PRIVATE ENFORCEMENT OF MEDICAID'S "FREE CHOICE OF PROVIDER" PROVISION

AUSTIN DIEHL*

Medicaid is a jointly administered federal and state program offering little to no cost health insurance to thousands of individuals in poverty-stricken areas of the United States. But what good is medical insurance if there are no providers nearby who accept that insurance? For many people living in rural parts of the United States, this is the unfortunate reality. This troubling situation is exacerbated when a state decertifies a Medicaid recipient's chosen provider for failure to be "qualified" as required by federal law. Both the federal government and the decertified provider could challenge the state's decertification decision, but neither has much incentive to do so. Whether the Medicaid recipient themself could bring a private suit to maintain access to their provider of choice is subject to a circuit split across the Court of Appeals.

42 U.S.C. § 1983 ("Section 1983") is the federal statute that Medicaid recipients can, in some circuits, rely on to bring a lawsuit to get their doctor back. Section 1983 provides a right of action when a person is deprived of "rights," and older jurisprudence limited that term to constitutional rights. But in a series of cases in the 1980s and 1990s, the Supreme Court set forth a framework for extending Section 1983 enforcement to federal statutes passed pursuant to the Spending Clause. That framework has come under attack in recent years, with some justices arguing for a return to the days when there was no Section 1983 enforcement of Spending Clause legislation.

This Note urges the Supreme Court to grant certiorari to decide whether Medicaid's provision requiring a provider to be qualified is enforceable by private litigants under Section 1983. In arguing that such a right exists, this Note will assess the arguments raised across the circuit split and dive into the history of both Medicaid and Section 1983. Not only would a private right to enforce this provision of Medicaid be of practical importance for Medicaid recipients with limited access to care, but it would also reaffirm the strength of a host of other important government programs passed pursuant to the Spending Clause and bump the United States closer to a view of healthcare as a right rather than a privilege.

* J.D. Candidate, 2023, University of Illinois College of Law; B.A., 2020, Kenyon College. Thank you to the members and editors of the University of Illinois Law Review for their diligent work on this publication. I would like to dedicate this Note to my loving parents for their support throughout my time in law school.

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I. INTRODUCTION

Suppose that a family of three, Stephanie and her two kids, live in a small town in a rural area of the United States. As a teacher at a local elementary school, Stephanie earns roughly $25,000 per year.[1] Her employer provides no health insurance coverage,[2] but because her state chose to participate in the ACA Medicaid expansion, which provides medical insurance for those within 133% of the federal poverty level, Stephanie and both of her children will qualify for Medicaid.[3] Stephanie can pay a monthly premium to receive insurance coverage from one of her state's managed care organizations ("MCO"), the organizations that most states rely on to issue insurance to Medicaid recipients.[4]

Unfortunately, Stephanie's family could be among the 660,893 individuals living in rural counties without a Federally Qualified Health Center, Rural Health Clinic, or acute care hospital—the three main primary care service providers to rural communities.[5] Alternatively, Stephanie's family may have a primary care provider nearby that does accept Medicaid insurance. If the Medicaid provider is not part of Stephanie's MCO, she may have to wait up to a year to get switched

1. Erin Richards & Matt Wynn, *'Can't Pay Their Bills with Love': In Many Teaching Jobs, Teachers' Salaries Can't Cover Rent*, USA TODAY NEWS (Dec. 16, 2019, 7:22 PM), https://www.usatoday.com/in-depth/news/education/2019/06/05/teachers-pay-cost-of-living-teaching-jobs/3449428002/ [https://perma.cc/9AT9-2XVA].

2. *Percent of Private Sector Establishments That Offer Health Insurance to Employees*, KFF (2020), https://www.kff.org/other/state-indicator/percent-of-firms-offering-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/SNM4-U3K8].

3. *Eligibility*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/eligibility/index.html (last visited July 4, 2023) [https://perma.cc/Z9QY-72BY]; *2022 Federal Poverty Levels / Guidelines & How They Determine Medicaid Eligibility*, AM. COUNS. ON AGING, https://www.medicaidplanningassistance.org/federal-poverty-guidelines/ (July 4, 2023) [https://perma.cc/DC8W-MRJL].

4. Elizabeth Hinton & Lina Stolyar, *10 Things to Know About Medicaid Managed Care*, KFF (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/#:~:text=As%20of%20July%202021%2C%2041,Medicaid%20beneficiaries%20(Figure%201) [https://perma.cc/78AD-EMSQ].

5. Meagan Clawar, Randy Randolph, Kristie Thompson & George H. Pink, *Access to Care: Populations in Counties with No FQHC, RHC, or Acute Care Hospital*, NC RURAL HEALTH RSCH. PROGRAM, https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/01/AccesstoPrimaryCare.pdf (last visited July 4, 2023) [https://perma.cc/UUZ9-BUKQ].

to a different MCO.[6] If the Medicaid provider is part of Stephanie's MCO, Stephanie and her children should be able to receive the preventive healthcare services that primary care doctors provide, services which have a demonstrable effect on long term health outcomes.[7]

As a Medicaid recipient, there is another hurdle that Stephanie may face in receiving care from her local primary care provider. Her primary care provider could be "decertified" by the state agency that administers Medicaid.[8] Although her provider can challenge the state's decision via an administrative hearing, the provider has little incentive to do so.[9] After all, Medicaid reimburses providers at some of the lowest rates among insurance carriers.[10] Depending on the state that she resides in,[11] Stephanie may also not be able to challenge the state's decision to decertify her doctor.[12] She will be forced to travel across counties, possibly quite far, to receive primary care for herself and her children.

Medicaid's "free choice of provider" provision, which gives Medicaid recipients a right to obtain care from any qualified provider, seemingly could provide a way for Stephanie to sue to get access to her primary care provider back.[13] The Courts of Appeals currently are split on this issue.[14] The Fourth, Sixth, Seventh, Ninth, and Tenth Circuits have held that Medicaid recipients have the right to challenge a state's decertification decision in federal court; the Fifth and Eighth Circuits have held individual recipients do not have this right.[15] The Supreme Court has yet to grant certiorari to any of the appeals arising from these cases.[16]

This Note urges the Supreme Court to (1) interpret 42 U.S.C. § 1396a(a)(23) as providing Medicaid beneficiaries a private right of enforcement under 42 U.S.C. § 1983 that includes the right to challenge provider

6. *Enrollment Process for Medicaid Managed Care*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/subtopic/enrollment-process-for-medicaid-managed-care/ (last visited July 4, 2023) [https://perma.cc/NK4A-BPDA].

7. Shi Leiyu, *The Impact of Primary Care: A Focused Review*, SCIENTIFICA (Dec. 31, 2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/ [https://perma.cc/YUN4-MB4W].

8. 42 C.F.R. § 455.416.

9. *See* Robin McKnight, *Increased Medicaid Reimbursement Rates Expand Access to Care*, NBER: BULL. ON HEALTH (Oct. 2010), https://www.nber.org/bh/increased-medicaid-reimbursement-rates-expand-access-care [https://perma.cc/9BYU-EUXP]; *Hearing by an Administrative Law Judge (ALJ)*, CMS, https://www.cms.gov/medicare/appeals-and-grievances/mmcag/alj (lJan. 12, 2023) [https://perma.cc/WUP6-PD5S].

10. Rebecca Beitsch, *Are Medicaid's Payment Rates So Low They're Discriminatory?*, PEW (Sept. 22, 2017), https://www.pewtrusts.org/en/research-and analysis/blogs/stateline/2017/09/22/are-medicaids-payment-rates-so-low-theyre-discriminatory [https://perma.cc/5NZE-SQ6U].

11. *See generally* Planned Parenthood S. Atl. v. Baker, 941 F.3d 687 (4th Cir. 2019); Harris v. Olszewski, 442 F.3d 456 (6th Cir. 2006); Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't Health, 699 F.3d 962 (7th Cir. 2012); Planned Parenthood Ariz. Inc. v. Betlach, 727 F.3d 960 (9th Cir. 2013); Planned Parenthood of Kan. v. Andersen, 882 F.3d 1205 (10th Cir. 2018). *But see* Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman, 981 F.3d 347 (5th Cir. 2020); Does v. Gillespie, 867 F.3d 1034 (8th Cir. 2017).

12. *See* sources cited *supra* note 11.

13. 42 U.S.C. § 1396a(a)(23).

14. *See* sources *supra* note 11.

15. *See* sources *supra* note 11.

16. *See* sources *supra* note 11.

decertification and (2) to clarify the standard for 42 U.S.C. § 1983 enforcement of Spending Clause legislation by reconciling its decisions in *Blessing v. Freestone*[17] and *Gonzaga v. Doe*.[18] Part II reviews Medicaid, the free choice of provider provision, and the existing remedies available to decertified providers.[19] Part II concludes by introducing 42 U.S.C. § 1983, surveying Supreme Court interpretations of the statute, and examining recent developments pertaining to 42 U.S.C. § 1983 enforcement of 42 U.S.C. § 1396a(a)(23).[20] Part III examines Circuit Court interpretations of the Supreme Court's 42 U.S.C. § 1983 jurisprudence and the differing applications of these standards to private enforcement of 42 U.S.C. § 1396a(a)(23).[21] Part IV recommends that 42 U.S.C. § 1983 allow Medicaid beneficiaries to question a State's decision to decertify a provider and that the Supreme Court integrate its decisions in *Gonzaga* and *Blessing*.[22]

II. BACKGROUND

A. Introduction to Medicaid

Medicaid was authorized by Title XIX of the Social Security Act and signed into law in 1965.[23] The law offers federal money for each state "to furnish medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."[24] The money made available under the statute is "used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance."[25]

The federal matching dollars that states receive to fund the program are conditioned upon compliance with mandatory program eligibility standards and other provisions outlined in the federal statute.[26] For example, federal regulations dictate that each service provided by a state's Medicaid program "be sufficient in amount, duration, and scope to reasonably achieve its purpose."[27] In total, there are sixty-three distinct statutory requirements that state Medicaid plans

17. Blessing v. Freestone, 520 U.S. 329, 329 (1997).

18. Gonzaga Univ. v. Doe, 536 U.S. 273, 278 (2002); *see* discussion *infra* Part IV.

19. *See* discussion *infra* Part II.

