Using Medicaid Funds for Planned Parenthood: Is the Medicaid Act's Choice of Free Provider Really a Free Choice?

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I. INTRODUCTION

Imagine a female medical patient in need of reproductive health services. As a Medicaid recipient, she hopes to use Medicaid funding to help alleviate her out-of-pocket costs for health services from Planned Parenthood.[1] In most states, this female patient would have no trouble using her Medicaid funds to help pay for her visit to Planned Parenthood.

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[1] According to Planned Parenthood, it is not uncommon for its patients to use government funding for its services, as at least 60% of Planned Parenthood patients rely on public health programs like Medicaid or Title X for their preventative and primary care. Miriam Berg, *How Federal Funding Works at Planned Parenthood*, PLANNED PARENTHOOD (Jan. 5, 2017), https://www.plannedparenthoodaction.org/blog/how-federal-funding-works-at-planned-parenthood [https://perma.cc/9MKK-ASD2].

A female patient in this same health situation, however, may not be able to use Medicaid funds for services she receives at Planned Parenthood if she is a resident of a state bound by the Eighth Circuit,[2] as the Eighth Circuit concluded in August 2017.[3]

For decades, health care issues have been a source of partisan conflict.[4] The contentious political environment and staunch partisanship of the past few years, however, have brought fundamental questions about the American health care system to the front of the political fray.[5] Specifically, what coverage can citizens receive while using funding from the government? Is there a fundamental right to this coverage? If so, when does a state go too far in exercising its deference

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[2] A woman in this situation may not be denied from obtaining services just at Planned Parenthood, but also from any provider that a state decertifies as "qualified," regardless of the types of medical services she is trying to receive. *See* Does v. Gillespie, 867 F.3d 1034, 1046–47 (8th Cir. 2017) (Shepherd, CJ., concurring) ("[T]he right provided is to a range of qualified providers . . . there exists no right to a particular provider the State has decertified.").

[3] *Does*, 867 F.3d at 1046.

[4] *See e.g.*, Howard Markel, *69 Years Ago, a President Pitches His Idea for National Health Care*, P.B.S. NEWS HOUR (Nov. 19, 2014), https://www.pbs.org/newshour/health/november-19-1945-harry-truman-calls-national-health-insurance-program [http://perma.cc/CK6R-5XS8] (explaining how Truman's plan of having every earning American pay monthly fees or taxes to cover the cost of medical expenses was condemned by the American Medical Association because it was too closely associated with "socialized medicine" and "Communism"); John Dickerson, *Kennedycare: Fifty Years Before Obamacare, JFK Had His Own Health Care Debacle*, SLATE (Nov. 17, 2013), http://www.slate.com/articles/news_and_politics/history/2013/11/john_f_kennedy_s_health_care_failure_jfk_and_barack_obama_s_tough_fights.html [http://perma.cc/WTL9-6L6X] (outlining how Kennedy's plan to provide health care for elderly Americans was a "flop" because it was viewed as an attempt to "socialize medicine" and "threat[en] individual liberty"); KANT PATEL & MARK RUSHEFSKY, HEALTH CARE POLITICS AND POLICY IN AMERICA 47–48 (3d ed. 2006) (explaining how Nixon struggled with plans to revamp health care to alleviate rising costs with a Democratic Congress).

[5] *See, e.g.*, Reed Abelson, *Health Care Issues Loom in Politics, Payments and Quality*, N.Y. TIMES (Nov. 14, 2016), https://www.nytimes.com/2016/11/15/business/dealbook/health-care-issues-loom-in-politics-payments-and-quality.html [http://perma.cc/KL7Z-25Y9] (discussing the potential for the Affordable Care Act to be repealed in the wake of Donald Trump being elected as president); *Wide Partisan Gap in Opinions About Legalizing Marijuana Use*, PEW RES. CTR. (Jan 5, 2018), http://www.pewresearch.org/fact-tank/2018/10/08/americans-support-marijuana-legalization/ft_18-01-05_marijuana_table_update/ [https://perma.cc/V9XW-ELSR]; David Mitchell, *A Patient's Optimistic Call for Bipartisan Drug-Pricing Reform*, FORBES (Mar. 27, 2017), https://www.forbes.com/sites/realspin/2017/03/27/a-patients-optimistic-call-for-bipartisan-drug-pricing-reform/#18de7938472c [http://perma.cc/624E-9M8K] (imploring politicians to find a way to work across the aisle to address exorbitant drug prices affecting the health and economic decisions of many Americans); *Views of 2010 Health Care Law Remain Highly Partisan*, PEW RES. CTR. (Dec. 11, 2017), http://www.pewresearch.org/fact-tank/2017/12/11/for-the-first-time-more-americans-say-2010-health-care-law-has-had-a-positive-than-negative-impact-on-u-s/ft_17-12-08_aca_highly-partisan/ [https://perma.cc/A3LP-5UE3] (finding that seven years after its passage, the ACA was supported by 85% of Democrats and only 14% of Republicans).

in determining what provider meets its definition of 'qualified' within the meaning of the Medicaid Act? Did Congress intend to create a judicially enforceable right for individual patients to choose any qualified provider that offers the services they seek?

In light of these questions, this Note examines whether Medicaid beneficiaries have a cause of action under 42 U.S.C. § 1983 when a state declines to provide Medicaid funding to certain medical providers.[6] Part II analyzes the purposes of the Medicaid Act, particularly the free choice of provider provision. This Note concludes that under the Act, individual states may not decline Medicaid funds to providers meeting the Act's "qualified provider" standard. With this in mind, Part III emphasizes that a provider does not have a claim against a state that denies the use of Medicaid funds for its services. This effectively makes a Medicaid beneficiary's ability to sue the only possible source of relief if a state wrongly determines that a provider is not "qualified" within the meaning of the Medicaid Act. Part IV explores negative outcomes of the Eighth Circuit's decision, particularly if it is adopted by other state and federal jurisdictions. Part V analyzes the Supreme Court's approach to determine whether a statute confers an enforceable federal right under Section 1983 and concludes that Medicaid beneficiaries should have a fundamental right to sue state governments for denying Medicaid funds to qualified providers.

II. OVERVIEW OF THE MEDICAID ACT

In 1965, the Medicaid Act was signed into law as Title XIX of the Social Security Act to provide health coverage to low-income Americans.[7] From the time it was enacted up to the present, the Medicaid Act has empowered the federal government to provide each individual state with its own Medicaid funding.[8] Each state in turn administers its Medicaid program differently based on the needs of each individual state.[9]

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[6] Congress passed 42 U.S.C. § 1983 (2012) to provide individuals with an avenue to defend individual rights guaranteed by the Constitution when such right is infringed by a state actor under color of law. The applicable language states: "Every person who, under color of any statute . . . 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, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . ." § 1983. To obtain relief under Section 1983, a plaintiff must "prove a violation of one of [his or her] *constitutional* rights or the violation of a right guaranteed under *federal* law" and that the actions giving rise to the suit were "taken or directly controlled by someone acting *under color of state law*." Paul Clabo, *42 U.S.C. § 1983*, 9 COLUM. HUM. RTS. L. REV. 65, 65–66 (1977). For greater detail regarding how this potential relief applies to the usage of Medicaid funding, *see infra* Part III.V.

[7] *Program History*, MEDICAID.GOV, https://www.medicaid.gov/about-us/program-history/index.html [https://perma.cc/Q2QJ-64KE]

[8] *Id.*

[9] *Id.*; *See, e.g.*, *State Overviews*, MEDICAID.GOV,

When Congress passed the Medicaid Act, its main goal for the legislation was to "provid[e] hospital, post-hospital extended care, and home health coverage to almost all Americans aged 65 or older."[10] In other words, the primary purpose of Medicaid and Medicare was to supplement health care coverage for retired individuals receiving Social Security benefits. This was particularly important given that at the time the Medicaid Act was enacted, "seniors were the population group most likely to be living in poverty."[11] At the same time, as life expectancy rates increased in the United States,[12] the Medicaid Act was Congress' way of addressing the issue of medical costs "rising sharply."[13] Congress passed the Medicaid Act with retired Americans in mind, but states also have the option to provide funding to other groups of Americans, including low-income children and their caregivers, the blind, and other individuals with disabilities.[14]

In 1967, just two years after the Medicaid Act was passed, Congress amended the Act to include a "freedom of choice provision," or freedom of provider provision, in the statute.[15] The purpose of this addition to the Act was to address states "relying exclusively on publicly operated health systems to furnish care."[16] In other words, Congress wished to avoid states directing Medicaid beneficiaries only to publicly operated health care providers for healthcare services. Additionally, statements from representatives in the House suggest that Congress also intended to prevent the federal government from imposing "moral judgments" on Americans in their decisions regarding family planning.[17]

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https://www.medicaid.gov/medicaid/by-state/by-state.html [https://perma.cc/Q43X-C72H] (analyzing Medicaid programs in each state, including factors such as eligibility requirements, applications, and how many children participate in each state's program).

