authorize federal spending and that instead the Article IV property clause authorizes limited spending powers for Congress. Professor Engdahl also asserted that the decision in *Thiboutot* "simply is nonsense" because beneficiaries of federal spending directed at states should never have had the right to sue to collect on the conditioned spending, and he predicted that the possibility of the opinion's "survival in the face of candid reassessment is very poor." *Id.* at 108. Fundamental elements of the *Thiboutot* doctrine have survived, but it certainly is a weakened precedent after nearly three decades of chipping away.

¹²⁵ See Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement*, 58 VA. L. REV. 600, 619-20 (1972) (explaining that federal agencies tend not to enforce spending programs they oversee against states — instead, they attempt to coax cooperation — and why beneficiary involvement would be helpful); see also Jane Perkins, *Medicaid: Past Successes and Future Challenges*, 12 HEALTH MATRIX 7, 32-33 (2002) (noting that DHHS can withdraw all funding from state if it fails to comply with its approved State Plan, but that this remedy has not been applied because it is too draconian).

¹²⁶ See U.S. CONST. art. VI, cl. 2. Medicaid enrollees have had some minor success with a Supremacy Clause argument that a state can "violate" the Supremacy Clause by providing benefits that are so minimal as to "conflict" with the federal scheme, even though Medicaid is a cooperative federalism program and not usually subject to preemption analysis. See generally *Lankford v. Sherman*, 451 F.3d 496 (8th Cir. 2006) (allowing claim that Missouri failed to comply with certain Medicaid Act requirements and thus had violated Supremacy Clause to survive summary judgment).

¹²⁷ See FARNSWORTH, *CONTRACTS*, *supra* note 104, § 10.3 (describing modern rule for contract beneficiaries); see also *Lawrence v. Fox*, 20 N.Y. 268, 272-75 (1859).

2. Trends

The thread of Spending Clause enforcement via § 1983 Supreme Court cases reveals at least three ongoing and important developments. First, the contract analogy for Spending Clause legislation that imposes conditions on states' use of federal funds remains in vogue. The Court first articulated the idea of conditions on spending as an agreement between the state and the federal government in *Steward Machine Co. v. Davis*, but the more severe contract analogy was made popular by Associate Justice Rehnquist in *Pennhurst*.¹²⁸ *Pennhurst* is the key citation for federal judges who believe that conditions on federal spending should be curbed to protect states.¹²⁹ One of the more notable examples, *Sabree v. Houston*, relied on *Pennhurst* for the proposition that spending legislation rarely confers individual causes of action through § 1983.¹³⁰ The district court's rejection of all causes of action related to enforcing Medicaid provisions¹³¹ was reversed by the Third Circuit

¹²⁸ See *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 16-17 (1981); see also *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 593-98 (1937) (describing and approving of conditions on federal spending as being in nature of agreement between state and federal government to undertake common goal). The majority in *Steward Machine* was careful to describe conditions on federal spending as statutory requirements that created an agreement with the states, and it did not wholly endorse or reject the idea of the contract analogy; in other words, Justice Rehnquist stretched the language of *Steward Machine's* majority in *Pennhurst*. See *Steward*, 301 U.S. at 597-98. Justice Cardozo wrote:

The inference of abdication thus dissolves in thinnest air when the deposit is conceived of as dependent upon a statutory consent, and not upon a contract effective to create a duty. By this we do not intimate that the conclusion would be different if a contract were discovered The states are at liberty, upon obtaining the consent of Congress, to make agreements with one another. We find no room for doubt that they may do the like with Congress if the essence of their statehood is maintained without impairment Nowhere in our scheme of government — in the limitations express or implied of our federal constitution — do we find that she is prohibited from assenting to conditions that will assure a fair and just requital for benefits received.

Id. at 597-98 (citations omitted). *Steward* is also an important case for rejecting the Tenth Amendment argument against allowing conditions on federal spending, an idea that seems to lurk behind the most recent Spending Clause decisions. *Id.* at 595-96.

¹²⁹ See, e.g., *Doe v. Kidd*, 501 F.3d 348, 366 (4th Cir. 2007); *Ball v. Rodgers*, 492 F.3d 1094, 1104 (9th Cir. 2007); *Sanchez v. Johnson*, 416 F.3d 1051, 1056 (9th Cir. 2005).

¹³⁰ See *Sabree ex rel. Sabree v. Houston*, 245 F. Supp. 2d 653, 657-58 (E.D. Pa., 2003), *rev'd*, 367 F.3d 180 (3d Cir. 2004).

¹³¹ See *id.* Judge Hutton wrote: “[S]ection 1396 of Title XIX does not have the rights-creating language integral to a showing of [c]ongressional intent to confer

Court of Appeals, but then-Judge Alito revealed in a concurrence that he believed the district court articulated the direction of “future Supreme Court cases.”¹³² The future described by the district court expressed skepticism that spending legislation can “confer individual rights.”¹³³ At first blush, Judge Alito’s concurrence would indicate a change of heart from *Pennsylvania Pharmacists Ass’n v. Houstoun* in which he had written that the new version of the Boren Amendment was not enforceable by pharmacists against the Secretary of the Pennsylvania Department of Public Welfare but then hinted that Medicaid enrollees might be able to assert § 1983 claims.¹³⁴ However, Judge Alito’s majority opinion in *Houstoun* is not so different from his *Sabree* concurrence, because in choosing to diverge from the trend in other circuits, the *Houstoun* opinion radically narrowed the ability of Medicaid healthcare providers to enforce standards regarding reimbursement for their services.¹³⁵

Dissenting justices have expressed apprehension over the contract analogy numerous times. Justice Souter’s and Justice Stevens’s concurrences in *Barnes v. Gorman* underscored the increasing rigidity with which the Court has applied the analogy.¹³⁶ Justice Souter, joined by Justice O’Connor, pointed out that the contract analogy would not be a proper model in all cases of private claims under Spending Clause legislation.¹³⁷ Justice Stevens highlighted the Court’s interest in expanding the contract-analogy reasoning from *Pennhurst*, which has been a clear trend.¹³⁸ The analogy taken literally also closes the courthouse doors, which was attempted in the Medicaid context in

rights.” *Id.* at 659.

¹³² *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 194 (3d Cir. 2004) (Alito, J., concurring).

¹³³ See *Sabree*, 245 F. Supp. 2d at 657.

¹³⁴ See *Pa. Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 541-42 (3d Cir. 2002) (holding that healthcare providers could not enforce Medicaid’s sufficient payment provision). This Medicaid provision is the somewhat weaker follow-up to the repealed Boren Amendment. See 42 U.S.C. § 1396a(a)(13) (1994) (repealed 1997) (concerning adequate payment for providers).

¹³⁵ Justice Alito appears to have drawn on the *Wilder* dissent’s insistence on narrow statutory interpretation in § 1983 causes of action. See *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 526 (1990).

¹³⁶ See 536 U.S. 181, 190-91 (2002) (Souter, J., concurring).

¹³⁷ See *id.* (“I . . . read the Court’s opinion as acknowledging, that the contract-law analogy may fail to give such helpfully clear answers to other questions that may be raised by actions for private recovery under Spending Clause legislation . . .”).

¹³⁸ See *id.* at 193 n.2 (Stevens, J., concurring) (pointing out dangers of contract analogy and denouncing district court’s decision in *Westside Mothers v. Haveman*).

the infamous district court decision in *Westside Mothers v. Haveman*.¹³⁹

A second notable trend is that changes in the composition of the Court during the Roberts era have enhanced support for the contract analogy and the corollary argument against private enforcement claims. Justice Alito, while serving on the Third Circuit, narrowed Medicaid healthcare providers' ability to enforce reimbursement provisions through § 1983 and endorsed a district court decision that would have denied entirely private causes of action to enforce Medicaid statutory provisions.¹⁴⁰ Also, though representing clients in private practice is not a perfect predictor, when Chief Justice Roberts represented Gonzaga University before the Supreme Court, he advanced the idea that § 1983 cannot apply to Spending Clause legislation due to the third-party beneficiary theory.¹⁴¹ John Roberts had also taken this position as Deputy Solicitor General submitting an amicus brief in *Wilder*.¹⁴² Justice Alito and Chief Justice Roberts thus appear to agree with the Scalia and Kennedy *Blessing* concurrence, which invited cases that would allow a direct attack on private enforcement of spending legislation.¹⁴³ Justice Thomas has likewise rejected private causes of action to enforce spending clause legislation.¹⁴⁴ Justice O'Connor's departure is also important for this

¹³⁹ See *Westside Mothers v. Haveman*, 133 F. Supp. 2d 549, 575-82 (2001); see also Chemerinsky, *supra* note 11, at 538-39 (describing trend toward limiting civil rights actions in Rehnquist Court years); Erwin Chemerinsky, *Ensuring the Supremacy of Federal Law: Why the District Court Was Wrong in Westside Mothers v. Haveman*, 12 HEALTH MATRIX 139, 147 (2002) (decrying district court's decision for taking contract analogy too literally, to nonsensical result) [hereinafter Chemerinsky, *Ensuring*].

¹⁴⁰ See *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 194 (3d Cir. 2004) (Alito, J., concurring).

¹⁴¹ See Brief of Petitioners at 39-43, *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002) (No. 01-679).

¹⁴² See Brief for the United States as Amicus Curiae Supporting Petitioners at 11, *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498 (1990) (No. 88-2043).

¹⁴³ See *Blessing v. Freestone*, 520 U.S. 329, 350 (1997) (Scalia, J., concurring). Justice Scalia wrote:

It must be acknowledged that *Wright* and *Wilder* permitted beneficiaries of federal-state contracts to sue under § 1983, but the [contract] argument set forth above was not raised. *I am not prepared without further consideration to reject the possibility that third-party-beneficiary suits simply do not lie.* I join the Court's opinion because, in ruling against respondents under the *Wright/Wilder* test, it leaves that possibility open.

Id. (emphasis added).

¹⁴⁴ See *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 683 (2003) (Thomas, J. concurring); see also *supra* note 123.

calculus, as she did not vote consistently with the other states'-rights Justices against private parties.¹⁴⁵

The third trend is that it appears an "intentionalist" reading currently dominates § 1983 jurisprudence, though the jurists who apply the narrow reading of § 1983's reach tend to claim a "textualist" approach.¹⁴⁶ In other words, Justices Scalia, Kennedy, and Thomas have championed the theory that the Congress that drafted § 1983 in 1871 would not have intended § 1983 to extend to the citizens benefited by federal spending programs or cooperative federalism programs (such as Medicaid). This idea is at least questionable, given that § 1983's plain words specifically protect something more than constitutional rights; the statute provides a claim for relief for violations of "rights, privileges, or immunities secured by the Constitution and laws . . ."¹⁴⁷ The language "and laws" includes statutory rights in § 1983's protections; and, if the language of the statute is clear, legislative history need not be consulted.¹⁴⁸ Justice

¹⁴⁵ See, e.g., *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167 (2005) (voting with individual-rights four to allow retaliation claim to move forward under Title IX). In *Jackson*, a male physical education teacher and coach complained of sex discrimination in the school's athletics program and was fired from his coaching job for repeated complaints of unequal funding and access for his girls' basketball team. *Id.* at 171-72. Justice O'Connor's majority read Title IX broadly to allow the retaliation claim, even though the coach had not experienced sex discrimination directly. *Id.* at 174. As Professor Baker has noted, Justice O'Connor read the statute as a civil rights-type statute and was inclined to interpret it broadly. See Lynn A. Baker, *Lochner's Legacy for Modern Federalism: Pierce County v. Guillen as a Case Study*, 85 B.U. L. REV. 727, 760-61 (2005).