20. *See* discussion *infra* Part II.

21. *See* discussion *infra* Part III.

22. *See* discussion *infra* Part IV.

23. National Health Law Program, *1965—The Medicare and Medicaid Act*, NAT'L HEALTH L. PROGRAM, https://healthlaw.org/announcement/medicare-and-medicaid-act-1965-2/ (last visited July 4, 2023) [https://perma.cc/55FZ-2H6M].

24. 42 U.S.C. § 1396–1.

25. *Id.*

26. Michele Johnson & Kristin Ware, *Medicaid Expansion by Any Other Name: Exploring the Feasibility of Expanded Access to Care in the Wake of* NFIB v. Sebelius, 1 BELMONT L. REV. 119, 120 (2014).

27. 42 C.F.R. § 440.230(b) (2011).

must fulfill.[28] States are not required to participate in Medicaid,[29] but for those that do, the amount of federal money that the state receives to administer the program is based on the state's own contribution.[30]

Since its adoption, all U.S. states and territories have utilized Medicaid programs to provide health coverage for low-income people.[31] Due to its immense popularity with the states (who may otherwise have been unable to bear the costs of providing public health insurance) and recipients (who may otherwise have been unable to afford health insurance at all), Medicaid enrollment has steadily grown over time.[32] As of 2000, 34.1 million individuals were enrolled in Medicaid.[33] By September 2021, Medicaid provided healthcare insurance to 84.8 million individuals,[34] and this number is only expected to increase as the cost of private health insurance continues to skyrocket.[35]

B. U.S.C. § 1396a(a)(23): The "Free Choice of Provider" Provision

Two years after passing the Social Security Act, Congress enacted 42 U.S.C. § 1396a(a)(23) (the "free choice of provider" provision) to prevent states from "relying exclusively on publicly operated health systems to furnish care."[36] The text of the statute requires that each state's plan for medical assistance provides that "any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services . . . ."[37]

28. Andy Schneider & Victoria Wachino, *Medicaid Administration*, *in* THE MEDICAID RESOURCE BOOK 129, 134 (Kaiser Comm'n on Medicaid & Uninsured ed., 2002), https://www.kff.org/wp-content/uploads/2013/05/mrbadministration.pdf [https://perma.cc/J2WL-6FE6].

29. Laura D. Hermer, *Federal/State Tensions in Fulfilling Medicaid's Purpose*, 21 ANNALS HEALTH L. 615, 617 (2012).

30. Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications?*, KFF (May 20, 2015), https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/ [https://perma.cc/97XC-LFKE].

31. *Program History*, MEDICAID.GOV, https://www.medicaid.gov/about-us/program-history/index.html (last visited July 4, 2023) [https://perma.cc/L37C-6WRP].

32. *Total Medicaid Enrollment from 1966 to 2021*, STATISTA (Feb. 20, 2023), https://www.statista.com/statistics/245347/total-medicaid-enrollment-since-1966/ [https://perma.cc/W9AL-7X7R].

33. *Id.*

34. Bradley Corallo & Sophia Moreno, *Analysis of Recent National Trends in Medicaid and CHIP Enrollment*, KFF (Mar. 3, 2022), https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/ [https://perma.cc/GV29-NNMH].

35. *See* Sarah O'Brien, *Average Family Premiums for Employer-based Health Insurance Have Jumped 47% in the Last Decade, Outpacing Wage Growth and Inflation*, PERS. FIN.: CNBC, https://www.cnbc.com/2021/11/11/premiums-for-employer-health-insurance-have-jumped-47percent-in-10-years.html (Nov. 11, 2021, 3:27 PM) [https://perma.cc/7NQV-VDXA] (stating that "[a]nnual premiums for family coverage this year reached an average $22,221, with workers contributing an average $5,969 . . . .").

36. Sara Rosenbaum, *Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure, and Administration of Federal Healthcare Financing Programs Supported Through Direct Public Funding*, *in* UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 664, 676 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003).

37. 42 U.S.C. § 1396a(a)(23).

The overarching purpose of the free choice of provider provision is to allow Medicaid recipients to choose from among the available providers of covered healthcare services that are normally offered to the general population.[38] In other words, the provision aims to "give Medicaid recipients the right to receive care from the Medicaid provider of *their* choice rather than the *government's* choice."[39] Medicaid recipients' rights under the free choice of provider provision are not, though, without limitation.[40] Recipients cannot receive care from an unqualified provider, and the right to obtain services is necessarily conditioned on providers' willingness and ability to provide those services.[41] Nonetheless, the free choice of provider provision is fundamental to Medicaid's aim to provide healthcare to the indigent equal in quantity and quality to the care available to the general population.[42]

"Qualified," the key term in the free choice of provider provision, is left mysteriously undefined by the statute itself.[43] The Supreme Court has interpreted the provision, as a whole, to give "recipients the right to choose among a range of qualified providers, without government interference" but did not explicitly define what it means to be "qualified."[44] One court has proffered that for a provider to be qualified, the provider must "be capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner."[45] Another court suggested that qualified providers are those "that are competent to provide the needed services."[46]

There are at least two existing means to challenge a state's determination that a medical provider is "unqualified" to deliver services to Medicaid recipients. First, federal regulations mandate that each State set forth appeal procedures for decertified Medicaid providers.[47] The regulation states that "[t]he State Medicaid agency must give providers terminated or denied under § 455.416 any appeal rights available under procedures established by State law or regulations."[48] Second, because Medicaid is jointly funded by the state and federal government, the federal government could, at least in theory, revoke Medicaid funding to a state that violated the free choice of provider provision by decertifying a qualified provider.[49] Whether Medicaid beneficiaries can themselves challenge a

38. Beth Holliday, Annotation, *Construction and Application of Medicaid Act's "Free Choice of Provider" Provision, 42 U.S.C.S. § 1396a(a)(23)*, 85 A.L.R. Fed. 2d 201 (2014).

39. *Id.* (emphasis added).

40. *Id.*

41. *Id.*

42. *See id.*

43. *See* 42 U.S.C. § 1396a(a)(23).

44. O'Bannon v. Town Ct. Nursing Ctr., 447 U.S. 773, 785 (1980).

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

46. Planned Parenthood Ariz., Inc. v. Betlach, 922 F. Supp. 2d 858, 864 (D. Ariz.), *aff'd*, 727 F.3d 960 (9th Cir. 2013)

47. *See* 42 C.F.R. § 455.422.

48. *Id.*

49. *See* Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 28 (1981) (stating that "[i]n legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed

state's decertification decision in federal court will depend on judicial interpretation of 42 U.S.C. § 1983 ("Section 1983").[50]

C. Introduction to 42 U.S.C. § 1983

Section 1983, which grants private litigants a cause of action to sue the state for violations of their federal rights, "broadly encompasses violations of federal statutory as well as constitutional law."[51] The statute provides in relevant part:

> Every person who, under color of any [law], of any State . . . subjects, or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws [of the United States] . . . shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .[52]

Section 1983 was passed by Congress as part of the Civil Rights Act of 1871 with two primary goals in mind.[53] First, Congress sought to constrain lawlessness in the South.[54] Following the Civil War, there was a period of widespread racial and extralegal violence, particularly in South Carolina.[55] The existing civil rights remedies were lacking, and the problem was further exacerbated by the failure of many states to evenly enforce those remedies.[56] Because it sought to alleviate this issue, the Civil Rights Act is colloquially referred to as the Ku Klux Klan Act.[57] Second, Section 1983 was meant to give a remedy to individuals for "the deprivation of their federal rights by state government actors."[58] Despite the statute's legislative intent, Section 1983 was infrequently invoked in civil rights cases until the 1960s.[59]

A turning point for Section 1983 litigation came in the 1961 case, *Monroe v. Pape*.[60] The plaintiff in *Monroe* alleged that police officers broke into his home without a warrant, took him to a police station, interrogated him for ten hours, and released him without being charged.[61] Referencing the legislative intent of Section 1983,[62] the Court ruled that the lower court's dismissal of the case was in error because the officers—even though they abused their power—acted under

conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State").

50. *See, e.g.*, Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman, 981 F.3d 347, 354 (5th Cir. 2020).

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

52. 42 U.S.C. § 1983.

53. Devi M. Rao, *"Making Medical Assistance Available": Enforcing the Medicaid Act's Availability Provision Through § 1983 Litigation*, 109 COLUM. L. REV. 1440, 1444 (2009).

54. *Id.*

55. Nicholas Mosvick, *Looking Back at the Ku Klux Klan Act*, NATIONAL CONST. CTR. (Apr. 20, 2021), https://constitutioncenter.org/interactive-constitution/blog/looking-back-at-the-ku-klux-klan-act [https://perma.cc/Q6RC-2QXX].

