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Two Wrongs Don't Make a Right: Medicaid, Section 1983 and the Cost of an Enforceable Right to Health Care

Mark A. Ison

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I. INTRODUCTION AND OVERVIEW

> More than a trillion dollars annually is spent on the health care system .... Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.... Despite our Nation's wealth, the health care system does not provide coverage to all Americans who want it.[1]

These words capture both the essence of America's public health care dilemma and the frustration felt by many of the lawmakers charged with the duty to solve it. The battle to lower costs and expand access to health care is not limited to the chambers of Congress, however. Recently, the fighting has spilled over into the federal courts as States battle Medicaid beneficiaries over the scope of the cooperative federal-state Medicaid program.[2] For example, in *Westside Mothers v. Haveman*, Michigan recently defended its Medicaid program against the charge that the State was not doing enough to ensure that Medicaid-eligible children were taking advantage of the medical services required under the program.[3] The plaintiffs, representing Medicaid-eligible children in Michigan, sought to force the State to take steps to promote increased utilization and provision of such services.[4]

The language of the Medicaid Act ("the Act") does not expressly provide beneficiaries with a private cause of action against the State.[5] Accordingly, the district court dismissed the case, concluding that the court did not have jurisdiction and that the plaintiffs did not have standing to sue.[6] The United States Court of Appeals for the Sixth

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1.S. 3063, 107th Cong. § 2 (2002). Senator Wyden introduced this bill in October 2002 in order to "establish a Citizens Health Care Working Group to facilitate public debate about how to improve the health care system for Americans ...."

2. Robert Pear, *Governors Say Medicaid Needs More Federal Help to Control Rising Costs*, N.Y. TIMES, Feb. 25, 2002, at A16; Robert Pear & Robin Toner, *Amid Fiscal Crisis, Medicaid is Facing Cuts from States*, N.Y. TIMES, Jan. 14, 2002, at A1. Medicaid is a "cooperative venture jointly funded between the Federal and State governments ... to assist States in furnishing medical assistance to eligible needy persons." CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID: A BRIEF SUMMARY, *at* http://www.cms.hhs.gov/publications/-overview-medicare-medicaid/default4.asp (providing an overview of Medicare) (last visited Sept. 22, 2003). It was enacted in 1965 as Title XIX of the Social Security Act. *Id*; *see also infra* Part II.A.

3. 289 F.3d 852, 856 (6th Cir. 2002), *cert. denied*, 537 U.S. 1045 (2002).

4. *Id.*

5. *See* 42 U.S.C. §§ 1396-1396v (2000); *see also* Harding v. Summit Med. Ctr., 2002 WL 1453743, at *1 (9th Cir. July 3, 2002); Cabinet for Human Res. v. N. Ky. Welfare Rights Ass'n, 954 F.2d 1179, 1186-87 (6th Cir. 1992).

6. Westside Mothers v. Haveman, 133 F. Supp. 2d 549, 587-89 (E.D. Mich. 2001).

Circuit ("Sixth Circuit"), following the Supreme Court's admittedly confusing precedent in this area,[7] reversed, allowing the plaintiffs to proceed under 42 U.S.C. Section 1983.[8] Section 1983 supplies a cause of action for an individual when anyone, acting under color of State law, deprives that individual of "rights, privileges, or immunities secured by the Constitution and laws" of the United States.[9]

The Sixth Circuit held that the Medicaid Act was within the term "laws" for the purposes of section 1983 because it "was intended to *benefit* the putative plaintiff," because it placed "a binding [rather than precatory] obligation on a government unit," and because the plaintiffs' asserted interests were not so "'vague and amorphous' that their enforcement would strain judicial competence."[10] One month later, however, in *Gonzaga University v. Doe*, the United States Supreme Court announced that section 1983 provided a cause of action only for violations of "unambiguously conferred rights," specifically precluding actions seeking to secure mere "benefits" or "interests" created by federal law.[11]

Since the Supreme Court later denied certiorari in both the *Westside Mothers* case[12] and a similar case from North Carolina,[13] it has not ultimately settled the question of whether private plaintiffs may sue under section 1983 to force a State to comply with specific Medicaid provisions. A State "must comply with certain requirements imposed by the [Medicaid] Act and regulations imposed by the Secretary of Health and Human Services" as long as the State continues to participate in the Medicaid program.[14] The unanswered question is whether Medicaid creates a *right* to certain enumerated health care services, enforceable by private individuals against participating States.

This Note concludes that the Act does not (and should not) confer an enforceable private right to such services. It further concludes that the federal courts have distorted the important political

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7. Chief Justice Rehnquist, writing for the Court in 2002, stated, "The fact that [many lower courts] have relied on the same set of opinions from this Court [and reached different conclusions] suggests that our opinions in this area may not be models of clarity. We therefore granted certiorari to resolve the conflict among lower courts and in the process resolve any ambiguity in our own opinions." Gonzaga Univ. v. Doe, 536 U.S. 273, 278 (2002) (citations omitted).

8. *Westside Mothers*, 289 F.3d at 863.

9. 42 U.S.C. § 1983 (2000).

10. *Westside Mothers*, 289 F.3d at 862-63 (emphasis added).

11. *Gonzaga*, 536 U.S. at 283.

12. 537 U.S. 1045 (2002).

13. Odom v. Antrican, 290 F.3d 178 (4th Cir. 2002), *cert. denied*, 537 U.S. 973 (2002).

14. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1990).

and financial relationship between Congress and the States by enforcing Medicaid provisions as if a right to such care existed, substantially hindering attempts to ensure some adequate level of health care for all Americans.

Part II briefly discusses the history of Medicaid, describes the financial and political attractiveness of the Medicaid program to both the States and Congress, and explains how the federal courts contribute to the States' present financial crises by imposing precatory federal health care priorities on the States with a vigor that Congress never intended.

Part III discusses the development of the Court's section 1983 jurisprudence as it has been applied to rights created by federal statutes. This Part pays particular attention to the Court's uneasy role in defining the rights of States and individuals within the context of cooperative federal-state programs enacted under the spending clause.

Part IV exposes the conflict between the concept of an enforceable private right to health care under Medicaid and the Supreme Court's decision in *Gonzaga University v. Doe*, which held that section 1983 provided a cause of action only where "unambiguously conferred rights" were implicated. This Note concludes that the Medicaid Act does not confer such unambiguous rights and that the enforcement of Medicaid provisions should be left solely to the Secretary for Health and Human Services.

Finally, Part V assumes that the *Gonzaga* decision or its eventual progeny will preclude plaintiffs from using section 1983 to enforce a private right to health care under Medicaid and explains why this is the best result if the United States is to make progress toward providing access to adequate health care for all citizens. The result, while perhaps harsh in the short term, will force Congress to recognize the true economic and political nature of the reforms that must occur if it is to successfully increase access to adequate health care services for an expanding Medicaid population.

II. THE FINANCIAL AND POLITICAL REALITY OF MEDICAID: A DEAL WITH THE DEVIL?

Congress enacted the Medicaid Act in 1965 in order to provide medical care to certain low-income persons.[15] The Medicaid Act authorizes Congress to appropriate federal funds for payments to

15. *See* James F. Blumstein & Frank A. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (Tenncare) as a Case Study and a Paradigm*, 53 VAND. L. REV. 125, 136 (2000).

States that have developed approved plans for providing health care to those who cannot otherwise afford it.[16] States choosing to develop health care plans use the congressional funds to pay professionals who provide health care services to Medicaid-eligible individuals.[17] The Act outlines minimum standards for State participation, but the actual implementation of any particular Medicaid program, including the decision whether to pay for certain kinds of treatment authorized by the Act, is largely a State concern.[18] Although Medicaid is, at least theoretically, a voluntary program, every State participates in it to some degree.[19]

A. Federal Financial Participation and the Externalization of Political Costs

The principal allure of the Medicaid program is its funding scheme. The amount of federal funding that a State receives for its Medicaid program is a function of the State's own Medicaid spending and a federal matching formula based primarily on the State's per capita income.[20] Each State's Medicaid budget, therefore, is a combination of actual State funding and some amount of federal assistance, known as "federal financial participation" (FFP).[21] Depending on a State's average per capita income, FFP can range from 50% to 83% of the State's total program costs.[22] Therefore, a State can provide health care services for low-income individuals at a

16. 42 U.S.C. § 1396 (2000). The Secretary of Health and Human Services (HHS) must find that a State's Medicaid plan satisfies the substantive and procedural requirements of the Medicaid statute. § 1396a(a)-(b); 42 C.F.R. § 430.10 (2003).

17. *See, e.g.*, § 1396a(a)(13)(A).

18. § 1396a(a)(17). In *Beal v. Doe*, 432 U.S. 438, 441 (1977), the court stated the following: Although [the Medicaid Act] does not require states to provide funding for all medical treatment falling within the . . . general categories [of treatment enumerated in the Act], it does require that State Medicaid plans establish 'reasonable standards . . . for . . . determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [the Act].'"). As a result of this State autonomy, in 2000, there were "essentially 56 different Medicaid programs—one for each State, territory, and the District of Columbia.
See HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., A PROFILE OF MEDICAID: CHARTBOOK 2000 at 6 (2000).

19. *See* Blumstein & Sloan, *supra* note 15, at 137, 138 n.37.

20. *See id.* at 138 & n. 40.

21. *Id.*

22. § 1396d(b). These numbers represent the statutory minimum and maximum figures. Actual figures vary from year to year. For example, in 2001, the Centers for Medicare and Medicaid Services reported that FFP (or Federal Medical Assistance Percentage) ranged from a high of 76.8% in Mississippi to a low of 50% in ten States. Centers for Medicare and Medicaid Services, *Medicaid: A Brief Summary*, *at* http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp (last visited July 22, 2003). The average FFP was 57%. *Id.*

level that greatly exceeds actual State cost, making it economically and politically sensible for a State to expand such services well beyond the limit that cost would normally impose.[23] Unfortunately, this funding scheme creates a political "moral hazard," whereby the States have incentives to expand their Medicaid programs beyond levels that they would be willing or able to fund independently.[24]

Medicaid's cooperative financial arrangement works well to a point. The States are understandably eager to accept so generous an offer from the federal government. Congress benefits, too, by expanding access to health care in a way that puts much of the budgetary decision making in the hands of the States—a valuable arrangement when elections draw near.[25] The State's temptation is to expand healthcare coverage, ensuring that program costs will eventually reach a level at which even the State's lesser obligation in the funding of its Medicaid program becomes difficult to pay.[26]

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23. For example, a State receiving FFP at a 50% rate would only have to spend $500 million to provide $1 billion of Medicaid services to its citizens. A State receiving 83% FFP would only have to spend $170 million to achieve the same result.

24. In 1963, economist Kenneth Arrow first used the term "moral hazard" in the context of medical insurance. *See generally* Kenneth Arrow, *Uncertainty and the Welfare Economics of Health Care*, 53 AM. ECON. REV. 941 (1963). Professors Blumstein and Sloan apply the term to "a broad range of circumstances in which the interest of a rational individual is not identical to the interest of the larger collective of which that individual is a member." Blumstein & Sloan, *supra* note 15, at 139 & n.45. In the Medicaid context, the term describes the fact that the citizens of all States bear the economic cost of increased Medicaid spending by one State but the benefits of the increased spending only accrue to the citizens of the State doing the spending. *Id.* at 139. Conversely, the benefit realized when one State decreases Medicaid spending is shared by the citizens of all States, but the cost of that benefit is borne only by the State reducing Medicaid expenditures. *Id.* From the point of view of an individual State, the only rational economic decision is to increase Medicaid spending, leading to a situation where finite federal health care dollars are stretched to their limit. *Id.* at 140, 148 n.70 ("Cooperative federalism makes it economically and politically rational to spend State funds that, were the State paying the full bill, might not comport with State priorities."); *see also* Editorial, *Runaway Medicaid*, WASH. TIMES, Sept. 28, 1995, at A18.

25. Total federal Medicaid expenditures are not limited by any cap or ceiling. *See* HEALTH CARE FIN. ADMIN., *supra* note 18, at 8; *see also* James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1465 (1994). Instead, under the matching formula, the Federal Medicaid expenditure for any year is solely a function of the discretionary spending of the States on their respective Medicaid programs. *See* HEALTH CARE FIN. ADMIN., *supra* note 18, at 8. Under such a scheme, it is easy for Congress to deflect the responsibility for increased federal spending, since no legislator is on record as having directly voted for an increase or decrease in Medicaid spending. Although the amount of such an "automatic" budgetary item can be increased or decreased by bills expanding or shrinking the scope of coverage and the size of the eligible population, this only indirectly affects absolute expenditures, since the States have considerable discretion in managing these aspects of their Medicaid programs. *Id.*

26. *See, e.g.*, Jackie Calmes, *Fiscal Health of States Is Worsening*, WALL ST. J., Feb. 5, 2003, at A2 ("The National Conference of State Legislatures . . . said States' current budget gaps have grown to a total of nearly $26 billion . . . . [T]he shortfall projected for fiscal year 2004 . . . is forecast to be at least $68.5 billion." Furthermore, "[t]he NCSL survey found that for fiscal year

Cutting expenditures matched by FFP is difficult because, for every dollar that a State wishes to save, the State has to cut between $2 and $6 in program costs.[27] Such a decision is politically unpopular for obvious reasons. Professor James Blumstein has referred to this inability to slow the growth of leveraged cooperative programs as the political "narcotic effect."[28] Professor Blumstein's label colorfully describes how participating States become increasingly dependent on federal money in order to meet political and social goals. A State reducing its own Medicaid expenditures must endure a painful economic withdrawal period as it also weans itself off of the accompanying federal funds. The State is then forced to raise taxes or cut other programs in order to make ends meet, alienating important political constituencies in the process.[29]

Congress has used the addictive effects of FFP to aggressively externalize some costs of its own. Once the States were politically and fiscally locked-in to the Medicaid program, Congress began imposing greater obligations on the States in exchange for FFP.[30] Congress thereby squeezed more political capital from every federal matching dollar. Unfortunately, this congressional exploitation of the narcotic effect made the States increasingly desperate to find some way of coping with the growing burdens of Medicaid compliance.[31]

B. Managed Care: A Solution to the Cost Problem?

The Medicaid Act requires participating States to provide care that is deemed "medically necessary" by a treating physician in any given case.[32] While considerable debate rages over the propriety of

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2003 . . . 13 States have cut Medicaid spending . . . . Medicaid and education are the States' biggest costs."); *see also* Pear, *supra* note 2; Pear & Toner, *supra* note 2.

