Enforcement of the Medicaid Act under 42 USC § 1983 after *Gonzaga University v Doe*: The "Dispassionate Lens" Examined

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I. INTRODUCTION

The Supreme Court's 2002 decision in *Gonzaga University v Doe*[1] harmonized the Court's § 1983 and implied private right of action jurisprudence in the field of Spending Clause statutory interpretation. *Gonzaga* utilized a text-centered inquiry—asking whether a particular provision of a Spending Clause program statute contained "unambiguous rights-creating language" by being "phrased in terms of the persons benefited"—to determine that a § 1983 action brought by a former student against his alma mater under the Family Educational Rights and Privacy Act of 1974 would not lie. The textualist inquiry used by the *Gonzaga* majority represented the latest, and most drastic, change in the Court's § 1983 jurisprudence relating to federal statutes enacted under Congress's spending power. Because *Gonzaga* presented a markedly different approach to the § 1983 inquiry in a suit brought under one of the lowest-profile Spending Clause statutes, lower courts have struggled to determine that decision's effect on the § 1983 inquiry for the highest-profile—and most expensive—statute enacted under the Spending Clause, the Medicaid Act. As courts have labored to determine the effect of *Gonzaga* in the Medicaid context—or even to determine what it means for a Medicaid Act provision to be "phrased in terms of the persons benefited"—circuit splits have developed regarding the proper scope of the textual analysis commanded by *Gonzaga* and, derivatively, the § 1983 enforceability of some of the Medicaid Act's most notable provisions.

This Comment examines the interpretative methodology utilized by the lower federal courts in § 1983 Medicaid Act suits after *Gonzaga*. While courts have recognized that *Gonzaga* commands a textual inquiry into whether a Medicaid Act provision "unambiguously confer[s] ... rights enforceable under § 1983,"[2] the district courts and courts of appeals in the various federal circuits have split on the

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1 536 US 273 (2002).

2 See, for example, *Deisenroth v Holsinger*, 356 F Supp 2d 763, 767 (ED Ky 2005).

proper scope of this textual analysis. In particular, the respective courts engaging in post-*Gonzaga* textual analysis of the Medicaid Act have utilized two distinct analytic frameworks: "pragmatic textualism" and "strict textualism." While pragmatic textualism has a host of doctrinal underpinnings to recommend it, strict textualism in the § 1983 context can only be justified on the basis of federalism. But the § 1983 federalist concerns that might justify strict textualism in the general Spending Clause context do not translate well to the Medicaid Act, where public health models, empirical evidence, and the Court's own Spending Clause doctrine counsel that the federalist concerns ostensibly justifying strict textualism in fact command pragmatic textual analysis.

II. THE MEDICAID ACT: PUBLIC (NON)ENFORCEMENT AND THE IMPORTANCE OF PRIVATE REMEDIES

The Medicaid Act, Title XIX of the Social Security Act,[3] authorizes federal grants to states for medical assistance to low-income persons who meet certain additional qualifications.[4] Medicaid, enacted under the authority of the Spending Clause,[5] is jointly financed by the federal and state governments and is administered by states. Under broad federal rules enumerated in the Medicaid Act[6] and its implementing regulations,[7] each state decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[8]

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3 42 USC § 1396 (2000).

4 42 CFR § 430.0 (2006) ("Program Description" of the Medicaid Act).

5 US Const Art I, § 8, cl 1 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States.").

6 42 USC § 1396 et seq (2000). In particular, § 1396a et seq sets out many of the Act's most important substantive guidelines, including the so-called equal access (§ 1396a(a)(30)(A)), reasonable standards (§ 1396a(a)(17)), reasonable promptness (§ 1396a(a)(8)), comparability (§ 1396a(a)(10)(B)), availability (§ 1396a(a)(10)(A)), and freedom of choice (§ 1396a(a)(23)) provisions. Located elsewhere within the Act are provisions governing the early and periodic screening, diagnosis, and treatment of Medicaid-eligible children (the "EPSDT" requirements) (§§ 1396a(a)(43) et seq, 1396r et seq) and certain requirements related to intermediate care facilities for the mentally retarded (the "ICF/MR" provisions) (§ 1396d(a)(15)).

7 Various federal regulations supplement and clarify the statutory provisions of the Medicaid Act. The question of whether federal regulations (as opposed to federal statutory provisions) can ever grant privately-enforceable rights is an interesting and important question in its own right, implicating nondelegation principles of administrative and constitutional law. That issue is, however, beyond the scope of this Comment. For a recent exploration of this topic, see John A. McBrine, Note, *The Selective Use of Administrative Regulations in Creating Rights Enforceable through § 1983 Actions*, 46 BC L Rev 183, 183 (2004) (arguing that "both our modern administrative state and public policy considerations support the derivation of § 1983 interests from federal regulations").

8 42 CFR § 430.0.

Despite the existence of an extensive scheme of federal statutory and regulatory requirements within the Medicaid Act—and despite massive federal and state expenditures on the program[9]—Medicaid has been rife with problems almost from its inception. Chief amongst these problems is physician underparticipation. Indeed, "physician refusal to participate in the program has been so rampant that it has led one commentator to categorically conclude that 'Medicaid has failed in its mission to care for the poor.'"[10]

Physician underparticipation and its attendant problems are so commonplace that, in a recent lawsuit, Illinois responded to allegations of sub-"break-even" reimbursement rates and rampant underprovision of "well-child" services in its Medicaid program by simply arguing that its "results were no worse than those in other industrial states."[11] The court barred Illinois from making this argument at trial, but the point is well-taken: relying on state self-enforcement of the Medicaid Act has often led to unsatisfactory results with respect to access to care.[12]

The lack of physician participation in Medicaid programs—commonly attributed to systematically low reimbursement rates[13]—and the attendant adverse effects on access to care are a bitter irony

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9 See, for example, Marlaina S. Freisthler, Comment, *Unfettered Discretion: Is* Gonzaga University v. Doe *a Constructive End to Enforcement of Medicaid Provider Reimbursement Provisions?*, 71 U Cin L Rev 1397, 1397 ("Currently, the Medicaid program serves eleven percent of the nonelderly population, and costs in excess of $184 billion annually. In fact, Medicaid is second only to education in state budget expenditures, and amounts to forty percent of federal contributions paid to states.") (internal citations omitted).

10 Id at 1397–98, quoting Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 Am J L & Med 191, 191 (1995).

11 See Frederick H. Cohen, *An Unfulfilled Promise of the Medicaid Act: Enforcing Medicaid Recipients' Right to Health Care*, 17 Loyola Consumer L Rev 375, 390 (2005). The case referenced is *Memisovski v Patla*, No 92-C-1982, on which Cohen served as lead counsel for the plaintiffs. See generally *Memisovski v Maram*, 2004 WL 1878332 (ND Ill Aug 23, 2004) (memorandum opinion and order issued twelve years after initial filing of action).

12 See, for example, *Memisovski*, 2004 WL 1878332 at *15 ("Pediatric practices throughout Cook County have closed to new Medicaid patients due to economic problems caused by a high Medicaid pediatric population and low Medicaid reimbursement rates and slow Medicaid payment systems."). See also id at *17 ("Most doctors in Cook County will either not see children on Medicaid or significantly limit the number of children on Medicaid that they will accept as patients.").

13 See, for example, id at *12 (finding that Illinois's Medicaid reimbursement rates "are, on average, approximately half of the Medicare reimbursement rates for the same service, delivered in the same location, by the same provider"). See also id at *13:

> A pediatrician practice relying solely on Medicaid beneficiaries maximum reimbursements could not survive since Medicaid pays nearly 10 percent less than the median practice costs. The major studies on physician reimbursement rates have concluded that physician reimbursements are the predominant factor in the decision to participate in the Medicaid program at all, to participate in a limited fashion, or to participate fully.

of sorts given the existence of a Medicaid Act "requirement" addressing just this problem. The Act's "equal access" provision reads:

> A state plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.[14]

The widespread failure of state Medicaid programs to enlist enough providers to even approximate equality of access—despite a clearly worded statutory provision requiring the contrary—is emblematic of a more general failure by the states to self-police Medicaid Act compliance.

Nor does the federal Department of Health and Human Services (HHS)—the agency ostensibly tasked with the duty to oversee the "federal" end of the state-federal Medicaid program—"enforce" state noncompliance with Medicaid Act provisions in a punitive sense. This is largely because the main "remedy" available to HHS for policing state compliance with the Medicaid Act is "the blunt and seldom-used club" of withholding federal Medicaid funding,[15] which is hardly a remedy for program beneficiaries.[16] In the absence of a direct private remedy at law, "[p]rogram beneficiaries desiring compliance with federal requirements could only ask the federal government to further cripple the program—not a result they are likely to seek."[17] Instead, "the posture of the federal agency toward its grantees is not generally that of a referee calling fouls, but that of a coach giving support in the form of cash and expertise."[18]

This general reluctance by federal agencies to police states by withholding program funding is particularly acute in the Medicaid context, where massive budget overruns in state programs are almost a matter of course and states are politically "locked-in" to federal fi-

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14 42 USC § 1396a(a)(30)(A).

15 See Sasha Samberg-Champion, Note, *How to Read* Gonzaga*: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 Colum L Rev 1838, 1839 (2003).

16 See, for example, *Pennhurst State School and Hospital v Halderman*, 451 US 1, 52 (1981) (White dissenting) ("[A] funds cutoff is [perceived to be] a drastic remedy with injurious consequences to the supposed beneficiaries of the Act.").