56. *See* Rao, *supra* note 53, at 1444.

57. *See* Mosvick, *supra* note 55.

58. *See* Rao, *supra* note 53, at 1444.

59. *Id.* at 1444–45.

60. *See* Monroe v. Pape, 365 U.S. 167, 168 (1961).

61. *Id.* at 168–69.

62. *Id.* at 172–81.

the color of the law and because the Civil Rights Act—which includes Section 1983—encompasses deprivation of rights by both the state and federal government.[63] While *Monroe* was groundbreaking in that the plaintiff relied on Section 1983 to enjoin state, rather than federal, actions,[64] he alleged a violation of rights secured by a federal criminal code as opposed to a right produced by legislation passed pursuant to the Spending Clause.[65]

D. Enforcement of Spending Clause Legislation with Section 1983

Private enforcement of Spending Clause legislation under Section 1983 began in the welfare context during the late 1960s and early 1970s, at a time of growing public approval of a government safety net.[66] In a series of cases, *King v. Smith*,[67] *Rosado v. Wyman*,[68] *Goldberg v. Kelly*,[69] and *Townsend v. Swank*,[70] the Supreme Court permitted plaintiffs to rely on Section 1983 to enjoin state violations of the Aid to Families with Dependent Children ("ADFC"), which is a public benefits statute passed pursuant to the Spending Clause.[71] Perhaps the limiting principle in these cases was that the plaintiffs in each one also raised other constitutional claims, independent of any violations of their "rights" under AFDC.[72]

Yet in *Maine v. Thiboutot*, several years later, the Court allowed a Section 1983 claim to proceed, even while the plaintiff's *only* claim was that the State of Maine had violated their rights under ADFC in failing to account for all of the plaintiff's expenses in calculating their welfare benefits.[73] The Court thus made explicit in this case what was less clear in the earlier ones: individual beneficiaries of public benefits programs (and other legislation passed under the Spending Clause) can rely on Section 1983 to enjoin state violation of the rights created pursuant to those programs.[74]

In *Pennhurst State School and Hospital v. Halderman*, the Supreme Court again addressed whether a statute passed under the Spending Clause[75] could generate rights enforceable under Section 1983.[76] The case involved the conditions

63. *Id.* at 183, 192.

64. *See id.* at 168–69.

65. *Id.* at 183–84.

66. *See* Sara Rosenbaum & Timothy Jost, *Is The Supreme Court Poised To Wipe Out Legal Rights For Medicaid Beneficiaries?*, HEALTHAFFAIRS (May 20, 2022), https://www.healthaffairs.org/do/10.1377/forefront.20220518.925566/ [https://perma.cc/95Z3-QX5E].

67. King v. Smith, 392 U.S. 309, 311–13 (1968).

68. Rosado v. Wyman, 397 U.S. 397, 399 (1970).

69. Goldberg v. Kelly, 397 U.S. 254, 255–57 (1970).

70. Townsend v. Swank, 404 U.S. 282, 283–85 (1971).

71. *See* Rosenbaum & Jost, *supra* note 66.

72. *See id*.

73. Maine v. Thiboutot, 448 U.S. 1, 3–4 (1980).

74. *See id.* at 6–8 (1980).

75. U.S. 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 Defen[s]e and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States . . . .").

76. *See* Pennhurst State Sch. & Hosp. v. Halderman, 465 U.S. 89, 99 (1984).

of care at a Pennsylvania institution for the cognitively disabled.[77] The plaintiffs, who included residents of the institution, alleged that the conditions at the facility violated their constitutional and statutory rights.[78] The Supreme Court concluded by instructing the Court of Appeals to consider "whether relief may be granted to respondents under the Developmentally Disabled Assistance and Bill of Rights Act,"[79] an act passed pursuant to the Spending Clause.[80] The door for enforcement of Spending Clause legislation had been cast wide open.

Nine years later, in *Wilder v. Virginia Hospital Association*, the Court dealt with the issue again, this time in the Medicaid context, and held that the Boren Amendment, a Medicaid provision that required states to reimburse providers for the "reasonable cost" of services, is enforceable by healthcare providers under Section 1983.[81] In taking its first steps to establish a definitive test for determining exactly which legislation is enforceable under Section 1983 and by whom, the Court considered (1) "whether 'the provision in question was intend[ed] to benefit the putative plaintiff'" and (2) whether the plaintiff's interest was "'too vague and amorphous' such that it is 'beyond the competence of the judiciary to enforce.'"[82] Relying on these elements, the Court concluded that the Boren Amendment generated a right enforceable by healthcare providers under Section 1983 and, in doing so, confirmed once again that private litigants can enforce rights generated by Spending Clause legislation under Section 1983.[83]

Following *Wilder*, the Court clarified its test for determining whether a federal statute can be privately enforced under Section 1983 by delineating a three-prong test in *Blessing v. Freestone*.[84] *Blessing*[85] did not overrule *Wilder* but fleshed out its test by drawing from *Wright v. City of Roanoke* and other existing case law.[86]

The first requirement under *Blessing* is that Congress intended the statutory provision in question to benefit the plaintiff.[87] *Blessing* borrowed this element from *Wright v. City of Roanoke*, where the Court determined that a statutory requirement that "tenants could be charged as rent no more and no less than 30 percent of their income" was undeniably intended to benefit project housing tenants.[88] In contrast, the Court in *Blessing* determined that a federal statute that merely served as a measuring stick for evaluating the "systemwide performance" of a state program did not benefit individual recipients of the program and, therefore, did not create a federal right.[89] As used in both cases, *Blessing*'s first prong

77. *Id.* at 92.
78. *Id.*
79. *Id.* at 125.
80. *See* 42 U.S.C. §§ 6011, 6063.
81. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 524 (1990).
82. *Id.* at 509.
83. *Id.* at 524.
84. Blessing v. Freestone, 520 U.S. 329, 340–41 (1997).
85. *Id.*
86. Wright v. City of Roanoke Redevelopment & Hous. Auth., 479 U.S. 418, 430 (1987).
87. *Blessing*, 520 U.S. at 340–41.
88. *Wright*, 479 U.S. at 430.
89. *Blessing*, 520 U.S. 329 at 343.

serves to ensure that the person asserting a claim under a federal statute is the type of person that statute was designed to protect.[90]

Second, a "'plaintiff must demonstrate that the right assertedly protected by the federal statute is not so 'vague and amorphous' that its enforcement would strain judicial competence.'"[91] *Blessing*'s second prong ensures that a statute be "sufficiently specific and definite" to create an enforceable right under Section 1983.[92]

Third, the federal statute upon which the plaintiff is requesting relief must unambiguously impose a binding obligation on the States.[93] This requirement ensures that "the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms."[94]

Even after satisfying *Blessing*'s three-prong test, the federal statute is only *presumptively* enforceable under Section 1983; the defendant can still preclude enforcement by showing that Congress intended to "specifically foreclose[] a remedy under § 1983."[95] This caveat ensures that the judicial interpretation of federal statutes does not run directly against clear legislative intent.[96]

The validity of *Blessing*'s three-prong test is, however, now unclear.[97] In *Gonzaga v. Doe*, the Supreme Court took its first steps toward limiting private enforcement of public benefits legislation while addressing whether the Family Educational Rights and Privacy Act of 1974 ("FERPA") produces rights enforceable under Section 1983.[98] Answering in the negative, the Court stated that "if Congress wishes to create new rights enforceable under Section 1983, it must do so in clear and unambiguous terms."[99] Furthermore, under the *Gonzaga* standard, statutes that have an "aggregate" focus are not concerned with the needs of any particular person and cannot create an enforceable right under Section 1983.[100] Because the *Gonzaga* court did not directly apply *Blessing*, some judges have interpreted its strong language to overturn *Blessing* by implication.[101]

The status of the *Wilder v. Virginia Hospital Association* test (and, by implication, the *Blessing* test) was further called into question by the plurality opinion in *Armstrong v. Exceptional Child Center, Inc*.[102] *Armstrong* concerned providers of residential habilitation services to Medicaid-eligible individuals, who brought a private cause of action against Idaho's Department of Health and

90. *Id.*; *Wright*, 479 U.S. at 430.

91. *Blessing*, 520 U.S. at 340–41.

92. *Wright*, 479 U.S. at 432.

93. *Blessing*, 520 U.S. at 341.

94. *Id.*

95. Smith v. Robinson, 468 U.S. 992, 1004, n. 9 (1984).

96. *Blessing*, 520 U.S. at 341.

97. *See* N.Y. State Citizens' Coal. for Child. v. Poole, 922 F.3d 69, 94 (2d Cir. 2019) (Livingston, J., dissenting), *cert. denied*, 140 S. Ct. 956 (2020) (noting "that the Supreme Court's more recent jurisprudence calls into question the vitality of the *Blessing* test").

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

99. *Id.* at 290.

100. *Id.*

101. *See, e.g.*, Planned Parenthood of Greater Tex. Fam. Planned & Preventative Health Servs., Inc. v. Kauffman, 981 F.3d 347, 371 (5th Cir. 2020) (Elrod, J., concurring).

102. *See* Armstrong v. Exceptional Child Ctr., Inc., 575 U.S. 320, 330–31 (2015).