[10] *Medicare & Medicaid Milestones: 1937-2015*, CTRS. FOR MEDICARE & MEDICAID SERVS. 1, 2 (July 2015), https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf [https://perma.cc/P33A-8MFL].

[11] *Id.*

[12] *Table 22. Life Expectancy at Birth, at 65 Years of Age, and at 75 Years of Age by Race and Sex: United States, Selected Years 1900-2007*, CDC, https://www.cdc.gov/nchs/data/hus/2010/022.pdf [https://perma.cc/6XTH-82P8].

[13] Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and Its Origins*, 27 HEALTH CARE FINANCING REV. 45, 47 (2005–2006).

[14] *Medicare & Medicaid Milestones: 1937-2015*, *supra* note 10, at 2.

[15] 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 HEALTHCARE 676 (Brian D. Smedley et al. eds., 2003).

[16] *Id.*

[17] 90 CONG. REC. 10701 (1967) ("The objectives of the departmental policy are to improve the health of the people, to strengthen the integrity of the family, and to provide families the freedom of choice to determine the spacing of their children and the size of their families.").

The language of the provision provides that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required."[18] Therefore, the freedom of provider provision affords a Medicaid recipient the ability to use Medicaid funds to pay for medical services from any provider he or she chooses, as long as the provider meets certain standards and is "qualified" within the Act.[19]

Because the freedom of provider provision offers Medicaid freedom of choice only with respect to providers that are deemed "qualified," it is imperative to understand what the definition of "qualified" is in the context of providers covered by Medicaid. The language of the provision states that Medicaid beneficiaries may obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide [a beneficiary] such services."[20] Thus, any medical provider that meets this definition is available as an option for Medicaid beneficiaries wishing to use their Medicaid funds for healthcare services.

Surprisingly,[21] Congress did not and has not defined what "qualified" means within the Medicaid Act.[22] Rather, each individual state is afforded deference in determining what the definition of "qualified" is, usually based on the state's medical boards and licensing requirements.[23] This can be problematic, especially considering that Congress' purpose in adding the freedom of choice provision was based on some states' decisions to prohibit Medicaid recipients from using Medicaid funds at private healthcare facilities.[24]

Determining which providers are "qualified" is at the crux of the inquiry of whether a certain provider, and therefore a beneficiary's choice to use Medicaid funding, is covered and protected by the Medicaid Act. However, Congress is mysteriously silent and does not explicitly define "qualified provider." This raises the question of what recourse (if any) a beneficiary may have when her state of residence rejects her ability to use Medicaid funding on the grounds that her provider of choice isn't "qualified."

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[18] The Social Security Act, 42 U.S.C. § 1396(a)(23) (2012).

[19] 42 C.F.R. § 431.51(a)(1) ("Section 1902(a)(23) of the Act provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.").

[20] 42 U.S.C. § 1396(a)(23).

[21] Or not surprisingly, depending on one's faith in Congress' drafting skills.

[22] *Medicaid Toolkit: Qualified Provider*, AM. SPEECH-LANGUAGE-HEARING ASS'N, https://www.asha.org/Practice/reimbursement/medicaid/Medicaid-Toolkit-Qualified-Provider/ [https://perma.cc/6FEY-6XGX].

[23] *Id.*

[24] Rosenbaum, *supra* note 15, at 676.

III. MEDICAID BENEFICIARIES' RIGHT TO SUE INDIVIDUAL STATES

The language of the free choice of provider provision is vague and ambiguous, particularly regarding the definition of what makes a health care provider "qualified" within the meaning of the statute.[25] This ambiguity leaves courts with the task of determining whether a statute is intended to benefit an individual and provide that individual with a judicially enforceable right under 42 U.S.C. § 1983.

A. *The Eighth Circuit's Interpretation of the Free Choice of Provider Provision*

In August 2017, the Eighth Circuit issued a decision in *Does v. Gillespie* in which it ruled against Planned Parenthood of Arkansas, Planned Parenthood of Eastern Oklahoma, and three female Planned Parenthood patients, validating the state of Arkansas' decision to block Medicaid beneficiaries from using Medicaid funds for health services from Planned Parenthood.[26] The three female Medicaid beneficiaries sued the state of Arkansas after the governor terminated the state's Medicaid provider agreements with Planned Parenthood as a result of the release of a controversial video allegedly showing local Planned Parenthood employees discussing fetal tissue sales.[27]

In issuing its decision, the Eighth Circuit vacated injunctions and a temporary restraining order (TRO) that the District Court put in place to protect the three Medicaid beneficiaries and prevent the state of Arkansas from withholding Medicaid funds to pay for the women's services because they were performed at Planned Parenthood.[28] As part of its reasoning, the Eighth Circuit

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[25] *See supra* Part II.

[26] Does v. Gillespie, 867 F.3d 1034, 1046 (8th Cir. 2017); Merrit Kennedy, *Federal Appeals Court Says Arkansas Can Block Medicaid Payments to Planned Parenthood*, NPR (Aug. 16, 2017), http://www.npr.org/sections/thetwo-way/2017/08/16/543974021/federal-appeals-court-says-arkansas-can-block-medicaid-payments-to-planned-paren [https://perma.cc/KQ7Y-4B8Y]; Jessie Hellmann, *Arkansas Cuts Off Medicaid Funds to Planned Parenthood Following Court Ruling*, THE HILL (Nov. 28, 2017), http://thehill.com/policy/healthcare/362120-arkansas-cuts-off-medicaid-funds-to-planned-parenthood-following-court [https://perma.cc/2U3Q-2WK7].

[27] *See Does*, 867 F.3d at 1038; Danielle Kurtzleben, *Planned Parenthood Investigations Find No Fetal Tissue Sales*, NPR (Jan. 28, 2016), https://www.npr.org/2016/01/28/464594826/in-wake-of-videos-planned-parenthood-investigations-find-no-fetal-tissue-sales [https://perma.cc/59CT-8QBM]. This video was investigated by Planned Parenthood, which concluded that it was falsified and the allegations regarding fetal tissue sales were false. Kurtzleben, *supra* note 27.

[28] Planned Parenthood Ark. & E. Okla. v. Gillespie, No. 4:15-cv-00566-KGB, 2016 WL 8928315, at *7 (E.D. Ark. Sept. 29, 2016) (issuing a preliminary injunction order on behalf of the patient class); Planned Parenthood Ark. & E. Okla. v. Selig, No. 4:15-cv-00566-KGB, 2015 WL 13307030, at *4 (E.D. Ark. Sept. 18, 2015) (issuing a TRO and a preliminary injunction).

held that a Medicaid beneficiary's free choice of provider is not a judicially enforceable right that is actionable under 42 U.S.C. § 1983, meaning that the three women had no cause of action and no right to sue the state of Arkansas for its decision regarding Planned Parenthood.[29]

The Eighth Circuit reasoned that the free choice of provider provision does not provide beneficiaries with an actionable right against states for a variety of reasons. First, because the Medicaid Act is a spending statute, it is not enough to establish that Congress intended to create an enforceable federal right; rather, "nothing 'short of an unambiguously conferred right' will support a cause of action under § 1983."[30] Second, the Eighth Circuit interprets the freedom of choice provision as a directive to a federal agency, not as conferring a right to individual beneficiaries that is judicially-enforceable.[31]

Additionally, the Eighth Circuit determined that Congress had already provided another way to enforce state compliance with the free choice of provider provision: if states fail to provide funding to qualified providers, the Secretary of Health may withhold federal funding for Medicaid under 42 U.S.C. 1396(c).[32] Similarly, the Eighth Circuit determined that because the free choice of provider provision is part of a "compliance regime," it is a statute with an "aggregate focus," and therefore does not confer any rights to individuals.[33] For these reasons, the Eighth Circuit determined that the plaintiffs could not use Section 1983 to compel the state government to provide Medicaid funding for their care at Planned Parenthood.[34]

In the wake of this surprising decision from the Eighth Circuit, many questions remain unanswered. Many Americans may wonder what motivated the Eighth Circuit to deviate from the reasoning of the District Court and other Circuits that have addressed the issue, and whether the *Gillespie* decision is here to stay. And if so, what kind of relief will be available for Medicaid beneficiaries who are disallowed from using Medicaid funding for health care services that they would likely be unable to afford otherwise?