¹⁴⁶ See Philip P. Frickey, *Transcending the Routine: Methodology and Constitutional Values in Chief Justice Rehnquist's Statutory Cases*, in *THE REHNQUIST LEGACY* 266-68 (Craig M. Bradley ed., 2006). Professor Frickey briefly describes three approaches to legislative interpretation: textualist, which denotes an inclination to read only the words of the statute; intentionalist, which signifies an interest in legislative history and congressional intent; and purposivist, which allows a judge to read statutes flexibly, as living documents, to fulfill "reasonable policy outcomes." *Id.*; see also WILLIAM N. ESKRIDGE, JR., PHILIP P. FRICKEY & ELIZABETH GARRETT, *LEGISLATION AND STATUTORY INTERPRETATION* 219-45 (2d ed. 2006) (describing and critiquing three theories and their postulates).

¹⁴⁷ 42 U.S.C. § 1983 (2006) (emphasis added).

¹⁴⁸ See, e.g., *Hartford Underwriters Ins. Co. v. Union Planters Bank, N.A.*, 530 U.S. 1, 6 (2000). Authoring the majority, Justice Scalia wrote:

[W]e begin with the understanding that Congress "says in a statute what it means and means in a statute what it says there." . . . [W]hen "the statute's language is plain, 'the sole function of the courts'" — at least where the disposition required by the text is not absurd — "is to enforce it according to its terms."

Scalia has asserted that “legislative intent is an oxymoron,”¹⁴⁹ yet his approach to § 1983 is not textualist, and limits plaintiffs’ access to the court system.¹⁵⁰

B. Beyond Gonzaga — The Double Circuit Split

Despite Chief Justice Rehnquist’s goal of clarifying § 1983 causes of action to enforce federal statutes,¹⁵¹ *Gonzaga’s* legacy is a hodgepodge of lower court decisions. Some courts have substituted *Gonzaga* for the first element of the *Blessing* test,¹⁵² some courts primarily have substituted *Gonzaga* for, or conflate, *Gonzaga* and *Blessing*,¹⁵³ and

Id. (internal citations omitted). Before Justice Scalia joined the Court, Justice Rehnquist had begun to seek a “constrained approach” to statutory interpretation, a legacy of the Rehnquist Court. See Frickey, *supra* note 146, at 267-68. Professor Frickey describes Justice Scalia’s approach as “text based.” See *id.* at 268-69. For a brief list of the major scholarship on Justice Scalia’s textualist approach to legislation, see ESKRIDGE, FRICKEY & GARRETT, *supra* note 146, at 230 n.33.

¹⁴⁹ Frickey, *supra* note 146, at 271 (adding that Justice Thomas tends to agree with Justice Scalia’s “absolute exclusionary rule” regarding legislative findings).

¹⁵⁰ See *supra* notes 107-12 and accompanying text.

¹⁵¹ Chief Justice Rehnquist wrote that *Blessing* might have created “confusion” and “uncertainty.” *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282-83 (2002). The majority acknowledged that its opinions in the § 1983 arena had created confusion in the lower courts and were not “models of clarity,” which inspired the Court to grant certiorari to “resolve any ambiguity.” *Id.* at 278.

¹⁵² See, e.g., *Ball v. Rodgers*, 492 F.3d 1094, 1104-06 (9th Cir. 2007); *Mandy R. v. Owens*, 464 F.3d 1139, 1146-48 (10th Cir. 2006), *cert. denied sub nom.* *Mandy R. v. Ritter*, 127 S. Ct. 1905 (2007); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542 (6th Cir. 2006); *Lankford v. Sherman*, 451 F.3d 496, 508-09 (8th Cir. 2006); *Harris v. Olszewski*, 442 F.3d 456, 461, 463 (6th Cir. 2006); *Watson v. Weeks*, 436 F.3d 1152, 1160 (9th Cir. 2006), *cert. denied sub nom.* *Goldberg v. Watson*, 127 S. Ct. 598 (2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1052 (9th Cir. 2005); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602-04 (5th Cir. 2004); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 184 (3rd Cir. 2004); *Equal Access for El Paso v. Hawkins*, 428 F. Supp. 2d 585, 610-13 (W.D. Tex. 2006), *rev’d*, 509 F.3d 697 (5th Cir. 2007); *Nelson v. Milwaukee County*, No. 04 C 0193, 2006 WL 290510 (E.D. Wis. Feb. 7, 2006); *Nat’l Med. Care, Inc. v. Rullan*, No. Civ. 04-1812(HL), 2005 WL 2878094 (D.P.R. Nov. 1, 2005), *motion to certify appeal granted by* No. Civ. 04-1812(HL), 2006 WL 130766 (D.P.R. Jan. 13, 2006); *Mundell v. Bd. of County Comm’rs of Saguache County*, No. Civ.A05CV00585REBMJW, 2005 WL 2124842 (D. Colo. Sept. 2, 2005); *Reynolds v. Giuliani*, No. 98 Civ.8877(WHP), 2005 WL 342106 (S.D.N.Y. Feb. 14, 2005); *Michelle P. ex rel. Deisenroth v. Holsinger*, 356 F. Supp. 2d 763 (E.D. Ky. 2005); *Health Care for All, Inc. v. Romney*, No. Civ.A.00-10833-RWZ, 2004 WL 3088654 (D. Mass. Oct. 1, 2004); *Memisovski ex rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332 (N.D. Ill. Aug. 23, 2004); *Masterman v. Goodno*, No. Civ.03-2939(JRI/FLN), 2004 WL 51271 (D. Minn. Jan. 8, 2004); *Kenny A. ex rel. Winn v. Perdue*, 218 F.R.D. 277 (N.D. Ga. 2003).

¹⁵³ See, e.g., *Hawkins*, 509 F.3d at 704; *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d

some courts effectively ignore *Gonzaga*.¹⁵⁴ In the context of Medicaid enforcement claims, the *Gonzaga* circuit split is further complicated by

452, 456-57 (7th Cir. 2007); *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F.3d 56, 73 n.10 (1st Cir. 2005) (applying *Gonzaga* analysis but *Blessing* requirements were also met); *Rabin v. Wilson-Coker*, 362 F.3d 190, 201-02 (2d Cir. 2004); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004); *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 911 (7th Cir. 2003); *Molina Healthcare of Ind. v. Henderson*, No. 1:06-cv-1483-JDT-WTL, 2006 WL 3518269, at *7-9 (S.D. Ind. Dec. 4, 2006); *Bertrand v. Maram*, No. 05 C 0544, 2006 WL 2735494, at *5 (N.D. Ill. Sept. 25, 2006), *aff'd*, 495 F.3d 452 (7th Cir. 2007); *M.K.B. v. Eggleston*, 445 F. Supp. 2d 400 (S.D.N.Y. 2006); *Bio-Med. Applications of N.C., Inc. v. Elec. Data Sys. Corp.*, 412 F. Supp. 2d 549, 553 (E.D.N.C. 2006); *Clark v. Richman*, 339 F. Supp. 2d 631, 637 (M.D. Pa. 2004); *Watson v. Thorne*, No. 03-227-JE, 2004 WL 1445113, at *2 (D. Or. Jun. 24, 2004), *aff'd in part, rev'd in part sub nom. Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006); *Sanders ex rel. Rayl v. Kan. Dep't of Soc. and Rehab. Servs.*, 317 F. Supp. 2d 1233, 1249-50 (D. Kan. 2004); *Ass'n of Residential Res. in Minn. v. Minn. Comm'r of Human Servs.*, No. Civ.03-2438(JRT/FLN), 2003 WL 22037719, at *5 (D. Minn. Aug. 29, 2003); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1305-08 (D. Utah. 2003); *Burlington United Methodist Family Servs., Inc. v. Atkins*, 227 F. Supp. 2d 593, 596 n.3 (S.D. W. Va. 2002); *Am. Soc'y of Consultant Pharmacists v. Concannon*, 214 F. Supp. 2d 23, 28 (D. Me. 2002).

¹⁵⁴ See, e.g., *Doe v. Kidd*, 501 F.3d 348, 355-56 (4th Cir. 2007), *cert. denied*, 128 S. Ct. 1483 (2008) (relying on *Blessing*); *Spry v. Thompson*, 487 F.3d 1272, 1275-76 (9th Cir. 2007) (relying on circuit precedent); *Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1214-15 (10th Cir. 2007), *cert. denied*, 128 S. Ct. 68 (2007) (relying on circuit precedent); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1014-15 (8th Cir. 2006) (arguing that *Gonzaga* did not alter precedent; even if it did, decisions in this litigation would have been correct); *Clayworth v. Bonta*, 140 F. App'x 677, 678-79 (9th Cir. 2005) (relying on circuit history); *Gean v. Hattaway*, 330 F.3d 758 (6th Cir. 2003) (ignoring *Gonzaga*); *Rolland v. Romney*, 318 F.3d 42, 52 (1st Cir. 2003) (appearing to ignore *Gonzaga* modification of *Blessing*); *Bryson v. Shumway*, 308 F.3d 79, 88-89 (1st Cir. 2002) (acknowledging *Gonzaga* but relying on *Blessing* test); *Barton v. Summers*, 293 F.3d 944, 953-54 (6th Cir. 2002) (ignoring *Gonzaga*); *Queer v. Westmoreland County*, No. 2:06-cv-325, 2007 WL 2407283, slip op. at *7 (W.D. Pa. Aug. 20, 2007) (ignoring *Blessing* and *Gonzaga*); *Lewis v. Rendell*, 501 F. Supp. 2d 671, 686-88 (E.D. Pa. 2007) (relying on circuit precedent pre- and post-*Gonzaga* and *Blessing* test); *Clark K. v. Guinn*, No. 2:06-CV-1068-RJ-RJJ, 2007 WL 1435428 (D. Nev. May 14, 2007) (relying on circuit precedent); *Katie A. v. Bonta*, 433 F. Supp. 2d 1065, 1070-71 (C.D. Cal. 2006), *rev'd on other grounds sub nom. Katie A. ex rel. Ludin v. L.A. County*, 481 F.3d 1150 (9th Cir. 2007); *Beeker v. Olszewski*, 415 F. Supp. 2d 734 (E.D. Mich. 2006) (relying primarily on *Wilder*); *A.G. ex rel. Giddens v. Arnold*, No. 5:05CV2790C10GRJ, 2006 WL 334218, at *2 (M.D. Fla. Feb. 13, 2006) (ignoring *Gonzaga*); *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52 (D. Mass. 2006) (relying on circuit precedent); *Protestant Mem'l Med. Ctr., Inc. v. Maram*, No. 5-CV-03-DRH, 2005 WL 2464460, at *4-5 (S.D. Ill. Oct. 4, 2005) (ignoring both *Gonzaga* and *Blessing* but employing *Wilder*); *Kapable Kids Learning Ctr., Inc. v. Ark. Dep't of Human Servs.*, 420 F. Supp. 2d 956, 959-62 (E.D. Ark. 2005) (ignoring *Gonzaga*); *Mejia ex rel. Ramirez v. City of New York*, No. 01 Civ. 3381(GBD), 2004 WL 2884407, at *9-11 (S.D.N.Y. Dec. 10, 2004) (ignoring *Gonzaga*); *Ball v. Biedess*, No.

a line of federal court cases that created an additional circuit split based upon a definition of “medical assistance” that asserts Medicaid is only a source of money.¹⁵⁵ At least two important possibilities arise from this double circuit split: first, the Roberts Court may revisit *Gonzaga* in the context of Medicaid entitlements; and second, the Court can affect Medicaid deeply by denying petitions for certiorari in cases that allow decisions to stand that limit private causes of action and that limit the courts’ understanding of the Medicaid program.