Welfare for failure to amend existing Medicaid reimbursement rates.[103] The plaintiffs relied on an implied right of action within the Medicaid Act rather than on Section 1983.[104] The Court rejected the plaintiffs' claim and noted that the providers did not rely on *Wilder* to proceed under Section 1983 because the Court in *Gonzaga* "plainly repudiate[d] the ready implication of a Sec. 1983 action that *Wilder* exemplified."[105]

Whether a Medicaid recipient can challenge a state's decision to decertify a provider will depend on what form of *Wilder*,[106] *Blessing*,[107] and *Gonzaga*[108] represents the current Section 1983 standard. For example, the Eighth Circuit, after stating that "*Armstrong* thus made explicit what was implicit in *Gonzaga* . . . that the Court '*sub silentio* overrule[d] . . . *Wilder*,'" held that Medicaid recipients could not challenge a state's decision to decertify a Medicaid provider.[109] Conversely, the Tenth Circuit applied the *Blessing* test while noting the additional requirements imposed by *Gonzaga* and held that Medicaid recipients could challenge a state's decision to decertify a Medicaid provider.[110] Although neither Circuit understood the *Blessing* test to be wholly intact following *Gonzaga*, the degree to which *Blessing* remains binding precedent will be nearly dispositive to whether the free choice of provider provision can be privately enforced.

E. Section 1983 and the Free Choice of Provider Provision: Recent Developments

Up until now, the Supreme Court has repeatedly denied appellants' requests for it to consider whether the free choice of provider provision can be privately enforced.[111] Yet a spirited dissent to the Court's recent denial of certiorari to this issue, and the Court's decision to hear a related case, suggest that the tide is turning.

In 2018, Justice Thomas, joined by Justice Alito and Justice Gorsuch, dissented to the majority's denial of certiorari in *Gee v. Planned Parenthood of Gulf Coast, Inc.* and observed that the question of whether Medicaid's free choice or provider provision can be enforced under Section 1983 is "important and recurring."[112] Justice Thomas pointed out that the current circuit split leaves Medicaid recipients in bordering states with different rights to challenge their State's provider decisions, even when the decisions concern the same provider.[113] He

103. *Id.* at 323–24.
104. *Id.* at 324.
105. *Id.* at 330.
106. Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990).
107. Blessing v. Freestone, 520 U.S. 329 (1997).
108. Gonzaga Univ. v. Doe, 536 U.S. 273, 290 (2002).
109. Does v. Gillespie, 867 F.3d 1034, 1040 (8th Cir. 2017).
110. Planned Parenthood of Kan. v. Andersen, 882 F.3d 1205, 1226, 1238 (10th Cir. 2018).
111. Baker v. Planned Parenthood S. Atl., 141 S. Ct. 550, 550 (2020); Gee v. Planned Parenthood of Gulf Coast, Inc., 139 S. Ct. 408, 408 (2018).
112. *Id.* at 409 (Thomas, J., dissenting).
113. *Id.*

lamented that "fundamental questions about the appropriate framework for determining when a cause of action is available under § 1983" are being ignored due to what he believed was the majority's reluctance to adjudicate an issue bordering abortion.[114] Obviously, any such reluctance due to abortion is no longer present in a majority of the Court.[115]

On May 22, 2022, the Supreme Court granted certiorari to *Health & Hospital Corporation of Marion County v. Talevski*[116] to consider both "[w]hether . . . the Court should reexamine its holding that Spending Clause legislation gives rise to privately enforceable rights under Section 1983" and, if so, "whether [the Federal Nursing Home Amendments Act's] transfer and medication rules do so."[117] While *Talevski* does not deal with Section 1983 enforcement of Medicaid's free choice of provider provision directly, if the Court declares a broad enough rule regarding Section 1983 enforcement of Spending Clause legislation, it would encompass the narrower free choice of provider issue as well.[118]

Only a step behind *Talevski*, *Planned Parenthood South Atlantic v. Kerr* (on appeal from the Fourth Circuit) is currently awaiting the Supreme Court's decision on certiorari.[119] And unlike *Talevski*, *Kerr* deals directly with whether the free choice of provider provision is enforceable under Section 1983, following the Court of Appeals for the Fourth Circuit's steadfast reiteration of its position via the 5-2 majority on this issue.[120] Given, however, that the Supreme Court is already accepting briefing on *Talevski* and is still sitting on *Kerr* months after the petitioner's request for certiorari, it appears that the two appeals will not be consolidated and that the free choice of provider enforcement question will be answered through *Talevski*, if at all. If nothing else, the Supreme Court's upcoming decision in *Talevski* will cast light on whether Spending Clause legislation remains enforceable under Section 1983, as the Court held over thirty years ago in *Wilder*.[121]

III. ANALYSIS

This Part focuses on the legal underpinnings of private enforcement of the free choice of provider provision.[122] This Part begins by reconciling the Supreme Court's decisions in *Gonzaga*[123] and *Blessing*[124] and offers a test supported by both of these cases that can be used to determine the enforceability under Section

114. *Id.*

115. *See generally* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

116. 142 S. Ct. 2673 (2022).

117. Petition for a Writ of Certiorari, Health and Hosp. Corporation of Marion County v. Talevski, 2021 WL 5702312.

118. *See infra* notes 243–44 and accompanying text.

119. *See generally* Planned Parenthood S. Atl. v. Kerr, 27 F.4th 945 (4th Cir. 2022).

120. *Id.* at 959.

121. Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 524 (1990).

122. Conversely, see discussion *infra* Part IV for a focus on public policy and broader legal ramifications.

123. Gonzaga Univ. v. Doe, 536 U.S. 273, 286 (2002).

124. Blessing v. Freestone, 520 U.S. 329, 344 (1997).

1983 of any federal statute.[125] Second, this Part applies this test to Medicaid recipient enforcement of the free choice of provider provision and explains why the free choice of provider provision should be deemed enforceable by individual Medicaid recipients.[126] Third, this Part addresses another issue frequently disputed in the Court of Appeals: whether the Supreme Court in *O'Bannon v. Town Court Nursing Center*[127] foreclosed a Section 1983 remedy for violations of the free choice of provider provision.[128] Finally, this Part concludes by wrestling with the scope of the right allotted to recipients under the free choice of provider provision and discussing why this right includes the ability to challenge a particular provider's decertification.[129]

A. Gonzaga *Did Not Overturn* Blessing *but Merely Modified the* Blessing *Test's First Prong*

That *Gonzaga* did not overturn *Blessing* is evident from the high degree of repudiation required for *sub silentio* reversal and the absence of such repudiation in the *Gonzaga* majority opinion. Courts do "not lightly conclude that the Supreme Court has overruled its prior cases—that job is for the Supreme Court alone."[130] This fundamental principle of the common law system, unfortunately, appears to have been forgotten in two circuits, specifically those that claim that the Supreme Court *sub silentio* overruled *Wilder*[131] and "similar cases" (referring to *Blessing*) in *Gonzaga*.[132] Before addressing the merits of this contention, it is necessary to consider the legal standard for *sub silentio* reversal.

1. Sub Silentio Reversal Is Disfavored and Rarely Invoked

Black's Law Dictionary defines "*sub silentio*" as "under silence; without notice being taken; without being expressly mentioned."[133] A court overrules precedent *sub silentio* by "'repudiating it without expressly overruling it.'"[134] In other words, the court overturns the case by "issuing decisions that discredit the rationale on which it stands."[135] Courts generally disfavor the concept of *sub silentio* repudiation because it clouds the law and undermines the legitimacy of both the new decision and the old precedent.[136] Because of its general disfavor for the doctrine, the Supreme Court has stated that it "does not normally overturn,

125. *See* discussion *infra* Section III.A.

126. *See* discussion *infra* Section III.B.

127. *See generally* O'Bannon v. Town Ct. Nursing Ctr., 447 U.S. 773 (1980).

128. *See* discussion *infra* Section III.C.

129. *See* discussion *infra* Section III.D.

130. Planned Parenthood S. Atl. v. Baker, 941 F.3d 687, 708 (4th Cir. 2019) (Richardson, J., concurring), *cert. denied*, 141 S. Ct. 550 (2020).

131. *See generally* Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990).

132. Does v. Gillespie, 867 F.3d 1034, 1039–40 (8th Cir. 2017).

133. *Sub Silentio*, BLACK'S LAW DICTIONARY (10th ed. 2014).

134. Amanda B. Hurst, *Gonzaga's Ghosts*, 86 TENN. L. REV. 289, 333 (2019) (internal citation omitted).

135. *Id.* at 333–34.

136. Lisa J. Allegrucci & Paul E. Kunz, *The Future of Roe v. Wade in the Supreme Court: Devolution of the Right of Abortion and Resurgence of State Control*, 7 ST. JOHNS J. LEGAL COMMENT, 295, 326–27 (1991).

or . . . dramatically limit, earlier authority *sub silentio*."[137] *Sub silentio* reversal is instead reserved for extreme circumstances and, even then, seldom invoked.[138]

In *Shalala v. Illinois Council on Long Term Care, Inc.*, the Supreme Court applied its rigorous standard for *sub silentio* reversal to address whether *Bowen v. Michigan Academy of Family Physicians* had implicitly overruled the Supreme Court's earlier cases, *Weinberger v. Salfi* and *Heckler v. Ringer*.[139] Each case concerned the interpretation of 42 U.S.C. § 405, a jurisdiction-limiting statute for Medicare, which provides that "[n]o findings of fact or decision . . . shall be reviewed by any person, tribunal, or governmental agency except as herein provided."[140] Such matters must only be reviewed at a Medicare-specific administrative hearing provided for in the same statute.[141] In *Salfi* and *Ringer*, the Court had interpreted § 405(h) to bar federal question review of all challenges arising under the Medicare Act.[142] Yet, in *Michigan Academy*, the Court held that "Section 405(h) does not apply on its own terms to Part B of the Medicare program."[143] In reconciling these apparently divergent decisions, the *Shalala* Court ruled that *Michigan Academy* did not limit the scope of the Court's earlier holdings; it merely created an exception pertaining only to Part B of Medicare, a section that did not reference Medicare's administrative review process.[144] The Court of Appeals was incorrect in believing that *sub silentio* reversal had occurred,[145] for the Supreme Court chose instead to integrate its previous decisions.[146]

2. The Supreme Court's Stringent Standard for Admitting Sub Silentio Reversal Was Not Fulfilled by Gonzaga*'s Treatment of* Blessing

With an understanding of the Supreme Court's disfavor toward *sub silentio* reversal, the question of whether *Wilder*[147] (and, by implication, *Blessing*) were *sub silentio* overruled by *Gonzaga*[148] can be addressed. The *Gonzaga* majority references *Wilder* throughout the opinion,[149] which is at odds with the definition of *sub silentio*, which includes "under silence."[150] Quite the opposite, the

137. Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1, 18 (2000).