27. This disparity results from the fact that FFP puts the State in what could be described as a leveraged position with respect to its investment in health care. *See supra* notes 22-26 and accompanying text. When the State removes funds from its Medicaid program, it loses the amount of FFP that was dependent on those funds. *See supra* notes 22-26 and accompanying text. The actual figure, of course, would depend on the level of FFP. *See supra* notes 22-26 and accompanying text.

28. Blumstein & Sloan, *supra* note 15, at 141-42.

29. *Id*; *see also* Calmes, *supra* note 26.

30. *See* Blumstein & Sloan, *supra* note 15, at 142-44.

31. *See id.* at 148-49.

32. Webster v. Reprod. Health Servs., 492 U.S. 490, 508 (1989) (holding that Congress has authorized "reimbursement for medically necessary services generally"); Blum v. Yaretsky, 457 U.S. 991, 994 (1982) (holding that an individual seeking Medicaid assistance "must seek medically necessary services"); Harris v. McRae, 448 U.S. 297, 316-17 (1980) (holding that "Congress has opted to subsidize medically necessary services generally"); Beal v. Doe, 432 U.S. 438, 444-45 (1977) (holding, "[The Medicaid Act] makes no reference . . . to any . . . particular medical procedure. Instead, the statute is cast in terms that require participating States to

including economic concerns in treatment decisions, some commentators recognize that the medical necessity standard encompasses not a single level, but a continuum of medical care.[33] One end of the continuum represents the level of care that is medically adequate and economically efficient (in terms of the cost of the care versus the benefit of the care to the patient) for the treatment of a particular condition.[34] The other end symbolizes the level of care that might produce the maximum possible medical benefit to the patient, notwithstanding the marginal cost of that care.[35] Applying this flexible concept of medical necessity, the States found that they could reduce Medicaid expenditures without visibly cutting health care services by encouraging doctors treating Medicaid patients to interpret "medical necessity" as a standard of *medical adequacy* rather than one of *maximum benefit*.[36]

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provide financial assistance with respect to . . . broad categories of medical treatment. But nothing in the statute suggests that participating States are required to fund every medical procedure that falls within the delineated categories of medical care." The Court added, "Although serious statutory questions might be presented if a State Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary—though perhaps desirable—medical services." (citations omitted)) .

33. CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY 169-71 (2d ed. 1998).

34. *Id.*

35. *Id.*

36. *Id.* It is important to note that "the threat of lower quality [in health care] should not ring the death knell for proposed policy shifts." Blumstein, *supra* note 25, at 1466. As Professor Blumstein points out,

[c]ost-benefit and risk-benefit calculations occur constantly and are an integral part of the economic marketplace. If lower quality were the death knell, we would not have different segments in the automobile industry—only the Lexus, the Infiniti, and the Mercedes would be manufactured.

In short, policies that lower the quality of care may be rational if higher levels of quality can be achieved only at extremely high costs. Intuitively, we all engage in such balancing. We take prudent (and sometimes even imprudent) risks to achieve objectives that are important to us, or because we believe that the cost of safety is excessive in that it would cause us to forego other valuable benefits. Indeed, these kinds of economic trade-offs are routinely made in the medical care marketplace, but usually out of the public's sight. But only academic types, who are not running for public office, are prepared to state what should be obvious—that it might be socially optimal to have lower quality medical care, at least in some circumstances, if the cost of the highest quality care is too high. In no other marketplace do we say 'spare no expense, cost is irrelevant.' It is not radical to suggest that the highest levels of quality might be sub-optimal and that the diminution-of-quality argument should not be checkmate in health policy debates.

Id. at 1466-67. Such cost-benefit decisions are evident in the fact that different qualities of artificial hips exist, as do different contrast agents used in radiological examinations, some of which are tremendously more expensive than others. *Id.* at 1467 n.27. Further,

[e]vidence shows that clinical uncertainty rather than a single scientific standard governs the actual practice of medicine. There are dramatically different procedure rates in similar regions for similar conditions. When variables are controlled for potentially relevant patient characteristics such as age, education, and income, researchers still observe widely divergent

The most formidable hurdle that the States faced in their search for Medicaid efficiency was the traditional fee-for-service system of health care delivery, under which a State participating in the Medicaid program was obligated to pay for any care provided or recommended by a physician.[37] The State had but one duty—to write a check.[38] This system created an additional moral hazard in which physicians had incentives to provide more and more care without regard to its cost, maximizing their own profits while maintaining the moral and ethical high ground by also maximizing care to patients.[39] States realized that they would have to replace the fee-for-service health care model if they were to achieve cost-containment goals.

One solution was to administer a State Medicaid plan through a Managed Care Organization (MCO). MCOs are health plans organized in such a way that physicians are encouraged to provide the least expensive medically adequate treatment for a particular condition.[40] A typical MCO receives a periodic, capitated (per head) payment for each person enrolled in its health care program.[41] This arrangement places the MCO at financial risk because it is obligated to provide medical care to members even if the cost of that care

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rates for such procedures as tonsillectomies, adenoidectomies, and hysterectomies in demographically comparable regions.

Id. at 1479. Such evidence shows that there is ample room in many treatment decisions for a cost-benefit analysis.

37. HAVIGHURST ET AL., *supra* note 33, at 169-71, 281-82.

38. *Id.* at 277, 281.

39. This particular moral hazard results from the fact that the doctor's ethical and financial interests and the patient's heath care quality interests are aligned with each other, but not with the public's financial interest. More care for the patient means that the patient is no worse off in terms of his health; the doctor is better off in terms of his bottom-line and his moral and ethical duty to do his best for each patient; and, the public is worse off in terms of expense. For a more thorough discussion of the nature of a moral hazard, see HAVIGHURST ET AL., *supra* note 33, at 181, 183, 208-09, Blumstein, *supra* note 25, at 1465, and *supra* note 24 and accompanying text, .

40. "[T]he essential feature that distinguishes [MCOs] from conventional health insurance is a contractual commitment to provide or arrange for care, not just to indemnify the subscriber for costs he or she reasonably incurs." HAVIGHURST ET AL., *supra* note 33, at 213-14. Additionally, the MCO contracts with physicians who agree to provide necessary care under the terms of the plan, but a contractual arrangement may not directly influence a treating physician's medical judgment in any given case without potentially exposing the MCO to liability for bad results. *See, e.g.*, Pegram v. Herdrich, 530 U.S. 211 (2000); Bowman v. Corr. Corp. of Am., 188 F. Supp. 2d 870 (M.D. Tenn. 2000); Muse v. Charter Hosp. of Winston-Salem, Inc., 452 S.E.2d 589 (N.C. Ct. App. 1995). The contractual framework creates incentives for the MCO's participating providers to consider the relative costs and benefits of the health care services that they provide. *See* HAVIGHURST, *supra* note 33, at 1181-82. Contracts between MCOs and providers address issues such as "the form and amount of the provider's compensation, utilization management and other administrative requirements, and the terms on which a provider's participation may be terminated." *Id.* "Such contracts frequently introduce financial incentives by which the plan hopes to discourage overutilization." *Id.* at 1182.

41. HAVIGHURST ET AL., *supra* note 33, at 209.

exceeds the aggregate capitated payments.[42] If the capitated payments exceed the cost of caring for enrollees, however, the MCO retains a profit.

Physicians participating in an MCO are encouraged to lower the cost of patient care through ownership interests in the MCO, salary and bonus structures, withhold payments contingent on specified economic targets, and other arrangements.[43] The resulting health care model costs less to operate, since over time the combined cost-benefit decisions of the participating physicians tend to push the standard of medical necessity away from the level of all maximum benefit and toward the level of adequate care.[44]

Congress passed legislation in the early 1980s allowing States to require that all Medicaid beneficiaries receive medical care through MCOs.[45] Most States have since implemented such reforms.[46] By allowing managed care in the Medicaid context, Congress acknowledged that economic considerations are an important part of the Medicaid calculus. In the final analysis, however, Congress has shown little sympathy to States increasingly burdened by Medicaid obligations.[47] This tension between federal health care priorities and State economic realities often leads to litigation by private parties seeking some federal health care benefit at State expense.[48]

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42. *Id.* at 1182.

43. *Id.* at 209, 1181-82; *see also* James F. Blumstein, *Medicine Isn't an Economics-Free Zone*, WALL ST. J., June 22, 2001, at A14 (noting that, fundamentally, MCOs "ask if treatment, even if effective, is of sufficient benefit or priority to warrant expenditure from a common pool of insurance money").

44. HAVIGHURST ET AL., *supra* note 33, at 169-71.

45. *See* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173, 95 Stat. 808 (1981). Subsequent legislation has made it even easier for States to administer their Medicaid programs through managed care organizations. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4712, 111 Stat. 509 (1997).

46. HAVIGHURST ET AL., *supra* note 33, at 283-85.

47. *See, e.g.*, Bipartisan State Budget Relief Act of 2003, S. 138, 108tb Cong. § 1(b) (2003) (giving emergency short term aid to the States by temporarily increasing FFP percentages, but requiring States to accept reduced FFP in the future in exchange for the help today); *see also* Calmes, *supra* note 26.

48. *See, e.g.*, Odom v. Antrican, 290 F.3d 178, 178 (4th Cir. 2002); Westside Mothers v. Haveman, 289 F.3d 852, 852 (6th Cir. 2002); John B. v. Menke, 176 F. Supp. 2d 786, 786 (M.D. Tenn. 2001).

C. EPSDT, Managed Care, and the Federal Courts: Westside Mothers v. Haveman

1. EPSDT and Managed Care

One of the most comprehensive provisions of the Medicaid statute is its Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) requirement.[49] The EPSDT provisions list the medical services that a State must provide to Medicaid-eligible children under the age of 21.[50] The list of required services is extensive. Generally, whatever care a child needs, that child gets.[51]

EPSDT requires the State program to provide, at intervals meeting "reasonable standards of medical practice," comprehensive physical examinations, health and developmental histories, blood and laboratory tests, immunizations, vision services, dental services, hearing services, and health education services.[52] Furthermore, States must fund treatment "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are generally covered under the State plan."[53] Federal utilization goals require each State to take steps to ensure that 80 percent of its Medicaid-eligible children are getting these services.[54] Finally, each State is expected to provide transportation, scheduling, and other ancillary services if such services will help the State meet its utilization goals.[55]

The EPSDT provisions requiring States to provide any treatment recognized by the Medicaid Act and recommended by a physician largely thwart attempts to control costs through managed care.[56] A State's decision to exclude certain health services from its

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49. 42 U.S.C. § 1396d(r) (2001).

50. § 1396d(a)(4)(B).

51. *Id.*; *see also* John A. Flippen, Note, *The Early and Periodic Screening, Diagnostic, and Treatment Program and Managed Medicaid Mental Health Care: The Need to Reevaluate the EPSDT in the Managed Care Era*, 50 VAND. L. REV. 683, 689-90 (1997).

52. §1396d(r).

53. § 1395(r)(5).

54. Wendy Wendland, *Key Programs Face Threats*, DETROIT FREE PRESS, June 21, 2001, at 1A.

55. *See, e.g.*, 42 C.F.R. §§ 441.62, 431.53 (2002).

56. *See, e.g.*, John B. v. Menke, 176 F. Supp. 2d 786, 800-05 (M.D. Tenn. 2001) (holding, "[a]though States may take advantage of Medicaid waivers [allowing the provision of Medicaid services through contracts with managed care organizations] . . . the 'waiver may not be used to deny, delay, or limit access to *medically necessary* services that are required to be available . . . under federal EPSDT rules.' EPSDT services . . . may not be limited, even pursuant to a

Medicaid program is meaningless in the EPSDT context.[57] Where children are concerned, the statute requires the State to provide any treatment within the general Medicaid Act even if the State would not cover the same treatment for an adult.[58] Critically, the operative language of section 1396d(r)(5) requires the State to pay for any "medically necessary" treatment that "correct[s] or ameliorate[s]" medical conditions discovered by the required screenings.[59] This language mandates a standard of medical necessity that strives for maximum benefits without consideration of marginal costs, eviscerating a managed care arrangement.[60]

Congress enacted the EPSDT provisions of the Act in 1967, when utilization levels were much lower and fee-for-service was the dominant delivery model for health care.[61] In today's health care environment of skyrocketing costs and increasing utilization of Medicaid services, the standard of medical necessity embodied in the EPSDT provisions is economically unworkable.[62] If managed care is not permitted in the EPSDT context, States cannot effectively control the health care costs incurred by millions of Medicaid-eligible children.