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[29] *Does*, 867 F.3d at 1046 ("Given our conclusion that § 23(A) of the Medicaid Act does not give the Jane Does or the class of Medicaid beneficiaries an enforceable federal right that supports a cause of action under § 1983, the plaintiffs do not have a likelihood of success on the merits of their claims.").

[30] *Id.* at 1040 (citing Gonzaga Univ. v. Doe, 536 U.S. 273, 283 (2002)).

[31] *See* The Social Security Act, 42 U.S.C. § 1396(a)(23) ("Any individual eligible for medical assistance . . . such assistance from any institution, agency community pharmacy, or person, qualified to perform the service or services required."); *Does*, 867 F.3d at 1041.

[32] *Does*, 867 F.3d at 1041. 42 U.S.C. 1396(c) provides that the Secretary of Health may withhold funding to the state agency supervising the administration of the state's Medicaid plan if "in the administration of the plan there is a failure to comply substantially."

[33] *Does*, 867 F.3d at 1042.

[34] *Id.* at 1046.

B. *The Fifth, Sixth, Seventh, and Ninth Circuits' Interpretation of the Free Choice of Provider Provision*

Prior to the Eighth Circuit's decision, each of the other Circuits that had decided the issue unanimously concluded that Medicaid beneficiaries do have a right to sue an individual state when the state disallows using Medicaid funding for Planned Parenthood.[35] Therefore, the Eighth Circuit stands alone on one side of the debate, while four other Circuits (the Fifth, Sixth, Seventh, and Ninth Circuits) stand on the opposite side.

For example, the Ninth Circuit has identified two criteria that Medicaid beneficiaries must meet in order to be free to choose any provider under the free choice of provider provision: "(1) the provider is 'qualified to perform the service or services required,' and (2) the provider 'undertakes to provide [the recipient] such services.'"[36] The Ninth Circuit stated that, although a state initially determines whether or not a provider is "qualified," "[a] court can readily determine whether a particular health care provider is qualified to perform a particular medical service."[37] To make this determination, the court suggested relying upon "evidence such as descriptions of the service required; state licensing requirements; the provider's credentials, licenses, and experience; and expert testimony regarding the appropriate credentials for providing the service."[38] In *Planned Parenthood Arizona, Inc. v. Betlach*, therefore, the Ninth Circuit determined that Planned Parenthood is a qualified provider and that Medicaid beneficiaries have an enforceable right if a state denies the ability to use Medicaid funds to pay for services at Planned Parenthood.[39] This right is also recognized in the dissent in *Does v. Gillespie*.[40]

The Seventh Circuit reached the same conclusion as the Ninth Circuit and added the idea that the free choice of provider provision "confers on [Medicaid beneficiaries] an individual entitlement—the right to receive reimbursable

[35] *See* Planned Parenthood of Gulf Coast, Inc. v. Gee, 862 F.3d 445, 457 (5th Cir. 2017) ("Joining every other circuit that has addressed this issue, we conclude that § 1396a(a)(23) affords the Individual Plaintiffs a private right of action under § 1983."); Planned Parenthood Ariz. Inc. v. Betlach, 727 F.3d 960, 966 (9th Cir. 2013) ("The statutory language unambiguously confers [an individual] right upon Medicaid-eligible patients, mandating 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.'"); Harris v. Olszewski, 442 F.3d 456, 459 (6th Cir. 2006) (holding that the free choice of provider provision provides a private right of action enforceable under § 1983).

[36] *Planned Parenthood Ariz. Inc.*, 727 F.3d at 967 (quoting 42 U.S.C. § 1396(23)(A)).

[37] *Id.* at 967–68.

[38] *Id.* at 968.

[39] *Id.*

[40] *Does*, 867 F.3d 1034, 1053 (Melloy, CJ., dissenting) ("The Fifth, Sixth, Seventh, and Ninth Circuits all applied the *Blessing/ Gonzaga* framework to hold that the freedom-of-choice provision creates a private right enforceable under § 1983 . . . I therefore read those circuits' opinions as persuasive authority . . . .").

medical services from any qualified provider."[41] Thus, the Fifth, Sixth,[42] Seventh, and Ninth Circuits are all in agreement that the free choice of provider provision should provide Medicaid beneficiaries with a judicially enforceable right to sue a state that denies them the right to use Medicaid funds for services from a qualified provider like Planned Parenthood, as for a state to do so would contradict the legislative purpose of the Medicaid Act.

C. *Providers May Not Be Able to Sue*

States are generally given broad discretion under the Medicaid Act to determine whether a provider is qualified within the meaning of the statute to receive Medicaid funding.[43] Suppose for a moment that instead of a Medicaid beneficiary suing the state for her inability to use Medicaid funding for healthcare, her health care *provider* chooses to sue the state in order to obtain Medicaid funds for the health care services rendered.

In this situation, District Courts have determined that providers have no cause of action and no right to demand a state to treat it as a qualified provider under the Medicaid Act.[44] This is because these courts have concluded that whether or not Medicaid funding may be used to pay a specific provider is not an issue of a provider's right.[45] It is important to note, however, that a provider *does* have the right to sue if it can prove it is a qualified provider under the Act.[46] But because states alone decide which providers are qualified, it is seemingly impossible for a provider to prove that it is qualified when the state has already determined that it is not.

Courts have uniformly held that health care providers do not have the right to enforce the free choice of provider provision of the Medicaid Act. If providers do not have this right, it must be the beneficiary's right that is put at risk. If both

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

[42] For an example of another case in which the Sixth Circuit found that the free choice of provider provision confers a judicially enforceable right under Section 1983, see Westside Mothers v. Haveman, 289 F.3d 852 (6th Cir. 2002) and *infra* Part V.B.

[43] *See* AM. SPEECH-LANGUAGE-HEARING ASS'N, *supra* note 22 and accompanying text.

[44] *See, e.g.*, Queer v. Westmoreland Cty., No. 2:06-cv-325, 2007 WL 2407283, at *8 (W.D. Penn. Aug. 20, 2007) ("To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead have a legitimate claim of entitlement to it.") (citing Bd. of Regents v. Roth, 408 U.S. 564, 577 (1972)).

[45] *Q & A: Case on Provider Enforcement of Medicaid Freedom of Choice*, NAT'L HEALTH L. PROGRAM (Aug. 1, 2007), http://www.healthlaw.org/issues/reproductive-health /qa-case-on-provider-enforcement-of-medicaid-freedom-of-choice#.WePcgBNSygQ [https://perma.cc/M59M-7HBW].

[46] Thomas Quarles, Jr., *Devine Health Update: New Hampshire Supreme Court Upholds Medicaid Free Choice of Provider Rights*, DEVINE MILLIMET (Aug. 21, 2014), https://www.devinemillimet.com/uploads/docs/enews/Healthcare/08-21-14/court-upholds-medicaid-free-choice-of-provider-rights.html [https://perma.cc/7Y6E-L796].

health care providers and beneficiaries are unable sue a state to enforce the free choice of provider provision, the question becomes what kind of relief *is* available? If the answer is *none*, does that answer comport with what Congress intended when it added the free choice of provider provision to the Medicaid Act in 1967?[47]

IV. IMPLICATIONS OF THE *DOES V. GILLESPIE* DECISION

By concluding that Medicaid beneficiaries do not have a judicially enforceable right arising from the free choice of provider provision, the *Does v. Gillespie* court has changed the rights available to plaintiffs in the Eighth Circuit.[48] Although *Does v. Gillespie* was decided relatively recently, it has already had an impact on subsequent cases decided within the Eighth Circuit.[49] There is no indication that future Eighth Circuit cases will be decided differently. *Does v. Gillespie* has denied plaintiffs the chance to challenge a state's decision denying access to particular health care providers.[50] It is a decision that will have adverse and disparate effects on the health of Medicaid beneficiaries.

This outcome could have stark political consequences nationwide; other federal courts could apply this reasoning to the free choice of provider provision and other similar statutes, denying plaintiffs the ability to challenge state action in multiple contexts. The reasoning of *Does v. Gillespie* may encourage other states to use their ability to decertify disfavored health care providers as a political vehicle to promote a pro-federalism or pro-life agenda to the detriment of Medicaid beneficiaries.

A. *Long-Term Effects of the Eighth Circuit Decision Stands*

The Eighth Circuit's decision clouds the future of Medicaid beneficiaries and, more specifically, Medicaid beneficiaries using federal funds for services at Planned Parenthood. For female Medicaid beneficiaries in this situation, *Does v. Gillespie* poses several troubling outcomes. Although there is some debate about what percentage of Planned Parenthood's services are abortion procedures,[51] the majority of what the organization does consists of providing

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[47] *See supra* note 14 and accompanying text.