17 Samberg-Champion, Note, 103 Colum L Rev at 1839 (cited in note 15).

18 Edward A. Tomlinson and Jerry L. Mashaw, *The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement*, 58 Va L Rev 600, 620 (1972) (illustrating how the agency enforcement of grant-in-aid programs has been deficient).

nancial participation (FFP).[19] One of the reasons for the massive budget overruns in state Medicaid programs is what has been called a political "narcotic effect."[20] Because FFP of 50 percent to 83 percent of total Medicaid expenditures makes each additional $1 in state expenditures worth $2 to $6 in extra care, there is, in economic terms, a moral hazard problem.[21] States, economically and politically encouraged to "expand their Medicaid programs beyond levels they would be willing or able to fund independently,"[22] eventually reach a level at which even their fractional commitment becomes difficult to pay. But at this point political constraints make cost-cutting (or "escape" from FFP and the federal requirements attached thereto) by a state nearly impossible, since for each dollar a state wants to save it must cut $2 to $6 in program costs.[23]

Coupled with the general nonenforcement by federal agencies of Spending Clause program requirements, the unique state budgetary problems involved with Medicaid make HHS enforcement of the Medicaid Act essentially a nullity. As one commentator has recently stated,

> Rarely does the federal bureaucracy itself comprehensively enforce state compliance with the terms of [Spending Clause] statutes. Instead, Spending Clause program requirements have been enforced primarily by citizens acting as "private attorneys general." These program beneficiaries, often aided by public interest lawyers who make careers of enforcing federal rights, use a variety of legal means to enjoin states that fail to live up to the commitments made in accepting federal funds.[24]

Since 1980, "the primary legal vehicle" for actions to enforce the requirements of Spending Clause programs has been § 1983.[25]

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19 See 42 USC § 1396d(b) (providing that FFP will range from 50 percent to 83 percent depending on a state's average per capita income). See also *Federal Medical Assistance Percentages*, online at http://aspe.os.dhhs.gov/health/fmap.htm (visited Apr 28, 2007) (providing tables listing FFP for each state and the District of Columbia for fiscal years 1996–2007).

20 See generally James F. Blumstein and Frank A. Sloan, *Health Care Reform through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 Vand L Rev 125, 141–44, 148–49 (2000) (commenting that "[a] form of state-level political dependency . . . resulted from state responses to the incentives that stemmed from the allure of federal matching moneys").

21 See Mark Andrew Ison, Note, *Two Wrongs Don't Make a Right: Medicaid, Section 1983 and the Cost of an Enforceable Right to Health Care*, 56 Vand L Rev 1479, 1484–85 (2003).

22 Id.

23 See id at 1485 (observing that the exact figure would be determined by the level of FFP).

24 Samberg-Champion, Note, 103 Colum L Rev at 1838 (cited in note 15).

25 Id.

III. THE ROAD TO *GONZAGA*: THE SUPREME COURT'S § 1983 SPENDING CLAUSE JURISPRUDENCE FROM 1980–2002

In 1980's *Maine v Thiboutot*,[26] the Supreme Court ruled, for the first time, that 42 USC § 1983, a statute granting a civil right of action for "the deprivation of any rights, privileges, or immunities secured by the Constitution *and laws*,"[27] applied to federal *statutory*—in addition to federal constitutional—rights.[28] Since *Thiboutot*—which itself authorized a § 1983 action in the context of a Spending statute, the Social Security Act[29]—the Supreme Court's opinions in this area have "not be[en] models of clarity."[30] However, it is safe to identify a general ebb and flow—tied closely to the makeup of the Supreme Court—in the scope of the § 1983 enforcement right for Spending Clause statutes.

In the decade following *Thiboutot*, the Supreme Court twice addressed the § 1983 right in the Spending Clause context. In *Wright v Roanoke Redevelopment and Housing Authority*,[31] the Court, in a 5-4 decision, allowed a § 1983 suit by tenants for alleged overcharges under the Brooke Amendment (a rent-ceiling provision) of the Public Housing Act of 1937 and its implementing regulations. The Court held that, *read in conjunction with its implementing regulations and the enforcement history of the statute*, the Brooke Amendment conferred a

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26 448 US 1 (1980).

27 42 USC § 1983 (2000) (emphasis added). Section 1983 reads, in relevant part:

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

28 *Thiboutot* responded to recent Supreme Court decisions restricting the situations in which a private right of action under a federal statute would be *implied*. See *Transamerica Mortgage Advisors, Inc v Lewis*, 444 US 11, 19–20 (1979) (restricting the availability of private actions under the Investment Advisers Act of 1940); *Touche & Co v Redington*, 442 US 560, 570 (1979) (restricting implied private actions under the Securities Exchange Act of 1934). By construing § 1983 to *expressly* authorize civil suits for the violation of federal statutory rights, the Court avoided the constitutionally difficult situation of a federal right unprotected by any federal remedy. See *Marbury v Madison*, 5 US (1 Cranch) 137, 163 (1893) ("The government of the United States has been emphatically termed a government of laws, and not of men. *It will certainly cease to deserve this high appellation, if the laws furnish no remedy for the violation of a vested legal right*.") (emphasis added).

29 42 USC § 601 et seq (2006). See *Thiboutot*, 44 US at 4 (holding that a plain language reading of "and laws" "undoubtedly embraces [claims under] the Social Security Act").

30 *Gonzaga*, 536 US at 278 (acknowledging that prior Court opinions might have created confusion in the lower courts).

31 479 US 418 (1987).

legally enforceable federal right presumptively enforceable under § 1983, and that the state did not rebut this presumption.[32]

Wilder v Virginia Hospital Association,[33] decided three years after *Wright*, held that the Boren Amendment[34] of the Medicaid Act conferred on providers a § 1983 private right of action. Also a 5-4 decision, *Wilder* looked to the legislative and enforcement history of the Boren Amendment and the Medicaid Act generally to determine whether the Amendment conferred enforceable § 1983 rights on providers.[35] The *Wilder* court explicitly noted that:

> [The § 1983 inquiry] *is a different inquiry than that involved in determining whether a private right of action can be implied from a particular statute*. In implied right of action cases, we . . . determine whether Congress intended to create the private remedy asserted for the violation of statutory rights. The test reflects a concern, grounded in separation of powers, that Congress rather than the courts controls the availability of remedies for violations of statutes. Because § 1983 provides an alternative source of express congressional authorization of private suits, these separation of powers concerns are not present in a § 1983 case.[36]

The same four justices—Rehnquist, O'Connor, Kennedy, and Scalia—dissented in both *Wright* and *Wilder*. In his *Wilder* dissent, Chief Justice Rehnquist advanced textualist arguments that would later form the basis of his opinion for the Court in *Gonzaga*.[37]

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32 See id at 419–20, 424–25 ("Not only are the Brooke Amendment and its legislative history devoid of any express indication that exclusive enforcement authority was vested in [the federal agency], but there have also been both congressional and agency actions indicating that enforcement authority is not centralized and that private actions were anticipated.").

33 496 US 498 (1990).

34 42 USC § 1396a(a)(13)(a) (repealed 1997):

> A State plan for medical assistance must provide . . . for payment of the . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

35 See *Wilder*, 496 US at 505 ("In order to determine whether the Boren Amendment is enforceable under § 1983, it is useful *first to consider the history* of the reimbursement provision.") (emphasis added), 509 ("We must therefore determine whether the Boren Amendment creates a 'federal right' that is enforceable under § 1983. Such an inquiry turns on whether 'the provision in question *was intended* to benefit the putative plaintiff.'") (emphasis added). Note that the *Wilder* inquiry focused on the *intent of the provision*, and not whether the provision was *phrased* in terms of the putative plaintiff.

36 Id at 508 n 9 (internal citations and quotations omitted; emphasis added).

37 Id at 524–27 (Rehnquist dissenting):

Despite vigorous dissents in *Wright* and *Wilder*, both cases seemed to establish a liberal doctrine relating to § 1983 rights of action under Spending Clause statutes. However, the 1992 replacement of Thurgood Marshall, a key member of the five-vote majority in *Wright* and *Wilder*, with Clarence Thomas, an avowed textualist and federalist, might have portended a change in the Court's § 1983 Spending Clause jurisprudence. But if a sea change was in the air, it did not follow immediately. While the Court did find that a Spending Clause statutory provision conferred no enforceable rights in a case argued just after Thomas's confirmation, the Court's 7-2 decision in *Suter v Artist M*[38] explicitly upheld both the holdings and framework of *Wright* and *Wilder*.[39]

Five years later, a unanimous Court decided *Blessing v Freestone*,[40] which clarified a three-step analysis for finding a § 1983 enforcement right under a Spending Clause provision. Although it did not overrule—and in fact purported to rely upon—precedents such as *Wilder*, the *Blessing* Court explained:

> We have traditionally looked at three factors when determining whether a particular statutory provision gives rise to a federal right. First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory rather than precatory terms.[41]

The Court ultimately held that the plaintiffs in that case, five mothers in Arizona, could not bring suit under § 1983 to force "substantial compliance" with the entirety of a federal child support statute

> [W]hile the Court's holding in *Thiboutot* rendered obsolete some of the case law pertaining to implied rights of action, a significant area of overlap remained. For relief to be had either under § 1983 or by implication . . . the language used by Congress must confer identifiable enforceable rights . . . . Yet the Court virtually ignores the relevant text of the Medicaid statute in this case.

38 503 US 347 (1992).

39 See id at 356–58.

40 520 US 329 (1997).

41 Id at 340–41, citing *Wright*, 479 US at 430, 431–32; *Wilder*, 496 US at 510–11; *Pennhurst*, 451 US at 17.

"[w]ithout distinguishing among the numerous provisions of th[at] complex program."[42]

IV. TEXTUALISM AND § 1983: *GONZAGA UNIVERSITY V DOE*

If the previous two Court cases—*Blessing* in particular—hinted at a narrowing trend in § 1983 Spending Clause jurisprudence, 2002's *Gonzaga* was that trend's true coming-out. In *Gonzaga*, a five-justice majority declared that the Family Educational Rights and Privacy Act of 1974[43] (FERPA) did not confer any personal rights enforceable under § 1983.[44] The Court, via Chief Justice Rehnquist, both adopted a framework hinted at in Rehnquist's *Wilder* dissent and harmonized the § 1983 inquiry with that of the Court in its implied private right of action cases. Utilizing this framework, the Court first stated, "[w]e now reject the notion that our cases permit anything short of an unambiguously conferred right to support a cause of action brought under § 1983."[45] In order to find such a "right conferral," the Court adopted a text-centered inquiry:

> The 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. For a statute to create such private rights, its text must be phrased in terms of the persons benefited. . . . For example, . . . the Civil Rights Act of 1964 . . . create[s] individual rights because [that] statute[] is phrased with an *unmistakable focus* on the benefited class.[46]

The *Gonzaga* majority's unrelenting focus on a provision's specific *text* was a marked departure from the more broad-based inquiry into legislative intent demonstrated in *Wilder* and other Court precedent. For example, *Pennhurst State School and Hospital v Halderman*[47] looked at "the Act['s] legislative history," its "language and structure," and "the 'overall' [and] 'specific' purpose of the Act" for evidence of "an intent to require the States to fund new, substantive rights."[48] In-

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42 *Blessing*, 520 US at 332–33 (disagreeing with the Ninth Circuit that the "statutory scheme [could] be analyzed so generally").