Medicaid waiver" (emphasis added)). For a discussion of why a standard of medical necessity is problematic in the managed care context, see *supra* notes 59-60, 248-251 and accompanying text.

57. *See supra* note 18 and accompanying text.

58. EPSDT requires a State to pay for any of the services enumerated in 42 U.S.C. section 1396d(a) in addition to the special services listed in section 1396d(r). It is difficult to conceive of a non-experimental medical service not contained in one of these two subsections.

59. *See, e.g.*, § 1396d(r)(1)(A)(i)-(ii) (stating the term "early and periodic screening, diagnostic, and treatment services" means the following items and services: Screening services . . . which are provided . . . at intervals which meet reasonable standards of medical and dental practice, and . . . at such other intervals, indicated as medically necessary. . . .").

60. The language of the statute seems to indicate that, notwithstanding any contractual arrangement between the State and an MCO, the MCO would he required to provide, and the State would be required to pay extra for, any treatment that, in the medical judgment of a physician, would benefit the child. *See* § 1396(d)(r)(5). This requirement might even force the State to pay for "experimental" procedures. *See, e.g.*, Brandi Hinds v. Blue Cross & Blue Shield of Tenn., Inc., No. 3:95-0508, at 10-17 (M.D. Tenn. Dec. 28, 1995) (unpublished opinion unavailable electronically and on file with author) (holding that Tennessee's Medicaid Demonstration Project, TennCare, was required to fund an arguably experimental small bowel transplant for a Medicaid-eligible child under the EPSDT requirements).

61. Flippen, *supra* note 51, at 684, 689.

62. For a brief discussion of the evolution and rejection of various Medicaid reimbursement schemes focusing on the shift from retrospective (fee-for-service) payment to managed care and prospective payment, see Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 505-08 (1990). Each change resulted in increased State control over reimbursement procedures. *Id.* The uncertainty of future cost created by the "all beneficial and preventative care" standard seemingly embraced by the EPSDT provisions of the Medicaid Act makes any prospective payment scenario difficult to enforce. *See* § 1396d(r)(5).

2. EPSDT and the Courts

Expenditures for EPSDT services, especially those designed to maximize utilization of the services, are closely scrutinized when State officials begin to feel the unpleasant budgetary effects of their increasingly expensive Medicaid plan. The States could simply begin to cut services as fiscally necessary, forcing the Secretary for Health and Human Services and Congress to address the funding and coverage issues. There are grave political and social costs associated with such action, since cutting Medicaid services would only serve to harm those that the program was designed to help.[63] Additionally, as *Westside Mothers* illustrates, when a State cuts its EPSDT expenditures it risks being sued by welfare-rights groups.[64]

In most cases the federal courts enforce the letter of the EPSDT provisions and, notwithstanding the precatory nature of the Medicaid Act,[65] allow private plaintiffs to force the States to provide the enumerated services.[66] Such judicial action usurps the enforcement role of the Secretary of Health and Human Services and imposes burdens on the States that Congress never intended. Congress is able to watch silently as the courts enforce federal health care policies at the expense of the already economically suffering States. Professor Blumstein refers to this phenomenon as "legislative schizophrenia."[67]

3. Legislative Schizophrenia and the *Westside Mothers* Litigation

Legislative schizophrenia is based on the concept that sweeping humanitarian goals "are widely shared *in the abstract.*"[68] In other words, it is hard to argue with the following statement: "Other

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63. States only cut Medicaid expenditures as a last resort, and while there is substantial debate over the characteristics of the population that Medicaid should cover, no State wants to see its most vulnerable citizens left without adequate bealtb care. *See, e.g.*, Rosen v. Tenn. Comm'r of Fin. & Admin., 288 F.3d 918, 920-31 (6th Cir. 2002) (illustrating how the State of Tennessee expanded TennCare, its health care program, to cover Medicaid-ineligible individuals in addition to its preexisting Medicaid population. The State was not required to cover these individuals under the Medicaid program but was sued when it tried to close enrollment of this class of individuals and drop individuals owing payment of TennCare premiums.); *see also* Marci A. Hamilton, *Assessing Claims that Federalism and States Are Anti-civil Rights*, *at* http://www.cnn.com/2003/LAW/01/06/findlaw.-analysis.hamilton.findlaw/index.btml (last visited July 27, 2003).

64. 289 F.3d 852, 856 (6th Cir. 2002).

65. *See infra* Parts II.C.3, IV.B (discussing the precatory nature of the Medicaid statute).

66. *See e.g., Westside Mothers*, 289 F.3d at 863.

67. James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L. REV. 1227, 1233 (1984).

68. *Id.* at 1234 (emphasis added).

things being equal, it would be better to provide improved access to medical care to indigent patients."[69] As a result, legislators "are unlikely to strenuously oppose pious aspirational language of a general precatory character in health policy legislation," even if they do oppose mechanisms by which the precatory language could be enforced.[70] Such enforcement gaps are accepted as a necessary part of political compromise, so Congress gives the supervising agency (the Department of Health and Human Services for Medicaid) wide discretion in its enforcement of the statutory language.[71]

Westside Mothers illustrates the reality of legislative schizophrenia and of the State struggle to make ends meet under the increasing pressure of Medicaid obligations. In 1999, several welfare-rights groups filed suit in federal court seeking an injunction that would have forced the State of Michigan to spend more money to make sure that EPSDT utilization goals were met.[72] The plaintiffs claimed that only 35 percent of Michigan's eligible children had received the required EPSDT services in 1997, and that this percentage had dropped for the second consecutive year.[73] The lawsuit, in addition to asking for the provision of required medical services for children, sought to force the State to better inform the parents of eligible children about EPSDT services and to provide transportation and scheduling assistance to the children and their parents, making it easier for them to take advantage of such services.[74]

The plaintiffs' most intriguing claim was that Michigan "develop[ed] a program . . . lack[ing] the capacity to deliver to eligible children the care required by [Medicaid]."[75] Michigan officials

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69. *Id.*

70. *Id.*

71. *Id.*

72. *See* Wendland, *supra* note 54.

73. *See id.*

74. Westside Mothers v. Haveman, 289 F.3d 852, 856 (6th Cir. 2002).

75. *Id.* The statutes allegedly implicated by Michigan's Medicaid program were 42 U.S.C. section 1396a(a)(8), which provides that "[a] state plan for medical assistance. . . must provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals"; section 1396a(a)(30)(A), which provides that the plan must "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"; and § 1396u-2(b)(5), which provides that

[e]ach Medicaid managed care organization shall provide the State and Secretary [of Health and Human Services] with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve expected enrollment in such service area, including assurances that the organization . . . offers an appropriate range of services and access to preventive and primary care services for the

disputed the utilization statistics that the plaintiffs relied upon to make this claim, maintaining that the utilization of EPSDT services had actually increased over the last two years.[76] Crucial to the plaintiffs' argument was the fact that since 1997, Michigan operated on a waiver from the Health Care Finance Administration allowing the State to provide Medicaid services (including EPSDT services) through an MCO.[77] In other words, the plaintiffs were claiming that Michigan's approach to managed care violated the EPSDT provisions of the Medicaid Act.

Interestingly, the plaintiffs' attack on Michigan's Medicaid program focused primarily on Michigan's failure to achieve overall utilization goals for EPSDT services rather than on individual cases in which care was denied.[78] It is true that when a State's Medicaid compliance is in question the relevant inquiry under the Medicaid statute concerns a State's program as a whole and not individual instances of noncompliance.[79] Michigan's Medicaid program as a whole, however, was acceptable to the Secretary of Health and Human Services.[80] Michigan correctly pointed out that it was in weekly contact with federal officials and that the office of the Secretary of Health and Human Services had continually approved the State's ongoing Medicaid program in required quarterly audits.[81] Importantly, the *Westside Mothers* plaintiffs challenged the actions of the State of Michigan and not the determination of the Department for Health and Human Services that Michigan's Medicaid program was in compliance the Medicaid Act.[82] Under these circumstances, it seems that the plaintiffs would have to extrapolate the existence of a systemic failure of Michigan's EPSDT program from many individual

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population expected to be enrolled in such service area, and . . . maintains a sufficient number, mix, and geographic distribution of providers of services.

76. *See* Wendland, *supra* note 54; *see also* Wendy Wendland, *State Sued over Kids' Checkups*, DETROIT FREE PRESS, July 13, 1999, at 1B. The State vehemently disputed the plaintiff's data, claiming that 93 percent (93%) of eligible children had at least one physical examination of the eyes, ears, nose, throat, chest, abdomen, and extremities in 1998, that 83 percent (83%) had received at least one preventive-care doctor's visit by their first and second birthdays in 1997, that 67 percent (67%) had a vision screening, that 63 percent (63%) had a hearing screening, that 47 percent (47%) had a dental examination, and that 46 percent (46%) were tested for lead poisoning. *Id.* Furthermore, the State asserted that the statistics the plaintiff provided did not take into account eligible children enrolled in managed care programs. *Id.*

77. *Westside Mothers*, 289 F.3d at 856.

78. *Id.*; *see also* Wendland, *supra* note 54.

79. *See infra* notes 197-200 and accompanying text.

80. *See* Wendland, *supra* note 54.

81. *Id.*

82. *See id.*

instances of noncompliance rather than from Michigan's failure to meet utilization goals set by the agency.[83] This the plaintiffs did not do.[84]

The plaintiffs claimed that they were asking a simple question of statutory compliance but the case actually presented several larger issues. Should a court, at the request of a private plaintiff, try to "fix" a State's Medicaid program, especially when the Secretary of Health and Human Services has found the program to comply with federal law? Should a court fill in the gaps of precatory federal health care policy with its own ideas, enabling Congress to externalize the political costs associated with making tough, detailed enforcement decisions? Should a court impose a massive financial burden (even a purely prospective one) on a State that has structured its conduct and finances according to its ongoing, functional relationship with the relevant federal officials? This is legislative schizophrenia in action.

III. SECTION 1983 AND THE SPENDING CLAUSE

A. Section 1983 Generally

42 U.S.C. Section 1983 was originally enacted as the Ku Klux Klan Act of 1871.[85] The goal of this act was "to override the corrupting influence of the Ku Klux Klan and its sympathizers on the governments and law enforcement agencies of the Southern States, and of course one strong motive behind its enactment was grave congressional concern that the State courts had been deficient in protecting federal rights."[86] In other words, section 1983 was enacted to protect the civil rights of "newly freed slaves and union sympathizers" by providing "a neutral federal forum" in which an aggrieved citizen could avoid the biases inherent in State courts of the post-Civil War era.[87]

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83. Although federal regulations had set Michigan's utilization goal for EPSDT services at 80 percent, the Secretary's continual approval of Michigan's Medicaid program, notwithstanding the State's failure to meet this statistical goal, shows that this number, at least in the opinion of the relevant regulatory authority, is aspirational rather than rigidly enforced. *See id.* (citing the EPSDT services goal). Any criticism that a particular Medicaid program was not capable of providing required care, therefore, would need to point to individual instances where the required care was refused or not available in order to show that a larger systemic problem existed. Such evidence would have to be more than anecdotal and would have to achieve some sort of critical mass in order to support a serious allegation of structural noncompliance.

84. *See id.*

85. H.R. REP. NO. 96-548, at 1 (1979), *reprinted in* 1979 U.S.C.C.A.N. 2609, 2609.

86. Allen v. McCurry, 449 U.S. 90, 98-99 (1980) (citations omitted).

87. H.R. REP. NO. 96-548, at 1.

The statute reads, in relevant part,

> [e]very person who, under color of any [law] of any State . . . subjects, or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws [of the United States] . . . shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .[88]

The statute remains today effectively unchanged from its original version.[89] How did a statute enacted to address civil rights abuses in the Reconstruction Era[90] evolve into an instrument by which private plaintiffs may impose judicially created health care policies on the States under the auspices of a voluntary federal-state program enacted under the spending clause?[91]

B. Section 1983 and the Spending Clause

While section 1983 was enacted in 1871, the Supreme Court did not interpret it as protecting statutorily created rights of any kind until 1980.[92] One year later, however, in *Pennhurst State School and Hospital v. Halderman*, then-Justice Rehnquist addressed the more specific question of whether a statute enacted under the spending clause could create rights enforceable under section 1983.[93] He wrote, "[i]n 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."[94]

Congress can write other remedies into the statute itself, but, as Justice Rehnquist continued, "[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."[95] As such, "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously. By insisting that Congress speak with a clear voice, we enable the States

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88. 42 U.S.C. § 1983.

89. *See* § 1983. The statute was amended in 1979 to include language applying the statute to the District of Columbia and again in 1996 to limit the scope of injunctive relief against State judicial officers, but the heart of the statute remains unchanged. Pub. L. No. 96-170, 93 Stat. 1284 (amending in 1979); Pub. L. No. 104-317, § 309(c), 110 Stat. 3853 (amending in 1996).

90. H.R. REP. NO. 96-548, at 1.

91. The spending clause empowers Congress to allocate and spend federal funds. U.S. CONST. art. I, § 8, cl. 1 ("The Congress shall have the Power To . . . provide for the Common Defence and general Welfare of the United States").