[48] Does v. Gillespie, 867 F.3d 1034 (8th Cir. 2017).

[49] *Id. See, e.g.*, M.B. v. Corsi, No. 2:17-cv-04102-NKL, 2018 U.S. Dist. LEXIS 3232, at *46 (W.D. Mo. Jan. 8, 2018) ("[N]othing short of an unambiguously conferred right will support a cause of action under § 1983."); Osher v. City of St. Louis, 903 F.3d 698, 702 (8th Cir. 2018) ("It is now clear that the proper focus is on congressional intent, and 'nothing short of an unambiguously conferred right' will support an implied right of action.") (quoting *Does*, 867 F.3d at 1040 (internal citations omitted)).

[50] *Does*, 867 F.3d at 1047.

[51] *See infra* note 57.

sexual education and general health exams, including breast exams, pap tests, and exams to check for sexually-transmitted diseases.[52]

If states are allowed more discretion and freedom to withhold Medicaid funding from being used for services at Planned Parenthood and beneficiaries have no cause of action against them, this could make it much more difficult for Planned Parenthood and similar organizations to provide these important services to Medicaid beneficiaries. Instead, beneficiaries may choose to forego such services without alternative means to afford them.

Although Planned Parenthood also provides health care services to men, withholding Medicaid funding from Planned Parenthood would have a disparate impact on female Medicaid beneficiaries, who would lose access to Planned Parenthood as a family planning provider.[53] Shutting off that access would raise Medicaid costs on a greater number of unwanted pregnancies in the states that choose to withhold Medicaid funding from Planned Parenthood.[54] Ultimately, decreasing a Medicaid beneficiary's ability to use funding at a provider of her choice places her at the mercy of the state in which she lives and could result in fewer safe, affordable health care options. This situation is exactly what Congress intended to avoid when it added the free choice of provider provision to the Medicaid Act.[55]

Another potential result of *Does v. Gillespie* is that courts may determine that other laws do not confer a judicially enforceable right under Section 1983, raising similar concerns of whether such a conclusion is consistent with Congressional intent. In fact, this situation has already occurred in the Eighth Circuit, where a District Court relied on the *Gillespie* decision to determine that the Adoption Assistance and Child Welfare Act does not confer an individual cause of action.[56] This result could change how courts interpret any statute in

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[52] *2016-2017 Annual Report*, Planned Parenthood 1, 29, https://www.plannedparenthood.org/uploads/filer_public/71/53/7153464c-8f5d-4a26-bead-2a0dfe2b32ec/20171229_ar16-17_p01_lowres.pdf [https://perma.cc/K5N4-FC4N] (stating that only 3% of Planned Parenthood services in 2016 and 2017 were abortions); *see also* Debra Goldschmidt & Ashley Strickland, *Planned Parenthood: Fast Facts and Revealing Numbers*, CNN (Aug. 1, 2017), https://www.cnn.com/2015/08/04/health/planned-parent hood-by-the-numbers/index.html [https://perma.cc/TC5S-QL3F] (stating that no federal funds are used for abortions at Planned Parenthood and that only 3% of the services Planned Parenthood provides are abortions).

[53] *See* Jeanne Pinder, *Men, Women, and Health Care Pricing Theory: Speaking Different Languages*, Health Care Blog (June 9, 2016), http://thehealthcareblog.com/ blog/2016/06/09/men-women-and-health-care-pricing-theory-speaking-different-languages/[https://perma.cc/E3PB-AYUZ].

[54] *See* Judith Solomon, *House Bill on Medicaid Providers Would Limit Beneficiaries' Access to Care*, Ctr. on Budget and Pol'y Priorities (Sept. 29, 2015), https://www.cbpp.org/research/health/house-bill-on-medicaid-providers-would-limit-beneficiaries-access-to-care [https://perma.cc/D63G-YR6J].

[55] *See supra* Part II and accompanying text.

[56] M.B v. Corsi, No. 2:17-cv-04102-NKL, 2018 U.S. Dist. LEXIS 3232, at *44–52 (W.D. Mo. Jan. 8, 2018).

which Congress does not include express language of an enforceable federal right, a potential chilling effect on otherwise cognizable claims.

If *Does v. Gillespie* stands, it serves as a threat to potential plaintiffs' ability to sue under the Medicaid Act and other similar statutes. Particularly, this decision has a disproportionate impact on individuals attempting to use Medicaid funding for reproductive health services. Without Medicaid funding, those services could be too costly for many Americans.

B. *Political Influences*

Although Planned Parenthood is frequently associated with abortions,[57] federal funds, including Medicaid funds, are currently not permitted to be used for abortion services.[58] However, Arkansas and Oklahoma have successfully blocked patients from using Medicaid funding for non-abortion reproductive health services at Planned Parenthood.[59] Other state legislatures may follow suit, particularly within federal jurisdictions where courts have not yet fully clarified the rights of beneficiaries under Medicaid's free choice of provider provision.

If other states deny Medicaid funding to Planned Parenthood patients, this could result in states withholding the funding as a political vehicle to decrease the number of abortions performed.[60] Given that abortion is among the most divisive political issues in the U.S., legislators could defend *Does v. Gillespie*

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[57] Planned Parenthood states that only 3% of all of its services are abortion-related, although multiple sources have come to the conclusion that this statistic is misleading. *See* Michelle Ye Hee Lee, *For Planned Parenthood Abortion Stats, '3 Percent' and '94 Percent' Are Both Misleading*, WASH. POST (Aug. 12, 2015), https://www.washingtonpost.com/news/fact-checker/wp/2015/08/12/for-planned-parenthood-abortion-stats-3-percent-and-94-percent-are-both-misleading/?utm_term=.ad4bc12a0d2f [https://perma.cc/5KTA-FP6D]; Logan Newman, *How Much of Planned Parenthood's Services Are Related to Abortions?*, ARIZ. REPUBLIC, (July 14, 2017), https://www.azcentral.com/story/news/politics/fact-check/2017/07/14/fact-check-planned-parenthood-abortion-services/448575001/ [https://perma.cc/RZ6A-MLMX]; Danielle Kurtzleben, *Fact Check: How Does Planned Parenthood Spend That Government Money?*, NPR (Aug. 5, 2015), https://www.npr.org/sections/itsallpolitics/2015/08/05/429641062/fact-check-how-does-planned-parenthood-spend-that-government-money [https://perma.cc/582L-TW65].

[58] *See* Lewis Morris, *Get the Facts Straight – There Is No Federal Funding of Abortions*, THE HILL (July 10, 2017), http://thehill.com/blogs/pundits-blog/healthcare/341324-get-the-facts-straight-there-is-no-federal-funding-of-abortions [https://perma.cc/6VRC-74CH] ("[S]ince the passage of the Hyde Amendment in 1976, there is no federal Medicaid funding of abortion, except in three narrowly defined situations: if continuing the pregnancy would endanger the life of the woman, or the pregnancy resulted from rape or incest.").

[59] *See* Lena H. Sun, *Obama Officials Warn States About Cutting Medicaid Funds to Planned Parenthood*, WASH. POST (Apr. 19, 2016), https://www.washingtonpost.com/news/post-nation/wp/2016/04/19/obama-officials-warn-states-about-cutting-medicaid-funds-to-planned-parenthood/?utm_term=.36de451c6f18 [https://perma.cc/6DQL-SY8N].

[60] *See* Solomon, *supra* note 54.

as a way to rally support among pro-life constituencies or to promote a federalist agenda.[61]

Indeed, even within the context of cases with similar Medicaid funding issues, government officials from *different states* than the one(s) being sued readily expressed their opinion publicly regarding the relevant issues.[62] For example, in a Fifth Circuit case, officials of the State of Arkansas filed an *amicus curie* brief to voice support for the state withholding Medicaid funding from Planned Parenthood and explain its position that Medicaid beneficiaries should not have an actionable right under Section 1983, even though a decision in the Fifth Circuit would not be binding on Arkansas.[63]

Finally, one may fairly wonder if the social and political atmosphere around Planned Parenthood influenced the Eighth Circuit. In 2015, a video surfaced which purported to show Planned Parenthood employees in Arkansas selling fetal tissue.[64] Arkansas terminated the state's Medicaid provider agreements with local Planned Parenthood locations, giving rise to *Does v. Gillespie*.[65] Even though this video was later found to be falsified and inaccurate,[66] Arkansas did not change its position on Medicaid funding being used for Planned Parenthood. *Does v. Gillespie* seems to validate Arkansas' political decision to deny Planned Parenthood as a choice for its Medicaid beneficiaries, even though its basis for doing so was seemingly grounded on false allegations.