43 20 USC § 1232g et seq (2006).

44 See *Gonzaga*, 536 US at 275. Justices Rehnquist, O'Connor, Scalia, Thomas, and Kennedy composed the majority.

45 Id at 283 (rejecting the notion that "implied private right of action cases have no bearing on the standards for discerning whether a statute creates rights enforceable by § 1983").

46 Id at 283–84 (alterations and last emphasis in original; internal quotations omitted; first two emphases added).

47 451 US 1 (1981).

48 Id at 18.

deed, the *Pennhurst* court cautioned: "In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy."[49] In *Wilder*, the Court looked to the legislative and judicial history of the Medicaid Act, both before and after the Boren Amendment, and concluded that "*experience* demonstrates clearly that Congress and the States both understood the Act to grant health care providers enforceable rights both before and after repeal of the ill-fated waiver requirement."[50] As Justice Stevens pointed out in his *Gonzaga* dissent, "[T]he sort of rights-creating language idealized by the court has *never* been present in our § 1983 cases. . . . None of [the statutes at issue in] *Wright*, *Wilder*, *Suter*, and *Blessing* involved the sort of 'no person shall' rights-creating language envisioned by the Court."[51]

To justify its textual focus, the *Gonzaga* majority opinion relied in large part on federalist concerns, declaring that "separation-of-powers concerns within the Federal Government [are not] the only guideposts in this sort of analysis. . . . '[I]f Congress intends to alter the usual constitutional balance between the States and the Federal Government, it must make its intention to do so unmistakably clear in the *language* of the statute.'"[52] The Court then argued that, in the context of FERPA, Congress would not have

> intended . . . to confer individual rights on millions of school students . . . without having ever said so explicitly. [To conclude otherwise would] entail[] a judicial assumption, *with no basis in statutory text*, that Congress intended to set itself resolutely against a tradition of deference to state and local school officials by subjecting them to private suits for money damages whenever they fail to comply with a federal funding condition.[53]

In this and other language, the *Gonzaga* majority adopted a federalist viewpoint, earlier explained by the Court in *Pennhurst*, in which a program enacted under the Spending Clause is seen as a "quasi-contract" between the federal government and a State.[54]

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49 Id, quoting *Philbrook v Glodgett*, 421 US 707, 713 (1975).

50 *Wilder*, 496 US at 518 (emphasis added) (finding that this understanding makes it "implausible to assume" that Congress intended to deprive providers of a private right of action under § 1983).

51 *Gonzaga*, 536 US at 297 (Stevens dissenting) (emphasis in original).

52 Id at 286 (majority), quoting *Will v Michigan Department of State Police*, 491 US 58, 65 (1989) (internal quotation marks omitted; emphasis added).

53 *Gonzaga*, 536 US at 286 n 5 (internal citations omitted).

54 *Pennhurst*, 451 US at 17 (1981):

> [L]egislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The

Many academics and civil rights lawyers saw *Gonzaga* as a fundamental change in the Supreme Court's § 1983 Spending Clause jurisprudence.[55] One civil rights lawyer said of *Gonzaga*, "[i]t was less a clarification than an evisceration of what the court's precedents had held. . . . [T]he case signals an intention to substantially curb private lawsuits on behalf of . . . beneficiaries of federal entitlements."[56] Of course, not everyone who saw *Gonzaga* as a fundamental change opposed the decision. One conservative lobbyist praised *Gonzaga*'s "anti-entitlement federalism" and "had high hopes . . . that the . . . justices would move to curb private lawsuits under 'the mother of all entitlement programs, Medicaid.'"[57]

V. THE ROAD TO *GONZAGA* REDUX: THE LOWER FEDERAL COURTS

Confronted with seemingly controlling precedent in *Wilder*, lower courts throughout the early- to mid-1990s generally allowed both providers and recipients to bring § 1983 suits to enforce many Medicaid Act provisions.[58] In 1997, however, the law grew somewhat murkier after Congress—at the behest of nearly every governor in the nation—repealed the Boren Amendment. Then in 2000, the Fifth Circuit split from other circuits that had ruled on the issue and held in *Evergreen Presbyterian Ministries, Inc v Hood*[59] that while Medicaid recipients could sue to enforce the Act's equal access provision, providers

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> legitimacy of Congress's power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the "contract." There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.

55 See generally, for example, Steve France, *Hearing Loss: High Court is Rolling Back Implied Rights of Action*, 89 ABA J 18 (Feb 2003) (noting that Chief Justice Rehnquist himself considered the decision one of the most influential of 2002).

56 Id (quoting New York City civil rights lawyer David Goldberg).

57 Id (quoting Michael Greve, director of the Federalism Project at the American Enterprise Institute).

58 See, for example, *Visiting Nurse Association of North Shore, Inc v Bullen*, 93 F3d 997, 1004 (1st Cir 1996) (holding that because the Boren Amendment and § 1396a(a)(30) contain nearly identical substantive requirements, *Wilder* supports the use of § 1983 by providers to enforce the subsection), overruled by *Gonzaga*, 536 US at 279–86, as recognized in *Long Term Care Pharmacy, Inc v Ferguson*, 362 F3d 50, 57 (1st Cir 2004) ("*Gonzaga* . . . compels us to reexamine *Bullen*."). See also *Methodist Hospitals, Inc v Sullivan*, 91 F3d 1026, 1029 (7th Cir 1996) (allowing providers to enforce the equal access provision using § 1983); *Wood v Tompkins*, 33 F3d 600, 608 (6th Cir 1994) (finding that § 1396n(c) et seq waiver requirements are more like the Boren Amendment in *Wilder* than the statute in *Suter* and therefore confer enforceable rights); *Arkansas Medical Society, Inc v Reynolds*, 6 F3d 519, 526 (8th Cir 1993) (holding that providers may use § 1983 to enforce the equal access provision); *Miller v Whitburn*, 10 F3d 1315, 1319–20 (7th Cir 1993) (stating that "early and periodic screening, diagnostic, and treatment services" (EPSDT) provisions confer enforceable rights on recipient under *Wilder* test).

59 235 F3d 908 (5th Cir 2000).

could not.[60] The *Evergreen* method—allowing recipients, but not providers, to bring § 1983 suit—would catch on in one more circuit before the Supreme Court's *Gonzaga* decision, after which such rulings became the norm rather than the exception throughout the federal judiciary.[61]

Three months *prior* to the *Gonzaga* decision in 2002, the Third Circuit, sitting en banc, broke from its own precedent and joined the Fifth Circuit by denying § 1983 standing for a class of independent pharmacists alleging violations of the Medicaid Act's equal access provision.[62] In a 6-5 opinion by then-Judge Alito (filed one month prior to oral arguments and three months prior to the decision in *Gonzaga*), *Pennsylvania Pharmacists Association v Houstoun*[63] relied on the first prong from the Supreme Court's three-part *Blessing* analysis—whether the provision in question was intended to benefit the plaintiffs—in finding that the plaintiff pharmacists lacked a private right of action under § 1983.[64] Judge Alito first noted that "the question whether a statute is *intended* to *benefit* particular plaintiffs is quite different from the question whether the statute *in fact benefits* those plaintiffs, or even whether Congress *knew* that the statute would benefit those plaintiffs."[65] Relying on Supreme Court implied right of action precedent, rather than § 1983, Alito framed the first-prong *Blessing* inquiry as a basically textual question, asking whether the statute was "phrased in terms of the persons benefited" and was "draft[ed] . . . with an unmistakable focus on the benefited class."[66] In drawing upon the implied right of action cases and applying a decidedly textual inquiry into congressional intent, Alito's *Pennsylvania Pharmacists* opinion anticipated *Gonzaga* to a significant extent.

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60 See id at 928 ("[I]t is apparent that while recipients have an individual entitlement to equal access to medical care, any benefit to health care providers is indirect at best.").

61 See note 68 and accompanying text.

62 See *Pennsylvania Pharmacists Association v Houstoun*, 283 F3d 531 (3d Cir 2002) (en banc). The "arguable" contrary Third Circuit precedent was a footnote in a 1999 decision, stating: "The Department argues at least in part that Rite Aid and the [Pennsylvania Pharmacists Association] may not sue to enforce [certain] Medicaid regulations as section 30(A) does not support a private cause of action. The district court rejected this argument and we agree with this result." *Pennsylvania Pharmacists*, 283 F3d at 534 n 4 (alterations in original; internal quotation marks and citations omitted), quoting *Rite Aid of Pennsylvania, Inc v Houstoun*, 171 F3d 842, 850 n 7 (3d Cir 1999).

63 283 F3d 531 (3d Cir 2002) (en banc).

64 Id at 535, citing *Blessing*, 520 US at 340; *Wilder*, 496 US at 509; *Wright*, 479 US at 430.

65 *Pennsylvania Pharmacists*, 283 F3d at 535–36 (emphasis in original).

66 Id at 536, quoting *Cannon v University of Chicago*, 441 US 677, 694 n 13 (1979) (alteration in original).

VI. CIRCUIT SPLITS: LOWER COURT RESPONSE AFTER *GONZAGA*

After *Gonzaga*, the overall trend in Medicaid Act cases has been towards a narrowed § 1983 enforcement right in an aggregate sense. In particular, post-*Gonzaga* holdings in the district courts and the circuit courts of appeals have restricted § 1983 Medicaid Act enforcement along two metrics: by party and by statutory provision. However, to merely identify a "narrowing trend" after *Gonzaga* fails to tell the whole story: in fact, multiple circuit splits have developed regarding the § 1983 enforceability of various Medicaid Act provisions. While *Gonzaga* no doubt commands a text-focused analysis in determining § 1983 enforceability of Medicaid Act provisions, lower courts have divided into two distinct camps regarding the proper "type" of textual analysis.