92. Maine v. Thiboutot, 448 U.S. 1, 4 (1980).

93. 451 U.S. 1 (1981).

94. *Id.* at 28.

95. *Id.* 451 U.S. at 17.

to exercise their choice knowingly, cognizant of the consequences of their participation."[96]

Only twice since *Pennhurst* has the Court found legislation enacted pursuant to the spending power to confer private rights enforceable under section 1983: *Wright v. City of Roanoke Redevelopment and Housing Authority* and *Wilder v. Virginia Hospital Association*.[97] Even in these two cases, however, the Court avoided a searching inquiry into the source of each asserted "right," leaving serious questions regarding the applicability of section 1983 to legislation enacted under the spending clause.

1. Wright v. City of Roanoke Redevelopment and Housing Authority

In *Wright*, tenants living in low-income housing projects sued the owner of the projects under section 1983, alleging that the owner had violated federal statutes and regulations by overbilling the tenants for their utilities.[98] The Housing Act provided that "[a] family shall pay as rent for a dwelling unit assisted under this chapter [no more than a specified percentage of its income],"[99] and that the rent amount included an allowance for "reasonable amounts of utilities" as defined by the Public Housing Authority.[100]

The Court applied a three-part test to determine whether the statute conferred a "right to a reasonable utility allowance" enforceable under section 1983.[101] First, the Court asked whether the language of the statute itself created a private right in the plaintiffs.[102] Drawing from the general language of the statute, the Court of Appeals had held that "the tenants were the intended beneficiaries [of the] Housing Act,"[103] and that the tenants had "certain rights" under the Act.[104] The Court accepted this conclusion.[105]

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96. *Id.*

97. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498 (1990); Wright v. Roanoke Redevelopment & Hous. Auth., 479 U.S. 418 (1987).

98. *Wright*, 479 U.S. at 419.

99. *Id.* at 420 n.2.

100. *Id.* at 420 n.3.

101. *Id.* at 423-32

102. *Id.* at 424.

103. Wright v. Roanoke Redevelopment & Hous. Auth., 771 F.2d 833, 835 (4th Cir. 1985).

104. *Id.* at 837.

105. *Wright*, 479 U.S. at 424 ("For the Court of Appeals, the barrier was not the lack of statutory right or its quality or enforceability."). This statement ignores the fact that the court of appeals failed to undertake any detailed analysis of the source of the "certain rights" created by the Housing Act. *See generally Wright*, 771 F.2d at 837.

Second, the Court asked whether Congress foreclosed private enforcement through its chosen administrative scheme.[106] In determining that the administrative remedies contained in the Housing Act were not "sufficiently comprehensive to demonstrate congressional intent to preclude the remedy of suits under section 1983," the Court first examined the legislative history of the Act.[107] Comments made during a House subcommittee hearing indicated some recognition of a tenant's right to privately enforce provisions of the Act in the federal courts.[108] More convincing, however, was the fact that Congress enacted but later repealed a provision of the Housing Act that would have limited the judicial review of agency decisions.[109] Furthermore, certain regulations implicitly contemplated judicial review of Public Housing Authority actions.[110] Finally, the Court noted that statutes in which it found congressional preclusion of a remedy under section 1983 had "themselves provided for private judicial enforcement, thereby evidencing congressional intent to supplant the section 1983 remedy."[111]

Third, the Court asked whether the asserted right to a "reasonable allowance for utilities" was so "vague and amorphous" that it was "beyond the competence of the judiciary to enforce."[112] In finding that the right was not "vague and amorphous," the Court held that the relevant regulations "specifically set out guidelines that [local housing officials] were to follow in establishing utility allowances."[113]

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106. *Wright*, 479 U.S. at 424.

107. *Id.* at 424-26.

108. *Id.* at 425 & n.7.

109. *Id.* at 425-26.

110. *Id.* at 427.

111. *Id.* at 428. *See also* Smith v. Robinson, 468 U.S. 992, 1004-05 (1984); Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n, 453 U.S. 1, 20 (1981). Where a statute includes a comprehensive judicial or remedial scheme that provides for private action, it does not include additional private remedies under section 1983. *Wright*, 479 U.S. at 423. While a statutory provision for private judicial enforcement is required to find that Congress precluded a private remedy under section 1983 through a "comprehensive administrative scheme," the *Gonzaga* case suggests that a less comprehensive administrative scheme might be one factor to consider in determining whether a private right exists at all. 536 U.S. 273 (2002); *see infra* notes 175-180 and accompanying text.

112. *Wright*, 479 U.S. at 431-32.

113. *Id.* The regulations provided, "The complexity and elaborateness of the methods chosen by the [Public Housing Authority (PHA)], *in its discretion* . . . will be dependent upon the data available to the PHA and the extent of the administrative resources reasonably available to the PHA to be devoted to the collection of such data, the formulation of methods of calculation, and actual calculation and monitoring of the allowances." 49 Fed. Reg. 31,399, 31,409-10 (Aug. 7, 1984) (emphasis added). The regulation recommends several sources of relevant data including technical data concerning energy requirements of appliances, the climactic location of the housing project, the size of the dwelling units, the type of construction and design of the housing project, the physical condition, including insulation and weatherization, of the housing project,

Consequently, the "benefits Congress intended to confer on tenants . . . [were] not . . . beyond the competence of the judiciary to enforce."[114]

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the temperature of domestic hot water, and any number of local, State, and federal government statistical studies. *Id.* While the *Wright* Court might have utilized these sources in order to set a "reasonable allowance for utilities" as required by the statute, the question whether an asserted right is too "vague and amorphous" for the judiciary to enforce would seem to contemplate "rights" such as this. *See* 479 U.S. at 431. Importantly, the plaintiff does not challenge administrative action here. *See id.* Instead, he asks the Court to declare his "right to a reasonable allowance for utilities." *See id.* Where a supposed "right" depends on a highly technical inquiry and the ultimate discretion of administrative officials (who essentially could change or eliminate the supposed "right" at any time), the issue seems particularly well suited to administrative oversight, subject only to the procedural safeguards mandated by the statute or regulations and, of course, judicial review of administrative action under the appropriate standard of deference. In *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844-45 (1984), the Court held

We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations 'has been consistently followed by this Court whenever decision as to the meaning or reach of a statute has involved reconciling conflicting policies, and a full understanding of the force of the statutory policy in the given situation has depended upon more than ordinary knowledge respecting tbe matters subjected to agency regulations. If this choice represents a reasonable accommodation of conflicting policies that were committed to the agency's care by the statute, we should not disturb it unless it appears from the statute or its legislative history that the accommodation is not one that Congress would have sanctioned. (citations omitted).

As to the related question of judicial competence in scientific areas, Professor Mark Hall has concluded

[T]he judicial system is ill-suited to decide scientific questions. Lay judges and juries must rely on expert testimony, and the adversarial setting in which this evidence is presented tends to distort its accuracy. In contrast to scientific processes, litigants in the adversarial system carefully choose their witnesses with tactical advantages in mind. Witnesses that are opinionated and dogmatic are favored over those that have a more balanced view of the competing merits. Moreover, because winning, not truth-finding, is the ultimate objective, litigants resort to tactics that actively undermine truthfulness from a scientific perspective, such as exploiting the demeanor of the opposing scientists and launching ad hominem attacks on their personal credibility. In this adversarial climate, it is difficult for judges and juries to divine scientific fact from science fiction.

MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 69 (1997). The Court's statement of the supposed "right" at issue in *Wright* simply fails to encompass the scope of the inquiry required. *See* 479 U.S. at 431. The same arguably could be said about the Medicaid provisions at issue in *Westside Mothers*. *See* 289 F.3d 852 (6th Cir. 2002).

114. *Wright*, 479 U.S. at 432. The Court's choice of the term "benefits" now has a significance that it did not have at the time. *See Gonzaga*, 536 U.S. at 283. Under the Court's opinion in *Gonzaga*, section 1983 provides a cause of action only where a federal "right" is involved, and mere "benefits" are specifically excluded from its scope of coverage. *Id.* Whether this holding indicates that the Court wrongly decided *Wright* or that the Court merely used the term with no way of anticipating its future significance remains an open question. *See infra* notes 156-159 and accompanying text.

2. Wilder v. Virginia Hospital Association

In *Wilder*, the Court focused on the language of the 1980 Boren Amendment ("the Amendment") to the Medicaid Act.[115] The Amendment required a participating State to reimburse providers in its Medicaid program at rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."[116] Importantly, neither the Amendment nor any regulations promulgated by the Secretary for Health and Human Services defined "reasonable and adequate" or "efficiently and economically," giving the States the power to interpret these critical terms.[117] Ultimately at issue was whether the language of the Amendment created a substantive right to such "reasonable and adequate" rates enforceable by health care providers under section 1983.[118]

The Court emphasized that section 1983 provided a cause of action only for violations of "rights, privileges, or immunities," not for mere violations of federal law, then applied a three-part inquiry to determine whether the Amendment created such a right.[119] First, the Court asked whether the Amendment "was intended to benefit the putative plaintiff," the individuals and entities providing medical services to the beneficiaries of Virginia's Medicaid program.[120] In a one-paragraph analysis reminiscent of that in *Wright*,[121] the Court held that health care providers were the beneficiaries of the Amendment because the Amendment was "phrased in terms benefiting health care providers."[122] Specifically, the Amendment "require[d] a State plan to [pay for] . . . the *hospital services, nursing*

115. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 501-02 (1990).

116. 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V) (codifying the Boren Amendment).

117. *Wilder*, 496 U.S. at 507.

118. *Id.* at 509-10.

119. This test differed from that announced in *Wright*, but the elements of the *Wright* test were all present. *See id.* at 508-09; *supra* notes 101-114 and accompanying text. Importantly, the *Wilder* court seemed to split the question whether a right existed in the first place into two parts. See *infra* notes 120-133 and accompanying text. Then, the court asked if the right was too "vague and amorphous" to enforce. *See infra* notes 134-137 and accompanying text. Finally, the *Wilder* court examined the supposed right in the context of the administrative enforcement scheme of the underlying statute to determine whether Congress intended to preclude private enforcement through a comprehensive administrative scheme. *See infra* notes 139-140 and accompanying text. It is instructive to think of *Wright*, *Wilder*, and *Gonzaga* not as announcing different tests, but as evidencing the Court's evolving understanding of the relationship between section 1983 and the spending clause.

120. *Wilder*, 496 U.S. at 509.

121. *See supra* notes 101-105 and accompanying text.

122. *Wilder*, 496 U.S. at 510.

facility services, and services in an *intermediate care facility* for the mentally retarded . . . ."[123]

Second, the Court asked whether the Amendment "impose[d] a 'binding obligation' on the States," rather than a mere "congressional preference for a certain kind of conduct."[124] In determining that the Amendment obligated the States to set "reasonable and adequate rates," the Court looked to the text of the Amendment, the Amendment's role as a condition of federal funding, the legislative history of the Amendment, and the history of similar provider lawsuits in federal courts.[125]

Examining the language of the Medicaid Act that provided, "[a] State plan for medical assistance must provide . . . for payment . . . of the [enumerated services] . . . through the use of [reasonable and adequate] rates," the Court held that the Amendment spoke in "mandatory rather than precatory terms,"[126] which were "wholly uncharacteristic of a mere suggestion or 'nudge.'"[127] Furthermore, the Court noted that the language of the Medicaid Act and its accompanying regulations conditioned a State's receipt of federal funds on its compliance with the Amendment.[128]

While Virginia conceded that the provisions required it to make a finding regarding the reasonable and adequate level of provider reimbursement for various health services, provide that level of reimbursement, and make the required assurances to the Secretary, the State and the Secretary both argued that the good-faith completion of these procedural requirements discharged the State's obligation.[129] The Court rejected this argument and held that the duty to make findings was distinct from the duty to provide assurances and that "[i]t would make little sense for Congress to require a State to make findings without requiring those findings to be correct," or to require a State to submit assurances "[if] the State's findings [were

123. *Id.* (emphases added).

124. *Id.* at 509-10.

125. *Id.* at 512-19.

126. *Id.* at 512.

127. *Id.*

128. *Id.* It is curious that the Court found this fact to support an enforceable private right under section 1983, considering Justice Rehnquist's pronouncement, in *Pennhurst*, that "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." *See* Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 28 (1981).

129. *Wilder*, 496 U.S. at 512-13. Under such an interpretation, the Secretary would review the reasonableness of the assurances, not the reasonableness of the underlying rates. *Id.* Any enforceable right, therefore, would only guarantee the procedural process outlined in the Amendment, a result that seems consistent with the wide discretion in rate setting given the States under the Amendment. *See id.* at 527-28 (Rehnquist, C.J., dissenting).

not] reviewable in some manner by the Secretary."[130] Consequently, by requiring a State to *correctly find* that its rates are reasonable and adequate, the Court held that "the statute impose[d] the concomitant obligation to adopt reasonable and adequate rates."[131]

The Court also held that the legislative history of the Amendment suggested that the Secretary might have the power to enforce the reasonableness and adequacy of the rates.[132] There was evidence that the Amendment was enacted against a background of provider reimbursement lawsuits, and the legislative history indicated that Congress failed to view the Amendment as a replacement for such private actions.[133]

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130. *Id.* at 514. While this analysis, on its face, made sense, nothing in the text of the Amendment called for correct findings or for the Secretary's approval of those findings. 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V) (codifying the Boren Amendment). Furthermore, the Medicaid history the Court highlights indicates that Congress repeatedly had tried and failed to set reimbursement rates at the national level. *Wilder*, 496 U.S. at 516-17. Congress passed the Boren Amendment in order to relinquish much of the federal control over reimbursement rates. *See id.* at 516. As such, the Amendment limited the Secretary's oversight to a common sense evaluation of the assurances provided by a State that its rates were "reasonable and adequate." *See id.* at 524 (holding that the State may adopt rates "that it finds are reasonable and adequate"). In this sense, a State's rationale for its assurances must only pass a laugh test of sorts, since only the most obviously unreasonable rates, based on patently false findings, would be invalidated under the Amendment. While this conception of the Amendment admittedly gives States the discretion to make bad choices in setting rates, the Court noted that the federal government had repeatedly reached such unacceptable results itself. *Id.* at 515-19. In any case, the Court failed to recognize that a congressional decision to give the States substantial discretion in a matter directly affecting State treasuries would have been a legitimate and understandable congressional policy choice.