Does v. Gillespie may expand state deference in choosing where its Medicaid funds may or may not be spent, possibly at the direct expense of Medicaid beneficiaries. Other states may follow Arkansas' lead and preclude Medicaid beneficiaries from using funds at local Planned Parenthood locations. This would be a particularly troubling result, leaving some women seeking non-abortion health services in some states in a disadvantageous position compared to their counterparts in other states.

V. MEDICAID BENEFICIARIES SHOULD HAVE A RIGHT TO SUE A STATE THAT VIOLATES THE FREE CHOICE OF PROVIDER PROVISION

Although the Medicaid Act does not explicitly provide a cause of action for individual beneficiaries, it should be read in a way that creates a judicially

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[61] Margot Cleveland, *Arkansas Decision Puts Urgency on GOP Promises to Cut Planned Parenthood Funding*, THE FEDERALIST (Aug. 22, 2017), http://thefederalist.com/2017/08/22/arkansas-decision-puts-urgency-gop-promises-cut-planned-parenthood-funding/ [https://perma.cc/SNF3-HVZW].

[62] *See generally* Brief of the States of Arkansas et al. as Amici Curiae Supporting Defendants, Planned Parenthood of Greater Texas Family Planning & Preventative Health Servs., Inc. v. Smith, 236 F. Supp. 3d 974 (W.D. Tex. 2017) (No. 17-50282).

[63] *Id.*

[64] *See generally* Kurtzleben, *supra* note 27.

[65] *Id.*

[66] Jackie Calmes, *Planned Parenthood Videos Were Altered, Analysis Finds*, N.Y. TIMES (Aug. 27, 2015), https://www.nytimes.com/2015/08/28/us/abortion-planned-parenthood-videos.html [https://perma.cc/RT33-4H2G].

enforceable right for Medicaid beneficiaries when a state does not provide funding to a qualified provider.[67] If a provider is qualified, a state should not be allowed to deny funding for any reason.[68] And if a state does deny such funding, beneficiaries should be able to bring the state to court.[69]

The fact that each state individually defines which entities are "qualified providers" within the Medicaid Act's free choice of provider provision adds an extra layer of ambiguity. Each state may have different provider qualifications, resulting in the possibility of Medicaid beneficiaries being treated differently compared to those in other states. However, this Note does not suggest that states should not have *any* discretion in determining which health care providers are qualified within the meaning of the Medicaid Act– to suggest otherwise would almost certainly be unconstitutional and contrary to the legislative intent behind the Act.[70]

The Supreme Court recently denied certiorari in two cases, one in the Fifth Circuit[71] and one in the Tenth[72], effectively affirming a Medicaid beneficiary's private right of action to challenge a state's denial of Medicaid funding in states

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[67] *But see* Marc Andrew Ison, *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, 1508–09 (2003) ("The Medicaid Act lacks the language necessary to create an enforceable private right. Since section 1983 'merely provides a mechanism for enforcing individual rights 'secured' elsewhere' by the Constitution and laws of the United States, the [Supreme] Court [of the United States] should not allow a section 1983 claim unless Congress, in the statute at issue, has spoken with a clear voice manifesting an 'unambiguous intent to confer individual rights.'").

[68] *See* Caitlin Owens, *States Can't End Medicaid Funding of Planned Parenthood*, THE ATLANTIC (Aug. 17, 2015), https://www.theatlantic.com/politics/archive/2015/08/states-cant-end-medicaid-funding-of-planned-parenthood/452283/[https://perma.cc/W3Q3-HA72] (quoting Cindy Mann, former director of Centers for Medicaid and Medicare Services (CMS)) ("Medicaid programs may not exclude qualified health care providers . . . from providing services under the program because they separately provide abortion services (not funded by federal Medicaid dollars, consistent with the federal prohibition) as part of their scope of practice.").

[69] *See* Brief of the Chamber of Commerce of the United States of America as Amicus Curiae at 4–5, Douglas v. Indep. Living Ctr. of S. Cal., 565 U.S. 606 (2012) (Nos. 09-958, -1158, 10-283) (arguing that Medicaid beneficiaries should have a broad right to sue in the context of states violating the Act's reimbursement rate provision). *But see* Douglas v. Indep. Living Ctr. of S. Cal., 565 U.S. 606, 616 (2012) (Roberts, C.J., dissenting) (arguing that Congress did not intend to create a private right of action when it passed Medicare).

[70] *See* Ison, *supra* note 67, at 1515 ("A Medicaid system without enforceable private rights would more closely resemble the program envisioned by its authors, who wished to enable 'each State, as far as practicable under the conditions in each State, to furnish [medical services to the poor].'").

[71] Gee v. Planned Parenthood of Gulf Coast, Inc., 139 S. Ct. 408 (2018).

[72] Anderson v. Planned Parenthood of Kan. & Mid-Missouri, No. 17-1340, 2018 LEXIS 7205 (S.C. Dec. 10, 2018).

within these circuits.[73] Supporters of Planned Parenthood, including its President Dr. Leana Wen, consider this a victory, ensuring that states within the Fifth and Tenth districts cannot limit Medicaid beneficiaries' access to Planned Parenthood services.[74] However, as Justice Thomas emphasized in his dissent to the Court's denial of certiorari, the Court's failure to opine on this issue results in women in different states having different rights under the same federal statute.[75] If the Court has the opportunity to grant certiorari with respect to the *Gillespie* case, it should do so to resolve this inconsistency.

There must be a balance in which the states can regulate providers, while at the same time ensuring that Medicaid beneficiaries do not have differing levels of *federal* protections. In other words, if *Gillespie* stands, Medicaid beneficiaries in states within the Eighth Circuit that wish to use their federal Medicaid funds for reproductive health services at Planned Parenthood seem to be at a tremendous disadvantage compared to beneficiaries who live in states under the jurisdiction of the Fifth, Sixth, Seventh, and Ninth Circuits. No matter which state a beneficiary lives in, she should have the ability to challenge the state's decision of whether Planned Parenthood is a qualified provider. A beneficiary who believes her state is arbitrarily discriminating against her because she is using Medicaid funds to defray her cost of reproductive health expenses should be able to challenge that alleged discrimination.

Without a private right of action for beneficiaries, Medicaid funding disbursements would have a disproportionately negative impact on female beneficiaries in states bound by *Gillespie.* Women spend much more on reproductive health services and "represent the majority of Medicare beneficiaries."[76] More women are low-income earners than men;[77] a lack of adequate Medicaid funding for women's health issues would certainly be contradictory to Medicaid's core purposes.[78]

Issues that are specific to reproductive health further exacerbate this disparity of health care availability to women. Although certain procedures,

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[73] *See* Manny Marotta, *Supreme Court will not Review Planned Parenthood Defunding Cases*, JURIST (Dec. 10, 2018), https://www.jurist.org/news/2018/12/supreme-court-will-not-review-planned-parenthood-defunding-cases/[https://perma.cc/VSF4-J8HL].

[74] *Id.* ("We are pleased that lower court rulings protecting patients remain in place. Every person has a fundamental right to health care, no matter who they are, where they live, or how much they earn.").

[75] *Gee*, 139 S. Ct. at 409 ("Because of this Court's inaction, patients in different States–even patients with the same providers–have different rights to challenge their State's provider decisions.").

[76] Gary M. Owens, MD, *Gender Differences in Health Care Expenditures, Resource Utilization, and Quality of Care*, 14 SUPPLEMENT TO J. OF MANAGED CARE PHARMACY 2 (2008).

[77] *See* Jasmine Tucker & Caitlin Lowell, *National Snapshot: Poverty Among Women & Families, 2015*, NAT'L WOMEN'S L. CTR. (Sept. 14, 2016), https://nwlc.org/resources/national-snapshot-poverty-among-women-families-2015/ [https://perma.cc/N2XU-MFY2] (reporting that women in 2015 were 35% more likely to live in poverty than men).

[78] *See* Pinder, *supra* note 53.

such as abortions, are more cost-effective and safer than they ever have been, many women still fall victim to unsafe abortions.[79] Allowing a state to deny Medicaid funding to providers that offer American women safe, effective, and regulated care would further require women, particularly those with lower incomes, to seek other potentially unsafe and illegal options.

Federal courts that have not yet decided the issue should decline to follow the Eighth Circuit's reasoning in *Does v. Gillespie* and instead read the Medicaid Act to include a federal right that is judicially enforceable under Section 1983. This would allow beneficiaries to sue when a state violates the Medicaid Act's free choice of provider provision. This would also fulfill Congress' intent to protect *all* Medicaid beneficiaries, regardless of the type of health care they seek. Such an approach would not automatically revoke a state's discretion in determining which providers are qualified within the meaning of the statute. Instead, it would prevent states from doing so in a way that discriminates against Medicaid beneficiaries who are seeking health services from providers that may be more politically sensitive than others.