1. Patterns in the Uneven Application of *Gonzaga*

Though *Gonzaga* applies to all private attempts to redress violations of federal law through § 1983 claims, this section will focus on studying Medicaid-related claims. There are multiple Medicaid Act provisions that enrollees seek to enforce, but three foundational statutory sections account for many splits among federal circuit courts. These statutory provisions mandate certain elements for state Medicaid plans to qualify for federal funding under Medicaid; as states must comply with these terms to receive federal funding, these are classic conditions on Spending Clause legislation that create a cooperative federalism program. The three provisions are 42 U.S.C. § 1396a(a)(8), the “reasonable promptness” provision; 42 U.S.C. § 1396a(a)(10), the “minimum services” provision (which also encompasses “comparability”); and 42 U.S.C. § 1396a(a)(30)(A), the “equal access” provision, which is the current statutory adaptation of the repealed Boren Amendment.¹⁵⁶

CIV00-0067-TUC-EHC, 2004 WL 2566262, at *5-6 (D. Ariz. Aug. 13, 2004), *affd in part, rev’d in part sub nom. Ball*, 492 F.3d 1094 (relying on circuit precedent); *In re NYAHSAs Litig.*, 318 F. Supp. 2d 30, 38 (N.D.N.Y. 2004), *affd per curiam sub nom. N.Y. Ass’n of Homes & Servs. for the Aging v. DeBuono*, 444 F.3d 147 (2d Cir. 2006) (relying on *Blessing* test, though mentioning *Gonzaga* for “creating rights” language); *Mendez v. Brown*, 311 F. Supp. 2d 134, 137-40 (D. Mass. 2004) (relying primarily on *Blessing*, but also analyzing Medicaid provisions in question under *Gonzaga* in response to defendant’s arguments that *Gonzaga* is new standard); *Kerr v. Holsinger*, No. Civ.A.03-68-H, 2004 WL 882203, at *3-4 (E.D. Ky. Mar. 25, 2004) (ignoring *Gonzaga*); *Lewis v. N.M. Dep’t of Health*, 275 F. Supp. 2d 1319, 1333 (D.N.M. 2003) (ignoring *Gonzaga*); *Collins ex rel. Collins v. Hamilton*, 231 F. Supp. 2d 840, 847 (S.D. Ind. 2002), *affd*, 349 F.3d 371 (7th Cir. 2003) (ignoring *Gonzaga*); *Wilson-Coker v. Thompson*, 222 F. Supp. 2d 190, 196-97 (D. Conn. 2002) (relying primarily on *Blessing* and circuit precedent pre-*Gonzaga*); *Martin v. Taft*, 222 F. Supp. 2d 940, 975-79 (S.D. Ohio 2002) (ignoring *Gonzaga*); *Alexander A. ex rel. Barr v. Novello*, 210 F.R.D. 27, 35 (E.D.N.Y. 2002) (ignoring *Gonzaga*).

¹⁵⁵ See *Bruggeman*, 324 F.3d at 910.

¹⁵⁶ See 42 U.S.C. § 1396a(a)(8) (2006) (“A State plan for medical assistance must . . . provide that all individuals wishing to make application for medical

Circuit courts that have addressed enrollee enforcement of the reasonable promptness provision often also addressed the minimum services provision and/or the equal access provision. Prior to *Gonzaga*, the Eleventh Circuit Court of Appeals provided the standard for parsing the reasonable promptness provision in *Doe v. Chiles*, which held that developmentally disabled individuals could seek redress for failure to provide Medicaid-promised services under § 1983.¹⁵⁷ After *Gonzaga*, most circuit courts have upheld the private enforceability of the reasonable promptness provision,¹⁵⁸ but some district courts have taken reasonable promptness claims as opportunities to declare that no private rights can be enforced under the Medicaid Act pursuant to *Gonzaga*.¹⁵⁹

Circuit courts that have addressed the minimum services provision

assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals”); 42 U.S.C. § 1396a(a)(10) (“A State plan for medical assistance must . . . provide — (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of [§] 1905a(a), to — all individuals —”); 42 U.S.C. § 1396a(a)(30)(A) (“A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”).

¹⁵⁷ See *Doe v. Chiles*, 136 F.3d 709, 714-19 (11th Cir. 1998). The decision also addressed sovereign immunity, finding that the *Ex parte Young* doctrine permitted the district court to award injunctive relief to the plaintiffs. See *id.* at 720-21.

¹⁵⁸ See *Kidd*, 501 F.3d at 356, *cert. denied*, 128 S. Ct. 1483 (Mar. 3, 2008) (No. 07-913); *Bertrand*, 495 F.3d at 457-58; *Fogarty*, 472 F.3d at 1214; *Mandy R. v. Owens*, 464 F.3d 1139, 1143 (10th Cir. 2006) (assuming that § 1983 allows private parties to challenge reasonable promptness provision and minimum care and services provision), *cert. denied* *Mandy R. v. Ritter*, 127 S. Ct. 1905 (2007); *Westside Mothers v. Olszewski*, 454 F.3d 532, 540-42 (6th Cir. 2006); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004); *Bryson*, 308 F.3d at 88-89. The First Circuit decided a related case in 2005 and upheld its opinion in *Bryson v. Shumway*. See *Rullan*, 397 F.3d at 73-75 (allowing § 1983 cause of action to require payment review for federally qualified health centers in Puerto Rico, and relying on similar decision by Second Circuit in *Community Health Center v. Wilson-Coker*, 311 F.3d 132 (2d Cir. 2002)).

¹⁵⁹ See, e.g., *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1307-08 (D. Utah 2003) (rejecting analyses of circuit courts that found reasonable promptness provision to be enforceable after *Gonzaga*, and holding provision unenforceable for lack of rights-creating language); *Sabree ex rel. Sabree v. Houston*, 245 F. Supp. 2d 653, 657, 660-61 (E.D. Pa. 2003) (explaining that Medicaid Act is never privately enforceable under theory that no third-party beneficiary rights exist under Spending Clause legislation), *overturned by Sabree*, 367 F.3d at 180.

have allowed Medicaid enrollees to seek redress through § 1983. The Third, Fifth, and Ninth Circuit Courts of Appeals have permitted Medicaid enrollees to enforce the Medicaid Act through § 1983, even applying *Gonzaga* to the claims.¹⁶⁰ The circuit courts have determined that the minimum services provision creates an enforceable right through § 1983 because the statutory language is framed in terms of individual rights to medical assistance.¹⁶¹ In analyzing and adopting the post-*Gonzaga* analysis of the Third and Fifth Circuits, the Ninth Circuit found the language of the minimum services provision (“A State plan . . . must provide for making medical assistance available . . . to all individuals”) indistinguishable from the language in Titles VI and IX that the *Gonzaga* Court used as an example of clearly created individual rights enforceable through § 1983.¹⁶² The trick to minimum services claims, however, is that the plaintiffs must be within a category of eligibility that entitles them to the claimed benefit; even if the plaintiffs are within that category, if the benefit is optional rather than mandatory, the state can apply for a waiver or amend its State plan to avoid the plaintiffs’ § 1983 action. An example of this kind of gamesmanship occurred in the Eighth Circuit Court of Appeals decision *Lankford v. Sherman* and prevented that court from determining whether minimum services are still enforceable after *Gonzaga*.¹⁶³

Federal appellate courts that have addressed the enforceability of the equal access provision have determined that providers, and sometimes enrollees, no longer have the ability to privately enforce the terms of the Medicaid statute.¹⁶⁴ A handful of cases highlight the trends

¹⁶⁰ See *Watson v. Weeks*, 436 F.3d 1152, 1159-62 (9th Cir. 2006), *cert. denied* 127 S. Ct. 598 (2006); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 603 (5th Cir. 2004) (explaining that minimum services provision contains “precisely the sort of ‘rights-creating’ language identified in *Gonzaga* as critical to demonstrating a congressional intent to establish a new right”); *Sabree*, 367 F.3d at 190 (“[I]t [is] difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant [Medicaid Act] language — ‘A State plan must provide’ — from the ‘No person shall’ language of Titles VI and IX.”).

¹⁶¹ See, e.g., *Watson*, 436 F.3d at 1160-61. The court wrote, “This language is unmistakably focused on the specific individuals . . . who meet eligibility requirements.” *Id.* at 1160. A related provision, 42 U.S.C. § 1396a(a)(17), was not enforceable through § 1983. See *id.* at 1162-63.

¹⁶² See *id.* at 1160-61.

¹⁶³ See *Lankford v. Sherman*, 451 F.3d 496, 506 (8th Cir. 2006).

¹⁶⁴ Most recently the Fifth Circuit so held. See *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 703-04 (5th Cir. 2007) (holding that healthcare providers and enrollees could not force Texas to increase payment rates to Medicaid providers in effort to force state to comply with equal access provision, overruling pre-*Gonzaga* decision in *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908 (5th Cir. 2000), to

regarding denying private enforcement of the equal access provision after *Gonzaga*. The Third Circuit augured the *Gonzaga* decision by three months in holding that pharmacists could not enforce the Medicaid equal access provision.¹⁶⁵ Then-Judge Alito reasoned that Congress did not intend to benefit Medicaid providers in enacting the equal access provision, and thus, they had no federal right that could be enforced under § 1983.¹⁶⁶ The majority stated in dicta that enrollees could enforce the equal access provision, or DHHS should ensure that states are administering their Medicaid plans as required.¹⁶⁷ As a result of *Gonzaga*, the First Circuit Court of Appeals also held that providers had no § 1983 cause of action to enforce the equal access provision, which reversed that circuit's position.¹⁶⁸ Next, the Ninth Circuit went a step further and decided that the equal access provision does not provide individuals a right that is enforceable after *Gonzaga* because the provision contains general language about requirements for state participation in Medicaid rather than an articulated individual right.¹⁶⁹ Thus, after *Gonzaga*, no § 1983 action by Medicaid providers or enrollees would be allowed in the Ninth Circuit under the equal access provision, but the opinion distinguished the reasonable promptness and minimum services provisions as permissible.¹⁷⁰ The Sixth Circuit Court of Appeals also held that the equal access provision could not be privately enforced by providers or enrollees after *Gonzaga*, though pre-*Gonzaga* the court

extent it allowed enrollees to enforce statutory rights under equal access provision).

¹⁶⁵ See *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 541-42 (3d Cir. 2002) (enrollees were not party to action).

¹⁶⁶ See *id.* at 536 (stating "it would be outlandish to argue that the *Wilder/Blessing* intended-to-benefit requirement permits ... 30(A) claims in federal court"); *id.* at 538 (reasoning that repeal of Boren Amendment and creation of equal access provision prevented interpreting 30(A) as federal right for Medicaid healthcare providers). The Third Circuit knowingly rejected the circuit decisions allowing Medicaid providers to enforce the equal access provision. See *id.* at 542.

¹⁶⁷ See *id.* at 543-44. Judge Becker's dissent vehemently disagreed and decried the belief that Medicaid enrollees could enforce the equal access provision without joining forces with Medicaid providers given the "severe financial hardship" enrollees suffer. *Id.* at 559 (Becker, J., dissenting).

¹⁶⁸ See *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57-59 (1st Cir. 2004) (enrollees were not party to action). The court in *Long Term Care* noted the circuit divide that predated *Gonzaga* and questioned whether *Gonzaga* would result in a "tidal shift or merely a shift in emphasis." *Id.* at 58-59.

¹⁶⁹ See *Sanchez v. Johnson*, 416 F.3d 1051, 1059 (9th Cir. 2005); see also Rosenbaum, *supra* note 14, at 34-35. In July 2007, the Ninth Circuit reiterated the *Sanchez* holding but permitted enforcement of Medicaid's "free choice" provisions. See *Ball v. Rodgers*, 492 F.3d 1094, 1102-03 (9th Cir. 2007).

