

THE YALE LAW JOURNAL

JON DONENBERG

Medicaid and Beneficiary Enforcement: Maintaining State Compliance with Federal Availability Requirements

ABSTRACT. When states accept federal funding to administer a joint federal-state program, what assurance is there that they will conform to the requirements of governing federal law? This question takes on a new urgency in the Medicaid context since the § 1983 lawsuits that have historically monitored state compliance with fundamental federal Medicaid requirements may now be impermissible due to recent legislative developments. Anticipating a scramble to find alternative means of enforcement, a novel solution—using administrative hearings to compel states to conform to the federal requirements—may prove to be the most appropriate remaining mechanism for bridging the impending accountability gap.

AUTHOR. Yale Law School, J.D. 2008; University of Cambridge, M.Phil. 2005; University of Illinois at Urbana-Champaign, B.S., B.A. 2004. I am indebted to Michael Graetz and Jerry Mashaw for their early guidance and encouragement in developing this piece. I am particularly thankful to Jerry Mashaw, Theodore Marmor, and Theodore Ruger for their helpful comments on administrative law and the vagaries of Medicaid policy. Thanks also to Amanda Aikman, Ben Siracusa, and in particular, Christen Linke Young, for their significant editorial assistance, and to my family, for their unwavering support.



NOTE CONTENTS

INTRODUCTION	1500
I. MEDICAID STRUCTURE AND IMPLEMENTATION	1504
II. THE EFFECTS OF THE DEFICIT REDUCTION ACT ON COST SHARING AND BENEFITS UNDER MEDICAID	1507
A. New Forms of Cost Sharing and Premiums	1508
B. New Restrictions on Benefits	1511
III. MEDICAID ENFORCEMENT UNDER 42 U.S.C. § 1983	1514
A. Emerging Limitations on § 1983 Actions	1517
B. The DRA and Compelling the Availability of Benefits Under § 1983	1521
1. The Text and Structure of the DRA Eliminate the Enforceability of Medicaid Under § 1983	1523
2. The Empirical Effects of DRA-Based Premiums and Cost Sharing Undermine Medicaid Enforceability Under § 1983	1525
3. The New DRA Benefits Packages Do Not Confer Individual Rights Enforceable Under § 1983	1526
IV. ENFORCING FEDERAL MEDICAID REQUIREMENTS THROUGH STATE-LEVEL “FAIR HEARINGS”	1527
A. The Boundaries of the Federal Fair Hearing Requirement	1531
1. Textual Analysis of the HHS Regulations and Supporting Materials	1533
2. Federal Case Law on the Fair Hearing Requirement	1534
B. Fair Hearings in the States	1537
C. The Efficacy of Fair Hearings for Enforcing the Terms of Medicaid State Plans	1542
CONCLUSION	1545

INTRODUCTION

The Medicaid program is the government's primary healthcare financing regime for low-income Americans. Created alongside the more contentious Medicare program in 1965, its original reach was quite limited.¹ Over time, Medicaid has grown significantly, and now helps provide care for more than twelve million elderly and disabled people, in addition to thirty-nine million beneficiaries with incomes in the vicinity of the federal poverty line.² Codified in Title XIX of the Social Security Act,³ the program is supervised by the Centers for Medicare and Medicaid Services (CMS), a federal oversight agency situated within the U.S. Department of Health and Human Services (HHS),⁴ but it is administered by individual implementing agencies within each state.