A. *The Test for a Judicially Enforceable Right Under Section 1983*

The Supreme Court of the United States has noted that Section 1983 does not provide an avenue for relief every time a state actor violates a federal law, but rather provides individuals with an enforceable federal right only for certain statutes.[80] Although the Supreme Court has not considered whether the Medicaid Act's free choice of provider provision gives rise to a private cause of action for Medicaid beneficiaries, it has had the opportunity to discuss whether Section 1983 creates a judicially enforceable right for private citizens in the context of other laws similar to the free choice of provider provision.[81] These

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[79] WORLD HEALTH ORGANIZATION, WOMEN AND HEALTH: TODAY'S EVIDENCE TOMORROW'S AGENDA 47 (2009).

[80] *See* City of Rancho Palos Verdes v. Abrams, 544 U.S. 113, 126–27 (2005) (holding that an individual may not enforce the Federal Telecommunications Act's limitations with regard to injunctive relief against a local zoning authority through a Section 1983 action).

[81] Gonzaga Univ. v. Doe, 536 U.S. 273, 284 (2002) (applying the *Wilder* and *Blessing* framework and holding that the Family Education Rights and Privacy Act (FERPA) did not create judicially-enforceable rights under 42 U.S.C. § 1983); Blessing v. Freestone, 520 U.S. 329, 341–49 (1997) (creating a three-part test to determine whether a statute conveys a judicially enforceable right under Section 1983 and determining that Title IV-D of the Social Security Act does not under 42 U.S.C. § 1983); Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 524 (1990) (holding that the Boren Amendment to the Medicaid Act does create judicially-enforceable rights under 42 U.S.C. § 1983); *see also* Sean Jessee, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 801 (2009) ("While the Supreme Court has not yet ruled whether a Medicaid recipient has an individualized federal right under the equal access clause to bring a § 1983 lawsuit, a significant number of judicial opinions relevant to this inquiry exist.").

cases, however, have raised as many questions as they have answers.[82] *Wilder v. Virginia Hospital Association* and *Blessing v. Freestone* outline the tests the Supreme Court has used in the past to address early issues of whether certain statutes provide individuals with judicially enforceable rights.[83] *Gonzaga University v. Doe* is especially important, as it is the most recent case in which the Court decided a substantive Section 1983 issue with respect to a federal statute,[84] and the majority's opinion there heavily influenced the Eighth Circuit's reasoning in *Gillespie*.[85]

1. Wilder v. Virginia Hospital Association

At issue in *Wilder* was the Boren Amendment, a provision of the Medicaid Act that requires a state's Medicaid program to provide "reasonable access . . . to inpatient hospital services of adequate quality" for the mentally retarded.[86] In *Wilder*, the Court determined that the language of the Boren Amendment to the Medicaid Act created an enforceable right, but that this right was not enforceable under Section 1983 because the statute does not include judicial intervention as a remedy.[87] The Court considered the language of the 1980 Boren Amendment to the Medicaid Act and concluded that it requires states to reimburse providers in its Medicaid program at rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."[88] Congress did not define "reasonable and adequate" behavior in the Boren Amendment, nor did the office of the Secretary of Health and Human Services promulgate regulatory guidance; ultimately the interpretation of "reasonable and adequate" is left to the states.[89] The Boren Amendment mirrors the free choice of provider provision in the sense that

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[82] *See* Jessee, *supra* note 81, at 792 ("The judicial split, and the confusion evident in the wide variety of reasoning used to apply the Supreme Court's test for whether a statute is enforceable through § 1983, suggests that the Supreme Court should directly address the enforceability [of a statute through Section 1983].").

[83] *Wilder*, 496 U.S. at 498; *Blessing*, 520 U.S. at 340–41.

[84] Jane Perkins, *Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983*, NAT'L HEALTH L. PROGRAM (Oct. 28, 2013), http://www.healthlaw.org/issues/medicaid/private-enforcement-of-the-medicaid-act-pursuant-to-42-usc-1983#.Wl0MIZM-eqA [https://perma.cc/Q4CD-8WD3].

[85] *See Does*, 867 F.3d at 1039 (citing *Gonzaga*, 586 U.S. at 283) ("To support an action under § 1983, a plaintiff relying on a federal law must establish that Congress clearly intended to create an enforceable federal right.").

[86] *Wilder*, 496 U.S. at 503 (citing 42 U.S.C. § 1396a(a)(13)(A)).

[87] *Wilder*, 496 U.S. at 501–02, 523 ("We also reject petitioners' argument that the existence of administrative procedures whereby health care providers can obtain review of individual claims for payment evidences an intent to foreclose a private remedy in the federal courts.").

[88] *Id.* at 503.

[89] Ison, *supra* note 67, at 1499.

neither Congress nor the Secretary of Health have defined what a "qualified provider" is, leaving states with broad discretion to define the phrase for themselves.[90]

In *Wilder*, the Court stated that Section 1983 provides a cause of action only for violations of "rights, privileges, or immunities" conferred by a federal statute; simply proving that a state violated a federal law is not enough to have a federal right.[91] The Court created a three-part test to determine if the Boren Amendment offers a private right for Medicaid beneficiaries.[92] First, the Court asked whether the Boren Amendment "was intended to benefit the putative plaintiff," meaning individuals and entities providing medical services to the beneficiaries of Virginia's Medicaid program.[93] The Court concluded that, because the Amendment was "phrased in terms of benefiting health-care providers," that it was intended to benefit providers, not beneficiaries.[94]

The Court then considered whether the Amendment "impose[s] a 'binding obligation on the States," or if it merely suggests a "congressional preference for a certain kind of conduct."[95] Because the Boren Amendment states that a "State plan…must provide [reasonable and adequate] rates," the Court held that this language spoke in "mandatory rather than precatory terms" which were "wholly uncharacteristic of a mere suggestion or 'nudge.'"[96] The Court also found that the Medicaid Act as a whole "conditioned a State's receipt of federal funds on its compliance with the Amendment."[97] Therefore, because the Amendment imposed an obligation on states rather than an idea or wish from Congress of how they should act, the Court determined that the second step of its three-part test was satisfied and could support a private right of action under Section 1983.[98]

The final step of the Court's analysis considered whether the Amendment's instructions to states were "too 'vague and amorphous' to be judicially enforceable."[99] Although the Court concluded that the language of the Boren

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[90] *See supra* Part II.

[91] *Wilder*, 496 U.S. at 508–09.

[92] *Id.*at 509–25.

[93] *Id.* at 509.

[94] *Id.* at 510.

[95] *Id.* at 509–10.

[96] *Id.* at 512 (emphasis omitted) (quoting W. Virginia Univ. Hosp., Inc. v. Casey, 885 F.2d 11 (CA3 1989) (quoting Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 19 (1981)).

[97] Ison, *supra* note 67, at 1500.

[98] *Wilder*, 496 U.S. at 509–20. *But see* Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 28 (1981) ("[T]he typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.").

[99] *Wilder*, 496 U.S. at 519; *see also* DAVID W. LEE, HANDBOOK OF SECTION 1983 LITIGATION § 1.01(C) (2017) ("[Section] 1983 provides a remedy for violations of federal statutory law unless the remedial devices provided in the federal statute in question are sufficiently comprehensive to demonstrate congressional intent to preclude the remedy of

Amendment created an enforceable right,[100] it simultaneously noted that the Medicaid Act precludes private enforcement actions under Section 1983 because, unlike the Boren Amendment, the Medicaid Act does not provide judicial proceedings as a remedial measure for noncompliant states.[101]

What would happen if the *Wilder* analysis were applied to the free choice of provider provision of the Medicaid Act? First, the language of the provision begins with the phrase, "any individual eligible for medical assistance *may* obtain such assistance,"[102] suggesting that it is intended to benefit beneficiaries, not providers.[103] This makes sense, especially considering the legislative intent behind the Medicaid Act and the addition of the free choice of provider provision.[104] Additionally, courts have determined previously that providers undoubtedly do not have a cause of action under the free choice of provider provision.[105] This points more strongly to an inference of a private right of action for beneficiaries under the first step of the *Wilder* test regarding the inquiry of whether legislation is intended to benefit certain individuals.

The second step of the test does not apply as neatly to the free choice of provider provision. There is no "mandatory" language within the free choice of provider provision unequivocally stating that states *must* act a certain way. Rather, the provision states that beneficiaries *may* choose to use Medicaid funding towards any "qualified provider" of his or her choice.[106] Unlike the Boren Amendment the Court analyzed in *Wilder*, the free choice of provider provision is phrased in terms of what individuals within each state are permitted to do within the confines of the Medicaid Act, rather than demanding that states act a certain way. But as a practical matter, if the provision allows beneficiaries discretion in where to use their Medicaid funds, this Note argues that it is mandatory for the states to allow beneficiaries to exercise this right.