¹⁷⁰ See *Sanchez*, 416 F.3d at 1059.

roundly rejected a notorious district court decision that would have eliminated all private causes of action for Spending Clause legislation.¹⁷¹

Finally, the Supreme Court was poised to decide a case on the triangle of Spending Clause jurisprudence, § 1983, and Medicaid, but the respondents settled the case and the Court issued a Disposal by Summary Action in *Selig v. Pediatric Specialty Care*.¹⁷² The Eighth Circuit issued three decisions in this litigation, and despite the intervening decision in *Gonzaga*, each of the decisions favored the private parties seeking redress through § 1983, which included both providers and enrollees in the Arkansas Medicaid program.¹⁷³ A 2002 opinion held that both the Medicaid providers and parents of enrollees could enforce Medicaid requirements via § 1983 against both the Arkansas Department of Human Services (“ADHS”) and its officers.¹⁷⁴ The circuit court remanded the case for further proceedings, but it returned to the appellate level in 2004.¹⁷⁵ The Eighth Circuit primarily reviewed the district court’s holding that failure to conduct a study to determine the implications of terminating services for special needs children was a violation of the equal access provision and the injunction prohibiting Arkansas from terminating services until an impact study was conducted.¹⁷⁶ The Eighth Circuit agreed that such a study was a prerequisite to terminating Medicaid services due to the

¹⁷¹ See *Westside Mothers v. Olszewski*, 454 F.3d 532, 540-43 (6th Cir. 2006) (rejecting private causes of action under § 1983 to enforce equal access provision and adopting Seventh Circuit’s interpretation of “medical assistance”); *Westside Mothers v. Olszewski*, 289 F.3d 852, 857-63 (6th Cir. 2002) (rejecting district court’s literal contract analysis for Spending Clause legislation and permitting § 1983 cause of action to enforce Medicaid programmatic requirements); *Westside Mothers v. Haveman*, 133 F. Supp. 2d 549, 575-76, 584 & n.20, 585 (E.D. Mich. 2001) (calling federal spending program contracts that did not create federal law unprotected by Supremacy Clause, avoiding *Ex parte Young* by declaring Michigan’s officers immune from suit, and rejecting use of § 1983 to enforce Medicaid provisions specifically and Spending Clause legislation generally).

¹⁷² See 127 S. Ct. 3000, 3000 (2007).

¹⁷³ *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs. (Pediatric III)*, 443 F.3d 1005, 1015-16 (8th Cir. 2006); *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs. (Pediatric II)*, 364 F.3d 925, 927-28 (8th Cir. 2004); *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs. (Pediatric I)*, 293 F.3d 472, 477-78 (8th Cir. 2002).

¹⁷⁴ See *Pediatric I*, 293 F.3d at 477-80. This decision primarily hinged upon the court’s interpretation of the minimum care and services provision, 42 U.S.C. § 1396a(a)(10). *Id.* at 479 n.5. The equal access provision, 42 U.S.C. § 1396a(a)(30), was not mentioned in the 2002 decision.

¹⁷⁵ See *Pediatric II*, 364 F.3d at 928-29.

¹⁷⁶ See *id.*

property interest Medicaid enrollees have in their benefits and the procedural due process claims that arise when proper methods are not used for withdrawing Medicaid benefits.¹⁷⁷

The circuit court issued its third opinion in *Pediatric Specialty Care* in 2006, and this go-round focused on the district court's damages award against past and present officers of ADHS and against ADHS as an agency.¹⁷⁸ Additionally, the Eighth Circuit considered *Gonzaga's* impact on its equal access provision analysis.¹⁷⁹ The opinion rejected the ADHS position that *Gonzaga* foreclosed all private causes of action to enforce provisions of the Medicaid Act and held that the equal access provision facilitates a cause of action for providers and enrollees alike.¹⁸⁰ Because the state officers appeared to be responsible for violations of the equal access provision and other elements of the Medicaid Act, the Eighth Circuit denied summary judgment based on Eleventh Amendment immunity for the officers as to both monetary damages and injunctive relief, but the court dismissed ADHS from the case based on state sovereign immunity.¹⁸¹

The Supreme Court granted certiorari to the state officers, whose brief argued both immunity from damages and the plaintiffs' inability to enforce the Medicaid equal access provision under § 1983.¹⁸² This

¹⁷⁷ See *id.* at 930-31. The Eighth Circuit did not agree, however, that the state's actions violated substantive due process. See *id.* at 931-32.

¹⁷⁸ See *Pediatric III*, 443 F.3d at 1008-09, 1017. Experts testified that ADHS restricted the care that could be approved for special needs children, contrary to the actual medical needs of the children. See *id.* at 1010. A private contractor for ADHS testified that it could approve only three and a half hours of care per day, even though six is generally medically indicated, and that doctors produced boiler-plate denials of care to facilitate the process of denying enrollees' claims. See *id.* The plaintiffs alleged that the state encouraged this conduct and that it supported deceptive behavior by the private contractor so that appeals would never be fruitful for the enrollee. See *id.* at 1011. A registered nurse who had worked for the contractor was certain that it was motivated to cut costs and services below the point intended by ADHS so that the contract would continue to be renewed. See *id.* at 1011-12.

¹⁷⁹ See *id.* at 1013-16. The court also reviewed *Gonzaga's* impact on the first *Pediatric Specialty Services* decision. See *id.* at 1013-14.

¹⁸⁰ See *id.* at 1015.

¹⁸¹ See *id.* at 1017.

¹⁸² See Petition for Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit at 9-11, 20-21, *Selig v. Pediatric Specialty Care, Inc.*, 127 S. Ct. 1356 (2006) (No. 06-415), 2006 WL 2726551. Arkansas wrote that the "more basic question is whether there is a private statutory right entitling the plaintiffs to litigate that issue under § 1983. The state's position is that no federal statute creates any right to receive Medicaid services that are not medically necessary as determined by [the state]." *Id.* at 4-5. The physicians who made those determinations were accused of denying care to keep their contract with the state, a decision that has no connection to

would have presented an intriguing combination of issues for the Roberts Court, as it would have facilitated discussion of both private enforcement actions for Spending Clause legislation under § 1983 and an exploration of sovereign immunity for state officers, perhaps even a revisiting of the *Ex parte Young* doctrine.¹⁸³ After meeting with the Solicitor General's office, however, the respondents withdrew the damages claims against the ADHS officers and permitted the Court to vacate and dismiss with prejudice the 2006 Eighth Circuit decision with regard to the individual claims against the state officers.¹⁸⁴

The variations in circuit courts' determinations regarding enforceability of these foundational Medicaid provisions have at least three implications. First, the uncertainty regarding enforcement among the circuits indicates the degree to which *Gonzaga* has failed to "resolve any ambiguities."¹⁸⁵ *Gonzaga* resulted in an about-face on the equal access provision, though circuit courts appear relatively comfortable allowing private enforcement of the reasonable promptness provision and the minimum services provision.¹⁸⁶ Nevertheless, these decisions often split the proverbial baby, as enrollees frequently raise all three provisions in litigation.¹⁸⁷ Also, they divide enrollees and providers, who were best able to work together to defeat inadequate state actions under the equal access provision.¹⁸⁸ Medicaid enrollees are poor, medically fragile, often

medical necessity. See Brief in Opposition to Petition for Writ of Certiorari at 7-10, *Selig*, 127 S. Ct. 1356 (No. 06-415), 2006 WL 3419817.

¹⁸³ See *supra* note 15.

¹⁸⁴ See *Selig v. Pediatric Specialty Care, Inc.*, 127 S. Ct. 3000, 3000 (2007) (granting certiorari and vacating judgment in *Pediatric III*); see also Petitioners' Response to Respondents' Suggestion of Mootness at 2-3, *Selig*, 127 S. Ct. 1356 (No. 06-415). The Tenth Circuit also held that the equal access provision was not enforceable under § 1983 after the Supreme Court granted certiorari in the *Pediatric Specialty Care* cases. See *Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1210 (10th Cir. 2007), *cert. denied*, 128 S. Ct. 68 (2007).

¹⁸⁵ *Gonzaga Univ. v. Doe*, 536 U.S. 273, 278 (2002).

¹⁸⁶ See *supra* notes 157-84 and accompanying text.

¹⁸⁷ See, e.g., *Westside Mothers v. Olszewski*, 454 F.3d 532, 539-44 (6th Cir. 2006) (finding that §§ 1396a(a)(8), 1396a(a)(10) are enforceable by § 1983 cause of action after *Gonzaga* but that § 1396a(a)(30)(A) is no longer enforceable).

¹⁸⁸ As Chief Judge Becker's dissent in *Houstoun* noted, Medicaid beneficiaries are not likely to be able to sue alone, as they are indigent by definition, and the opinion in *Pennsylvania Pharmacists Ass'n* does not square with *Wilder*. See *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 547-60 (3d Cir. 2002) (Becker, C.J., dissenting); see also *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 510 (1990). Chief Judge Becker accused the Alito majority of deliberately narrowing the holding in *Wilder*, stating: "[I]t is not our function to rewrite a Supreme Court opinion to narrow its holding . . ." *Houstoun*, 283 F.3d at 554.

either minors or elderly, and generally politically disenfranchised. Joining forces with healthcare providers provides an advantage in litigation, as enrollees have a hard time gaining access to courts otherwise. The Medicaid Act's purpose, to create the same basic rights for all enrollees with flexibility for states to provide extra services for their citizens,¹⁸⁹ is defeated by differing and changing interpretations in the federal circuits.¹⁹⁰

Second, if the equal access provision is no longer enforceable, then *Wilder* may no longer be supported by its statutory foundations and the precedent risks being overturned by a Court that appears interested in limiting § 1983 causes of action and in limiting the scope of conditions on Spending Clause legislation.¹⁹¹ The Roberts Court contains a majority that has demonstrated opposition to private enforcement of conditions on federal spending in any context.¹⁹² A number of federal appellate courts have determined that the equal access provision is unenforceable after *Gonzaga*.¹⁹³ The equal access

¹⁸⁹ Though many aspects of state Medicaid coverage are optional, the federal statutory scheme imposes an important floor regarding how little each state can provide and still be entitled to the open-ended funding that Medicaid provides. See Timothy Stoltzfus Jost, *Our Broken Healthcare System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 559-60 (2006) (noting that despite federal requirements for state participation in Medicaid, states still have leeway in providing benefits).

¹⁹⁰ Congress envisioned Medicaid as an "egalitarian social contract for the poor" that mandated basic elements of each state's Medicaid plan and that permitted optional elements of each State plan. See RAND E. ROSENBLATT, SYLVIA A. LAW, & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM 416-17 (1997); see also STEVENS & STEVENS, *supra* note 21, at 57 (noting that newly enacted Medicaid program contained "important provisions for minimal coverage of specified types of care, which put Medicaid far beyond the Kerr-Mills program and were designed to lead to comprehensive care").

¹⁹¹ Justice Stevens's dissent in *Gonzaga* noted that the new requirement for unambiguous congressional intent "*sub silentio* overrules" *Wilder* and *Wright* because those cases allowed causes of action when the underlying statutes did not necessarily intend § 1983 to be a source of enforceable rights. See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 300 n.8 (2002) (Stevens, J., dissenting).

¹⁹² See *infra* Part III.A.1. Justices Scalia and Kennedy joined Chief Justice Rehnquist's dissent in *Wilder*, 496 U.S. at 524-29, and wrote a concurrence in *Blessing*, 520 U.S. 329, 349 (1997). Justice Thomas joined the majorities in *Barnes v. Gorman*, 536 U.S. 181, 187 (2002), and *Gonzaga*, 536 U.S. at 283. Justice Alito addressed the issue as a judge on the Third Circuit in *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 181 (3d Cir. 2004). Finally, Chief Justice Roberts wrote about the issue both as Deputy Solicitor General and while in private practice. See Brief for Petitioners at 39-43, *Gonzaga*, 536 U.S. 273 (No. 01-679); Brief for the United States as Amicus Curiae Supporting Petitioners at 11, *Wilder*, 496 U.S. 498 (No. 88-2043).