131. *Wilder*, 496 U.S. at 514-15.

132. *Id.* at 515-17. "The committee expects that the Secretary will keep the regulatory and other requirements to the minimum necessary to assure proper accountability, and not to overburden the States and facilities with unnecessary and burdensome paperwork requirements." *Id.* at 516. "The Secretary retains final authority to review the rates and to disapprove [them] if they do not meet the requirements of the statute." *Id.* Interestingly, however, while the legislative history shows that the purpose of the statute was to obligate a State "to pay reasonable rates," that history never expressly provides that rates are *independently* reviewable *outside* of the assurances context, nor does it distinguish between the "assurances" that are expressly reviewable in the statute and the rates that are not. *Id.* While statutory canons are of limited use in statutory interpretation because they exist in opposing pairs, one must always remember that statutory language is never an accident, and neither is legislative history. *See* Karl N. Llewellyn, *Remarks on the Theory of Appellate Decision and the Rules or Canons About How Statutes Are To Be Construed*, 3 VAND. L. REV. 395, 401-06 (1950). Consider this statement by Congressman Jack Brooks of Texas, "I'll let you write the statute if you let me write the committee report." ARTHUR MAASS, CONGRESS AND THE COMMON GOOD 139 (1983). The fact that the statute, the regulations, and the legislative history fail to clearly answer the question whether rates are reviewable suggests that the Court unwittingly was forced into an interstitial enforcement role. *Wilder*, therefore, serves as a useful example of legislative schizophrenia. *See supra* notes 68-71 and accompanying text (discussing legislative schizophrenia).

133. *Wilder*, 496 U.S. at 516-19.

Third, the Court considered whether a right to "reasonable [reimbursement rates] . . . adequate to meet the costs which must be incurred by efficiently and economically operated facilities" was "too 'vague and amorphous' to be judicially enforceable."[134] Just like the statute examined in *Wright*, the Amendment enumerated factors that a State had to consider before setting reimbursement rates.[135] Specifically, a State had to "judge the reasonableness of its rates against the benchmark of an efficiently . . . operated facility providing care in compliance with federal and State standards while at the same time ensuring 'reasonable access' to eligible participants."[136] "While there may be a range of reasonable rates," the Court recognized, "there certainly are some rates outside that range that no State could ever find to be reasonable and adequate under the Act."[137]

After holding that the statute created an enforceable right, the Court looked to the statutory and administrative enforcement provisions of the Act and found that Congress did not foreclose private enforcement actions by creating a comprehensive remedial scheme.[138] Because the administrative remedial scheme of the Medicaid Act did not include judicial proceedings,[139] the Court found that the scheme failed to demonstrate Congress' implicit preclusion of private enforcement actions under section 1983.[140]

Four justices vehemently dissented in *Wilder*, concerned that the Court had manufactured a substantive right enforceable under section 1983 in order that the "policy underlying the Boren Amendment would [not] be thwarted."[141] This concern, coupled with the Court's subsequent decision in *Blessing v. Freestone*,[142] hinted that

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134. *Id.* at 519.

135. *Id.*

136. *Id.*

137. *Id.* at 519-20.

138. *Id.* at 523.

139. Medicaid's sole statutory enforcement provisions authorize the Secretary of Health and Human Services to withhold approval of plans under section 1396(a) or reduce or eliminate federal funding for a State plan under section 1396(c). 42 U.S.C. §§ 1396(a), (c) (2000). It seems that a statute must include some sort of judicial remedy if it is to be comprehensive enough to preclude actions under section 1983. *See supra* note 111.

140. *Wilder*, 496 U.S. at 523.

141. *Id.* at 525 (Rehnquist, C.J., dissenting). Justices Scalia, O'Connor, and Kennedy joined the Chief Justice in his dissent. *Id.* at 524.

142. 520 U.S. 329 (1997). In *Blessing*, the Court found unenforceable under section 1983 the child support provisions of Title IV-D of the Social Security Act because under the relevant statute the State program needed only "substantially comply" with the requirements of the Act. *See id.* at 343. Because the plaintiffs essentially asked the Court to force the director of the State program to bring the program into substantial compliance with federal law, they in effect asserted a private right to enforce the entirety of the Act. *Id.* at 341. Since the concept of substantial compliance has an aggregate focus and is not concerned with whether the needs of

the sources of supposed private rights might be subjected to some heightened level of scrutiny in the future.

3. *Westside Mothers v. Haveman*

In *Westside Mothers*, the Sixth Circuit ultimately determined that the EPSDT provisions of the Medicaid Act conferred a private right on beneficiaries enforceable under section 1983.[143] In an analysis spanning less than one-third of a page, the court applied the *Wilder* test to the relevant statutory language. First, the court decided that the EPSDT provisions were "clearly intended to benefit the putative plaintiffs, children who are eligible for the screening and treatment services," because "[i]t is well settled that Medicaid-eligible children under the age of twenty-one are the intended beneficiaries of the screening and treatment provisions."[144]

Second, the court held that the EPSDT provisions "set a binding obligation on [the State]," since "they are couched in mandatory rather than precatory language, stating that Medicaid services 'shall be furnished' to eligible children . . . and that the screening and treatment provisions 'must be provided . . . .' "[145] Third, the court found that the "provisions are not so vague and amorphous as to defeat judicial enforcement, as the statute and regulations carefully detail the specific services to be provided."[146] Finally, the court decided that Congress had not expressly (in a discrete statutory provision) or implicitly (through a comprehensive remedial scheme) precluded private actions seeking enforcement of Medicaid's EPSDT provisions under section 1983.[147]

IV. A RIGHT TO HEALTH CARE?

When the Sixth Circuit decided *Westside Mothers* on May 15, 2002, the *Wilder* test for determining whether a statute enacted under the spending clause conferred a right enforceable by private

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any particular person have been satisfied, the Court cannot define the scope of any enforceable right smaller than the right to enforce the statute as a whole. *See id.* at 341-45. The Court was not willing or able to define the right in such a manner. *See id.*

143. Westside Mothers v. Haveman, 289 F.3d 852, 863 (6th Cir. 2002); *see supra* notes 3-10, 73-77 and accompanying text.

144. *Westside Mothers*, 289 F.3d at 863. The court cited section 1396a(a)(10)(A) (providing, "A State plan for medical assistance must provide for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) . . . of this title [including EPSDT services], to [all eligible individuals].").

145. *Westside Mothers*, 289 F.3d at 863 (citing §§ 1396a(a)(8), (a)(10)(A)).

146. *Id.* (citing § 1396d(r)).

147. *Westside Mothers*, 289 F.3d at 863.

individuals under section 1983 was relatively clear. First, the court had to find that "the statutory section was intended to benefit the putative plaintiff."[148] Second, the statute had to set "a binding obligation on a governmental unit," rather than merely express a congressional preference.[149] Finally, the interests of the plaintiff must not have been so "vague and amorphous that their enforcement would have strained judicial competence."[150] One month later, however, the Supreme Court changed (or, at least, finally clarified) that test in *Gonzaga University v. Doe*, placing the *Westside Mothers* decision and perhaps the entire Medicaid enforcement scheme in jeopardy.[151]

A. Unambiguously Conferred Rights: Gonzaga University v. Doe

In *Gonzaga*, the Court held that the Family Education Rights and Privacy Act (FERPA) did not create rights enforceable under section 1983.[152] Noting, however, that its previous opinions applying section 1983 to spending clause legislation were not "models of clarity," the Court decided to use *Gonzaga* to "resolve any ambiguity" in this area, giving the opinion importance far beyond its immediate context.[153] Chief Justice Rehnquist, writing for the Court, reiterated, "[i]n legislation enacted pursuant to the spending power, the typical remedy for State noncompliance with federally imposed conditions is not a private cause of action . . . but rather action by the federal government to terminate funds to the State."[154] This principle allowed the Court to narrow what it characterized as an erroneous and "relatively loose standard for finding rights enforceable by [section] 1983."[155]

The key inquiry, the Court emphasized, is whether Congress has spoken "with a clear voice" manifesting an "unambiguous intent to confer individual rights."[156] This requires more than a mere showing

148. *Id.* at 862 (quoting Blessing v. Freestone, 520 U.S. 329, 341 (1997)).

149. *Id.*

150. *Id.*

151. Gonzaga Univ. v. Doe, 536 U.S. 273, 273 (2002).

152. *Id.* at 276. The statute at issue provided in relevant part, "No funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of releasing, or providing access to, any personally identifiable information in educational records other than directory information . . . unless . . . there is written consent from the student's parents specifying records to be released, the reasons for such release, and to whom, and with a copy of the records to be released to the student's parents and the student if desired by the parents." 20 U.S.C. § 1232g(b)(2)(A) (2000).

153. *Gonzaga*, 536 U.S. at 278.

154. *Id.* at 280 (quoting Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 28 (1981)).

155. *Id.* at 282.

156. *Id.* at 280.

that Congress intended to "benefit" the putative plaintiff, since "[t]o seek redress through [section] 1983, a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*."[157] Without such "specific, individually enforceable rights, there [is] no basis for private enforcement, even by a class of the statute's principal beneficiaries."[158] Section 1983 "merely provides a mechanism for enforcing individual rights 'secured' elsewhere, i.e., rights independently 'secured by the Constitution and laws' of the United States."[159]

This clarified standard is strikingly similar to the Court's reasoning in implied right of action cases.[160] In both contexts a court must determine whether the statute in question creates a federal *right*, as opposed to a mere benefit or interest.[161] The Court's implied right of action cases, therefore, "should guide the determination of whether a statute confers rights enforceable under [section] 1983."[162]

According to these cases, "[t]he question whether Congress . . . intended to create a private right of action [is] definitively answered in the negative" where "a statute by its terms grants no private rights to any identifiable class."[163] In other words, a statute creating private rights must be "phrased in terms of the persons benefited."[164] Applying this test, the Court has held that Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and section 5 of the Voting Rights Act of 1965 implicitly confer enforceable individual rights.[165] Conversely, the Court has refused to recognize

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157. *Id.* at 282 (quoting Blessing v. Freestone, 520 U.S. 329, 340 (1997)).

158. *Id.* at 281 (quoting Suter v. Artist M., 503 U.S. 347, 357 (1992)).

159. *Id.* at 285. "[O]ne cannot go into court and claim a violation of [section] 1983 [since section] 1983 by itself does not protect anyone against anything." Chapman v. Houston Welfare Rights Org., 441 U.S. 600, 617 (1979).

160. An implied right of action allows a private plaintiff to sue for injunctive relief or damages for the violation of a federal statute even though the statute itself does not expressly provide for such a remedy. *See, e.g.*, Alexander v. Sandoval, 532 U.S. 275, 279-80 (2001). A court must determine whether an implied right of action exists by examining the statutory text. *See id.* at 289.

161. *Gonzaga*, 536 U.S. at 283.

162. *Id.*

163. *Id.* at 283-84 (quoting Touche Ross & Co. v. Redington, 442 U.S. 560, 576 (1979)).

164. *Id.* at 284 (quoting Cannon v. Univ. of Chicago, 441 U.S. 677, 690 n.13 (1979)).

165. *Id.*; *see also* Cannon v. Univ. of Chicago, 441 U.S. at 690 n.13. Title VI of the Civil Rights Act of 1964 provides, "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefit of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d (2000). Title IX of the Education Amendments of 1972 provides, "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance . . . ." 20 U.S.C. § 1681(a) (2000). Section 5 of the Voting Rights Act of 1965

such implied rights under statutes that "create duties . . . for the benefit of the public at large."[166] Once a court finds an enforceable right, the two approaches diverge. In the implied right of action context, a plaintiff must further prove that Congress intended to create a private statutory remedy. In contrast, section 1983 supplies a general remedy for the vindication of rights secured by federal statutes.[167]

After the *Gonzaga* court clearly identified the burden that a section 1983 plaintiff must carry, it examined FERPA's statutory text.[168] First, the Court found that FERPA's provisions "entirely lack the sort of 'rights-creating' language critical to showing the requisite congressional intent to create new rights."[169] FERPA's provision that "[n]o funds shall be made available under any applicable program to any educational agency or institution" is a directive to the Secretary of Education, not a statement creating a private right.[170] Second, the

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provides, "To assure that the right of citizens of the United States to vote is not denied or abridged on account of race or color, no citizen shall be denied the right to vote in any Federal, State, or local election because of his failure to comply with any test or device [not approved under section 5 of the Act]." 42 U.S.C. § 1973b (2000). The original, pre-enactment versions of these statutes were phrased not in terms of the persons benefited, but as directives to federal agencies. Title IX originally provided, "*The Secretary shall not make* any . . . payment . . . *nor shall the Secretary enter into any contract* with an institution of higher education . . . unless the application, contract, or other arrangement . . . contains assurances . . . that any such institution . . . will not discriminate on the basis of sex . . . ." 117 Cong. Rec. 30, 411 (1971) (emphases added). Title VI originally provided, "[N]o . . . *financial assistance shall be furnished* in circumstances under which individuals participating in or benefiting from the program or activity are discriminated against on the ground of race, color, religion, or national origin." S. 1731, 88th Cong. (1963) (emphasis added). Congress drastically changed the language of these statutes prior to enactment because, as originally drafted, the statutes "did not authorize a private remedy for a person against whom discrimination had been practiced." *See Hearing on S. 1731 and S. 1750 Before the Senate Comm. on the Judiciary*, 88th Cong., 334-335, 349-352 (1963); *see also Cannon*, 441 U.S. at 693 n.14.