In applying the *Wilder* test to the free choice of provider provision, the third step of the analysis asks whether or not the language of the provision is too "vague" or "amorphous" to render it judicially unenforceable.[107] The only phrase of the free choice of provider provision that lacks an explicit definition

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suits under § 1983." (citing City of Rancho Palos Verdes v. Abrams, 544 U.S 113, 119–20 (2005)).

[100] *Wilder*, 496 U.S. at 519–20.

[101] *Id.* at 523; *see also* Ison, *supra* note 67, at 1502–03 ("This concern, coupled with the Court's subsequent decision in *Blessing v. Freestone*, hinted that the sources of supposed private rights might be subjected to some heightened level of scrutiny in the future.").

[102] 42 U.S.C. § 1396(a)(23)(2012) (emphasis added).

[103] For an analysis of the language of the provision, see *supra* note 19 and accompanying text discussing the interpretation found in the Code of Federal Regulations.

[104] *See supra* Part II.

[105] See *supra* Part III.A.

[106] *See supra* note 19 and accompanying text.

[107] *Wilder*, 496 U.S. 512, 519 (1990).

from Congress is what it means for a provider to be "qualified."[108] Therefore, the free choice of provider provision should not be considered so vague or ambiguous as to preclude a judicially enforceable private right of action for Medicaid beneficiaries under the *Wilder* framework.

Although the *Wilder* framework is the beginning of Section 1983 litigation in the civil context and is still considered good law, this test has been modified significantly by the Court's reasoning in *Gonzaga University v. Doe*[109] in 2002, changing the inquiry of whether a statute provides a beneficiary with an enforceable federal right.

2. Gonzaga University v. Doe

In *Gonzaga University v. Doe*, the Supreme Court held that the Family Education Rights and Privacy Act (FERPA) does not confer a judicially enforceable right for its beneficiaries under Section 1983. This is because the statute was enacted pursuant to Congress' spending power and does not include language that creates a federal right.[110] The Court recognized that its previous decisions determining whether individuals had a private right of action under Section 1983 within the context of certain statutes were not "models of clarity" and strove to "resolve any ambiguity."[111]

The Court noted that, because FERPA was enacted pursuant to Congress' spending power, "the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action . . . but rather action by the Federal Government to terminate funds to the State."[112] This is one way that the Court narrowed the previous standard for determining whether there is a private right of action under Section 1983, which it interpreted as a "relatively loose standard for finding rights enforceable."[113] The Court concluded that FERPA did not create a judicially enforceable right under Section 1983 because of the statute's enforcement mechanism, "direct[ing] the Secretary of Education to deal with violations by creating a review board for investigating and adjudicating violations of the statute."[114]

Although the statute allows aggrieved parents or students an opportunity to file complaints with administrative officials, these complaints do not provide an individual remedy through Section 1983.[115] Instead, the statute has a different

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[108] *See supra* Part II (a qualified provider is "any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide [a beneficiary] such services").

[109] Gonzaga Univ. v. Doe, 536 U.S. 273 (2002).

[110] *Id.* at 279.

[111] *Id.* at 278.

[112] *Id.* at 280 (quoting *Halderman*, 451 U.S. at 28).

[113] *Id.* at 282.

[114] Ison, *supra* note 67, at 1507 (citing 20 U.S.C. § 1232g(f)-(g) (2000)).

[115] *See* 34 C.F.R. § 99.63 (2002); Gonzaga Univ. v. Doe, 536 U.S. 273, 278–79, 287–90 (2002). While the complaint may eventually force the violating institution to comply with

remedy in place: the Secretary is able to send an institution instructions on how it may correct its violation.[116] Therefore, the Court has come to the conclusion that if the "remedial devices provided in a federal statute in question are sufficiently comprehensive to demonstrate congressional intent to preclude the remedy of suits under § 1983,"[117] an individual does not have a federal cause of action under Section 1983.

In addressing the applicable standard, the Court emphasized that the most important question to answer is whether Congress has spoken "with a clear voice" to demonstrate "unambiguous intent to confer individual rights" under Section 1983.[118] In other words, "a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*."[119] The Court went on to say that "[t]he question whether Congress . . . intended to create a private right of action [is] definitively answered in the negative" where "a statute by its terms grants no private rights to any identifiable class."[120] Specifically, a statute creates a private right of action for individuals if it is "phrased in terms of the persons benefitted."[121] With this reasoning, the Court attempted to clarify the first prong of the three-part test it outlined in *Blessing v. Freestone*: whether Congress enacted a certain provision with the intention to benefit someone in the plaintiff's situation.[122]

To provide examples of statutes drafted with "rights creating" language, the Court offered Title VI of the Civil Rights Act of 1964 and Title IX of the Education Act Amendments.[123] The Court determined that FERPA lacked this language because it served as a "directive to the Secretary of Education, not a statement creating a private right."[124] Additionally, the Court found that FERPA

FERPA's privacy requirements or forego federal funding, the complaining student receives neither a curative remedy nor damages as compensation for the release of his academic information. *Id.* at 289–91.

[116] *See* 34 C.F.R. § 99.66(b), (c)(1).

[117] LEE, *supra* note 99, § 1.01(C).

[118] *Gonzaga*, 536 U.S. at 280.

[119] *Id.* at 282 (quoting *Blessing*, 520 U.S. at 340).

[120] *Id.* at 283–84 (quoting Touche Ross & Co. v. Redington, 442 U.S. 560, 576 (1979)).

[121] *Id.* at 284 (quoting Cannon v. Univ. of Chi., 441 U.S. 677, 692 n.13 (1979)).

[122] *Id.* at 283. The *Blessing* Court determined that a statute confers a federal right if (1) Congress must have intended that the provision in question benefit the plaintiff, (2) the plaintiff demonstrates that the right asserted is not so vague and ambiguous "that its enforcement would strain judicial competence," and (3) if the statute unambiguously "imposes a binding obligation on the States," in mandatory rather than precatory terms. *Blessing*, 520 U.S. at 340–41.

[123] *See* Jessee, *supra* note 81, at 800 n.71 ("Title VI provides that '[n]o person in the United States shall, on the ground of race, color, or national origin, be . . . subjected to discrimination under any program or activity receiving federal assistance.' 42 U.S.C. § 2000d (2006). Title IX provides that '[n]o person in the United States shall, on the basis of sex . . . be subjected to discrimination . . .' 20 U.S.C. § 1681 (a) (2006).").

[124] Ison, *supra* note 67, at 1506. The text of FERPA states "[n]o funds shall be made available under any applicable program to any educational agency or institution . . . which

did not create an enforceable federal right for individuals because it is not concerned with "whether the needs of a particular person have been satisfied."[125] Furthermore, the Court found that FERPA's provisions speak "only in terms of institutional policy and practice, not individual instances of disclosure,"[126] giving the statute an aggregate focus.

There are a few differences between FERPA and the Medicaid Act's free choice of provider provision that imply the free choice of provider provision could confer an enforceable federal right under the *Gonzaga* reasoning. Although the Medicaid Act allows the Secretary of Health and Human Services to reduce or cut off funding from states that do not comply with the program's requirements, an enforceable federal right is still available under Section 1983 where Congress has not established a "carefully crafted and intricate remedial scheme . . . for the enforcement of a particular federal right."[127] The Medicaid Act simply allows the Secretary to reduce or cut off funds if a state's program does not meet federal requirements.[128] It does not empower the Secretary of Health and Human Services to create a review board and engage in an investigative process like the remedial scheme under FERPA.[129] Therefore, the Medicaid Act lacks the detailed remedial scheme necessary to preempt the existence of an enforceable federal right under Section 1983.

The next issue under *Gonzaga* is whether the Medicaid Act and its free choice of provider provision grant rights to an identifiable class. Following the *Gonzaga* reasoning, the Medicaid Act's language can be said to grant rights to an identifiable class if it is "phrased in terms of the persons benefitted."[130] One argument is that the Medicaid Act is not phrased in terms of the persons benefitted because "its provisions speak 'only in terms of institutional policy and practice' and not in terms of the provision of care to any individual."[131] Put another way, "the focus of the Secretary's inquiry is on the plan or the administration of the plan, not on individual instances of noncompliance."[132]

The language of the Medicaid Act's free choice of provider provision is permissive with the word "may,"[133] in contrast with the mandatory language of the statutes the Court provided as examples of rights-creating language in

effectively prevents . . . the right to inspect and review . . . education records." 20 U.S.C. § 1232g(a)(1)(A).