One camp, which I call the "strict textualist"[67] camp, has conducted an exceedingly narrow textual inquiry into whether a provision is unambiguously phrased in terms of the persons bringing suit in a particular case. Courts adopting a strict textual method of analysis—including the Courts of Appeals for the Sixth, Ninth, and Tenth Circuits—have endorsed sweeping curtailments of § 1983 rights under some of the more ambiguously phrased provisions the Medicaid Act (of which the equal access provision is a paradigmatic example). A second camp, which I call the "pragmatic textualist" camp—including many district courts and the Court of Appeals for the Eighth Circuit—has conducted a more flexible analysis of the text of certain Medicaid Act provisions, often resolving textual ambiguities by reference to the structure and purpose of the Medicaid Act on the whole.

However, while these two camps have come to differing conclusions on some of the more ambiguous issues of § 1983 enforceability (e.g., whether Medicaid beneficiaries can bring suit under the Equal Access provision of the Act), federal courts after *Gonzaga* have—with one notable exception—uniformly held that *providers* cannot bring § 1983 suit under any Medicaid Act provision.[68]

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67 For commentary on strict textualism, see, for example, William N. Eskridge, *All About Words: Early Understandings of the "Judicial Power" in Statutory Interpretation, 1776–1806*, 101 Colum L Rev 990, 1088 (2001) (associating "strict textualism" with Scalia's views of originalism and a complete rejection of legislative history); Ellen P. Aprill, *The Law of the Word: Dictionary Shopping in the Supreme Court*, 30 Ariz St L J 275, 278–79 (1998).

68 See *Sanchez v Johnson*, 416 F3d 1051, 1062 (9th Cir 2005) (holding that neither providers nor recipients can sue under equal access provision); *National Medical Care v Rullan*, 2005 WL 2878094, *7 (D Puerto Rico) (declaring that providers cannot sue under comparability provision); *Protestant Memorial Medical Center, Inc v Maram*, 2005 WL 2464460, *4–5 (SD Ill) (dismissing provider's suit to enforce "provisions of the Medicaid Act, specifically § 1396 et seq" for failure to state a claim and rejecting provider's argument that "[*Wilder*] couches its language in terms of § 1396 generally"); *Oklahoma Chapter of the American Academy of Pediatrics v Fogarty*, 366 F Supp 2d 1050, 1102–11 (ND Okla 2005) (holding that providers cannot sue under equal

A. "Pragmatic Textualism"

The *Gonzaga* majority opinion probably ended any general presumption of § 1983 enforceability of substantive Medicaid Act requirements that may have lingered from *Wilder*, and may even have created the opposite presumption. In subsequent cases, however, lower courts have shown resistance to such a broad reading of *Gonzaga* in the Medicaid context—particularly where *Wilder* is still ostensibly good law.[69] Instead, many lower courts—at least when faced with recipient suits—have used a rather flexible textual analysis in deciding whether the various provisions of the Medicaid Act are "phrased in terms of the persons benefited." When the words of a particular Medicaid Act provision are sufficiently ambiguous with respect to "phras[ing] in terms of the persons benefited," courts engaging in "pragmatic textualist" analysis will resolve such ambiguities by looking to the meaning and importance of that provision within the purpose and structure of the Medicaid Act as a whole.[70] Moreover, there is

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access, reasonable promptness, or EPSDT provisions); *In re NYAHSA Litigation*, 318 F Supp 2d 30, 38–40 (NDNY 2004) (deciding that providers cannot sue under § 1396a(a)(13)(A)'s rate-setting "process" provision, equal access provision, or § 1396r nursing care "quality of life" provision); *Clayworth v Bonta*, 295 F Supp 2d 1110, 1121–24 (ED Cal 2003) (holding that providers cannot sue under equal access provision); *Burlington United Methodist Family Services, Inc v Atkins*, 227 F Supp 2d 593, 595–97 (SD W Va 2002) (same). See also *Long Term Care Pharmacy Alliance v Ferguson*, 362 F3d 50, 58–59 (1st Cir 2004):

> Prior to *Gonzaga*, whether subsection (30)(A) authorized private rights for providers was a close question; the circuits were split on the issue, and well reasoned opinions had been written on both sides. . . . Whether *Gonzaga* is a tidal shift or merely a shift in emphasis, we are obligated to respect it, and it controls this case. Providers such as pharmacies do not have a private right of action under subsection (30)(A); if they think that state reimbursement is inadequate—and cannot persuade the Secretary to act—they must vote with their feet.

A skeptic might note that providers "voting with their feet"—i.e., leaving state Medicaid programs—is precisely the *problem*, and not a step towards a solution. For the first post-*Gonzaga* opinion to hold that providers *do* have enforceable rights under the equal access provision, see *Pediatric Specialty Care, Inc v Arkansas Department of Human Services*, 443 F3d 1005, 1015–16 (8th Cir 2006).

69 See, for example, *Pediatric Specialty Care*, 443 F3d at 1015 (rejecting defendants' argument that *Gonzaga* "foreclose[d] private causes of action based on the Medicaid Act").

70 The post-*Gonzaga* interpretive differences in the lower courts were—like the *Gonzaga* opinion itself—largely anticipated by the Third Circuit in *Pennsylvania Pharmacists*. Although that case dealt with the right of providers to bring § 1983 suits under the equal access provision, the *Pennsylvania Pharmacists* dissent—joined by five Third Circuit judges—advocated for "pragmatic textualism" in interpreting whether Medicaid Act provisions grant § 1983–enforceable rights. According to the dissent, a doctrine under which only Medicaid beneficiaries can bring suit "lacks context [in] the real world of health care, which implicates the relationship between provider costs and the availability of services to Medicaid recipients." 283 F3d at 545 (Becker dissenting). As Chief Judge Becker explained, there is "a nexus between the interests of providers and the interests of recipients, *which is recognized by the express terms of Section 30(A)*." Id (emphasis added).

specific language in *Gonzaga* which ostensibly supports such a method.[71]

A recent opinion by Judge Lefkow of the Northern District of Illinois provides an apt example of such "pragmatic textualism" in the wake of *Gonzaga*. In *Memisovski v Maram*,[72] a district court held that the Medicaid Act's "equal access" and EPSDT provisions conferred individual rights that could be enforced by a class of Medicaid-eligible children via § 1983. After citing *Gonzaga*, however, the *Memisovski* court's § 1983 "textual" analysis included a policy argument: "Through § 1396a(a)(30)(A), a mandatory obligation was imposed on the states and no administrative mechanism was formulated so as to ensure compliance with this obligation. This . . . weighs in favor of a private right of action to enforce this statutory section under § 1983."[73] One might observe, in reading *Memisovski* and similar district court opinions, that the reality of a courtroom full of needy litigants seeking medical care can appear far removed from federalism-motivated arguments about whether a certain sentence was "phrased in terms of the persons benefited."[74]

In addition to the many district courts adopting a decidedly "pragmatic textualist" approach after *Gonzaga*, the Eighth Circuit recently utilized an exceedingly broad textual analysis in *Pediatric Specialty Care, Inc v Arkansas Department of Human Services*,[75] a case in which that court "did not read *Gonzaga* to require a different result than [the court's] earlier decisions [holding that both recipients *and providers* were unambiguously granted a federal right under the Medicaid Act's equal access provision]."[76]

The *Pediatric Specialty Care* court first disposed of ADHS's argument that "*Gonzaga* . . . forecloses private causes of action based on the Medicaid Act," noting that "[a]lthough *Gonzaga* takes a far more

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71 See *Gonzaga*, 536 US at 286 ("[W]here the text *and structure* of a statute provide no indication that Congress intends to create new individual rights, there is no basis for a private suit, whether under § 1983 or under an implied right of action.") (emphasis added).

72 2004 WL 1878332 (ND Ill).

73 Id at *6. See also id at *6–7 (relying on a different section of Medicaid Act to "supplement" text of 30(A), examining the act's legislative history, and acknowledging that 30(A) is not phrased in "typical rights creating language" but explaining that such language would not fit in with the "structure" of statute).

74 On the other hand, critics might say that by "stray[ing] from … sound and established constitutional principles in order to reach what [they] consider[] just result[s] in [ ] particular case[s]," these courts "give[ ] meaning to the ancient warning that hard cases make bad law." *Vlandis v Kline*, 412 US 441, 459 (1973) (Burger dissenting). On that subject, see *Sabree v Richman*, 367 F3d 180, 183 (3d Cir 2004) ("That plaintiffs merit sympathy does not escape our notice, but neither does it govern our reasoning. Rather, *Gonzaga University* provides the dispassionate lens through which this matter must be viewed.").

75 443 F3d 1005 (8th Cir 2006).