138. *See* Olson v. Paine, Webber, Jackson & Curtis, Inc., 806 F.2d 731, 734 (7th Cir. 1986) (stating that sub silentio reversal only occurs in "rare cases" where circumstances "have created a near certainty that only the occasion is needed" for the Supreme Court itself to effectuate the reversal) (quoting Salerno v. Am. League of Pro. Baseball Clubs, 429 F.2d 1003, 1005 (2d Cir. 1970)).

139. *See generally* Bowen v. Mich. Acad. of Fam. Physicians, 476 U.S. 667 (1986); Weinberger v. Salfi, 422 U.S. 749 (1975); Heckler v. Ringer, 466 U.S. 602 (1984); *Shalala*, 529 U.S. at 1.

140. 42 U.S.C. § 405.

141. *Id.*

142. *Bowen*, 476 U.S. at 679.

143. *Id.* at 680.

144. *Shalala*, 529 U.S. at 3.

145. Ill. Council on Long Term Care Inc. v. Shalala, 143 F.3d 1072, 1075–76 (7th Cir. 1998), *rev'd*, 529 U.S. 1 (2000).

146. *Shalala*, 529 U.S. at 3.

147. *See generally* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498 (1990).

148. Gonzaga Univ. v. Doe, 536 U.S. 273, 290 (2002).

149. *Id.* at 274.

150. *Sub Silentio*, BLACK'S LAW DICTIONARY (10th ed. 2014).

majority in *Gonzaga* appears to mention the *Wilder* with approval.[151] The Third Circuit was correct in observing that "*Gonzaga* . . . did not overrule *Wilder*; rather, it explained that 'Congress left no doubt of its intent for private enforcement [of federal statutes].'"[152] The type of harsh repudiation required for *sub silentio* reversal was absent from the *Gonzaga* opinion, and that alone is enough for *Wilder* and *Blessing* to remain binding precedent.

3. The First Prong of the Blessing *Test Now Requires the Unambiguous Conferral of a Right to the Plaintiff*

Rather than overturning *Wilder*, *Gonzaga* merely clarified the *Blessing* test's first prong.[153] Following *Gonzaga*, it is no longer enough for the Spending Clause legislation to benefit the plaintiff; the statute must "unambiguously confer" a right to the class of individuals of which the plaintiff is a part.[154] This is the view taken by a majority of the circuit courts[155] and the view most in line with the Supreme Court's disapproval of *sub silentio* reversal.[156]

Under this interpretation, a statute passed under the Spending Clause can be enforced by a given plaintiff only if (1) the statute was intended to benefit the plaintiff and unambiguously conferred a right that will support a cause of action, (2) the right is not so vague and amorphous that its enforcement would strain judicial competence, and (3) the provision "impose[s] a binding obligation on the States."[157] With those three elements met, the court can invoke the caveat, asking whether Congress specifically intended to foreclose a remedy under Section 1983.[158] As the most sound synthesis of *Blessing* and *Gonzaga*, this standard will be applied to the free choice of provider provision in the following Section.

B. 42 U.S.C. § 1983, as Interpreted in Blessing *and* Gonzaga, *Provides Medicaid Beneficiaries with a Right to Enforce the Free Choice of Provider Provision*

The free choice of provider provision was intended to benefit Medicaid recipients, the right allotted by the provision is not so vague and amorphous that its enforcement would strain judicial competence, and the provision is phrased in mandatory rather than precautionary terms.[159] Because Congress did not

151. *Gonzaga*, 536 U.S. at 288 n.6 (noting that the plaintiff's claim was "a far cry from the sort of individualized, concrete monetary entitlement found enforceable in . . . *Wilder*").

152. Sabree ex rel. Sabree v. Richman, 367 F.3d 180, 192 (3d Cir. 2004).

153. Does v. Gillespie, 867 F.3d 1034, 1049 (8th Cir. 2017) (Melloy, J., dissenting).

154. *Gonzaga*, 536 U.S. at 290.

155. *See, e.g.*, Johnson v. Hous. Auth. of Jefferson Par., 442 F.3d 356, 360 (5th Cir. 2006); *Sabree*, 367 F.3d at 192.

156. Allegrucci & Kunz, *supra* note 136, at 326–27.

157. *Does*, 867 F.3d at 1049 (Melloy, J., dissenting).

158. Smith v. Robinson, 468 U.S. 992, 1004, n. 9 (1984).

159. *See* discussion *infra* Subsection III.B.3.

specifically foreclose a remedy,[160] the free choice of provider provision should be deemed enforceable under Section 1983.

1. Unambiguous Conferral of a Right to the Plaintiff

The first prong of *Blessing* required that Congress intend that the statute in question benefit the plaintiff,[161] a standard which has subsequently been updated by the Supreme Court to require nothing "short of an unambiguously conferred right . . . ."[162]

The free choice of provider provision satisfies this requirement by even a cursory glance at the statute's text. Section 1396a(a)(23) demands that all state Medicaid plans provide that "*any individual* eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required."[163] In contrast to an "aggregate plan requirement,"[164] the "any individual" phrase of the free choice of provider provision indicates legislative intent to specifically benefit the individual recipients of Medicaid.[165] That intent is made unambiguous by the inclusion of "individually focused terminology" required by *Gonzaga*.[166]

Only the Fifth Circuit has seriously contested this element of the *Gonzaga*/*Blessing* test, and its objection is not persuasive.[167] Writing for the majority, Judge Owen stated that "the text of § 1396a(a)(23) does not unambiguously grant Medicaid patients the right to be involved in . . . a state agency's determination that a provider is not 'qualified.'"[168] According to Judge Owen, it is up to each provider to determine whether it is qualified and willing to render Medicaid services because only providers have access to the factual information required to make that determination.[169] But whether Medicaid recipients have the factual information to make qualification determinations is beside the point. Section 1983 challenges require only that the *courts* make factual determinations, and these are the type of decisions that courts are adept at making.[170]

Despite the Fifth Circuit's contention to the contrary, the first prong of the modified *Blessing*/*Gonzaga* test is therefore met.[171]

160. *See* discussion *infra* Subsection III.B.4.

161. Blessing v. Freestone, 520 U.S. 329, 340–41 (1997).

162. Gonzaga Univ. v. Doe, 536 U.S. 273, 283 (2002).

163. 42 U.S.C. § 1396a(a)(23) (emphasis added).

164. Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't Health, 699 F.3d 962, 974 (7th Cir. 2012).

165. Harris v. Olszewski, 442 F.3d 456, 461–62 (6th Cir. 2006).

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

167. Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman, 981 F.3d 347, 358–59 (5th Cir. 2020).

168. *Id.* at 358.

169. *Id.*

170. Planned Parenthood of Ind., Inc., v. Comm'r of Ind. State Dep't Health, 699 F.3d 962, 974 (7th Cir. 2012).

171. Harris v. Olszewski, 442 F.3d 456, 461–62 (6th Cir. 2006).

2. Adjudication of the Right Is Within Judicial Competence

The second prong of the *Blessing*/*Gonzaga* test, that the right be "not so vague and amorphous that its enforcement would strain judicial competence"[172] is a prong that none of the circuit courts have contested regarding the free choice of provider provision.[173] Judicial interpretation of the free choice of provider provision would only require establishing whether (1) the provider is 'qualified to perform the service or services required;' and (2) the provider 'undertakes to provide . . . such services.'"[174] Qualification can be decided according to whether the provider is "capable of performing the needed medical services in a professionally competent, safe, legal, and ethical manner."[175] Whether the provider undertook to provide the requested services is a simple factual determination, the kind that courts make every day. Clearly, neither determination is outside of judicial competence.