166. *Cannon*, 441 U.S. at 690 n.13; *see also* T.I.M.E., Inc. v. United States, 359 U.S. 464, 469-70 (1959) (holding that the sections of the Motor Carrier Act that provide it shall be the duty of interstate motor carriers to establish, observe, and enforce just and reasonable rates, charges, and classifications, and further provide that all charges made for any service rendered by such carriers shall be just and reasonable, do not create a judicially enforceable right in a shipper to be free from exaction of unreasonable charges as to past shipments); Mont.-Dakota Utils. Co. v. Northwestern Pub. Serv. Co., 341 U.S. 246, 251 (1951) (holding that the provision in Federal Power Act requiring reasonable electric utility rates is a standard for the Federal Power Commission to apply and, independently of Commission action, creates no right which courts may enforce).

167. *Gonzaga*, 536 U.S. at 284.

168. For a discussion of the statutory text, see *supra* note 152.

169. *Gonzaga*, 536 U.S.at 287.

170. 20 U.S.C. § 1232g(b)(1) (2000). As the Court in *Cannon* stated, "There would be far less reason to infer a private remedy in favor of individual persons if Congress . . . had written [Title IX] simply as a ban on discriminatory conduct by recipients of federal funds." 441 U.S. at 690-93.

Court found that FERPA's provisions speak "only in terms of institutional policy and practice, not individual instances of disclosure.[171] As such, FERPA has an aggregate focus, indicating that the statute is not concerned with "whether the needs of any given person have been satisfied."[172] Futhermore, the Court noted that an institution does not violate FERPA so long as the institution substantially complies with FERPA's requirements.[173] FERPA's standard of substantial compliance, which requires the Secretary of Education to use his independent judgment in determining whether an institution is in violation of the Act, was strong evidence that Congress did not intend to provide students or their parents with a private right of action under section 1983.[174]

Finally, the Court found that FERPA's enforcement mechanism supported its conclusion that FERPA does not provide a private right of action.[175] FERPA directs the Secretary of Education to deal with violations by creating a review board for investigating and adjudicating violations of the statute.[176] Pursuant to this directive, the Secretary promulgated administrative regulations that allow aggrieved students or their parents to file complaints with administrative officials.[177] Such a complaint, however, does not entitle the parent or student to any individual remedy even if a violation of FERPA is found as a result of the investigation instigated by the complaint.[178] Instead, when the Secretary decides that an institution has violated FERPA he sends that institution instructions as to how it may correct the violation.[179] If the institution fails to correct the violation to the Secretary's satisfaction, the institution becomes ineligible to receive federal funding.[180] By blurring the discrete prongs of the *Wright* and *Wilder* tests, the Court broadened the scope of

171. *Gonzaga*, 536 U.S. at 288 (noting that FERPA prohibits the funding of an institution only when the institution has "*a policy or practice* of permitting the release of education records").

172. *Id.*

173. *Id.*; *see* 20 U.S.C. § 1234c(a) (2000).

174. *Gonzaga*, 536 U.S. at 288.

175. *Id.* at 289-90.

176. 20 U.S.C. § 1232g(f)-(g) (2000).

177. *See* 34 C.F.R. § 99.63 (2002).

178. *See Gonzaga*, 536 U.S. at 278-79, 287-290. While the complaint may eventually force the violating institution to comply with FERPA's privacy requirements or forego federal funding, the complaining student receives neither a curative remedy nor damages as compensation for the release of his academic information. *Id.* at 289-91.

179. *See* § 99.66(b), (c)(1).

180. *See* 20 U.S.C. § 1232g(b)(1)-(2).

inquiry and made it more difficult for a plaintiff to prove the existence of an alleged statutory right enforceable under section 1983.

B: Why Medicaid Should Be Interpreted as Not Conferring Enforceable Rights

It is extremely unlikely that the *Westside Mothers* opinion could survive scrutiny under the *Gonzaga* standard, as the logic of *Westside Mothers* depends primarily on the Sixth Circuit's determination that Medicaid-eligible children are the beneficiaries of Medicaid's EPSDT provisions.[181] It is true that the Medicaid Act benefits eligible children by allocating federal funds to enable States to provide for the medical needs of such children.[182] However, the *Gonzaga* standard requires more than a mere showing that the statute is intended to *benefit* the putative plaintiff to support a claim under section 1983.[183] The standard requires that the statute unambiguously create an *enforceable private right* in the beneficiary.[184]

The Medicaid Act lacks the language necessary to create an enforceable private right. Since section 1983 "merely provides a mechanism for enforcing individual rights 'secured' elsewhere" by the Constitution and laws of the United States, the Court should not allow

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181. Westside Mothers v. Haveman, 289 F.3d 852, 863 (6th Cir. 2002). A determination that the EPSDT provisions were intended to benefit these children was enough, in the opinion of the Sixth Circuit, to satisfy the first prong of the *Wilder* test. *See id.* The *Wilder* opinion is discussed in detail above. *See supra* notes 120-123 and accompanying text.

182. The relevant language provides,

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children . . . whose income and resources are insufficient to meet the costs of necessary medical services, . . . there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

42 U.S.C. § 1396 (2000).

The term 'medical assistance' means payment of part or all of the cost of the following care and services . . . for individuals . . .who are . . . under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, but whose income and resources are insufficient to meet all of such cost—early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21 . . . .

§ 1396d(a)(i), (a)(4)(B). "A State plan for medical assistance must provide for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) . . . of Section 1396d(a) of this title [including EPSDT services] to [Medicaid-eligible children]. § 1396a(10)(A).

183. *See supra* notes 156-158 and accompanying text.

184. *Id.*

a section 1983 claim unless Congress, in the statute at issue, has spoken with a clear voice manifesting an "unambiguous intent to confer individual rights."[185] Like the FERPA provisions that the Court examined in *Gonzaga*, the Medicaid Act does not contain the rights-creating language "critical to showing the requisite congressional intent to create new rights."[186]

A statute creating enforceable rights must be "phrased in terms of the persons benefited."[187] The Medicaid Act, however, consists of directives to the federal government,[188] the Secretary of Health and Human Services,[189] and, perhaps, State officials designing and administering a Medicaid program.[190] Since the Court has repeatedly held that it will interpret any single part of a statute in relation to, and in harmony with, the text and purpose of the statute as a whole, it is instructive to examine the various Medicaid provisions relevant to a *Gonzaga* analysis of the *Westside Mothers* case.[191]

The appropriations section of the Act, for example, illustrates the Act's failure to confer enforceable rights. According to that section, the Act's purpose is to enable "each State, *as far as practicable under the conditions in each State*, to furnish" medical services to the poor.[192] A direct comparison between the aforementioned civil rights

185. Gonzaga Univ. v. Doe, 536 U.S. 273, 280 (2002).

186. *Id.* at 287.

187. *Id.* at 284.

188. *See, e.g.*, § 1396 (providing, "[T]here is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter").

189. *See, e.g.*, § 1396c(2) (providing, "[T]he Secretary shall notify the State agency that further payments will not be made to the State . . . .").

190. *See, e.g.*, § 1396a (providing, "A State plan for medical assistance must provide . . ."). The statutes at issue in *Westside Mothers* fall into this latter category of directives to State officials. *See* 289 F.3d 852 (6th Cir. 2002). These Medicaid directives are not a proper source from which to fashion individual rights because they "focus on the person regulated rather than the individuals protected" and therefore "create no implication of an intent to confer rights on a particular class of persons." Alexander v. Sandoval, 532 U.S. 275, 289 (2001).

191. *See, e.g.*, FDA v. Brown-Williamson, 529 U.S. 120, 132-33 (2000); Holloway v. United States, 526 U.S. 1, 9 (1999); United States v. Morton, 467 U.S. 822, 828 (1984).

192. § 1396 (emphasis added). One can envision Chief Justice Rehnquist seizing on this language and invoking an argument similar to the one he expressed in his concurring opinion to *The Benzene Case*, where he interpreted the language "to the extent feasible" in the Occupational Safety and Health Act. *See* 29 U.S.C. § 6(b)(5) (2000); Indus. Union Dep't v. Am. Petroleum Inst., 448 U.S. 607 (1980) (Rehnquist, J., concurring) (commonly known as *The Benzene Case*). He wrote then that the language "to the extent feasible" in that statute rendered "what had been a clear, if somewhat unrealistic, standard largely, if not entirely, precatory." *Indus. Union Dept.*, 448 U.S. at 681-82. It is difficult for this author to distinguish the words "as far as is practicable" from the words "to the extent feasible." Additionally, the original version of the Medicaid Act passed by the Senate placed the words "as far as practicable under the conditions in each State" in parentheses. 1965 U.S.C.C.A.N 1943, 2144. The version appearing in the

statutes[193] and the Medicaid Act exposes the precatory character of this language. Such a comparison is particularly instructive considering that Congress enacted Medicaid during the same period in which it passed these landmark civil rights laws.[194] For example, one cannot imagine Congress enacting legislation providing, "No person in the United States shall, on the ground of race, color, or national origin . . . be subjected to discrimination under any program or activity receiving federal financial assistance *as far as practicable under the conditions in each State.*"[195] The Medicaid Act contains no language even approximating that of the contemporaneously enacted civil rights statutes that the Court has held to confer enforceable private rights.[196]

The Medicaid Act is also unable to support a claim under section 1983 because its provisions speak "only in terms of institutional policy and practice" and not in terms of the provision of care to any individual.[197] While the EPSDT provisions do generally operate for the benefit of eligible children,[198] when a State's Medicaid compliance is in question, the focus of the Secretary's inquiry is on the plan or the administration of the plan, not on individual instances of noncompliance.[199] Medicaid, like FERPA, has an aggregate focus,

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United States Code sets off these words with commas. 42 U.S.C. § 1396 (2000). One cannot read either version and fail to notice the importance of these words. The change from parentheses to commas indicates that these words were not mere rhetorical flourish but were important enough to survive some sort of editing process prior to their inclusion in the United States Code.

193. *See supra* note 165 and accompanying text. These civil rights statutes are The Civil Rights Act of 1964, The Voting Rights Act of 1965, and the Education Amendments of 1972.

194. These civil rights statutes were enacted in 1964, 1965, and 1972. *See supra* note 165. Medicaid was enacted in 1965. *See supra* note 15.

195. Such a construction is particularly ridiculous considering that the purpose of federal civil rights laws has been to place certain rights "beyond hazard" of State interference. *See infra* note 209. Instead of *adapting* to the conditions in each State, federal statutory rights aim at *changing* the conditions in each State. In no case can the very nature of the right itself change from State to State. Such inconsistency in application, however, is inherent in the operative language of the Medicaid Act.

196. *See upra* note 165.

197. Gonzaga Univ. v. Doe, 536 U.S. 273, 288 (2002).

198. 42 U.S.C. § 1396d(a)(4)(B) (2000) ("The term "medical assistance" means payment of part or all of the cost of the following care and services . . . to individuals . . . who are under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose . . . but whose income and resources are insufficient to meet all of such cost . . . early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21 . . . .").

199. *See, e.g.*, § 1396a ("A State *plan* for medical assistance must provide . . .") (emphasis added). The statute does not read, "the State must provide to eligible children . . .," or read, "no eligible child shall be denied . . . ." § 1396c(1)-(2) ("If the Secretary . . . finds that the *plan* has been changed so that it no longer complies . . . or that in the *administration of the plan* there is a failure to comply . . ." (emphases added)).

indicating that the statute is not concerned with "whether the needs of any given person have been satisfied."[200]

Additionally, the requirements of the Medicaid Act are met so long as a State's plan and the State's administration of its plan substantially comply with those requirements.[201] The possibility of substantial compliance supported the *Gonzaga* Court's determination that FERPA did not confer enforceable rights, since the determination whether there had been substantial compliance was left to the sound discretion of the Secretary of Education.[202] Similarly, the decision of whether or not there has been substantial compliance with Medicaid provisions rests solely within the discretion of the Secretary of Health and Human Services.[203] A loose standard of substantial compliance is clearly at odds with the idea of a judicially enforceable private right since the standard gives potential defendants little guidance on how they should regulate their conduct to avoid litigation and judicially imposed liability.[204]

Finally, the Medicaid Act's existing statutory enforcement scheme clearly does not contemplate private causes of action under section 1983. While States do provide internal administrative hearings for those who feel that they have wrongfully been denied care, the sole external enforcement mechanism is the termination or reduction of federal payments to States failing to comply substantially with Medicaid provisions.[205] Most importantly, the Medicaid Act

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200. *Gonzaga*, 536 U.S. at 288.