76 Id at 1014.

restrictive view of rights-creating statutes, it did not overrule *Wilder*."[77] The court then went on to conclude that "plaintiffs still prevail *within the terms of the Gonzaga framework*,"[78] concluding, as to the plaintiffs' equal access claim:

> 42 U.S.C. § 1396a(a)(30)(A)[] is intended to benefit both CHMS recipients and providers, and creates enforceable rights for both groups. That subsection requires states to provide methods and procedures for payment of care and services in a manner that ensures equal access to quality care for needy children. The beneficiaries are both the recipients of the services and the recipients of the state's payment, who are the CHMS providers. The statute is clear on its scope: to ensure payments are not too high, but yet high enough to secure the participation of enough clinics so that needy children receive equal access to quality health care.
>
> In sum, as our prior cases have held, the rights conferred by §§ 1396d(a)(13) and 1396a(a)(30)(A) are clearly established federal rights. Moreover, even accepting ADHS's invitation to reconsider prior established precedent, we find no error in the district court's holding that these provisions of the Medicaid Act are enforceable by both CHMS recipients and providers through a § 1983 private cause of action.[79]

In *Pediatric Specialty Care*, the Eighth Circuit demonstrated some of the hallmarks of the "pragmatic textualist" approach. In deciding whether a provision was phrased in "unambiguous rights-creating language," the court focused on whether the provision should naturally be read to confer benefits on readily identifiable parties, rather than looking only to black-letter phraseology. In deciding whether the "right" described therein was judicially enforceable, the court recognized that courts can—and often do—make decisions based on metrics that require some degree of judgment (for example, the "reasonableness" standard in tort law). Finally, the court took notice of the nature and importance of the putative right asserted: namely, assuring that "*needy children* receive equal access to quality care,"[80] in contradistinction to the claim involved in *Gonzaga*, which the *Pediatric Specialty Care* court described as "[a] student at Gonzaga's school of education su[ing] the school under FERPA when he found out that the school's teacher certi-

77 Id at 1015.
78 Id (emphasis added).
79 Id at 1015–16 (internal citation omitted).
80 Id (emphasis added).

fication specialist disclosed allegations of sexual misconduct to Washington's teacher certification agency without his permission."[81]

It is important to note that some Medicaid Act provisions are unquestionably codified in the kind of "unambiguous rights-creating language" lionized by the *Gonzaga* majority. There is reasonably well-settled post-*Gonzaga* law in a majority of circuits upholding recipient enforcement of the EPSDT,[82] reasonable promptness,[83] availability,[84] comparability,[85] freedom of choice,[86] and ICF/MR[87] provisions.

The fact remains, however, that most lower courts have not ignored the ideological shift—culminating in *Gonzaga*—in the Supreme Court's post-*Wilder* opinions. Nor has the Court's emphasis on a specific textual "hook" on which to hang the hat of § 1983 standing gone unnoticed. Since *Gonzaga*, an increasing number of circuit and district courts have denied *recipient* standing to enforce certain provisions of the Medicaid Act.[88] The most recent—and most drastic—restrictions of

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81 Id at 1014.

82 See *Dickson v Hood*, 391 F3d 581, 603–07 (5th Cir 2004) ("[W]e conclude that the EPSDT treatment provisions of the Medicaid Act contains the 'rights-creating language critical to showing the requisite congressional intent to confer a new right.'") (internal citation omitted); *OKAAP*, 366 F Supp 2d at 1110–11 (same); *Health Care For All, Inc v Romney*, 2004 WL 3088654, *2–3 (D Mass) (same); *Memisovski*, 2004 WL 1878332 at *8–11 (same); *Winn v Perdue*, 218 FRD 277, 293–95 (ND Ga 2003) (same).

83 See *Bryson v Shumway*, 308 F3d 79, 88–89 (1st Cir 2002) (applying the *Blessing* three-factor test); *Mundell v Board of County Commissioners of Saguache County*, 2005 WL 2124842, *3 (D Colo) (holding that § 1396a(a)(8) confers enforceable rights on recipients while §§ 1396a(a)(10) and (17) do not); *OKAAP*, 366 F Supp 2d at 1107–09 (upholding the provision); *Reynolds v Giuliani*, 2005 WL 342106, *14–16 (SD NY) (same); *Mendez v Brown*, 311 F Supp 2d 134, 138–40 (D Mass 2004) (same); *Romney*, 2004 WL 3088654 at *2 (same); *Rabin v Wilson-Coker*, 266 F Supp 2d 332, 341 (D Conn 2003) (same); *White v Martin*, 2002 WL 32596017, *6 (WD Mo) (same).

84 See *Watson v Weeks*, 436 F3d 1152, 1159–62 (9th Cir 2006) (holding that § 1396a(a)(10) confers enforceable rights on recipients while § 1396a(a)(17) does not); *Mendez*, 311 F Supp 2d at 138–40 (stating that § 1396a(a)(10) confers an enforceable right).

85 See *Deisenroth v Holsinger*, 356 F Supp 2d 763, 767–68 (ED Ky 2005) ("[T]he Court concludes that the comparability of services provision . . . is privately enforceable under § 1983."); *Romney*, 2004 WL 3088654 at *2 (same); *Masterman v Goodno*, 2004 WL 51271, *9–10 (D Minn) (same); *Ball v Biedess*, 2004 WL 2566262, *5 (D Ariz) (same); *Clayworth v Bonta*, 295 F Supp 2d 1110, 1121–24 (ED Cal 2003) (same).

86 See *Deisenroth*, 356 F Supp 2d at 768 (upholding a § 1983 suit under §1396n(c)(2)(C), the compliance provision of § 1396(a)(23)); *Masterman*, 2004 WL 51271 at *10 (same); *Ball*, 2004 WL 2566262 at *5 (same).

87 See *Sabree*, 367 F3d at 182–83 (holding that the provision "unambiguously confer[s] rights vindicable under § 1983"); *Deisenroth*, 356 F Supp 2d at 766–67 (same).

88 See, for example, *Romney*, 2004 WL 3088654 at *2 (holding that recipients may not bring § 1983 suit to enforce equal access provision because, although other Circuits have decided otherwise, § 1396a(a)(30) "displays no intent to benefit any single class of individuals . . . [since] the statute 'has no rights creating language and identifies no discrete class of beneficiaries'"), quoting *Long Term Care Pharmacy Alliance*, 362 F3d at 57. See also *Watson*, 436 F3d at 1162–63 (barring recipients from suing to enforce the § 1396a(a)(17) "reasonable standards" provision); *Sanchez*, 416 F3d at 1062 (finding that neither providers nor recipients may sue to enforce the

the § 1983 right in the Medicaid context have, relying specifically on *Gonzaga*, adopted an exceedingly narrow "strict textualist" methodology.

B. "Strict Textualism"

Courts adopting what I call a "strict textualist" inquiry look solely to the black-and-white, objective words of a single statutory provision—to the exclusion of any analysis of statutory context or purpose—to determine whether that particular provision unambiguously grants enforceable rights. The benchmark used by these courts is whether a single provision is "phrased in terms of the person(s) benefited." A strict textualist court might, for example, compare a single Medicaid Act provision to the paradigmatic "rights-creating language" used in certain provisions of the Civil Rights Act of 1964.[89] Under this paradigm, a court looks to see whether a Medicaid Act provision is phrased in terms such as, "*[a]ll persons shall be entitled* to . . . public accommodation"[90] or "[n]o person . . . shall deny *the right of any individual* to vote."[91] If a particular Medicaid Act provision is not so phrased, that is likely the end of the matter.[92]

The most notable examples of post-*Gonzaga* strict textualism in Medicaid Act jurisprudence have occurred within the past year in three respective federal circuit courts. After the Court of Appeals for the Ninth Circuit held, in successive decisions, that neither the equal access nor the "reasonable standards" provisions of the Medicaid Act confer enforceable rights on *any* private party,[93] the courts of appeals of the Sixth and Tenth Circuits quickly reached similar holdings with respect to the Act's equal access provision.[94] The textual analysis lead-

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equal access provision); *Mundell*, 2005 WL 2124842 at *3 (holding that a recipient may not sue to enforce the § 1396a(a)(10) "availability" or the § 1396a(a)(17) "reasonable standards" provisions); *Sanders v Kansas Department of Social and Rehabilitation Services*, 317 F Supp 2d 1233, 1248–51 (D Kan 2004) (stating that recipient may not sue to enforce the § 1396a(a)(8) "reasonable promptness" or the § 1396a(a)(17) "reasonable standards" provisions); *M.A.C. v Betit*, 284 F Supp 2d 1298, 1304–08 (D Utah 2003) (holding that recipients may not sue to enforce the § 1396a(a)(8) "reasonable promptness" provision, the § 1396a(a)(23)(A) and § 1396n(c)(2)(C) freedom of choice provisions, or the more general "right to services" under the Medicaid Act).

89 Pub L 88-352, 78 Stat 241, codified at 28 USC § 1447, 42 USC §§ 1971, 1975a–d, 2000a et seq (2000). For an example of this correlation, see *Sanchez*, 416 F3d at 1058 (noting that the *Gonzaga* Court used Title VI of the Civil Rights Act of 1964 "[a]s [an] example[] of paradigmatic rights-creating language").

90 42 USC § 2000a(a) (emphasis added).

91 42 USC § 1971(a)(2)(B) (emphasis added).

92 See *Sanchez*, 416 F3d at 1062 ("Because we hold that § 30(A) fails the first prong of the *Blessing* test, we do not need to consider the second and third prongs.").

93 See id at 1062; *Watson*, 436 F3d at 1162.

94 See *Westside Mothers v Olszewski*, 454 F3d 532, 542–43 (6th Cir 2006) (concluding that subsection (30)(A) "has an aggregate focus rather than an individual focus" and its "broad and

ing to these holdings—and in particular, the Ninth Circuit's analysis—can only be characterized as exceedingly strict.

In *Sanchez v Johnson*,[95] the Ninth Circuit held that, "[b]ecause [the equal access provision] lack[ed] 'rights-creating' language and 'any focus on individual entitlements,' and d[id] not anticipate a judicially-enforceable remedy," it did not create any federal right enforceable through § 1983.[96] Shortly after its *Sanchez* decision, the Ninth Circuit held in *Watson v Weeks*[97] that § 1396a(a)(17) of the Medicaid Act, the Act's so-called "reasonable standards" requirement, was "not framed in terms of the persons benefited, which is fatal under *Gonzaga* to the existence of a section 1983 right."[98]

The narrowness of the inquiry utilized by courts in the "strict textualist" camp cannot be overstated. Consider, first, the text of 42 USC § 1396a(a)(17), the so-called "reasonable standards" provision of the Medicaid Act:

> A state plan for medical assistance must . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and . . . as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources.

Next, consider the relevant text of 42 USC § 1396a(a)(10): "A state plan for medical assistance must . . . provide—for making medical assistance available . . . to—(i) all individuals [meeting specified conditions, and] (ii) at the option of the state, [certain groups]."