¹⁹³ See *supra* notes 164-71 and accompanying text.

provision is the successor to the repealed Boren Amendment, which was the basis for the all-important *Wilder* decision; thus, *Wilder* may be in jeopardy.

Third, Medicaid is one statutory program by which Congress intended to deliver a comprehensive set of benefits to fragile populations. Federal courts, nonetheless, have read some provisions to be enforceable by enrollees, some provisions to be enforceable by providers, and some provisions to be enforceable by no one. Though the statutory framework is long and complex, inconsistent and variable enforcement possibilities can only confound the problem. The statute is not necessarily clarified by *Arlington*, in which the Court reformulated the standard for conditions on spending, demanding clear notice to the states.¹⁹⁴ The *Arlington* clear notice standard favors the states, ignoring the idea of balance in a cooperative federalism program, and strengthening the *Gonzaga* modification of the first element of the *Blessing* test by narrowing the demand for an “unambiguously conferred right” to a “clearly” conferred right for a cause of action to exist under § 1983.¹⁹⁵

2. The Seventh Circuit Theory of Medical Assistance

An additional circuit split also affects the Medicaid Act; the Seventh Circuit Court of Appeals formulated a novel definition of “medical assistance” that a handful of additional circuits have adopted. In *Bruggeman v. Blagojevich*, the Seventh Circuit considered whether Illinois violated the Medicaid Act by failing to provide intermediate care facilities in the northern part of the state to developmentally disabled adults.¹⁹⁶ From the start, this decision was unconventional in the realm of Medicaid Act jurisprudence. Rather than borrow the Supreme Court’s *Wilder* description of Medicaid as a “cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals,” which many (if not all) other circuits had done,¹⁹⁷ Judge Posner called the program one that “defrays certain medical expenses of individuals . . . who lack the wherewithal to pay

¹⁹⁴ See *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

¹⁹⁵ *Id.* (analyzing conditions placed on spending from perspective of state agreeing to federal funds).

¹⁹⁶ See *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 908 (7th Cir. 2003).

¹⁹⁷ See, e.g., *Doe v. Chiles*, 136 F.3d 709, 714 (11th Cir. 1998) (citing *Wilder*, 496 U.S. at 502) (borrowing Court’s *Wilder*-based description of Medicaid program).

the expenses themselves.”¹⁹⁸ The subsequent statutory analysis determined that “medical assistance” indicates financial assistance, not access to medical services, contrary to the interpretations of the First and Eleventh Circuits, who were accused of missing the “distinction.”¹⁹⁹ The Seventh Circuit wrote that Medicaid is a “payment scheme, not a scheme for state-provided medical assistance” and held that the reasonable promptness provision was not violated by the state’s failure to distribute intermediate care facilities to all qualified citizens.²⁰⁰

Judge Posner distorted the fundamental nature of Medicaid with that short description. His definition of Medicaid as merely money rather than a program of medical care and access is a revisionist reading that is contrary to conventional designs for and understandings of Medicaid.²⁰¹ Legislative history from the passage of the Medicaid Act consistently uses the term “medical assistance” to indicate something more than just money.²⁰² Though the legislative

¹⁹⁸ *Bruggeman*, 324 F.3d at 908.

¹⁹⁹ *See id.* at 910 (citing *Bryson v. Shumway*, 308 F.3d 79, 81, 88-89 (1st Cir. 2002); *Chiles*, 136 F.3d at 714, 717). The First and Eleventh Circuits were the only two circuits to address private enforcement of the reasonable promptness provision at the time *Bruggeman* was decided and thus the only decisions addressed by the Seventh Circuit in this regard.

²⁰⁰ *See id.* The court held that all of the Medicaid Act claims failed and noted that some were insufficient for private causes of action after *Gonzaga* and the “Supreme Court’s hostility . . . implying such rights in spending statutes.” *Id.* at 911.

²⁰¹ *See* STEVENS & STEVENS, *supra* note 21, at 52. Medicare and Medicaid had dissimilar philosophical foundations; while Medicare was structured like Blue Cross and Blue Shield insurance programs, Medicaid “was based not on the insurance principles of specified benefits for specified contributions but on the time-worn structure of federal grants-in-aid to states for medical assistance [P]rovision of medical care to the poor appeared at last to be accepted as a national problem” *Id.* The legislation that preceded Medicaid, called Kerr-Mills for the bill’s sponsors, underlined the idea that Medicaid was intended to provide more than money; Congress had passed Kerr-Mills with an “expectation that each state would indeed provide *adequate care* so that a national problem would be avoided.” *Id.* at 29 (emphasis added). Stevens and Stevens further note:

Kerr-Mills was built on the dilemma that foreshadowed Medicaid. If benefits for the medically indigent were to be viewed as a program of health services, there was no actual virtue in attaching them administratively to a program of public assistance cash benefits Kerr-Mills . . . was both a reflection of *inadequate medical services* to those with low and middle incomes and an extension of traditional notions of cash assistance under welfare programs.

Id. at 36 (emphasis added).

²⁰² *See* S. REP. NO. 89-404, at 9 (1965), as reprinted in 1965 U.S.C.C.A.N. 1943, 1950. The legislative history declared: “[T]o provide a more effective Kerr-Mills medical

history does refer to assistance with medical costs, the goal in improving the precursor Kerr-Mills medical assistance program and creating Medicaid was something more. In creating Medicaid, Congress strove not only to match money for the states but also to ensure that “Medical assistance [is] made available to all individuals receiving money payments under these programs and [that] the medical care or services available to all such individuals [are] equal in amount, duration, and scope.”²⁰³ The language used to describe Medicaid also is different from that used for Medicare, passed in the same amendment to the Social Security Act, which called its basic plan “Hospital Insurance” and clearly was modeled on Blue Cross and Blue Shield.²⁰⁴ The legislative history demonstrates that Congress modified the medical assistance program to require states “to provide inpatient hospital services, outpatient hospital services” and other enumerated services; in other words, the states accepting Medicaid money must provide services, not just money, to enrollees, which is something that Kerr-Mills did not require.²⁰⁵

Despite historical and legislative evidence that Medicaid is more than “financial assistance” and despite the Seventh Circuit’s limited statutory reading,²⁰⁶ the Sixth and Tenth Circuits have adopted the *Bruggeman* interpretation of medical assistance.²⁰⁷ The Sixth Circuit

assistance program for the aged and to extend its provisions to additional needy persons, the bill would establish a single and separate *medical care program* to consolidate and expand the differing provisions for the needy” *Id.* (emphasis added).

²⁰³ *Id.*

²⁰⁴ See *id.* at 4; see also PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 374-75 (1982) (describing plan to make Medicare look like Blue Cross and Blue Shield so that hospitals and physicians would participate in plan of which they were wary).

²⁰⁵ See S. REP. NO. 89-404, at 73-74, as reprinted in 1965 U.S.C.A.N. at 1951, 2014-15; see also MEDICAID COMM’N, *FINAL REPORT AND RECOMMENDATIONS* vi (2006), <http://aspe.hhs.gov/medicaid/122906rpt.pdf> (stating that Medicaid “can and must continue to provide *quality care to promote the best possible health* for all beneficiaries”) (emphasis added).

²⁰⁶ One circuit court highlights an additional problem with the Seventh Circuit’s definition of “medical assistance” — it is read alone rather than in the context of the statute. See *Rabin v. Wilson-Coker*, 362 F.3d 190, 192 (2d Cir. 2004) (explaining that any one of statutes that comprise Medicaid Act “is difficult to decipher if read either independently of the history of the program or in isolation from other provisions of the Medicaid Act”).

²⁰⁷ See *Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208, 1214 (10th Cir. 2007); *Mandy R. v. Owens*, 464 F.3d 1139, 1143 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006). In 2007, the Seventh Circuit allowed that a reasonable promptness claim could proceed in Illinois. See *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 456-58 (7th Cir. 2007).

rejected the plaintiffs' contention that medical assistance under Medicaid requires the state to provide actual services. It also held, however, that under the reasonable promptness provision all eligible people could apply for Medicaid and receive prompt financial assistance upon enrolling, and that the minimum services provision required the state to pay for certain enumerated items of medical care.²⁰⁸ The court did not preclude the plaintiffs from reframing their argument that failure to pay enough frustrates the application of the reasonable promptness and the minimum services provisions, but it did reject the § 1983 claim for better payment under the equal access provision.²⁰⁹ The Tenth Circuit twice has addressed the Posner reading of medical assistance. In both instances it adopted the Seventh Circuit's interpretation while still allowing claims to proceed, agreeing with the Sixth Circuit that the reasonable promptness and minimum services provisions theoretically were enforceable under § 1983 and rejecting claims under the equal access provision.²¹⁰ The Third Circuit declined to consider the Seventh Circuit's interpretation of medical assistance, and the Fifth Circuit apparently ignored it.²¹¹

The Seventh Circuit's version of medical assistance is problematic for at least three reasons. First, it creates circuit court divisions where they might not otherwise exist. Though circuits reviewing the reasonable promptness and the minimum services provisions generally have upheld § 1983 enforceability, these same circuits do not agree on the meaning of medical assistance. This adds to the confusion resulting from the *Gonzaga* divide, but thus far the Court has denied petitions for certiorari in these cases, thereby allowing this definition to persist.²¹²

²⁰⁸ See *Westside Mothers*, 454 F.3d at 540.

²⁰⁹ See *id.* at 541-43.

²¹⁰ See *Mandy R.*, 464 F.3d at 1142-43, 1147-48 (adopting Posner interpretation and agreeing with Sixth Circuit that reasonable promptness provision and minimum services provision are still redressable under § 1983). The Tenth Circuit determined that the plaintiffs' claim of too few services was not sufficiently linked to the lack of money, or underfunding, and thus the "State must pay for medical services, but it need not provide them." *Id.* at 1146. One year later, the Tenth Circuit reiterated its *Mandy R.* analysis and rejected the district court's holding that low rates of reimbursement effectively deny care by virtue of reducing the number of healthcare providers enrollees can see, thereby defeating the reasonable promptness and minimum services provisions. See *Fogarty*, 472 F.3d at 1214-15 (applying medical assistance as money theory and rejecting plaintiff's assertion that rates were too low to have appropriate numbers of providers participating in Medicaid program).

²¹¹ See *S.D. ex rel. Dickinson v. Hood*, 391 F.3d 581, 605 n.31 (5th Cir. 2004); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 181 n.1 (3d Cir. 2004) (declaring circuit split matter for district court).

²¹² See *Fogarty*, 472 F.3d at 1208, *cert. denied*, 128 S. Ct. 68 (2007); *Mandy R.*, 464

Second, the Seventh Circuit's interpretation is inconsistent with the statutory definition of medical assistance as the definition applies to the total Medicaid Act.²¹³ This leads to a disconnect where, for example, courts permit states to reimburse so little that their Medicaid programs are virtually ineffective, while admonishing them to pay promptly when they do pay.²¹⁴ Under this analysis, a state must agree to provide money while not ensuring that the Medicaid program it has promised to its citizens and to the Secretary of DHHS actually is effective. This is contrary to the congressional intent in establishing Medicaid as a program that provides "care and services" to the needy.²¹⁵

F.3d at 1139, *cert. denied sub nom. Mandy R. v. Ritter*, 127 S. Ct. 1905 (2007).

²¹³ See 42 U.S.C. § 1396d(a) (2006) (providing that "medical assistance" means payment of part or all of the cost of the following care and services . . ." and delineating 28 items that must be covered by state). Though standing alone this provision refers only to payment, read within the context of the entire statutory scheme (even setting aside legislative history), interpreting medical assistance as mere payment is not consistent with its use throughout the Medicaid Act, wherein medical assistance consistently indicates provision of care and services. For example, the minimum services provision requires that a State plan "provide for making medical assistance available, including at least the care and services listed . . . to all individuals [who qualify]." 42 U.S.C. § 1396a(a)(10)(A) (2006); see also *Petition for Writ of Certiorari at 20-21, Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, No. 06-1482 (10th Cir. May 7, 2007). The brief also describes how interpreting the free choice provision with the Posner definition of medical assistance is difficult, given that the free choice provision requires the State plan to allow "any individual eligible for medical assistance (including drugs)" to "obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . ." See *id.* at 21 (citing 42 U.S.C. § 1396a(a)(23)).