3. The Statute Is Mandatory Rather Than Precautionary

Third, the free choice of provider provision is phrased in mandatory rather than precautionary terms.[176] The Medicaid statute, in general, reads that a state "must" provide a plan for medical assistance that meets the following requirements.[177] This is the exact sort of mandatory, rather than precautionary, language contemplated by *Blessing*.[178] The statute's mandatory nature is further evident from the existing legal consequences that follow from noncompliance.[179] As the Fourth Circuit stated, "[i]t is difficult to imagine a clearer or more affirmative directive."[180]

4. Lack of Congressional Intent to Foreclose a Remedy

Upon satisfying the three prongs of *Blessing* as amended by *Gonzaga*, "there is only a rebuttable presumption that the right is enforceable under § 1983."[181] The defendant can overcome this presumption by "demonstrating that Congress did not intend that remedy for a newly created right."[182] This can be accomplished in two ways: (1) by "pointing to evidence of such congressional intent" or (2) by an inference from the statute's creation of a "comprehensive enforcement scheme."[183]

172. Does v. Gillespie, 867 F.3d 1034, 1049 (8th Cir. 2017) (Melloy, J., dissenting).
173. *See, e.g.*, *Harris*, 442 F.3d at 461.
174. 42 U.S.C. § 1396a(a)(23).
175. *Planned Parenthood of Ind., Inc.*, 699 F.3d at 968.
176. *See* 42 U.S.C. § 1396a(a)(23).
177. 42 U.S.C. § 1396a(a).
178. Blessing v. Freestone, 520 U.S. 329, 341 (1997) (stating that "the provision giving rise to the asserted right must be couched in mandatory, rather than precatory, terms").
179. *See* discussion *supra* Section II.B.
180. Planned Parenthood S. Atl. v. Baker, 941 F.3d 687, 694 (4th Cir. 2019).
181. City of Rancho Palos Verdes v. Adams, 544 U.S. 113, 120 (2005) (internal quotations omitted).
182. Harris v. Olszewski, 442 F.3d 456, 461 (6th Cir. 2006) (internal quotations omitted).
183. *Id.*

Neither means of overcoming the presumption of enforceability is present. Regarding the congressional intent option, the Court need only consider that Medicaid was passed to give recipients "the right to receive care from the Medicaid provider of *their* choice rather than the *government's* choice."[184] Regarding the existence of an alternate enforcement scheme, even if there is an existing scheme for enforcing Medicaid provisions, that scheme is insufficient. Providers, who could, in theory, appeal their terminations from Medicaid, lack an incentive to do so because of the low rate of reimbursement that Medicaid offers in comparison to private insurance.[185] The federal government, who could, in theory, revoke a state's Medicaid funding, has bigger problems on its hands.[186] There is no evidence the federal government has ever exercised its remedy of revoking state Medicaid funding to enjoin a program violation.

Much like the judicial competence prong, none of the circuit courts have denied a plaintiff a cause of action under Section 1983 based on this caveat of the *Blessing* test,[187] and for the foregoing reasons, it is unlikely that the Supreme Court would become the first.

The free choice of provider provision thus satisfies all the requirements for Section 1983 enforceability by private litigants under the *Gonzaga*/*Blessing* test. The subsequent legal question concerns the scope (as opposed to the mere existence of that right) and asks whether an individual's rights under the free choice of provider provision include the right to challenge the decertification of a particular provider.[188]

C. The Supreme Court Case, O'Bannon v. Town Court Nursing Center*, Does Not Preclude Allowing for Section 1983 Challenges to Provider Decertification*

Circuits that oppose private Section 1983 enforcement of the free choice of provider provision assert that *O'Bannon v. Town Court Nursing Center*[189] necessarily limited the scope of the right conferred by the free choice of provider provision.[190] Under this interpretation, the question of whether recipients can challenge provider decertification was answered definitively in the negative over forty years ago.[191] Because these courts mistake what was at issue in *O'Bannon*, this argument can be discarded.

In *O'Bannon*, the Supreme Court addressed whether nursing home residents have a constitutional right to a hearing before a government agency may revoke their nursing home's authority to provide them with nursing care at

184. Holliday, *supra* note 38.

185. Beitsch, *supra* note 10.

186. Martin Crutsinger, *US Budget Deficit Hits $2.77 Trillion in 2021, 2nd Highest*, U.S. NEWS (Oct. 22, 2021, 3:41 PM), https://www.usnews.com/news/business/articles/2021-10-22/us-budget-deficit-hits-277-trillion-in-2021-2nd-highest [https://perma.cc/ZMP2-YC62].

187. *See* sources cited *supra* note 11.

188. *See* discussion *infra* Section III.D.

189. *See generally* O'Bannon v. Town Ct. Nursing Ctr., 447 U.S. 773 (1980).

190. Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kaufman, 981 F.3d 347, 350 (5th Cir. 2020).

191. *Id.* at 358–59.

government expense.[192] The Department of Health, Education, and Welfare had previously notified the nursing center that its funding would be revoked for failure to comply with Medicaid regulations.[193] After being transferred from the nursing center, the former residents sued, claiming they "were entitled to an evidentiary hearing on the merits of the decertification decision before the Medicaid payments were discontinued."[194]

In asserting their claim, the plaintiffs raised a novel due process argument based on property rights and relied on an implied right of action rather than Section 1983.[195] Specifically, they argued that the transfer had such severe physical and emotional side effects that it was equivalent to a deprivation of life or liberty and should have been preceded by a due process hearing.[196] The Court stated in response that because the Medicaid statute involves "the Government's attempt to confer an indirect benefit on Medicaid patients," the enforcement of that regulation "did not directly affect the patients' legal rights or deprive them of any constitutionally protected interest in life, liberty, or property."[197] In basing its conclusion on the principle that "the due process provision of the Fifth Amendment does not apply to the indirect adverse effects of governmental action," the Court responded to the plaintiff's procedural rather than substantive claims.[198]

To use a case involving procedural rights to foreclose a remedy for the violation of a substantive, constitutional violation would be an error. Opponents of this view have asserted that because *O'Bannon* demonstrates that the right created by the free choice of provider provision is "the right to choose among a range of qualified providers," it necessarily meant that the right stopped there.[199] But *O'Bannon* said nothing to that effect.[200] *O'Bannon* merely held that indirectly conferred Medicaid benefits do not give rise to procedural due process protections.[201]

By focusing on Fifth Amendment due process issues, the Supreme Court in *O'Bannon* did not answer the relevant question for the Section 1983 action, which is whether the scope of the right granted to Medicaid recipients under the free choice of provider provision includes the right to challenge provider decertification.[202] The Supreme Court should grant appeal to a future case concerning this issue (such as *Planned Parenthood South Atlantic v. Kerr*[203]) and answer the

192. *O'Bannon*, 447 U.S. at 775.
193. *Id.* at 776.
194. *Id.* at 777.
195. *Kauffman*, 981 F.3d at 400 (Dennis, J., dissenting).
196. *O'Bannon*, 447 U.S. at 784.
197. *Id.* at 787, 790.
198. *Id.* at 789.
199. Does v. Gillespie, 867 F.3d 1034, 1046 (8th Cir. 2017) (Shepherd, J., concurring).
200. *See generally O'Bannon*, 447 U.S. 773.
201. *Id.* at 789.
202. *See generally id.*
203. *See, e.g.*, Planned Parenthood S. Atl. v. Kerr, 27 F.4th 945 (4th Cir. 2022).

question by freshly applying the *Gonzaga*/*Blessing* Section 1983 test.[204] The following Section offers the Supreme Court guidance in its application.[205]

D. The Scope of Medicaid Beneficiaries' Rights Under Section 1983 Includes the Right to Question a State's Decision to Decertify a Provider

Having determined that the free choice of provider provision confers an enforceable right upon Medicaid beneficiaries, the final inquiry must be into the scope of that right.[206] Because *O'Bannon* did not answer this definitively,[207] this question is also open for judicial interpretation. There are currently two competing views on this issue.

For one set of courts, a Section 1983 action to enforce the free choice of provider provision would include the right to challenge a particular provider's decertification.[208] In *Planned Parenthood v. South Baker*, the Fourth Circuit adjudicated a Section 1983 challenge to South Carolina's termination of its provider agreements with a pair of Planned Parenthood centers as Medicaid providers.[209] After applying the *Blessing* test and concluding that the free choice of provider provision conferred an enforceable right upon individual Medicaid recipients, the court turned to the issue of scope.[210]

The court began with a plain meaning analysis and observed that "qualified" typically means "having an officially recognized qualification to practice as a member of a particular profession; fit, competent."[211] South Carolina argued against plain meaning, instead offering that the free choice of provider provision only enabled recipients to see any provider that meets the *state's* qualifications and that states are largely without limit in deciding what those qualifications are.[212] The court rejected this argument, holding that "states retain discretionary authority to disqualify providers as professionally incompetent [only] for nonmedical reasons such as fraud and for any number of unprofessional behaviors."[213]

For the Fourth Circuit, then, the free choice of provider provision protects Medicaid recipients' right to receive services from a provider that is professionally competent to perform those services. A state acts in violation of that right when imposing a stricter standard for qualification that is not based on professional misfeasance or another legitimate nonmedical reason.[214] Accordingly, the

204. *See, e.g.*, Gonzaga Univ. v. Doe, 536 U.S. 273, 290 (2002); Blessing v. Freestone, 520 U.S. 329, 340–41 (1997).

205. *See* discussion *infra* Section III.D.

206. *See* Planned Parenthood S. Atl. v. Baker, 941 F.3d 687, 701 (4th Cir. 2019), *cert. denied*, 141 S. Ct. 550 (2020) (differentiating the scope issue from the mere existence of a right of action).

207. *See* discussion *supra* Section III.C.

208. *See Baker*, 941 F.3d at 700.

209. *Id.* at 692.

210. *Id.* at 701.

211. *Id.* at 702 (citation omitted).

212. *Id.* at 703.

213. *Id.* at 705.