Certainly, § 1396a(a)(10), the "availability" requirement, is "unambiguously phrased in terms of the persons benefited:" the "individuals" to whom medical assistance must be made available. Section 1396a(a)(17), while it does not mention individuals specifically, is certainly cast in terms of Medicaid recipients, referring to standards for "eligibility for . . . medical assistance." Certainly, Medicaid-eligible individuals are the intended beneficiaries of this provision. Moreover,

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nonspecific" language is "ill-suited to judicial remedy"); *Mandy R. v Owens*, 464 F3d 1139, 1147–48 (10th Cir 2006) (finding that the equal access provision "does not create a federal right enforceable under § 1983" and noting the circuit split).

95 416 F3d 1051 (9th Cir 2005).

96 Id at 1061 (internal citations omitted).

97 436 F3d 1152 (9th Cir 2006).

98 Id at 1163.

§ 1396a(a)(17) is rather obviously meant as a companion provision to § 1396a(a)(10): not only shall medical assistance be made available to *eligible* individuals, the standards governing such *eligibility* must be determined reasonably, i.e., solely on the basis of certain nondiscriminatory factors such as income and resources. Section 1396a(a)(17) is not explicitly phrased in terms of the persons benefited because *it is meant to constrain and modify* § 1396a(a)(10), which *is* explicitly phrased in terms of the persons benefited. Faced with a lawsuit by putative Medicaid beneficiaries alleging that medical assistance was not available under reasonable eligibility standards, a "pragmatic textualist" court—relying, perhaps, on *Gonzaga*'s admonition to examine whether "the text *and structure* of a statute provide [an] indication that Congress *intends to create new individual rights*,"[99] would consider the two asserted provisions, § 1396a(a)(10) and (17), as complementary components of a single asserted right. Whatever the court's ultimate decision on the merits, these companion provisions would, logically, rise or fall together.

As for a "strict textualist" court, consider the *entire* analysis utilized by the Ninth Circuit in *Watson v Weeks* before it decided that, although § 1396a(a)(10) granted § 1983-enforceable rights, § 1396a(a)(17) failed to grant enforceable rights to *any* private party:

> There is insufficient evidence of congressional intent to create a section 1983 right under this provision. Section 1396a(a)(17) is a general discretion-granting requirement that a state adopt reasonable standards. It fails to provide an "unambiguously conferred right" and fails the first prong of *Blessing*. The key wording of section 1396a(a)(17) fails to even mention individuals or persons. Unlike section 1396a(a)(10), section 1396a(a)(17) is not framed in terms of the individuals benefited, which is fatal under *Gonzaga* to the existence of a section 1983 right. Moreover, the parenthetical statement in section 1396a(a)(17) that the state's reasonable standards "shall be comparable for all groups" puts a focus on the standards themselves and on their aggregate impact, rather than on the benefits to individuals.[100]

If *Gonzaga*—which used textualism to find no "right" to prevent the disclosure of educational records—can be seen as "benign" strict textualism, the *Watson* analysis is strict textualism at its most "malignant." Ignoring all other signals of legislative intent, the Ninth Circuit determined, solely on a difference in wording, that there was a "right"

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99 *Gonzaga*, 536 US at 286 (emphases added).

100 *Watson*, 436 F3d at 1162 (internal citations omitted).

to availability of treatment, but that there was *no right* to have reasonable standards in determining what treatment will be made "available." In coming to this determination, the *Watson* court completely ignored—indeed, failed to even mention—that § 1396a(a)(10) and § 1396a(a)(17) are *companion* provisions that, *read together*, guarantee that "reasonable" treatment will be made "available." Without § 1396a(a)(17), on the other hand, the only services which are required to be made "available" are frozen by federal statute.[101] Thus, millions of Medicaid beneficiaries in our nation's largest judicial circuit are no longer guaranteed treatment not specifically enumerated in § 1396d(a)(1)–(5) *no matter how many physicians certify this treatment as medically necessary*, because a provision in the Medicaid Act was "not phrased in terms of the persons benefited, which is *fatal* under *Gonzaga*."[102]

This distinction may seem irrational on its face, but is even more deleterious in its effects. Between the Ninth Circuit's *Sanchez* and *Watson* decisions, the Medicaid beneficiaries in that circuit now have no private "right" to equal access to medical care or to have their coverage scope determined under "reasonable procedures." Thanks to *Sanchez*, the eleven million Medicaid beneficiaries in the Ninth Circuit now have a "right" to have medical assistance available, but *no* right to have sufficient doctors, nursing facilities, and pharmacists to provide it. Of course, after *Watson*, even if doctors are plentiful, medically necessary care need not be: states have been known to deny medically necessary care based on arbitrary criteria,[103] after which the

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101 See 42 USC § 1396a(a)(10) ("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 § 1396d(a) of this title.").

102 For example, if current Ninth Circuit law had prevailed in 1989, California could have decided not to cover off-label uses of azidothymidine ("AZT") through MediCal and neither providers nor beneficiaries would have any judicial recourse, despite the general agreement of the medical community that this was the only available treatment for HIV or AIDS. See *Weaver v Reagen*, 886 F2d 194, 198 (8th Cir 1989) (holding that § 1396a(a)(17) required Missouri's Medicaid program to cover such uses of AZT under similar facts).

103 See, for example, *Hern v Beye*, 57 F3d 906, 911 (10th Cir 1995):

> [T]his Circuit, as well as several other courts, has interpreted [the Medicaid Act] as imposing a general obligation on states to fund those mandatory coverage services that are medically necessary. . . . It may be that, pursuant to a generally applicable funding restriction or utilization control procedure, a participating state could deny coverage for a service deemed medically necessary in a particular case. But a state law that categorically denies coverage for a specific, medically necessary procedure . . . is not a reasonable standard . . . consistent with the objectives of the [Act].

(citations omitted). See also *Weaver*, 886 F2d at 198 (holding that a state plan cannot categorically deny coverage for off-label uses of AZT); *Fred C. v Texas Health and Human Services Commission*, 988 F Supp 1032, 1036 (WD Tex 1997), affd mem, 167 F3d 537 (5th Cir 1998) (declaring that the state may not deny treatment solely based upon age as there is no rational basis

aggrieved beneficiary's only meaningful recourse has been to § 1983. As one court of appeals articulated, "[The 'reasonable standards'] provision has been interpreted to require that a state Medicaid plan provide treatment that is deemed 'medically necessary' *in order to comport with the objectives of the Act*. . . . '*[S]erious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage.*'"[104]

VII. METHODOLOGIES COMPARED

The foregoing has identified two distinct textualist methodologies employed by lower courts interpreting the Medicaid Act in § 1983 adjudications after *Gonzaga*. On their faces, both interpretive methodologies have some plausible legal basis in the general § 1983 context. Pragmatic textualism approaches an intentionalist method of statutory interpretation; while rooted in the text of a spending program *statute*, this method looks beyond the text of a given *provision*, crediting sources such as statutory context (for example, companion provisions) and overarching programmatic purposes. Strict textualism, in contrast, relies upon federalist concerns surrounding § 1983 enforcement of the Spending Clause requirements; this method is rooted in concerns for state autonomy.

As I argue below, however, the federalist concerns putatively justifying strict textualism in the general spending program context simply do not translate to the Medicaid Act, where public health models, empirical evidence, and the Court's own Spending Clause doctrine turns the federalist justification for strict textualism on its ear. Indeed, public health considerations, far from rendering federalist concerns inapplicable to the Medicaid Act, counsel that *pragmatic* rather than strict textualism best preserves the long-term autonomy of the states.

A. Federalist Concerns, Clear Statement Rules, and the Medicaid Act

While Part VI.B argues that a strict textualist methodology could have illogical, and even deleterious, effects on Medicaid *beneficiaries*, this does not resolve the dilemma facing lower courts after *Gonzaga*. After all, *Gonzaga* was hardly decided with an eye toward the welfare of FERPA *beneficiaries*: indeed, the primary holding of that case subor-

for distinguishing between those over and under twenty-one); *McDaniel v Betit*, 1996 WL 426816, *2 (D Utah) (same); *Hunter v Chiles*, 944 F Supp 914, 920 (SD Fla 1996) (same); *Salgado v Kirschner*, 878 P2d 659, 665 (Ariz 1994) (same).

104 *Weaver*, 886 F2d at 198, quoting *Beal v Doe*, 432 US 438, 444–45 (1977) (internal citation omitted) (emphasis added).

dinated the welfare of a FERPA beneficiary to broader federalist concerns for state autonomy and for the well-being of overtaxed state treasuries. Accordingly, while the weight of the putative "right" involved might hold some sway in post-*Gonzaga* § 1983 analysis—this would seem relevant to an inquiry into "Congress['s] inten[t] to create new individual rights"[105] and into the "structure of [the relevant] statute"[106]—courts must also consider the interwoven considerations of state autonomy and fiscal well-being based on *Gonzaga*'s federalist concerns.

There are a few distinct areas of federalist concern regarding the § 1983 enforcement right in the Medicaid context. The first concern is straightforward: health care regulation is an area of traditional state hegemony, so federal intrusion into state Medicaid programs should be minimal.[107] A related "new federalist" concern—one repeatedly advanced by Chief Justice Rehnquist throughout his career on the bench—is that the "rights" conferred by entitlement programs such as Medicaid aren't rights in the traditional, "constitutional" sense, but are rather *positive* grants from the government that should be able to be limited or withheld without the same degree of judicial scrutiny.[108] Of particular applicability to § 1983 suits is the concern that the federal government cannot be sued under § 1983, and Medicaid is in theory a state-federal "partnership" of sorts.

A final concern—and one which speaks with particularity to the textual analysis required by *Gonzaga*—is a "clear statement" concern related to Medicaid's enactment under the Spending Clause: while Congress's power to impose particularized requirements in areas of traditional state hegemony by conditioning the use of federal funds has been repeatedly upheld as a legal principle,[109] concrete applications

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105 *Gonzaga*, 536 US at 286.

106 Id.

107 See, for example, *Hillsborough County v Automated Medical Laboratories, Inc*, 471 US 707, 719 (1985) ("[R]egulation of health and safety is primarily, and historically, a matter of local concern.").