²¹⁴ See Kenneth R. Wiggins, *Medicaid and the Enforceable Right to Receive Medical Assistance: The Need for a Definition of "Medical Assistance,"* 47 WM. & MARY L. REV. 1487, 1509 (2006) (noting that Seventh Circuit's interpretation of medical assistance would render minimum services provision ineffective).

²¹⁵ See, e.g., *Fogarty*, 472 F.3d 1208, 1215. The court wrote:

[T]he Medicaid Act requires participating states to provide beneficiaries financial assistance rather than actual medical services. Thus, not only do the statutes cited by plaintiffs not obligate defendants to ensure that EPSDT services are "fully" delivered to the plaintiff class, those statutes impose no obligation whatsoever on defendants to deliver any medical services. Rather . . . defendants' obligation under these statutes is to pay promptly for the medical services outlined in the Medicaid Act, including EPSDT services.

Id.; see also S. Rep. No. 89-404, at 74, as reprinted in 1965 U.S.C.C.A.N. 1951, 2015 (adding provisions to Medicaid that require "a consistent statewide program at a reasonable level of adequacy" and emphasizing that states must "utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff"). The legislative history shows that Congress expects the states to "bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance

Third, this interpretation of medical assistance, when read in conjunction with the DRA, may prevent private enforcement of that provision, which up to this point has been enforceable even after *Gonzaga*. This is true even though this interpretation does not currently prevent private enforcement of the minimum services provision under traditional Medicaid. As described above, the DRA Benchmark Provision permits states to alter State plans so that the actuarial equivalent of Medicaid is provided to enrollees, which means that states only have to provide premium support rather than particular services as delineated in the minimum services provision.²¹⁶ If medical assistance only means money, and the minimum services provision can be eliminated from a state's Medicaid plan by virtue of the DRA, then enrollees have no benefit to enforce under § 1983. The same problem exists with the reasonable promptness provision — it becomes spectral given that money but no benefit is promised. Medicaid enrollees could be effectively prevented from enforcing the access to medical care that has been secured historically by § 1983 claims for specific benefits based on the Medicaid Act, because those benefits are no longer promised.²¹⁷

III. PROPOSED REMEDIES

Assuming Judge Alito's prophetic concurrence in *Sabree* is correct, Medicaid benefits are in danger of being limited to the agreement

[T]he State plan must . . . assure that . . . such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipient." *Id.* at 76-77.

²¹⁶ See *supra* notes 52-60 and accompanying text.

²¹⁷ Some think this would be a good thing. See, e.g., Michael S. Greve, *The Supreme Court Term That Was and the One That Will Be*, FEDERALIST OUTLOOK, AMERICAN ENTERPRISE INSTITUTE FEDERALISM PROJECT, July 1, 2002, http://www.aei.org/publications/pubID.15849/pub_detail.asp (analyzing Rehnquist Court's anti-entitlement federalism). Mr. Greve wrote in analyzing the *Gonzaga* holding:

Not much further down the road, the Supreme Court's federalism will hit the mother of all entitlements, Medicaid. Stripped of legal details, the central question in cases banging around in several federal circuits is whether Medicaid benefits are an entitlement for individuals *or for the states*. The former answer — Justice William Brennan's answer, which is still enshrined in law — means that Medicaid benefits will be defined and enforced by Senator Hillary Clinton's friends at the Children's Defense Fund in some federal court. The latter answer implies that Medicaid benefits are shaped in a negotiating process between the states and the national government, with some prospect of cost control and good sense.

Id.

between the federal government and states with limited recourse for enrollees who are not receiving the promised medical assistance.²¹⁸ Courts have consistently deemed claims based on the equal access provision unenforceable after *Gonzaga*, opening the door for *Wilder* to be overturned overtly.²¹⁹ Even though federal appellate courts have upheld § 1983 private causes of action based on the reasonable promptness provision and the minimum services provision, the Seventh Circuit analysis of medical assistance, the Roberts Court's expected hostility to enforcement of Spending Clause conditions through § 1983, and the Benchmark Provision leave little hope for individual plaintiffs, whether they be providers or enrollees.

A. *Why the Courts Are a Weakened Part of the Medicaid Safety Net*

Congress appears to believe that § 1983 is sufficient for Medicaid enforcement claims for both providers and enrollees. This is evidenced by Congress's actions after the Supreme Court decided in *Suter v. Artist M.* that a provision of the Adoption Assistance and Child Welfare Act was unenforceable through § 1983 because it imposed only generalized duties on a state and not individual rights.²²⁰ Congress's rejoinder was the "*Suter* fix,"²²¹ federal legislation that responded directly to the Court's decision by stating that in any action to enforce a provision of the Social Security Act (of which Medicaid is a part), private enforcement would not be prevented by the existence of a statutorily required state plan.²²² In other words, Congress

²¹⁸ See *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 194 (3d Cir. 2004) (Alito, J., concurring).

²¹⁹ See *supra* notes 164-84 and accompanying text.

²²⁰ See 503 U.S. 347, 363 (1992). This decision also narrowed *Thiboutot*, discussed above. See *id.* at 365-66 (Blackmun, J., dissenting); see also *supra* notes 77-81.

²²¹ See, e.g., *Ball v. Rodgers*, 492 F.3d 1094, 1112 (9th Cir. 2007) (calling Congress's actions "*Suter* fix").

²²² 42 U.S.C. § 1320a-2 reads in full:

In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in *Suter v. Artist M.*, but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in *Suter v. Artist M.* that [§] 471(a)(15) of the Act is not enforceable in a private right of action.

42 U.S.C. § 1320a-2 (2006) (citations omitted).

expected Medicaid enrollees to be able to enforce their statutory rights through § 1983, thereby tacitly acknowledging reliance on *Thiboutot* and its progeny.²²³ As has been discussed herein, however, that line of case law is jeopardized by changes in the Court's composition and the Court's hostility to § 1983 claims to enforce conditions on spending.²²⁴ Congress cannot rely on the assumption that federal statutory rights such as those found in the Medicaid Act will be enforceable through § 1983. Congress should take legislative action to provide the enforcement mechanisms it has intended should exist for Medicaid enrollees and providers.

Some would respond that the Court intended this; if Congress wants a cause of action for Medicaid enrollees and providers, Congress should clearly state that intent in the language of the Medicaid Act.²²⁵ After all, this is the objective of clear statement rules.²²⁶ Another issue exists, though, that is not necessarily addressed by statutory insertions into the Medicaid Act. Justices currently sitting on the Supreme Court have suggested that conditions on spending can never be privately enforced through § 1983 because beneficiaries of cooperative federalism programs are the equivalent of third-party beneficiaries.²²⁷ Though the cases in which the third-party beneficiary contract theory was advanced did not involve legislation that provided a private cause of action, the juridical skepticism regarding the structure and purpose of conditions on spending and the statutory entitlement that conditions can create should not be overlooked. The contract analysis in *Barnes* may not be the last of the discussions regarding the Spending Clause power that suggest congressional exercises of this

²²³ See Chemerinsky, *Ensuring*, *supra* note 139, at 152-53 (noting that Congress has had opportunities to change Court's interpretation of § 1983 since *Thiboutot*, and yet Congress has never acted to reverse that decision, and indeed reinforced it with "Suter fix"). Professor Chemerinsky explains too that Congress rejected attempts to eliminate § 1983 as a cause of action four times, and President Clinton vetoed legislation that would have eliminated private causes of action. *Id.* at 152.

²²⁴ As Professor Rosenbaum has noted, individual actions to enforce statutory obligations against states are "increasingly confined to selected program elements." See Rosenbaum, *supra* note 14, at 23-24.

²²⁵ See Brian Galle, *Getting Spending: How to Replace Clear Statement Rules with Clear Thinking about Conditional Grants of Power*, 37 CONN. L. REV. 155, 162-66 (2004) (describing Rehnquist Court's application of clear statement rules to variety of laws, not limited to Spending Clause legislation).

²²⁶ See *id.* at 183 (calling clear statement rules proxy for ideological federalism-oriented ends); see also Merrill, *supra* note 121, at 827-28 (describing and defining clear statement rules during Rehnquist Court era).

²²⁷ See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002); *Barnes v. Gorman*, 536 U.S. 181, 187 (2002); *Blessing v. Freestone*, 520 U.S. 329, 350 (1997).

enumerated power are somehow less viable than other sources of congressional authority.²²⁸

Notably, Justices' examination of § 1983's legislative purpose can cut against the conclusion that § 1983 is unavailable for Medicaid enrollees and providers. Section 1983 was created, as stated by the majority in *Thiboutot*, as Reconstruction Era legislation with remedial intent to prevent racial injustices.²²⁹ Allowing private enforcement of Medicaid conditions on states helps to ensure that the states do not treat disparately the populations that § 1983 originally protected.²³⁰ Thwarting § 1983 causes of action is particularly troubling given the populations that receive the greatest benefit from Medicaid coverage.²³¹ Indeed, allowing § 1983 causes of action against state officers arguably furthers the original intent of that statute's creation (inasmuch as legislation created ninety years later can do); in many ways, the War on Poverty and Great Society programs, which helped to create the Medicaid Act, were an extension of the stymied civil rights movement following the Civil War.²³²

Nevertheless, the jurisprudence regarding the triangle of Medicaid, the Spending Clause, and § 1983 has been steadily marching away from access for private parties. Though the courts are not necessarily

²²⁸ See *Barnes*, 536 U.S. at 186; see also Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L.J. (forthcoming 2008); Galle, *supra* note 225, at 168 (rejecting contract analogy of spending legislation as inconsistent with textual reading of power to spend for "general welfare").

²²⁹ See *Maine v. Thiboutot*, 448 U.S. 1, 6-8 (1980).

²³⁰ One could argue that the parallels go even farther, as southern states statistically spend less on each Medicaid enrollee. See Matthew, *supra* note 36, at 991 (charting disparities in state Medicaid enrollment and expenditures using public information collected by DHHS). Of course, if there were racial discrimination in the administration of programs such as Medicaid, a stand-alone cause of action would exist under § 1983.

²³¹ See Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 28-29 (2001) (reporting that African Americans, women, and children are populations primarily covered by Medicaid).

²³² See STEVENS & STEVENS, *supra* note 21, at 42-48, 63-64 (describing how Medicaid grew out of Great Society and War on Poverty programs); see also Vernellia R. Randall, *Racist Healthcare: Reforming an Unjust Health Care System to Meet the Needs of African-Americans*, 3 HEALTH MATRIX 127, 146-48 (1993) (explaining that disparities based on race in healthcare system were not addressed effectively during Reconstruction by Freedman Bureau and that during post-Reconstruction era African Americans were excluded from medical system by virtue of segregation and outright discrimination). The Warren Court's criminal rights decisions and the public's initial embrace of those holdings as remedying racial inequities also demonstrate this kind of connection. See Barry Friedman, *The Birth of an Academic Obsession: The History of the Countermajoritarian Difficulty, Part Five*, 112 YALE L.J. 153, 210-12 (2002).

correct to so move, it is hard to predict if the judicial branch will diverge from this course. This Article thus suggests a new set of enforcement possibilities for this fragile set of statutory rights.