201. *See* § 1396c(2) (providing that the Secretary may stop Medicaid payments to a State if, in the administration of the State's Medicaid plan, there is a failure "to comply substantially" with Medicaid provisions).

202. § 1234c(a); *Gonzaga*, 536 U.S. at 288.

203. § 1396c(2); *see also* Blessing v. Freestone, 520 U.S. 329, 343 (1997) ("Far from creating an *individual* entitlement to services, the [substantial compliance] standard is simply a yardstick for the Secretary to measure the *systemwide* performance of [the] program. Thus, the Secretary must look to the aggregate services provided by the State, not to whether the needs of any particular person have been satisfied.") Additionally, where a Medicaid plan fails to substantially comply with statutory and regulatory provisions because it is *poorly designed*, as the plaintiffs in *Westside Mothers v. Haveman*, 289 F.3d 852, 856 (6th Cir. 2002), allege, a challenge based on that alleged fact "invite[s] the District Court to oversee every aspect" of the program, a task which clearly is beyond the competence of the judiciary and uniquely suited to administrative oversight. *Blessing*, 520 U.S. at 341.

204. Justice Cardozo eloquently described the uselessness of such a legal system when he stated, "Law as a guide to conduct is reduced to the level of mere futility if it is unknown and unknowable." BENJAMIN N. CARDOZO, THE GROWTH OF THE LAW 3 (1924). Professor Jeremy Bentham famously compared such ad hoc legal decision making to dog training: "When your dog does anything you want to break him of, you wait till he does it, and then beat him for it." JEREMY BENTHAM, THE TRUTH VERSUS ASHHURST; OR, LAW AS IT IS, CONTRASTED WITH WHAT IT IS SAID TO BE, THE WORKS OF JEREMY BENTHAM 231, 235 (1792).

205. The State of Michigan, for example, required every Medicaid provider to "incorporate an internal administrative grievance procedure as a condition of its contract with the State."

empowers the Secretary to restore payments to a State plan when he is "satisfied that there will no longer be any such failure to comply."[206] The Secretary's wide discretion suggests a congressional intent to foreclose private remedies under section 1983.[207]

The foregoing discussion has focused on demonstrating why the plain language of the Medicaid Act does not create private rights within the meaning of section 1983. The plain language of section 1983, however, presents its own vexing problem. Section 1983, by its terms, is merely a mechanism for the enforcement of individual rights that are *secured* elsewhere.[208] Section 1983's use of the word "secured" renders it wholly inapplicable to the Medicaid Act.

The district court in *Westside Mothers* engaged in an analysis of the term "secured" and held, in the context of section 1983, that "to secure" meant "to put beyond hazard of losing or of not receiving."[209] The court further held that a meaningful synonym was the word "guarantee," as in "guarantee the blessings of liberty to ourselves and our posterity."[210] If "secure" is given its plain meaning, section 1983 cannot be used to remedy violations of the Medicaid Act, since the Medicaid Act, as an exercise of the spending power, guarantees nothing.[211]

The Medicaid Act has no effect in a State until that State implements a health care plan meeting Medicaid requirements and accepts federal funds.[212] Until both requirements are met, the otherwise Medicaid-eligible citizens of a State have no guarantee that

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Westside Mothers v. Haveman, 133 F. Supp. 2d 549, 554 (E.D. Mich. 2001). While courts that have addressed the issue of administrative appeal proceedings have held that the presence of such procedures does not indicate a congressional intent to foreclose a private remedy through a comprehensive remedial structure, those cases involved an inquiry in which the court already had found a right to exist. *See, e.g.*, Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 509-512, 521 (1990); Wright v. Roanoke Redevelopment & Hous. Auth., 479 U.S. 418, 424 (1987); *Westside Mothers*, 289 F.3d at 863.

206. § 1396c(2).

207. Even if a plaintiff were somehow able to coherently articulate a private "right" to force State compliance with the Medicaid Act, the fact remains that Congress defined the right only in terms of the personal satisfaction of an extra-judicial enforcement officer. *Id.* As a practical matter, such a right is in reality not defined at all, making it unenforceable by a court in a private enforcement action that does not directly challenge the Secretary's discretion.

208. Gonzaga Univ. v. Doe, 536 U.S. 273, 285 (2002) (quoting Chapman v. Houston Welfare Rights Org., 441 U.S. 600, 617 (1979)); *accord* Golden State Transit Corp. v. City of Los Angeles, 493 U.S. 103, 105 (1989). The actual text of section 1983 provides a cause of action against any person who under color of State law deprives an individual of "any right, privileges, or immunities *secured* by the Constitution and laws" of the United States. 42 U.S.C. § 1983 (2000) (emphasis added).

209. *Westside Mothers*, 133 F. Supp. 2d at 581.

210. *Id.*

211. *Id.*

212. *Id.* at 582.

they will receive anything under the federal statute.[213] Even if the subsequent accrual of benefits to eligible individuals is characterized by the State as a right, privilege, or immunity, these benefits are not secured within the meaning of section 1983 because tbe State could alter or end its participation in the Medicaid program at any time.[214] Medicaid, like all legislation enacted under the spending clause, has at best a tenuous relationship with section 1983.[215]

V. LIFE AFTER SECTION 1983: THE GOOD, THE BAD, AND THE UGLY

Medicaid as it currently exists simply cannot support a private right to health care enforceable under section 1983. This result is simultaneously intellectually satisfying and socially troubling. While States freed from the financial uncertainties of private lawsuits could more aggressively restrain costs in the face of their current fiscal crisis, Medicaid beneficiaries would have no recourse if State officials wrongfully denied them benefits. Importantly, the Supreme Court has not yet spoken conclusively on the issue, giving Congress a rare opportunity to proactively reform the Medicaid program.

Congress could expressly authorize private plaintiffs to enforce the Medicaid Act against the States in one of three ways. First, it could amend the Medicaid statute to explicitly and unambiguously confer enforceable private rights.[216] Second, it could force the States tc voluntarily abrogate their sovereign immunity as a condition of participating in the Medicaid program.[217] Finally, Congress could create a comprehensive enforcement scheme within the federal government that is accessible by beneficiaries.[218] Each of these congressional actions would likely establish some sort of an enforceable right to health care under Medicaid. Unfortunately, the

213. *Id.*

214. *Id.*

215. *See, e.g.*, Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 28 (1981); *see also supra* notes 92-96 and accompanying text.

216. Congress could, for example, merely reword sections of the Medicaid Act to mirror the language of the Civil Rights Act of 1964 or similar statutes.

217. *See, e.g.*, Atascadero State Hosp. v. Scanlon, 473 U.S. 234, 238 (1985). It is interesting to note that Congress attempted this requirement in the limited context of provider reimbursement claims under Pub. L. No. 94-182, § 111, 89 Stat. 1054 (1975) but repealed the law one year later after strong opposition and outcry from States. *See* Pub. L. No. 94-552, 90 Stat. 2540 (1976).

218. Such a scheme probably would have to provide its own level of judicial review, however, in order to preclude section 1983 actions. *See supra* note 111 and accompanying text.

economic reality of the current Medicaid program demonstrates that the United States simply cannot afford such a right.[219]

If the underlying economic dimension of the Medicaid program, and of public health care generally, is to be addressed in a principled fashion, Congress cannot continue to externalize political costs at the public expense. Instead, Congress must implement disciplined Medicaid reforms that address the causes, rather than the symptoms, of the system's failure.

A. The Good: Gonzaga Could Provide the States with Much-Needed Fiscal Relief

The cost of Medicaid is staggering. Medicaid's cooperative financial structure has led to double-digit growth of the program in almost every year since its inception.[220] The cost of Medicaid has risen dramatically, from $770 million in its first year[221] to over $270 billion today.[222] Medicaid expenditures grew by over 11% in 2001 alone.[223] Designed as a health care safety net for the deserving poor, Medicaid has reached proportions never imagined by its creators. On average, Medicaid spending now accounts for approximately 20% of all State budgets,[224] ranking second only to education.[225]

A recent study by the National Health Policy Forum indicated that nearly every State is experiencing a financial crisis.[226] Medicaid expenditures are a major cause of these budgetary troubles. In 2001,

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219. Bill Frist, *Runaway Medicaid*, WASH. TIMES, Sept. 28, 1995, at A18 (arguing that "nobody can responsibly argue against the fiscal necessity of reducing the growth rate of the [Medicaid] program"). This Note suggests that the elimination of private enforcement actions is a necessary part of any effort to reduce Medicaid's rate of expansion. *See infra* notes 239-242 and accompanying text.

220. *See* Frist, *supra* note 219.

221. *Id.*

222. Robert Pear, *Governors Resist Bush Plan to Slow Costs of Medicaid*, N.Y. TIMES, May 25, 2003, at 1-1.

223. Pear, *supra* note 2.

224. Richard Wolf, *Medicaid Outcome Will Affect All*, USA TODAY, Sept. 9, 1996, at A10; *see also* Pear & Toner, supra note 2.

225. Pear, *supra* note 2.

226. RANDY DESONIA, RUNNING ON EMPTY: THE STATE BUDGET CRISIS WORSENS 5 (Nat'l Health Policy Forum, Issue Brief No. 783, 2002), *available at* http://www.nhpf.org/pdfs_ib/IB783%5FState%5FBudgets%5F9%2D25%2D02%2Epdf (last visited July 31, 2003). Kansas faces a $108 million shortfall in 2003. *Id.* at 2. In South Carolina, the number is $331 million, and in Maryland, a staggering $1.3 billion. *Id.* Rhode Island has slashed all agency budgets by eight percent (8%). *Id.* By August 2002, Georgia had experienced its fourteenth straight month of declining tax revenues and fee collections. *Id.* In all, State deficits are expected to reach $26 billion in 2003 alone. *See* Calmes, *supra* note 26. Nearly every State now sees Medicaid as an overgrown program in need of slimming. *See* DESONIA, *supra*, at 8-9, 11-13.

for example, Medicaid expenditures exceeded budgeted amounts in 37 States.[227]

The *Gonzaga* decision may be just what the States need to remedy their financial crisis. States freed from the specter of private lawsuits could act more aggressively to streamline Medicaid programs. Each State would have more freedom to work with the Department of Health and Human Services in an attempt to balance the costs and benefits of its Medicaid program. The Department would naturally be hesitant to find a State's program insufficient, since the resulting withdrawal of FFP would only harm those that the Medicaid Act was designed to help. A Medicaid system without enforceable private rights would more closely resemble the program envisioned by its authors, who wished to enable "each State, as far as practicable under the conditions in each State, to furnish [medical services to the poor]."[228]

Some commentators cringe at the thought of allowing the States more latitude with regard to the specifics of their Medicaid programs, but their concerns are unfounded and fail to address the economic and social realities of modern medicine.[229] First, the States are deeply concerned with the health of their citizens, and while States may require federal funds to help them achieve their public health goals, they do not need Congress to tell them what those goals should be.[230] Second, the Medicaid Act was not designed to provide all desired care to all needy people. It was designed to help fulfill State

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227. *See* Pear & Toner, *supra* note 2.

227. 42 U.S.C. § 1396 (2000).

229. *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, 989 (2002) (asking, "Are the [S]tates committed and capable of executing the responsibility of financing health care for the poor even with substantial federal assistance, and are resulting disparities in the treatment of protected groups by [S]tates tolerable?").

230. Jeffrey A. Modisett, *Discovering the Impact of "New Federalism" on State Policy Matters: A State Attorney General's Perspective*, 32 IND. L. REV. 141, 141 (1998) (arguing that policymakers are "rethinking the presumption that national problems require a solution initiated or controlled by the federal government"). Attorney General Modisett observes that while "the influence of the federal government over matters traditionally within state purview has marked the post-New Deal era," especially in the areas of criminal law, labor relations, civil rights, and environmental law, "States are [now] taking the initiative to analyze and attempt to solve problems that the federal government has declined to address. *Id.* at 151-52. By way of example, Modisett notes that "welfare reform as a concrete plan of action—as opposed to a vague attack on liberalism—finds its antecedents in several state experiments." *Id.* at 152. Further, "it is the state tobacco litigation that provides the best example of state-initiated reform achieving national results." *Id.* "This trend is a challenge to states, especially "small-government" states . . . to find the best solutions for these problems that our national government has been unable to solve. *Id.* at 144.

health care priorities, *to the extent practicable in each State.*[231] Consequently, the mere existence of a disparity between State and Federal public health care priorities does not require the imposition a unitary federal public health policy. If Congress has additional health care priorities, Congress should fund those priorities directly, outside of the Medicaid program, rather than abdicate its responsibilities to the courts.

Third, health care is a business, and as such there are economic dimensions to every treatment and coverage decision.[232] If judicial action were limited, the citizens of each State would have to focus their health care reform efforts on legislators rather than on judges. The increased political activity, conducted in a public forum, would provide citizens and legislators with a better opportunity to accurately define the level of public health for which they are willing to pay.[233] Presumably, such preferences would be embodied in State laws. Congress, in turn, could see more clearly the differences between State and federal health care priorities and allocate scarce resources more efficiently. Most importantly, the ensuing public debate over additional funding and the socially acceptable scope of services would restore political accountability to the Medicaid program.