108 See *Harris v McRae*, 448 US 297, 316–17 (1980):

> Although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, the fact remains that the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all.

See also *Rust v Sullivan*, 500 US 173, 201–02 (1991) (upholding an HHS regulation making it impermissible for Title X programs to pay for abortion counseling and advocacy because, inter alia, "Congress' refusal to fund abortion counseling and advocacy leaves a pregnant woman with the same choices as if the Government had chosen not to fund family-planning services at all").

109 See, for example, *South Dakota v Dole*, 483 US 203, 206–07 (1987) (upholding the condition of raising the state drinking age). See also *Fullilove v Klutznick*, 448 US 448, 474 (1980) (upholding a set-aside program reserving federal funds for minority-owned businesses); *Ivanhoe Irrigation District v McCracken*, 357 US 275, 295 (1958) ("[B]eyond challenge is the power of the

of this power are subject to examination. One "general restriction articulated by [the Supreme Court's] cases . . . require[s] that if Congress desires to condition the States' receipt of federal funds, it 'must do so unambiguously, . . . enabl[ing] the States to exercise their choice knowingly, cognizant of the consequences of their participation.'"[110]

At its base, however, federalism—no matter how embodied—is fundamentally concerned with *preserving state autonomy*. In particular, the Rehnquist Court's jurisprudence has emphasized that federal courts faced with private § 1983 suits under Spending Clause statutes must have due regard for the rights of states as autonomous parties to a federal-state "quasi-contract." Under a system of federalism in which each state is, in some sense, a sovereign, Congress cannot simply "commandeer," by fiat, state governments,[111] particularly in traditional areas of state sovereignty such as health care. But the same conception of state quasi-sovereignty allows that state to enter into quasi-contractual "bargains" with the federal government in which the consideration provided by the states in exchange for federal funding takes the form of federal conditions upon state regulation in a certain area.[112] Like any bargained-for exchange, however, such a quasi-contract can only be effective if, inter alia, both parties are fully informed of the terms of the bargain.[113] On the quasi-contract theory of Spending Clause regulation, limiting suits against the states for "un-

Federal Government to impose reasonable conditions on the use of federal funds."); *Oklahoma v United States Civil Service Commission*, 330 US 127, 144 (1947) ("The offer of benefits to a state by the United States dependent upon cooperation by the state with federal plans, assumedly for the general welfare, is not unusual."); *Steward Machine Co v Davis*, 301 US 548, 597–98 (1937) (holding that the Social Security Act constitutionally offers conditions to the states in return for state-created retirement systems); *United States v Butler*, 297 US 1, 66 (1936) (disallowing the condition that farmers reduce their output in exchange for federal funds). But see *Pennhurst*, 451 US at 17 n 13 ("Even the . . . respondents, like the court below, recognize the 'constitutional difficulties' with imposing affirmative obligations on the States pursuant to the spending power.").

110 *Dole*, 483 US at 207 (first alteration added, all other alterations in original), quoting *Pennhurst*, 451 US at 17.

111 See *New York v United States*, 505 US 144, 161 (1992) ("Congress may not simply commandee[r] the legislative processes of the states by directly compelling them to enact and enforce a federal regulatory program.") (alteration in original; quotation marks omitted).

112 See *Pennhurst*, 451 US at 17 ("Legislation 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.").

113 See id:

> The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' There can, of course, be no knowing acceptance if a state is unaware of the conditions or is unable to ascertain what is expected of it.

foreseeable" (that is, not "clearly stated") obligations merely follows the familiar principle of *Hadley v Baxendale*.[114]

Of particular importance, however, is the fact that none of the Rehnquist Court's federalism-infused § 1983 Spending Clause jurisprudence—not *Suter*, nor *Blessing*, nor, of course, *Gonzaga*—actually involved the Medicaid Act. This is highly material on the Rehnquistian quasi-contract or market-based view of the Spending Clause because, simply put, the uniquely regulated domestic health care market differs materially from every other domestic market, including that for education.

B. Market Considerations: EMTALA, Public Health, and the Cost of U.S. Health Care

The cost of medical treatment increases with (1) decreased wellness and (2) increased urgency. The first of these factors is simply a measure of "quantity" in the health care market—the amount of "curing" that needs to be accomplished to achieve wellness should be expected to correlate positively with cost. However, unlike in most markets, the relationship between decreased wellness and increased cost-to-cure is, for many maladies, nonlinear. Indeed, a significant body of public health research suggests that cost-to-cure can rise almost exponentially for certain maladies if they are allowed to develop for a significant period of time.[115] That the cost of medical treatment can grow exponentially as wellness deteriorates can be seen as a literal embodiment of the old adage: "an ounce of prevention is worth a pound of cure."

The second factor related to increased cost-to-cure—increased urgency of care—is related to supply inelasticity in the market for

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[114] 156 Eng Rep 145 (Ex 1854) (limiting consequential damages for breach of contract to those damages reasonably foreseeable to the parties at the time of contracting and requiring disclosure, at the time of contracting, of unique circumstances in order to recover unique damages for breach).

[115] See generally, for example, Hensin Tsao, Gary S. Rogers, and Arthur J. Sober, *An Estimate of the Annual Direct Cost of Treating Cutaneous Melanoma*, 38 Journal of the American Academy of Dermatology 669 (1998). See also Joan Schwartz, *Late-stage Melanoma Patients Have Most Expenses for Treatment*, B.U. Bridge Research Briefs (May 15, 2003), online at http://www.bu.edu/phpbin/researchbriefs/display.php?id=88 (visited Apr 28, 2007):

> About 90 percent of the total annual direct cost for treating melanoma, a deadly form of skin cancer, is spent on those with advanced disease—less than 20 percent of all melanoma patients .... The staggering medical expense in treating these late-stage patients provides an incentive for better skin cancer surveillance and prevention programs.... [T]he annual direct cost of treating newly diagnosed melanoma in 1997 was estimated to be at least $560 million, and it may exceed $1 billion.... When discovered early, melanoma can often be treated effectively, but is more deadly when discovered at an advanced stage.... "Our study shows that early detection saves both lives and money."

(quoting Dr. Gary Rogers).

medical care, and is most obvious in the emergency room setting. Hospital emergency rooms must be equipped to handle nearly every treatment specialty under rigorous time constraints. As a result, few of the cost-saving efficiencies from specialization that are present in nonemergency medical treatment can be achieved in the emergency room setting, and the aggregate cost of a given procedure administered in a hospital emergency room is significantly higher than the cost of that same procedure in a nonemergency room setting.[116]

Neither of the above factors would seem to be particularly harmful in a market in which the participants are made to bear the full cost of their actions. Indeed, a cost-conscious, self-paying health care consumer should be expected to (1) utilize preventative and diagnostic care whenever possible, given the large long-run cost savings from procedures such as, for example, regular well-checkups and vaccinations; and (2) utilize emergency care—and in particular, hospital emergency rooms—only when faced with a real medical emergency, given the disproportionate cost of emergency room utilization.

In the publicly funded health care market, however, neither of these conditions necessarily holds true. In particular, in the *Medicaid* market in many states, the first condition above—utilization of preventative and diagnostic care such as well-checkups—is foreclosed to beneficiaries by inadequate physician reimbursement under Medicaid.[117] Lacking adequate access to regular physicians, Medicaid bene-

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116 It had long been believed that the cost of nonurgent emergency room care was as much as triple the cost of nonurgent, nonemergency care. Indeed, in a televised speech to a joint session of Congress and the nation in September 1993, President Clinton referred to emergency departments as "the most expensive place of all." Robert M. Williams, *The Costs of Visits to Emergency Departments*, 334 New Eng J Med 642, 642 (1996). As a 1996 article in the New England Journal of Medicine put it:

> It is widely believed that about half of all visits to emergency departments are for minor medical problems and that the cost of a nonurgent visit to an emergency department is triple the cost of a visit to a physician's office. Diverting nonurgent visits from emergency departments to private physicians' offices is viewed as a way to gain substantial savings.

Id. Williams—and certain other recent empirical studies—suggest that there was less cost disparity between nonurgent emergency care and nonurgent, nonemergency care than was previously thought. See id. ("The potential savings from a diversion of nonurgent visits to private physicians' offices may . . . be much less than is widely believed."). However, these recent studies have been criticized by some medical professionals and policy analysts for, inter alia, failing to take into account the significant collateral costs of emergency care. See, for example, Carolyn L. Baier, Letter to the Editor, *Costs of Visits to Emergency Departments*, 335 New Eng J Med 209, 209 (1996) (arguing that "[t]he lack of access in certain areas to any care other than that provided by the emergency department is an argument for improving access, not for providing nonurgent care in emergency departments, whatever the cost").

117 See Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 Am J L & Med 191, 194–98 (1995) (reviewing empirical evidence), 192–93:

ficiaries are therefore likely to wait for a serious illness or other health condition to develop before seeking medical assistance, and to seek this medical assistance from a location that is required—perhaps independently of Medicaid—to provide care.[118] Because of an independent federal statute—the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)[119]—requiring that Medicare-eligible hospitals treat any patient presenting at that hospital with emergency symptoms, Medicaid beneficiaries denied access to regular physician care are likely to present (1) with later-stage illnesses or medical conditions (2) at a publicly funded hospital emergency room.[120] Both of these, however, are major sources of the disproportionate cost of care.

> America[] [has a] long tradition of dual-track medical care: one track for those with money and another for those without. Medicaid promised to end this dual class delivery system by providing poor people with health insurance they could use to purchase private medical care. However, this promise has never been fulfilled, and the dual system continues. Privately insured patients receive primary care in private physicians' offices. Medicaid enrollees and uninsured people generally receive services in underfunded and understaffed hospital emergency rooms and outpatient clinics where overcrowding effectively rations care. Medicaid has failed to end dual-track medical care for the poor because it has failed to attract physicians to the program. Twenty-five percent of our nation's physicians simply refuse to treat Medicaid patients. Perhaps more importantly, of those physicians who do treat Medicaid patients, two-thirds limit the number of Medicaid patients they treat. Nearly all doctors share the same rationale for avoiding Medicaid patients: low Medicaid reimbursement. Put simply, doctors avoid Medicaid patients because they are paid less to treat them. To make matters worse, most doctors can afford to avoid Medicaid patients who comprise only a marginal source of income for most physicians. [I]f Medicaid is ever to end the separate and unequal system of medical care it must attract private physicians into the program. . . . Th[e] history [of Medicaid reimbursement and access to care], read in light of empirical studies, shows that physicians respond to the lure of higher fees.