B. Seeking Safety Elsewhere

A question often arises: why must enrollees and providers have the ability to privately enforce the Medicaid Act?²³³ States that participate in Medicaid must agree to comply with the statutes and regulations the federal government prescribes in creating State plans.²³⁴ If a state does not perform as required by federal law and the state's own plan, it can be denied federal funds,²³⁵ as the Court has noted repeatedly and pointedly.²³⁶ Yet, in forty years of Medicaid, CMS has shown that it is not interested in the funding withdrawal remedy.²³⁷ CMS, which is responsible for Medicaid, is notoriously uninterested in enforcing the terms of State plans against the states; instead it seeks cooperation, when it makes demands at all.²³⁸ Even if CMS were active in enforcing

²³³ Violations of statutory entitlements are not the same as the federal government demanding "unconstitutional conditions" on the receipt of funds. See, e.g., Lynn A. Baker, *The Prices of Rights: Toward a Positive Theory of Unconstitutional Conditions*, 75 CORNELL L. REV. 1185, 1193-94 (1990) (describing unconstitutional conditions doctrine as one that "prohibits conditions on allocations in which the government indirectly impinges on a protected activity or choice in a way that would be unconstitutional if the same result had been achieved through a direct governmental command"). Medicaid enrollees have no constitutionally protected right to healthcare that is impinged, as no constitutional right to healthcare exists for any American.

²³⁴ See 42 C.F.R. § 430.10 (2006).

²³⁵ See 42 U.S.C. § 1396c (2006). The Secretary of DHHS has the power to determine that a State plan "has been so changed that it no longer complies with the provisions of [§] 1396a . . . ; or that in the administration of the plan there is a failure to comply substantially with any such provision" after notice and an opportunity for a hearing, and then the Secretary can withhold all Medicaid payments or certain payments, continuing to pay for elements of the State plan that have not fallen out of compliance with the Medicaid Act. *Id.* The Secretary can withhold funds until the state complies. *Id.*

²³⁶ E.g., *Pennhurst St. Sch. & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981) (noting that for legislation enacted pursuant to the Spending Clause, typical remedy for noncompliance is termination of federal funds).

²³⁷ See Key, *supra* note 65, at 292 (explaining that federal agencies seek state compliance rather than cutting off federal funds when states fail to comply with conditions on spending); see also Samberg-Champion, *supra* note 6, at 1839 (noting that denial of federal funds is "blunt and seldom-used club" for all federal funding programs in context of arguing that § 1983 claims are important enforcement tool, even after *Gonzaga*).

²³⁸ See JOST, *supra* note 4, at 89 (noting that Department of Health, Education, and Welfare (precursor to DHHS) only performed 16 State plan conformity hearings in

Medicaid withholding provisions, as Justice White noted in his *Pennhurst* dissent,²³⁹ removing a state from the program is a draconian measure that is not necessarily desirable or effective; this is especially true for a long-standing federal spending program such as Medicaid upon which many vulnerable citizens, and states, rely.²⁴⁰

Medicaid is an important safety net,²⁴¹ especially in an age when fewer and fewer Americans are able to access health insurance through employers.²⁴² Although Congress never intended to cover every indigent person in need of medical assistance,²⁴³ the program still covers important and needy populations.²⁴⁴ Medicaid providers and enrollees cannot rely on states to provide Medicaid benefits as they are statutorily required to do, otherwise governors would not constantly seek flexibility, and the parade of litigation regarding Medicaid would not exist.²⁴⁵ States often defy the requirements of the Medicaid Act, and even when granted waivers, do not supply the benefits promised to Medicaid enrollees. Also, under the DRA Benchmarking Provision, the promised benefit only need be an actuarial equivalent, but history indicates that states may try to circumvent even this loose

first three decades of Medicaid program's existence).

²³⁹ See *Pennhurst*, 451 U.S. at 52-53 (White, J., dissenting). Justice White wrote that "a funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act" in the context of the Developmentally Disabled Act, and the same is true for Medicaid beneficiaries. *Id.*

²⁴⁰ See JOST, *supra* note 4, at 45-46 (explaining that courts traditionally were sympathetic to plight of Medicaid enrollees but that "today's courts cannot always be depended on to protect the poor").

²⁴¹ See generally CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006 (2007), <http://www.census.gov/prod/2007pubs/p60-233.pdf>. The percentage of people uninsured and the raw number of uninsured rose to 47 million people, or about 15.8% of the population, in 2006. See *id.* at 18. The number and percentage of uninsured African Americans also rose, to 20.5% of that population (roughly 7.6 million people). See *id.* at 19.

²⁴² See *id.* at 18 (showing that 59.7% of people were covered by employer-based health insurance in 2006, down from 60.2% in 2005).

²⁴³ See, e.g., STEVENS & STEVENS, *supra* note 21, at 63-65 (describing categories of eligibility under original Medicaid Act).

²⁴⁴ See Rosenbaum & Rousseau, *supra* note 231, at 25-38 (describing populations served by Medicaid and ways in which program helps to battle disparities in care related to race, poverty, and sex); see, e.g., Kevin Sack, *Study Finds Cancer Diagnosis Linked to Insurance*, N.Y. TIMES, Feb. 18, 2008, available at <http://nytimes.com/2008/02/18/health/18cancer.html> (describing study that shows "uninsured and those covered by Medicaid are more likely" to be diagnosed with cancer in later stages of disease, which not only increases morbidity but also costs of treatment).

²⁴⁵ See *supra* Part III.

requirement.²⁴⁶ Providing Medicaid enrollees and healthcare providers with a cause of action has the added benefit of potentially aiding CMS to prevent states from gaming the Medicaid system through methods such as inter-governmental transfers (while not reducing funding, the current CMS proposal), a problem CMS admits it has struggled to prevent and that has interested Congress.²⁴⁷

At least three approaches would bypass Medicaid's judicial jeopardy. First, administrative remedies could be implemented to provide procedures where none currently exist for Medicaid enrollees.²⁴⁸ Second, CMS could be tasked with greater responsibility for ensuring that benefits are provided as promised.²⁴⁹ And third, Congress could write the long-missing cause of action into the Medicaid Act.²⁵⁰ The remedies suggested are not intended to be exclusive of one another, nor exhaustive. These proposed remedies simply provide a starting point for exploring appropriate protections. The National Governors' Association recently asked Congress to end private causes of action in providing suggestions for Medicaid reform; Congress did not choose to incorporate this request into the DRA.²⁵¹ One could infer that

²⁴⁶ See BARRY FURROW ET AL., *HEALTH LAW: CASES, MATERIALS & PROBLEMS* 844-45 (6th ed. 2008).

²⁴⁷ See, e.g., KAISER COMM'N ON MEDICAID AND THE UNINSURED, *MEDICAID: OVERVIEW AND IMPACT OF NEW REGULATIONS* 4-5 (2008), <http://www.kff.org/medicaid/upload/7739.pdf>; see also H.R. 5613, 110th Cong. § 5 (2008) (preventing CMS from implementing rules to address problem of state overcharges by capping payments at cost of covering Medicaid enrollees); *Medicaid Financing: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 110th Cong. (2008) (describing past efforts by CMS to prevent states from overcharging Medicaid through inter-governmental transfers); OFFICE OF THE INSPECTOR GEN. OF THE DEP'T OF HEALTH AND HUMAN SERVS., *FISCAL YEAR 2007 AGENCY FINANCIAL REPORT, MANAGEMENT ISSUE 4: MEDICAID ADMINISTRATION* 8-10 (2008), http://www.oig.hhs.gov/publications/challenges/files/TM_Challenges07.pdf. The Office of the Inspector General ("OIG") notes that once states receive federal funds for their Medicaid programs, those funds can be reallocated easily to non-Medicaid purposes through inter-governmental transfers that the OIG cannot trace. See *id.* at 7-8. *Intra-governmental* seems the correct terminology given that the improper transfers occur within the state government, but this is the term as defined by the OIG. See *id.* The OIG states that six states obtained more than \$3 billion in Medicaid funding by "requiring providers operated by units of government, such as county-owned nursing homes, to return Medicaid payments to State governments through [inter-governmental transfers]." *Id.* at 7.

²⁴⁸ See *infra* Part IV.B.1.

²⁴⁹ See *infra* Part IV.B.2.

²⁵⁰ See *infra* Part IV.B.3.

²⁵¹ See NAT'L GOVERNORS' ASS'N, *supra* note 59, at § 16.2.5. The NGA made multiple suggestions for reforming Medicaid, including some provisions that Congress adopted as part of the DRA. See *id.* §§ 16.2.2, 16.2.3. The states suggested in section 16.2.5, *Judicial Reforms*, that states have a "right" to "manage the optional Medicaid

Congress continues to find the private enforcement mechanism appropriate and useful, and that the following suggestions could find some political traction.²⁵²

1. Individual Administrative Remedies

Limited administrative remedies exist within the Medicaid Act that apply to narrow circumstances, such as denial of enrollment to Medicaid applicants and mechanisms for Medicaid healthcare providers to contest payment rates.²⁵³ Medicaid could be structured to include administrative remedies that mirror those provided in the Medicare statutory scheme.²⁵⁴ A model already exists for this type of administrative process that would make its implementation reasonably straightforward.²⁵⁵ And, administrative hearings (and resolutions) can be faster and less expensive than judicial remedies, which is important in the context of healthcare.

On the other hand, exhaustion of administrative remedies can be burdensome, particularly in the medical context where every level of administrative review before reaching a courthouse means more time that access to healthcare services or payment for those services is denied.²⁵⁶ The model of Medicare beneficiaries' detailed administrative process leads eventually to judicial intervention, however, and thus other remedies must be considered for both expediency and efficiency.²⁵⁷ Avoiding administrative exhaustion requirements may become even more important in light of the Benchmark Provision and looming limits on judicial remedies for all beneficiaries of Spending Programs. Also, allowing enrollees and

categories . . . and the federal government should remove legal barriers that impede this fundamental management tool." *Id.* § 16.2.5. The preliminary report regarding Medicaid reform stated more assertively: "Federal reforms are needed to constrain the broad ability of judicial decrees in Medicaid cases that clearly impede state innovation and reform." NAT'L GOVERNORS' ASS'N, MEDICAID REFORM: A PRELIMINARY REPORT 8 (2005), <http://www.nga.org/Files/pdf/0506medicaid.pdf>.

²⁵² Congress has rejected repeated attempts to limit the scope of § 1983 to permit causes of action for civil rights laws, which supports this inference. See Key, *supra* note 65, at 313 (noting that Senator Hatch introduced legislation three times to so limit § 1983 and was rebuffed each time).

²⁵³ See 42 U.S.C. § 1396a(a)(3) (2006) (providing hearing for those denied medical assistance or for whom application is not acted upon with "reasonable promptness"); 42 C.F.R. § 447.253(e) (2008).

²⁵⁴ See 42 U.S.C. § 1395ff (2006).

²⁵⁵ See *id.*

²⁵⁶ See JOST, *supra* note 4, at 34-36.

²⁵⁷ See 42 U.S.C. § 1395ff(b)(1)(A).

providers to have causes of action, whether administrative or judicial in nature, could help to prevent gaming of the federal match, which federal agencies have a difficult time detecting.

2. Agency Oversight

A related remedy could require CMS to police individual access and provider rates in such a way that private causes of action are not necessary.²⁵⁸ Though CMS exercises no such oversight currently, DHHS engages in other forms of administrative supervision, including administrative processes for disgruntled Medicare enrollees (described above) and an extensive, and lucrative, fraud watch over federal healthcare programs.²⁵⁹ The latter programs provide a framework for creating greater CMS oversight of Medicaid, as the federal government and the states, through Medicaid Fraud Control Units, work together to catch fraud that funnels federal dollars away from their designated programs.²⁶⁰ In this vein, the DRA strengthened Medicaid integrity initiatives by creating a Comprehensive Medicaid Integrity Plan and channeling additional money into CMS to help states “combat fraud, waste and abuse in the Medicaid program.”²⁶¹ Even though states primarily are responsible for fraud prosecution through their Medicaid Fraud Control Units, the DRA gives CMS the power and money to provide “technical assistance, guidance and oversight” in states’ fraud control efforts.²⁶² This new fraud provision provides an example of political will finding a way. Though Medicaid can be politically fragile, its financial integrity is still a priority to Congress and CMS. Perhaps protecting enrollees and participating providers should be viewed as forms of program integrity too.