214. *See id.* at 704–05 (clarifying that "states retain discretionary authority to disqualify providers as professionally incompetent for nonmedical reasons such as fraud and for any number of unprofessional behaviors").

plaintiff was granted the right to challenge South Carolina's determination that the Medicaid provider was not "qualified."[215]

For the other set of courts, "even if § 23(A) [the free choice of provider provision] provides a substantive right that the plaintiffs can enforce through a § 1983 suit, the right provided is to a range of qualified providers—not the right to a *particular* provider the State has decertified."[216] In *Does v. Gillespie*, the Eighth Circuit adjudicated a Section 1983 challenge to Arkansas's termination of its provider agreements with several Planned Parenthood locations.[217] The majority held that the free choice of provider provision does not give Medicaid recipients an enforceable right and did not reach the question of scope,[218] but Judge Shepherd's concurrence dealt with the scope issue.[219]

Judge Shepherd stated that "even if [the free choice of provider provision] provides a substantive right that the plaintiffs can enforce through a § 1983 suit, the right provided is to a range of qualified providers—not the right to a particular provider the State has decertified."[220] But he based this conclusion entirely on the idea that *O'Bannon* had already delineated the bounds of such a right. [221] As discussed in Section III.C., this argument is without merit, and the fact that opponents of the right to challenge provider decertification lack another rationale for their view is itself telling.[222]

In addition to the justifications given in *South Baker*, "[i]f the states are free to set any qualifications they want—no matter how unrelated to the provider's fitness to treat Medicaid patients—then the free-choice-of-provider requirement could be easily undermined by simply labeling any exclusionary rule as a 'qualification.'"[223] A limited judicial interpretation of the right to qualified care could thus lead to the exclusion of providers fully capable of providing the requested services.[224] In such a case, states would likely be acting according to political concerns rather than with regard for the recipients who Medicaid is designed to benefit.[225]

In short, broader interpretation of the right conferred by the free choice of provider provision is necessary to prevent state restrictions, such as the one in *Does v. Gillespie*, from swallowing the right intended by Congress in adding the free choice of provider provision: to "give Medicaid recipients the right to receive care from the Medicaid provider of *their* choice rather than the

215. *Id.* at 707.

216. Does v. Gillespie, 867 F.3d 1034, 1046 (8th Cir. 2017) (Shepherd, J., concurring) (emphasis added).

217. *Id.* at 1037.

218. *Id.* at 1046 (Shepherd, J., concurring).

219. *Id.* (Shepherd, J., concurring).

220. *Id.* (Shepherd, J., concurring).

221. *Id.*

222. *See* discussion *supra* Section III.C.

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

224. *Id.*

225. *See, e.g.*, Planned Parenthood of Kan. v. Andersen, 882 F.3d 1205, 1212–14 (10th Cir. 2018) (discussing how Arkansas terminated Medicaid funding for Planned Parenthood after a political controversy involving leaked videos).

government's choice."[226] A right to sue to reinstate qualification for a decertified provider would safeguard that purpose.

IV. RECOMMENDATION

This Note recommends that the Supreme Court grant the petitioner's writ of certiorari in *Planned Parenthood South Atlantic v. Kerr*[227] and hold that there is a right for Medicaid recipients to bring Section 1983 actions in federal court to challenge the decertification of a provider. For the reasons outlined in Part III,[228] this holding would be consistent with the principles of statutory interpretation and relevant case law that govern Section 1983 disputes. As this Part details, this holding also strengthens the right to accessible healthcare, guides the enforcement of other Medicaid provisions, and fulfills Medicaid's purpose.[229] While other papers have described the importance of this issue for abortion rights,[230] this Part will describe the broader implications of allowing for enforcement of the free choice of provider provision. Finally, the proposed holding would be consistent with the legislative intent behind Medicaid.

The second, related, recommendation of this Note is that the Supreme Court must clarify the standard for determining when Section 1983 confers a right to enforce legislation passed under the Spending Clause. As Parts II and III detailed, the legal terrain in this area is muddled following *Gonzaga*, and the Supreme Court to date has only granted Section 1983 rights of enforcement to litigants on two occasions.[231] This Part will focus on the practical consequences of not allowing for enforcement of legislation passed under the Spending Clause, especially for the individuals whom the Spending Clause legislation is intended to benefit.

A. The Supreme Court Should Determine That Medicaid Recipients Can Challenge a State's Decision to Decertify a Provider by Bringing a Claim Under Section 1983

Clear judicial approval of Medicaid recipients' right to challenge provider decertification would uphold Medicaid's legislative intent and produce clarity across the Courts of Appeals. But, even more importantly, it would combat the growing access to care problem that persists throughout rural parts of the United States.

226. Holliday, *supra* note 38 (emphasis added).

227. 27 F.4th 945 (4th Cir. 2022).

228. *See* discussion *supra* Part III.

229. *See* discussion *infra* Part IV.

230. *See, e.g.*, Caroline Eversman, *Using Medicaid Funds for Planned Parenthood: Is the Medicaid Act's Choice of Free Provider Really A Free Choice?*, 80 OHIO ST. L.J. 133, 157 (2019).

231. *See, e.g.*, Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 524 (1990).

1. The Proposed Holding Would Be Consistent with the Legislative Intent of Medicaid to Confer a Right on Its Recipients Rather than an Administrative Obligation on the States

Legislative intent is the most common criterion that courts use to interpret statutes.[232] An oft-cited recitation of the principle comes from the English case, *River Wear Commissioners v. Adamson*.

> In all cases the object is to see what is the intention expressed by the words used. But, from the imperfection of language, it is impossible to know what that intention is without inquiring f[u]rther, and seeing what the circumstances were with reference to which the words were used, and what was the object, appearing from those circumstances, which the person using them had in view; for the meaning of the word varies according to the circumstances with respect to which they were used.[233]

Applying this principle to Medicaid and Section 1983, the Supreme Court should ask whether Congress intended to create enforceable rights for recipients through Medicaid legislation.[234] Of course, a right without a means to personally enforce it is not really a right, so the Supreme Court need only consider whether Congress intended to confer a right to recipients generally, rather than the narrower issue of enforcement.

In 1965, Congress structured Medicaid as a federal welfare program, which meant that it served as a temporary form of assistance for when people became "medically indigent."[235] While the exact intent of Congress from 1965 may be impossible to know, the program's classification as a welfare program, passed among other welfare programs in the midst of the "War on Poverty," provides useful evidence.[236] These are the "circumstances . . . with reference to which the words were used" that the principle explicated in *Adamson* refers statutory interpreters to.[237] Although this has been a matter of some debate, the majority opinion during the War On Poverty was that welfare was a right and one that the federal government should protect.[238] Of course, this became even clearer several years later in *Goldberg v. Kelly*.[239]

232. SHAMBIE SINGER & NORMAN SINGER, 2A SUTHERLAND STATUTORY CONSTRUCTION § 45:5 (7th ed. 2022) (citations omitted) (citing U.S. Federal Election Com'n v. NRA Pol. Victory Fund, 513 U.S. 88 (1994)). *See* U.S. v. Savage, 970 F.3d 217, 251 (3d Cir. 2020); Oil & Gas Transfer L.L.C. v. Karr, 928 F.3d 1120, 1125 (8th Cir. 2019); City of L.A. v. Barr, 941 F.3d 931, 940 (9th Cir. 2019); Izzo v. Wiley, 620 F.3d 1257, 1260 (10th Cir. 2010).

233. River Wear Comm'rs v. Adamson, 1877 WL 16902 (HL 1877).

234. *Id.*

235. Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 418 (2008).

236. Dylan Matthews, *Everything You Need to Know About the War on Poverty*, WASH. POST (Jan. 8, 2014), https://www.washingtonpost.com/news/wonk/wp/2014/01/08/everything-you-need-to-know-about-the-war-on-poverty/ [https://perma.cc/JMH2-358U].

237. *See Adamson*, 1877 WL 16902 (HL 1877).

238. *See* Shapiro v. Thompson, 394 U.S. 618, 627 n.6 (1969) (noting that "[t]his constitutional challenge cannot be answered by the argument that public assistance benefits are a 'privilege' and not a 'right.'") (citing Sherbert v. Verner, 374 U.S. 398, 404 (1963)).

239. *See* Goldberg v. Kelly, 397 U.S. 254, 254 (1970).

2. A Supreme Court Holding in Favor of Private Enforcement of the Free Choice of Provider Provision Would Produce Clarity Among the United States Court of Appeals Circuits and District Courts

While this Note has described the judicial debate regarding the free choice of provider provision, there have also been considerable disputes surrounding private enforcement of other Medicaid provisions. For example, in *Watson v. Weeks*, the Ninth Circuit held that Medicaid's "availability provision" creates an individual right that is enforceable through § 1983 litigation.[240] Another court soon after came to the exact opposite conclusion.[241] Additionally, the Eighth and Ninth Circuits recently "found insufficient evidence of congressional intent to infer a § 1983 right under the 'reasonable standards' provision" of Medicaid, but other circuits have been slow to follow.[242]

If the Supreme Court grants certiorari for a case involving a plaintiff's attempt to enforce the free choice of provider provision through Section 1983, it would generate guidance for Section 1983 litigation regarding not only this provision but also regarding all similar provisions. Moreover, it would spare courts the trouble of further deep dives into Medicaid's legislative intent.[243] This is independently true even if the Supreme Court chose to not clarify the *Gonzaga/Blessing* test, for it would give courts a clear reference point when struggling with similar issues.[244]

3. Section 1983 Enforcement of the Free Choice of Provider Provision Would Safeguard Access to Healthcare

Overall, Medicaid has been very effective at fulfilling its primary purpose: to provide healthcare insurance to those who could not otherwise afford it.[245] Since 2014, when many states added the Affordable Care Act's Medicaid expansion,[246] Medicaid has been part of lowering the number of uninsured Americans from forty-five million to twenty-nine million.[247] Medicaid has also been relatively successful in fulfilling its ultimate purpose—increasing access to healthcare itself. Studies indicate that since the expansion took effect, the proportion of low-income adults with a "personal physician, getting check-ups and

240. Watson v. Weeks, 436 F.3d 1152, 1159 (9th Cir. 2006).

241. Casillas v. Daines, 580 F. Supp. 2d 235, 243 (S.D.N.Y. 2008).

242. Devi M. Rao, *"Making Medical Assistance Available": Enforcing the Medicaid Act's Availability Provision Through §§ 1983 Litigation*, 109 COLUM. L. REV. 1440, 1462 (2009).