B. The Bad: Individual Instances of Noncompliance Could Be Catastrophic for Beneficiaries

Medicaid itself does not provide for a private right of action, and the Court has held that no implied right of action exists.[234] The complete preclusion of section 1983 actions could create a significant bar to enforcement in certain rare situations where a private enforcement action is the only means to compel the provision of wrongfully denied care.[235] Depending on the nature of the services

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231. *See* § 1396.

232. Blumstein, *supra* note 43.

233. This dialogue is one possible use for the Citizens' Health Care Working Group proposed by Senators Wyden and Hatch. *See supra* note 1 and accompanying text.

234. Michael A. Platt, Note, *Westside Mothers and Medicaid: Will This Mean the End of Private Enforcement of Federal Funding Conditions Using Section 1983?*, 51 AM. U. L. REV. 273, 284 (2001).

235. Medicaid contains two primary enforcement mechanisms. At the systemic level, the Secretary of Health and Human Services can compel compliance by threatening to withdraw Medicaid funding. *See supra* notes 197-203 and accompanying text. At the individual level, each State is required to implement an internal appeals procedure through which a beneficiary can challenge a denial of care. *See supra* note 205 and accompanying text. The extraordinary situation contemplated here is one in which there is a discrete denial of care, a wrongful rejection of the Medicaid beneficiary's appeal, and the possibility that the beneficiary could wait for

involved, a wrongful denial of care could result in a medical and human tragedy. The challenge is to develop a public health system that properly allocates scarce economic resources while avoiding tragic denials of necessary care.

Severe injuries or deaths resulting from the denial of medical care, also known as tragic choices, focus public attention on an issue in a way that rhetoric and abstract discussion cannot.[236] If politicians and voters are to reduce public health care costs in any meaningful way, however, occasional tragic choices are inevitable.[237] Health care resources are finite and no program can provide every beneficiary with all the care that he or she wants. Realistic Medicaid reformers must ask, "What level of tragedy should an enlightened and compassionate society accept in the face of the economic realities of public health care?"

Since the socially acceptable *minimum* level of public health care is probably that which provides the most protection against tragic choices for the most people, each beneficiary of a public health program must be willing to sacrifice some measure of health care for the overall good.[238] The resulting level of public health resembles the standard of adequacy contemplated by managed care. Section 1983 actions and legislative schizophrenia largely thwart attempts to push this unpleasant issue into the arena of reasoned public debate.[239] If, through principled public debate over the cost of health care, the public's expectations with regard to public health care could be aligned more closely with the public's willingness to pay for that care, the required baseline of public health care would shift. The States and the federal government would then be able to openly and prospectively allocate the resources necessary to achieve the popularly dictated level of public care. In such a fully funded and politically and economically accountable public health care system, the need for private

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treatment until the resolution of his case in the federal courts. Such a situation would not trigger systemic review under the aggregate focus the Secretary of Health and Human Services, and the preclusion of private enforcement actions would prevent the beneficiary from seeking a remedy.

236. The term "tragic choice" refers to the situation where beneficial or life-saving treatment exists for a patient's condition but the government or another financially responsible entity is unable or unwilling to commit the resources necessary for the provision of that treatment, resulting in the serious injury to, or death of, the patient. *See* Muse v. Charter Hosp. of Winston-Salem, Inc., 452 S.E.2d 589, 589 (N.C. Ct. App. 1995); *see also* HAVIGHURST ET AL., *supra* note 33, at 6-7.

237. *See* Muse v. Charter Hosp. of Winston-Salem, Inc., 452 S.E.2d 589, 589 (N.C. Ct. App. 1995); *see also* HAVIGHURST ET AL., *supra* note 33, at 6-7.

238. Robert Gavin, *Cutting Benefits for Some Can Mean Extending Coverage to Others*, WALL ST. J., Nov. 14, 2001, at B8.

239. *See supra* notes 65-67 and accompanying text.

enforcement actions would necessarily decrease.[240] The preclusion of section 1983 enforcement actions, therefore, could actually help to eliminate the need for such actions by keeping the discussion of public health care priorities in the democratic process where it belongs.

Importantly, the level of public health for which the public is willing and able to pay is a flexible concept. It is entirely possible, and indeed likely, that an informed public would want to provide as much care as possible for Medicaid-eligible children. As such, the public could direct lawmakers to allocate the resources necessary to pay for that care. This funding priority would likely necessitate a reduction in the level of care provided to other Medicaid-eligible individuals.[241] For example, the elderly might find themselves facing decreased public health services.[242] It is also possible that the public would decide to fully fund public health care programs at the expense of other budgetary items or through higher taxes. Perhaps some citizens view public health as more important than education or national defense. Regardless, the point is that citizens, not courts, should weigh the costs and benefits of public health decisions.

C. The Not-So-Ugly: A Proactive Approach to Medicaid Reform

The *Gonzaga* decision gives political actors a rare opportunity to make proactive changes in the cooperative Medicaid scheme and avoid the consequences of a sudden change in the Act's enforcement mechanism. By gradually addressing the funding, coverage, and enforcement issues that prevent the Medicaid program from providing adequate care to all eligible citizens, society as a whole can capture the benefits of an economically balanced health care system without harming those individuals that the program was designed to protect. While a comprehensive solution to the Medicaid funding problem will be incredibly complex, several key issues must figure into any reforms.

First, Congress must provide States with the funding that they need to substantially comply with current Medicaid standards. While Congress will have to risk political accountability in order to do so,

240. This is not an extraordinary observation, but it is an important one. This Note does not suggest that each Medicaid beneficiary will suddenly acquire a selfless desire to sacrifice some small measure of his own medical security for the good of the whole, nor does it suggest that welfare rights groups will cease vigorously advocating for their special interests. In a fully funded and clearly articulated public health care system made possible in part by the increased political dialogue resulting from the elimination of private enforcement actions, however, questions of individual non-compliance will be resolved through administrative appeals and requests for systemic reforms will be addressed to the proper political officials.

241. *See* Gavin, *supra* note 227.

242. *Id.*

political accountability is an important check on runaway Medicaid spending that enables the program to function properly.[243]

Second, Congress must both clarify the Medicaid enforcement scheme and phase out private enforcement actions under section 1983. Any Medicaid reform effort will fail without the uniformity of treatment and the policy-making expertise that only a wholly administrative enforcement scheme can provide. A gradual move away from private enforcement will reduce the impact of this change in the short term, when the risk of tragic choices will be the highest.

Third, Congress and the States need to engage in open dialogue about a feasible scope of coverage for the Medicaid program. The current system pits the States against Congress in a battle to maximize political gain and externalize political cost.[244] Such an arrangement ignores Medicaid's cooperative purpose in which the States and the federal government are supposed to work together for the benefit of vulnerable citizens.[245] State governments are fully capable of identifying the health care priorities of their citizens, and Medicaid was designed to help them fulfill those priorities.[246] One alternative that recognizes this reality would require the federal government to directly and fully fund certain health care priorities enumerated in the Medicaid statute. The federal government could then use Medicaid FFP as a means of encouraging States to exceed this level of care.[247]

Fourth, the most important change that must be made to the Medicaid statute is the establishment of bright-line health care priorities. Since society cannot pay for all the health care that all the people want, there must be some objective method to determine what society should provide. This will be the most painful part of the reform process but citizens must fully understand the economic consequences of their health care choices.

The enemy of any attempt to clearly define the scope of a health care program is the concept of medical necessity. It may seem

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243. *See supra* note 30 and accompanying text.

244. *See supra* notes 20-31 and accompanying text.

245. 42 U.S.C. § 1396 (2000).

246. *Id.*

247. An amended statute could serve as an affirmative statement of federal health care priorities rather than a baseline of care below which a State incurs liability or administrative sanctions. Perhaps the federal government should pay for all care up to this "ceiling" and then allow the States to supplement the health care of their poor citizens to the extent possible. The federal priorities undoubtedly would include services for children under a reworked EPSDT provision, but such services probably would be streamlined. Under such a system, citizens would be better able to bring political forces to bear on health care issues because they would know whether to direct their efforts toward the federal government or State officials in any given case.

obvious that a physician would only prescribe treatment that is medically necessary, but the use of this term carries significance far beyond the truism that unnecessary or harmful care should be avoided.[248] The real problem with the use of the term "medical necessity" in the Medicaid statute (or any other medical coverage context) is that the term has an inherent meaning independent of any contractual or statutory definition.[249] This meaning, derived solely from the professional standards of the medical community, effectively requires the provision of all beneficial care without regard to the marginal cost of that care.[250] This conception of medical necessity eliminates the cost-benefit analysis that is vital to any efficient health care model.[251]

The concept of medical necessity must be removed from the Medicaid statute if Congress is to adopt bright lines of health coverage. The task of creating such bright lines will most likely result in a pair of lists: one for covered services and one for services not covered.[252] Additionally, there may be a desire to cover certain services in some circumstances but not in others, subject to the requirements of the Americans with Disabilities Act[253] and the Rehabilitation Act of 1973,[254] both of which limit the circumstances under which differences in the provision of medical services are permitted.

Finally, all Medicaid funding must contemplate the cost-saving characteristics of managed care. The big question is "not whether, but

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248. *See* Blumstein, *supra* note 43.

249. *See* Hughes v. Blue Cross of N. Cal., 263 Cal. Rptr. 850, 857 (Cal. Ct. App. 1989); Blumstein, *supra* note 43.

250. *Hughes*, 263 Cal. Rptr. at 845; *see also* HAVIGHURST ET AL., *supra* note 33, at 1228-29; Blumstein, *supra* note 43.

251. *See* Blumstein, *supra* note 43.

252. In this respect, the result could resemble the original conception of Oregon's Basic Health Services Act. *See* HAVIGHURST ET AL., *supra* note 33, at 105-07; *see generally* James F. Blumstein, *The Oregon Experiment: The Role of Cost-Benefit Analysis in the Allocation of Medical Funds*, 45 SOC. SCI. & MED. 545 (1997) (discussing the Oregon plan in detail and highlighting the political, social, and legal challenges associated with the operation of such a public health care system).

253. *See* §§ 42 U.S.C. 12101(a)(7)-(8) (2000) (preamble and purposes of the ADA). Certain interpretations of the ADA might prevent cost effectiveness by precluding a treating physician's ability to refuse to administer "futile" treatment. *See, e.g.*, *In re* Baby K, 832 F. Supp. 1022 (E.D. Va. 1993). *But see* Haavi Morreim, *Futilitarianism, Exoticare, and Coerced Altruism: The ADA Meets its Limits*, 25 SETON HALL L. REV. 883, 889-90 (1995) (arguing that the ADA should not be interpreted as requiring futile or exotic care at the public expense).

254. 29 U.S.C. §§ 701-718b. Denial of care violates the Rehabilitation Act only if the plaintiff is a "handicapped individual" under the Act, "otherwise qualified" for the benefit sought, and is denied care solely because of his handicap, and if the program or activity denying the care receives federal financial assistance. *See* Johnson *ex rel* Johnson v. Thompson, 971 F.2d 1487, 1492 (10th Cir. 1992).

how, to make managed care serve the needs of the Medicaid population."[255] Managed care is necessary because Medicaid is publicly funded and susceptible to the moral hazard of over utilization by beneficiaries. Congress should provide funding on a prospective payment basis and assume that each State program will be administered through an MCO in order to maximize the purchasing power of every health care dollar.[256]

VI. CONCLUSION

After *Gonzaga*, it appears clear that the language of the Medicaid Act does not support an enforceable private right to Medicaid services under section 1983. The logic of the *Westside Mothers* decision and of similar private enforcement actions, therefore, is potentially invalid. Some commentators fear that such a result will hinder progress toward the goal of providing health care to all who need it. *Gonzaga*, however, may ultimately encourage principled and responsible political debate on the topic of Medicaid reform by preventing Congress from relying on private plaintiffs to enforce precatory federal health priorities against the States.

If Congress is to proactively and seriously address the impact of *Gonzaga*, it must also examine the causes and effects of decades of runaway health care spending as well as the economic impact of a health care delivery model limited at the bottom but not at the top. A serious look at the economic realities of public health care will require belt-tightening and soul-searching by State and federal officials as well as a basic change of attitude and a new health care vocabulary.

Current political rhetoric about providing each citizen with all the health care that he needs addresses the normative and ethical dimensions of health care but ignores the critical economic consequences of a supposed right to health care.[257] Health care resources are finite while demand for health care is potentially infinite. Rationing of services, in the form of managed care decisions contemplating a standard of adequacy, must occur now and in the future.

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255. HAVIGHURST ET AL., *supra* note 33, at 285.

256. Prospective payment systems are akin to capitation payments in that payment amounts for specific services are fixed in advance and designed to encourage providers to the weigh the costs and benefits of various treatment options. *See id.* at 228. President George W. Bush recently proposed such a payment scheme but met stiff resistance from State governors. *See* Pear, *supra* note 2.

257. *See, e.g.*, President George W. Bush, State of the Union Address (Jan. 28, 2003).

Presented honestly, the debate is about what degrees of difference [in public health care] society will allow, what obligation society has to finance care for those unable to pay, and who should benefit from public subsidy and in what magnitude. [S]erious analysts cannot persuasively defend the principle of total equality of end result.[258]

The *Gonzaga* decision may mean that Congress has no choice but to address Medicaid reforms according to these principles, but it will require painful intellectual honesty and vigorous, unfettered public debate to get it right.

Mark Andrew Ison[*]

258. Blumstein, *supra* note 25, at 1468.

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