²⁵⁸ See Timothy Stoltzfus Jost, *Pharmaceutical Research and Manufacturers of America v. Walsh: The Supreme Court Allows the States to Proceed with Expanding Access to Drugs*, 4 YALE J. HEALTH POL’Y L. & ETHICS 69, 79-82 (2004) (noting that justices, in different pieces of decision, signaled interest in having DHHS resolve Medicaid disputes).

²⁵⁹ This is a result of fraud-prosecution support provisions contained in the Health Insurance Portability and Accountability Act of 1996. See Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, §§ 201-05, 110 Stat. 1936 (1996).

²⁶⁰ See CTRS. FOR MEDICARE AND MEDICAID SERVS., MEDICAID FRAUD & ABUSE — GENERAL INFORMATION (2008), www.cms.hhs.gov/MDFraudAbuseGenInfo; OFFICE OF THE INSPECTOR GEN., DEP’T OF HEALTH AND HUMAN SERVS., SEMI-ANNUAL REPORT TO CONGRESS, APR.-SEPT. 2007, at 27-33, <http://www.oig.hhs.gov/publications/docs/semiannual/2007/SemiannualFinal2007.pdf>.

²⁶¹ CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 260.

²⁶² *Id.*

3. Statutory “Clarity”

Congress could write a cause of action into the Medicaid Act, which it assumes exists by virtue of § 1983.²⁶³ The § 1983 cause of action, though, is not only fragile but also malleable and thus inherently not as protective as an unambiguous, statutorily-provided private cause of action would be.²⁶⁴ Also, writing a cause of action into Medicaid would provide the “clear notice” to states that *Arlington* required (and arguably *Gonzaga*) so that states can be held liable for failure to provide promised benefits by not only the federal government but also enrollees and healthcare providers.²⁶⁵ In addition, Congress must either modify (or repeal) the Benchmark Provision, or it must ensure that any statutory causes of action are explicitly recognized in states with Benchmark plans.

States likely would protest the addition of a statutory cause of action. One of the reasons that states have pushed for amendments to Medicaid is that they have craved freedom from judicial review.²⁶⁶ But, states will ignore the demands of the Medicaid Act if possible, so allowing them to be unaccountable except for agency oversight, as suggested above, is not ideal. One benefit of § 1983 causes of action for Medicaid enrollees has been the relative ease of access to federal courthouses; compared to Medicare, which requires administrative exhaustion in most instances, Medicaid enrollees have had fewer procedural hurdles (though being impoverished and in poor health are limiting factors, to be sure).²⁶⁷ Congress should recognize the Court’s ongoing interest in clear statement rules when drafting a Medicaid private enforcement action, especially given new precedents such as *Arlington*.²⁶⁸ *Arlington* signals the Court’s interest in reining in federal spending legislation while protecting states’ interests, which in the

²⁶³ See JOST, *supra* note 4, at 95 (describing history of “Suter fix” and how it demonstrated Congress’s intent to incorporate decisions such as *Thiboutot* and *Wilder* into federal statutory scheme).

²⁶⁴ Jost, *supra* note 14, at 152. Professor Jost recommends that Congress should at least “explicitly recognize the federal right of action to enforce federal Medicaid requirements that it has long assumed exists.” *Id.*

²⁶⁵ See *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (setting forth “clear notice” test for conditions on federal monies accepted by states in cooperative federalism programs); see also Huberfeld, *supra* note 75, at 470.

²⁶⁶ See, e.g., NAT’L GOVERNORS’ ASS’N, SHORT-RUN MEDICAID REFORM 9 (2005), <http://www.nga.org/Files/pdf/0508medicaidreform.pdf> (asking, among other things, for option of benchmark coverage, for federal government to “remove legal barriers that impede” states’ ability to manage Medicaid, and for DHHS to help states that are sued).

²⁶⁷ See JOST, *supra* note 4, at 36.

²⁶⁸ 548 U.S. 291.

Medicaid context includes limiting individuals' ability to enforce conditions on spending against the states through § 1983.

A more radical means to facilitate enrollee (and provider) safeguards would be to create a qui tam relator cause of action and accompanying protections within the Medicaid Act. The goal of facilitating qui tam actions (which are sometimes referred to as whistleblower actions), whether it be in Medicare and Medicaid fraud and abuse statutes, environmental protection policy, antitrust litigation, or securities regulations, generally is to protect the public by permitting enforcement through private suits as well as public prosecutions.²⁶⁹ Though CMS has not made protecting Medicaid enrollees a high priority, the dual-track method of protection that is facilitated by qui tam actions could help CMS to institute stronger protections for Medicaid beneficiaries.²⁷⁰ These actions would enhance scrutiny of states as they implement conditions on federal spending and would help Medicaid enrollees by facilitating their causes of action from both a procedural and a monetary perspective.

Congress could limit qui tam actions by permitting standing only for enrollees and providers who have suffered direct injury from the state's actions or omissions, rather than allowing any state citizen to bring a cause of action regardless of harm (in contrast with the qui tam relator provisions of the civil False Claims Act).²⁷¹ For example, antitrust litigation can only be initiated by a party that has been harmed directly by the alleged wrongdoing.²⁷² This limits the

²⁶⁹ See Joseph F. Brodley, *Antitrust Standing in Private Merger Cases: Reconciling Private Incentives and Public Enforcement Goals*, 94 MICH. L. REV. 1, 12 (1995).

²⁷⁰ Arguably this could work to protect states, enrollees, and providers alike; though sometimes the states align with the federal proposals, states can be harmed by changes to the Medicaid program. See, e.g., Robert Pear, *Governors of Both Parties Oppose Medicaid Rules*, N.Y. TIMES, Feb. 24, 2008, at A18 (stating that governors protested promulgation of new rules for state cost sharing when CMS decided it would no longer match states for graduate medical education and other services).

²⁷¹ See 31 U.S.C. §§ 3729-33 (2006). The qui tam provisions of the federal False Claims Act allow anyone with direct and independent knowledge of violations of the law to bring the information to the government's attention and file an action on behalf of the government. See 31 U.S.C. § 3730. No direct injury to the whistleblower is necessary for the action to be brought or to be successful; the only requirement is that the terms of the statute be violated. See *Vt. Agency of Natural Res. v. United States ex rel. Stevens*, 529 U.S. 765, 773, 777-78 (2000) (holding that relator's interest is tied to government's interest, conferring sufficient Article III standing).

²⁷² See *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488-89 (1977) (formulating rule for antitrust standing that requires plaintiff be injured in way that was intended to be prevented by federal laws at issue); see also *Clayton Act*, 15 U.S.C. § 15 (1994).

misincentives that arise under statutes like the False Claims Act for parties to bring actions because they can win the prosecution lottery.²⁷³ Further, CMS could set up an internal review system to ensure that the litigation is consistent with the goals of enabling qui tam actions (i.e., protecting Medicaid enrollees and the Medicaid program). An example of this structure exists in Section 7623 of the Internal Revenue Code, which provides an award for whistleblowers who are original sources for tips to the IRS that lead to recovering underpayment of taxes.²⁷⁴ The IRS prosecutes cases after evaluation by a newly formed Whistleblower Office, unlike the False Claims Act, which allows the qui tam relator to proceed without government intervention.²⁷⁵ Under the IRS regulatory scheme, the party providing the information need not be harmed, so the example is most useful for modeling governmental intervention and oversight.²⁷⁶

CONCLUSION

Though Medicaid was created to provide a statutory entitlement to states, providers, and enrollees, it has failed to ensure that enrollees receive promised benefits, both by lack of agency action and lack of statutory enforcement provisions. DRA § 6044, combined with personnel changes on the Supreme Court and the double circuit split, likely will continue to narrow enforcement of Medicaid entitlements through § 1983 claims if not eliminate them entirely. We have seen already that the Roberts Court will not hesitate to revisit precedent, and the *Gonzaga* decision certainly appears ripe for reconsideration given the multiple interpretations that federal courts have issued. Revisiting *Gonzaga* may result in a severe tightening, if not outright elimination, of private causes of action to enforce conditions on

²⁷³ See generally Dayna Bowen Matthew, *The Moral Hazard Problem with Privatization of Public Enforcement: The Case of Pharmaceutical Fraud*, 40 U. MICH. J.L. REFORM 281 (2007) (describing empirically phenomenon of over-litigation that has occurred under federal False Claims Act, particularly with regard to pharmaceutical industry).

²⁷⁴ See Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 406, 120 Stat. 2922, 2958-59 (codified as amended at 26 U.S.C. § 7623 (2007)).

²⁷⁵ See 31 U.S.C. § 3730. The lack of requirement for suffering an injury has led to what Professor Matthew describes as a moral hazard problem, resulting in a glut of qui tam relator cases. See Matthew, *supra* note 273, at 331-33. This Article does not advocate for such a broad remedy, which Professor Matthew convincingly argues opens the courthouse doors too widely. See *id.*

²⁷⁶ Also, recognizing the doctrine of *Ex parte Young*, Medicaid beneficiaries would not be able to receive monetary damages against the state, but they should receive attorneys' fees and expert witness costs. See *Ex parte Young*, 209 U.S. 123, 148-50 (1908).

federal spending provided to the states. A majority of the currently sitting Justices have expressed skepticism that this avenue should be open at all. Congress should act to protect Medicaid and its enrollees.

In a year of presidential primaries, debates, and soaring political dialogue, the bizarre love triangle between Medicaid, Spending Clause jurisprudence, and § 1983 also serves as a cautionary tale for federal healthcare proposals. Major candidates described plans for universal insurance coverage mandates; a strengthened Medicaid program is consistent with this vision. Weakened Medicaid with greater state flexibility has tended to lead to denials of benefits and denial of enrollment; this is yet another reason that Congress should take a harder look at modifications to the Medicaid Act such as the DRA's Benchmarking Provision, and perhaps even repeal the Benchmarking Provision. Ironically, as soon as the states cried for flexibility in Medicaid State plans, they asked for greater federal assistance in covering the uninsured by increases in Medicaid matching funds, limits on new rules promulgated by CMS that will cut Medicaid funding, and increases in State Children's Health Insurance Program funding.²⁷⁷ With the number of uninsured at forty-seven million and growing, Congress cannot continue to assume that tinkering with Medicaid at the expense of enrollees, while assuming that court enforcement will help to smooth out any kinks, is a viable arrangement.²⁷⁸

²⁷⁷ See KAISER FAMILY FOUND., STATES PROMOTED BROADER COVERAGE FOR CHILDREN IN 2007, BUT REPORT THAT A DECLINING ECONOMY COUPLED WITH LACK OF SCHIP REAUTHORIZATION AND NEW FEDERAL RULES NOW COMPROMISE EFFORTS TO REDUCE THE NUMBER OF UNINSURED (2008), <http://www.kff.org/medicaid/kcmu012808nr.cfm>.

²⁷⁸ At least one author is waiting with bated breath for the Court to discontinue enforcement of Spending Clause legislation through § 1983. See William H. Pryor, Jr., *The Demand for Clarity: Federalism, Statutory Construction, and the 2000 Term*, 32 CUMB. L. REV. 361, 372-73 (2002) (writing that district court decision in *Westside Mothers v. Haveman* was "sublime" and stating that spending clause jurisprudence, "the area of federalism jurisprudence that has produced the fewest and most deferential constitutional standards[,] may offer the best hope for the next landmark decisions" and may soon move in *Blessing* concurrence direction).