243. *See* Hurst, *supra* note 134, at 294 (remarking on "how *Gonzaga* has spawned confusion in the circuits").

244. Even without clarifying the Section 1983 standard, a Section 1983 case regarding the free choice of provider provision would provide a critical reference point for future cases involving private enforcement of Spending Clause legislation.

245. *Policy Basics: Introduction to Medicaid*, CTR. ON BUDGET & POL'Y PRIORITIES, https://www.cbpp.org/research/health/introduction-to-medicaid (Apr. 14, 2020) [https://perma.cc/7MSB-6NJN].

246. *Id.*

247. *Id.*

other preventive care, and getting regular care for chronic conditions rose in expansion states relative to non-expansion states."[248]

There is, however, still plenty of room for improvement both in terms of access to insurance and healthcare, particularly in rural areas.[249] Barriers to healthcare include workforce shortages and health insurance status, transportation, health literacy, and the stigma associated with conditions in rural communities.[250] As described in Part I,[251] traveling to reach a primary care provider may be expensive and onerous for patients living in rural areas, and subspecialty care can be even further away.[252] While these problems persist in urban areas as well, they are exacerbated in rural ones.[253]

With the current access to care situation in mind, the legal dispute concerning private enforcement of the free choice of provider provision is put in proper context. Section 1983 is used to enforce traditional constitutional rights, and the value of those rights to American society is undeniable.[254] As such, Section 1983 enforcement is not frequently denied.[255] But the practical consequences of losing access to the only primary care provider near you because that provider was decertified—perhaps for a political reason—is also undeniable.[256]

In 2012, 2,539 unique individual providers were disqualified from participating in Medicaid.[257] For each provider terminated, numerous patients were affected.[258] In some cases, the terminations were for valid reasons, but in other cases, the termination may have been based on a political, administrative, or otherwise insufficient reason.[259] In geographic areas where access to care is limited, a plaintiff with the right to do so could bring that insufficient reason to light in court and thereby improve access to care for themselves and others who were relying on that provider for care. There is a lack of empirical data on how often provider termination is for an invalid reason, but if the case law is any indication, it is more often than one might like to think.

248. *Id.*

249. *Healthcare Access in Rural Communities*, RHI HUB, https://www.ruralhealthinfo.org/topics/healthcare-access (Nov. 21, 2022) [https://perma.cc/2E5T-F9MV].

250. *Id.*

251. *See* discussion *supra* Part I.

252. *See* discussion *supra* Part I.

253. *See* discussion *supra* Part I.

254. *The Constitution*, WHITE HOUSE, https://www.whitehouse.gov/about-the-white-house/our-government/the-constitution/ (last visited July 4, 2023) [https://perma.cc/9HN5-FUJC].

255. This has been the case since *Monroe v. Pape*, 365 U.S. 167 (1961).

256. *See* Clawar et al., *supra* note 5.

257. DEP'T HEALTH & HUM. SERV.: OFF. INSPECTOR GEN., PROVIDERS TERMINATED FROM ONE STATE MEDICAID PROGRAM PARTICIPATING IN OTHER STATES 5 (2015), https://oig.hhs.gov/oei/reports/oei-06-12-00030.pdf [https://perma.cc/2HEU-N79V].

258. *See* KURT D. GILLIS, PHYSICIANS' PATIENT MIX–A SNAPSHOT FROM THE 2016 BENCHMARK SURVEY AND CHANGES ASSOCIATED WITH THE ACA 12, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2017-physician-benchmark-survey-patient-mix.pdf (last visited May 15, 2023) [https://perma.cc/X7JN-59BU] (stating that for a majority of doctors surveyed, Medicaid patients were up to 10% of their clientele).

259. Planned Parenthood S. Atl. v. Baker, 941 F.3d 687, 704–05 (4th Cir. 2019), *cert. denied*, 141 S. Ct. 550 (2020).

For these additional reasons, this Note urges the Supreme Court to step in and grant Medicaid recipients the right to bring a Section 1983 action to enforce their rights under the free choice of provider provision.[260]

B. The Supreme Court Should Synthesize the Gonzaga *and* Blessing *Frameworks to Offer a Rule That Allows for Easier Judicial Enforcement and a Broader Definition of Civil Rights*

The issues pertaining to private enforcement of a specific Medicaid provision are just one area in which civil rights have been constrained by the changing Section 1983 standard.[261] Because clarifying the *Gonzaga/Blessing* framework is likely necessary to reach the holding suggested in Section IV.A., it is worth pointing out the other positive effects that adopting a clear test and synthesizing the two cases would have on civil litigation.

Since the Supreme Court decided *Gonzaga v. Doe* in 2002, civil rights litigants across the federal circuit courts have been able to enforce fewer federal statutes under Section 1983.[262] As discussed above,[263] a majority of the Court of Appeals since *Gonzaga* have held that Medicaid's "availability provision" and "reasonable standards provision" are unenforceable by private litigants.[264] In a Section 1983 Supreme Court case unrelated to Medicaid, the Telecommunications Act of 1996 was held to be unenforceable by a private litigant seeking relief.[265]

There is no guarantee that these cases would have come out differently before *Gonzaga* under *Blessing*, but there is also no denying that *Blessing* is a more lenient standard for plaintiffs than *Gonzaga* and that there will be at least some borderline cases where that extra leeway would be decisive.[266]

While these concerns may feel hollow in the abstract, the effect of a more difficult standard for Section 1983 enforcement of Spending Clause legislation is quite real. The Spending Clause has been relied on to pass legislation promoting healthcare,[267] poverty relief,[268] nutrition,[269] and housing.[270] If private enforcement of the legislation in each of these areas is to continue decreasing following *Gonzaga*, the effects will be acutely felt by those most in need of these programs. Conversely, if the Supreme Court saves important aspects of the *Blessing* test, it is foreseeable that many of the programs that began to grow during

260. *See* discussion *supra* Section IV.A.
261. *See, e.g.*, City of Rancho Palos Verdes v. Abrams, 544 U.S. 113, 120 (2005).
262. *Id.* at 119–20.
263. *See* discussion *supra* Subsection IV.A.2
264. *See* discussion *supra* Subsection IV.A.2.
265. *Abrams*, 544 U.S. at 120.
266. *See* Hurst, *supra* note 134, at 293.
267. 42 U.S.C.A. § 1396a (West 2011).
268. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104–193, 110 Stat. 2105 (1996).
269. Nutrition CARE Act of 2021, S.584, 117th Cong. (2021).
270. 42 U.S.C. § 1437.

the *Blessing* era will continue to prosper under the proposed modified approach to enforcement of these important statutes.

V. CONCLUSION

Stephanie, the single mom from Part I who lost access to the only primary care provider near her, would be unable to assert her rights under Medicaid if the current trend among the Court of Appeals circuits continues.[271] With an annual salary of roughly $25,000 per year (which is rather standard for Medicaid recipients[272]), it seems likely that Stephanie would not be able to afford traveling to receive the primary care services that she and her children need. The effect that this would have on her family's health outcomes in the long term is demonstratable.

But if the Supreme Court follows the first recommendation of this Note, Stephanie, with the help of a local legal aid clinic, could regain access to the primary care provider of her choice through a Section 1983 civil action. Aside from the tangible advantages that Stephanie will gain by increasing her family's access to healthcare, Stephanie will have regained confidence in the legal system's ability to work for her.

More broadly, giving Medicaid recipients the ability to enforce Medicaid provisions will have the additional benefit of reducing the stigma associated with government associated healthcare.[273] After all, there is no stigma with enforcing many of one's constitutional rights. There is, unfortunately, still a stigma associated with certain privileges or entitlements—which are generally not enforceable. Thus, through private enforcement, the needle would move slightly closer to a system where healthcare and other public benefits are more like rights than privileges and where the stigma associated with accepting public healthcare would be reduced.

Finally, if the second recommendation of this Note is followed, civil enforcement of federal statutes will increase in general.[274] While progress was made on this front during the 20th century, *Gonzaga v. Doe* represented a step in the wrong direction because it imposed tougher requirements for federal statutes to be privately enforced. A synthesis of the *Gonzaga v. Doe* and *Blessing v. Freestone* tests would restore clarity, facilitate private enforcement of federal statutes, and result in fewer state government violations of federally created rights.

271. Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman, 981 F.3d 347, 394 (5th Cir. 2020); Does v. Gillespie, 867 F.3d 1034, 1046 (8th Cir. 2017).

272. *See* Richards & Wynn, *supra* note 1.

273. For a more in-depth analysis of stigma in public healthcare, see Heidi Allen, Bill J Wright, Kristin Harding & Lauren Broffman, *The Role of Stigma in Access to Health Care for the Poor*, MILLBANK QUARTERLY 289, 289 (2014).

274. *See* Hurst, *supra* note 134, at 293.