[125] *Gonzaga*, 536 U.S. at 288.

[126] *Id.*

[127] Seminole Tribe of Fla. v. Florida, 517 U.S. 44, 73–74 (1996) (finding no enforceable right under Section 1983 for a statute that included remedial measures such as timetables, incentives, and "intricate procedures" to cajole Indian tribes to negotiate agreements on gambling).

[128] *See* 42 U.S.C. § 1396c.

[129] *See supra* note 108.

[130] Ison, *supra* note 67, at 1499 (citing to Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 510 (1990)).

[131] Ison, *supra* note 67, at 1510 (citing *Gonzaga*, 536 U.S. at 288).

[132] *Id.*

[133] *See* 42 U.S.C. § 1396c.

Gonzaga.[134] However, the freedom of choice provision is still phrased in terms of the group of people it is intended to benefit: Medicaid beneficiaries. The text of FERPA that the Court interpreted in *Gonzaga* did not mention any individuals or groups of people, but rather stated that "[n]o funds shall be made available under any applicable program to any educational agency or institution."[135] In contrast, the free choice of provider provision in particular states that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required."[136] Because the free choice of provider provision is phrased in terms of "any individual" that receives Medicaid funding,[137] it arguably would pass the *Gonzaga* standard and confer a judicially enforceable right upon Medicaid beneficiaries.

Medicaid Act's free choice of provider provision lacks a detailed remedial scheme and is phrased in terms of the individuals it is intended to benefit. Therefore, it should be distinguishable from FERPA and said to authorize an enforceable federal right under Section 1983.

B. *The Medicaid Act's Free Choice of Provider Provision Should Be Enforceable Under Section 1983*

If the free choice of provider provision is not interpreted to meet the standards outlined by the Supreme Court in *Wilder* and *Gonzaga*, then did the Fifth, Sixth, Seventh, and Ninth Circuits all got it wrong?[138] Or is there another possibility specific to statutes like the Medicaid Act that allow individuals to sue a state when they are denied certain benefits provided under the statute?

Just one month before the Supreme Court decided *Gonzaga v. Doe*, the Sixth Circuit applied the *Blessing* test to a provision of the Medicaid Act and determined that it does confer an enforceable federal right on Medicaid beneficiaries.[139] In *Westside Mothers v. Haveman*, the Sixth Circuit analyzed the language of the Medicaid Act, particularly its mandate for states to provide "early and periodic screening, diagnostic, and treatment services . . . for individuals who are eligible under the plan."[140] The Sixth Circuit determined that this particular provision was "intended to benefit the putative plaintiffs, children who are eligible for the screening and treatment services" because the Court "found no appellate cases to the contrary."[141] This is significant because

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[134] *Gonzaga*, 537 U.S. at 284.

[135] 20 U.S.C. § 1232g(a)(1)(A).

[136] 42 U.S.C. § 1396(a)(23).

[137] *Id.*

[138] For an overview of the reasoning of the Fifth, Sixth, Seventh, and Ninth Circuits in deciding this issue, *see supra* Part III.B.

[139] Westside Mothers v. Havemen, 289 F.3d 852, 863 (6th Cir. 2002), cert denied, 537 U.S. 1045. For an outline of the *Blessing* test, see *supra* note 122.

[140] 42 U.S.C. § 1396d(a)(4)(B).

[141] *Westside Mothers*, 298 F.3d at 863 (citing 42 U.S.C. § 1396a(a)(10)(A)).

it suggests that the inquiry of whether an individual has a right to sue under Section 1983 depends not on the statutory scheme, but rather seems to favor reading a specific provision of a statute in a way that does confer a federal right, unless court precedent says otherwise.[142]

The Sixth Circuit also found that the provisions of the Medicaid Act set a "binding obligation" on states because "[t]hey are couched in mandatory rather than precatory language, stating that Medicaid services '*shall* be furnished' [to eligible individuals]," and that treatment "must be provided."[143] Finally, the court determined "the provisions are not so vague and amorphous as to defeat judicial enforcement, as the statute and regulations carefully detail the specific services to be provided."[144] Perhaps the most important language from the Court is its statement that "Congress did not explicitly foreclose recourse to § 1983 in this instance, nor has it established any remedial scheme sufficiently comprehensive to supplant § 1983" in the context of the Medicaid Act.[145]

The reasoning in *Westside Mothers* is significant because the Sixth Circuit showed a willingness to treat discrete portions of the Act differently. This is different compared to the *Wilder*, *Gonzaga*, and *Blessing* cases that apply the same reasoning to each provision within the act in question, a holistic approach that can overlook key textual discrepancies within a given statutory scheme. In *Wilder*, *Gonzaga*, and *Blessing*, the courts read entire acts as barring individual claims, regardless of whether a specific provision suggested otherwise.[146]

Although *Westside Mothers* addresses only the screening and treatment provisions of the Medicaid Act and determines that it gives rise to a cause of action under Section 1983,[147] the Sixth Circuit's reasoning is applicable to the free choice of provider provision as well. There is little doubt that the free choice of provider provision is intended to benefit Medicaid beneficiaries as a group of individuals. If this is not a specific enough class to entitle beneficiaries to sue under Section 1983, this Note argues that the free choice of provider provision should be read to benefit Medicaid beneficiaries who wish to use Medicaid funding for all non-abortion reproductive health services. This is a logical reading of the provision, given that many of the decisions states make in denying the ability to use Medicaid funding is within the context of family planning and reproductive health services.[148] If the *Westside Mothers* reasoning is applied to

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[142] *See id.* (citing *Blessing*, 520 U.S. at 341) ("If these conditions [of the *Blessing* test] are met, we presume the statute creates an enforceable right unless Congress has explicitly or implicitly foreclosed this.").

[143] *Id.* (citing 42 U.S.C. § 1396a(a)(10)(A)).

[144] *Id.* (citing 42 U.S.C. § 1396d(r)).

[145] *Id.*

[146] *See supra* Part V.A.1 and Part V.A.2.

[147] *Westside Mothers*, 298 F.3d at 863 ("Plaintiffs have a cause of action under § 1983 for alleged noncompliance with the screening and treatment provision of the Medicaid Act.").

[148] This reading of the free choice of provider provision is consistent with the legislative history behind its addition to the Medicaid Act and Congress' intent to provide Medicaid

the free choice of provider provision in future cases, a plaintiff is likely to have a cause of action under Section 1983 because the provision can be read to benefit a specific group of individuals, and no other remedial scheme or relief is available.

VI. CONCLUSION

Since Congress passed the Medicaid Act, the United States' healthcare system has remained highly politicized, with elected officials unable to agree on how large of a role the federal government should have in providing coverage to low-income and elderly Americans. While the addition of the freedom of choice provision to the Medicaid Act seems to allow a beneficiary to have access to any qualified provider of her choosing, in practical terms is unclear whether this choice is a fundamental right that beneficiaries may enforce and protect through a Section 1983 action.

With the addition of the free choice of provider provision, Congress intended to allow states a significant amount of deference in determining which health care providers meet the meaning of "qualified." Therefore, the provision allows states to decide which providers are available to Medicaid beneficiaries wishing to use federal and state funds to finance health care services. More specifically, the legislative history of the Medicaid Act's free choice of provider provision indicates that Congress wished to prevent states from barring Medicaid beneficiaries from private health care facilities. There is also evidence that Congress wished to deter states from imposing moral judgments on Americans' choices regarding family planning with the provision's enactment.

Since the passage of the freedom of choice provision, courts have struggled with the notion of whether it awards Medicaid beneficiaries the right to sue a state for denying access to a certain provider. While most federal circuits have concluded that Medicaid beneficiaries do have the right to bring Section 1983 claims,[149] the Eighth Circuit's decision in *Does v. Gillespie* casts doubt onto whether plaintiffs in this situation do have an enforceable right.[150]

The free choice of provider provision should be interpreted to provide Medicaid beneficiaries with an enforceable federal right and a cause of action under Section 1983 to challenge a state's determination of which health care providers are "qualified." Since providers are not given any rights under the provision, if beneficiaries are unable challenge state action, then no one can. This cannot be the intended result of the provision, given that Congress added it to the original Medicaid Act to prevent states from limiting access to certain providers. Therefore, courts should decline to adopt the *Does v. Gillespie* reasoning and instead decide in future cases that Medicaid beneficiaries have

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beneficiaries with more freedom in family planning decisions. *See supra* note 17 and accompanying text.

[149] *See supra* Part III.B.

[150] *See Does*, 867 F.3d at 1046.

the right to challenge a state's determination of whether a provider is qualified through a Section 1983 action.