118 See id at 198 (noting that "[t]he [cost] problem is exacerbated by overcrowding and long waits at public facilities which cause patients to delay seeking treatment until their conditions become so serious that they require even more expensive treatment and more frequent hospitalization").

119 42 USC § 1395dd (2006). EMTALA, established under the Consolidated Omnibus Budget Reconciliation Act of 1985, is often referred to as the "Anti-Dumping" statute. See generally, for example, Thomas A. Gionis, Carlos A. Camargo, Jr., and Anthony S. Zito, Jr., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 Am U L Rev 173 (2002) (detailing the anti-dumping provisions of both EMTALA and similar state statutes).

120 Watson describes the phenomenon as follows:

> [L]ow Medicaid physician reimbursement forces Medicaid enrollees to turn to public hospitals and public clinics, hospital emergency rooms, and outpatient departments for medical care. This phenomenon greatly increases the cost of the Medicaid program because providing primary care in hospital outpatient facilities and emergency rooms is more expensive than providing the same care in a physician's office. The problem is exacerbated by overcrowding and long waits at public facilities which cause patients to delay seeking treatment until their conditions become so serious that they require even more expensive treatment and more frequent hospitalization.

Watson, *Medicaid Physician Participation*, 21 Am J L & Med at 198 (cited in note 117), citing Physician Payment Review Commission, Report to Congress: Physician Payment Under Medicaid 23–24

Indeed, as a 2004 Policy Statement by the American Academy of Pediatrics' Committee on Pediatric Emergency Medicine put it:

> Subsequent revisions, reinterpretation, and increased enforcement of this law over the past decade have expanded the reach of EMTALA, delineating the responsibility of hospitals, EDs, and their physicians to provide services to all patients who request them in a nondiscriminatory and consistent manner. The law specifies that the scope of the MSE should include all ancillary services routinely available to the ED, such as physician consultation and inpatient care, if required. *In the absence of a national universal health benefits program, hospital EDs are essentially the only place in our current health care system at which all patients are guaranteed medical care*.[121]

Given these realities, selective nonenforcement of Medicaid Act provision does not necessarily equate to selective reductions in health care expenditures. Instead, EMTALA and similar laws provide an almost perfectly inelastic baseline of care from government-funded hospitals—and *at the highest possible cost*.

The upshot of this analysis is that it is in the long-term financial interest of state treasuries to have a comprehensive, well-functioning Medicaid system with a public health and wellness-based focus. Of absolute necessity to this goal in the medium-to-short term is reasonable access to medical care in a regular, nonemergency setting. This, of course, is the exact mandate of the Medicaid Act's "equal access" provision. Over a longer time horizon, preventative measures such as childhood screening and vaccination—covered by some of the EPSDT provisions of the Medicaid Act—are important steps towards efficient health care spending.

(1991), reprinted in 3 Medicare & Medicaid Guide (CCH) Special Rep No 661 (July 18, 1991). See also Robert E. Hurley, Hoangmai H. Pham, and Gary Claxton, *A Widening Rift in Access and Quality: Growing Evidence of Economic Disparities*, Health Affairs Web Exclusive, online at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.566 (visited Apr 28, 2007):

> EMTALA obligates EDs [emergency departments] to evaluate and stabilize all patients who seek care. This open door is subject to exploitation, and the ED directors interviewed decried the extent to which patients and competing providers, including private physicians, rely on this policy to use EDs for care that should be available elsewhere. In some cases, this . . . *reveals the frustration of community-based primary care providers who, knowing that they will be unable to find office-based specialty care for a Medicaid or uninsured patient, send such patients to the ED because the hospital has a call list of available specialists who will see patients in the ED*.

(emphasis added).

121 *Overcrowding Crisis in our Nation's Emergency Departments: Is Our Safety Net Unraveling?* 114 Pediatrics 878 (2004), online at http://pediatrics.aappublications.org/cgi/content/full/114/3/878 (visited Apr 28, 2007) (emphasis added) (characterizing EMTALA as "The Underfunded Federal Mandate for Universal Health Care").

But the foregoing merely provides empirical evidence regarding "a State's long-term best interest": at first glance, this is the language of *paternalism*, not of federalism. How, then, can it be that concerns about state autonomy would counsel federal courts to give due regard to their *own* determinations about "long term financial interest"? The initial answer to this is that adopting "pragmatic," rather than "strict," textualism in interpreting the Medicaid Act focuses *not* on the federal judiciary's determinations, but on *Congress's*.[122] This, of course does not end the federalist inquiry, but merely refocuses it: congressional paternalism would be paternalism nonetheless.

It turns out, however, that pragmatic textualism's focus on congressional intent and the structure of the Medicaid Act as a whole is highly material—even dispositive—to federalist concerns about state autonomy. Congress's Spending Clause power is only legitimate to the extent that it is not "so coercive as to pass the point at which 'pressure turns into compulsion.'"[123] But "a conditional grant of federal money . . . is [not] unconstitutional *simply by reason of its success in achieving the congressional objective*."[124] Instead, where "the enactment of . . . laws remains the prerogative of the States not merely in theory, but in fact," a state's autonomy is preserved even though Congress might regulate, through encouragement, "what it might lack the power to impose . . . directly."[125] Chief Justice Rehnquist's opinion in *South Dakota v Dole*[126]—the leading modern case on the limits of Congress's Spending power—makes clear that a state's autonomy is threatened where "*the enactment of . . . laws*" is no longer the state's prerogative.[127] The crucial inquiry under *Dole*, therefore, is whether a state retains the prerogative, in *fact*, to *exit Medicaid*, since the Medicaid quasi-contractual bargain exchanges (A) federal financial participation for (B) adherence to the regulatory conditions embodied in the Medicaid Act.

Whether states, in fact, have an "exit prerogative" under Medicaid as it presently exists is not necessarily answered in the affirma-

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122 Focusing on the "text *and structure*," *Gonzaga*, 536 US at 286 (emphasis added), of the Medicaid Act and on what "Congress intended," id, clearly focuses upon *congressional intent*. This intent-centered inquiry stands in stark contrast to a narrow determination of whether each provision, in textual isolation, is "framed in terms of the persons benefited," *Watson*, 416 F3d at 1163, which centers upon *notice to the states*.

123 *Dole*, 483 US at 211, quoting *Steward Machine Co*, 301 US at 590.

124 *Dole*, 483 US at 211 (emphasis added).

125 See id at 211–12 (stating that "[h]ere Congress has offered relatively mild encouragement to the States to enact higher minimum drinking ages than they would otherwise choose," through which the states retained their lawmaking prerogative).

126 483 US 203 (1987).

127 See id at 211–12 (emphasis added).

tive. The "narcotic" theory of FFP[128] provides a plausible story as to why states might be locked in to the program for at least the short term. Moreover, *any* federalist theory under which Medicaid Act enforcement should be limited by the federal courts must necessarily rely on some variant of this theory—otherwise, the proper institution to "limit" Medicaid would be the states themselves, by utilizing their *right to refuse FFP*. But if the "narcotic theory" is correct, and state autonomy is threatened because of the states' inability to wean themselves from FFP, then the Medicaid-linked threat to state autonomy is inextricably bound up with budgetary concerns.

Once it is understood that *this* story—a story *linking Medicaid cost overruns and state autonomy*—underlies the federalist concern with private enforcement of the Medicaid Act, pragmatic textualism becomes a methodology in service of rescuing state autonomy from the "narcotic effects" of FFP. To the extent that a strict textualist methodology merely tears at the Medicaid Act, provision-by-provision, and eschews long-term efficiency in favor of short-term cost deferment, states shoot themselves—and their future ability to rid themselves of FFP, should they so choose—in the foot. Instead of enhancing state autonomy, such a methodology forges the chains of long-term FFP dependence by the states: where state Medicaid programs are inefficiently run, and perpetually broke, dependence upon federal assistance is all but assured.

VIII. CONCLUSION

Even faced with a reality of excess Medicaid expenditures, any meaningful cost-cutting or utilization-limiting scheme must be attuned to the Act itself as an integrated scheme of providing a meaningful entitlement to medical care. A meaningful health care delivery system balances access, quality of care, choice of providers, and cost and utilization control—and the Medicaid Act is an integrated scheme developed by Congress and HHS to balance these factors.

Where administrative realities turn limitations on the § 1983 enforcement right into limitations on Medicaid Act enforcement generally, sifting through the Act provision by provision and cutting out those provisions "not phrased in terms of the persons benefited" is a limiting principle that is consistent neither with the Act's aims *nor* with the aim of actually cutting the public cost of indigent health care. If limitations on Medicaid spending and "tough choices" involving putative beneficiaries are necessary, the proper way to make these

[128] See text accompanying notes 19–23.

choices is *not* by comparing the text of individual Medicaid Act provisions to the Civil Rights Act of 1964.[129] While the aim of some courts to find a "dispassionate lens through which [Medicaid beneficiary suits] must be viewed"[130] might seem admirable as a means of controlling cost-overruns in state health care budgets, this cost-limiting aim is perverted by a mode of textual analysis that can lead to underenforcement of the very mandates that would serve efficiency and long-run savings in public health care expenditures.

Finally, in determining whether a Medicaid Act provision grants enforceable private rights, a "pragmatic textualist" approach—one that recognizes the Medicaid Act as a complex, interlocking scheme—can do more than just vindicate the welfare of our nation's underprivileged; it can help to restore the long-term autonomy of the states by bringing fiscal sanity to a wildly inefficient system of public health care.

129 See *Watson*, 436 F3d at 1159, citing *Gonzaga*, 536 US at 284.

130 *Sabree v Richman*, 367 F3d 180, 183 (3d Cir 2004) (describing *Gonzaga*).