Medicaid, like all joint state-federal spending programs, operates pursuant to a series of contractually styled agreements between the federal government and individual states.⁵ States agree to provide financing for certain groups of eligible enrollees and to cover a portion of their healthcare costs. In exchange, the federal government partially subsidizes the financing of healthcare for these individuals.⁶ Ostensibly a voluntary program, all fifty states have chosen to participate in Medicaid, taking full political credit for healthcare expansions while shouldering only a portion of the costs of service. Over time, state budgets have become so inextricably linked with federal Medicaid funding that withdrawal from the program on the part of any state seems politically and financially untenable.⁷

-
1. See RAND E. ROSENBLATT, SYLVIA A. LAW & SARA ROSENBAUM, *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 15-16 (1997) (noting how the various limitations of the original program led Medicaid to reach only "one half or less of families with incomes below the federal poverty line"); see also *id.* at 410-21 (providing additional history on the massive growth of the Medicaid program since its inception).
 2. ROBIN RUDOWITZ & ANDY SCHNEIDER, *KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE NUTS AND BOLTS OF MAKING MEDICAID POLICY CHANGES: AN OVERVIEW AND A LOOK AT THE DEFICIT REDUCTION ACT 4* (2006), available at <http://www.kff.org/medicaid/upload/7550.pdf>.
 3. 42 U.S.C. §§ 1396-1396v (2000).
 4. Medicaid: Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov/home/medicaid.asp> (last visited Mar. 6, 2008).
 5. See Michael A. Platt, Comment, *Westside Mothers and Medicaid: Will This Mean the End of Private Enforcement of Federal Funding Conditions Using Section 1983?*, 51 AM. U. L. REV. 273, 297-307 (2001).
 6. *Id.*
 7. See Bruce J. Casino, *Federal Grants-In-Aid: Evolution, Crisis, and Future*, 20 URB. LAW. 25, 40 (1988) (arguing that financial strain on the states means that their participation in federal

Like many state-federal partnerships, ensuring that states faithfully implement the federally defined requirements of the Medicaid program can be a difficult task. When states agree to participate in Medicaid, they must provide assurances that they will act “in conformity with the specific requirements” of the federal Medicaid statute and applicable CMS regulations.⁸ Although states may feel compelled for fiscal and political reasons to take Medicaid funding, however, it is not always the case that they will comply with the requirements of the federal statute or continue over time to provide the services that they have agreed to provide.⁹

By design, the intended mechanism for keeping states accountable for their obligations under Medicaid is found in 42 U.S.C. § 1396c, which allows the Secretary of HHS, upon a sufficient finding of noncompliance, to withhold some or all of the federal government’s grant payments until the state begins to act in accordance with the requirements of its program.¹⁰ As a practical matter, however, this mechanism is ill-equipped to ensure compliance for several reasons. First, since the primary role of federal grant-in-aid agencies is to facilitate cooperation with the states, enforcement takes on a low priority.¹¹ Second, the remedy is so destructive to the underlying aid program that it is “rarely, if ever, invoked.”¹² Third, the funding cutoff provision requires CMS to hold a hearing to determine whether or not a state is out of compliance with the requirements of the program. This process can be burdensome and time-consuming.¹³ Finally, federal administrators are not accountable to local

grants-in-aid programs is de facto compulsory); see also James F. Blumstein & Frank A. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 VAND. L. REV. 125, 141-44 (2000) (discussing the effects of political “lock-in” that make it increasingly difficult for states to scale back on Medicaid funding).

8. 42 C.F.R. § 430.10 (2007).
9. See Frederick H. Cohen, *An Unfulfilled Promise of the Medicaid Act: Enforcing Medicaid Recipients’ Right to Health Care*, 17 LOY. CONSUMER L. REV. 375, 390 (2005) (noting that “[m]any states . . . are under-funding their Medicaid programs” in violation of their obligations under the federal statute). See generally Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement*, 58 VA. L. REV. 600, 619-21 (1972) (discussing the relative ineffectiveness of federal agencies at enforcing statutory requirements).
10. 42 U.S.C. § 1396c (2000).
11. Tomlinson & Mashaw, *supra* note 9, at 619-21.
12. Lisa E. Key, *Private Enforcement of Federal Funding Conditions Under § 1983: The Supreme Court’s Failure To Adhere to the Doctrine of Separation of Powers*, 29 U.C. DAVIS L. REV. 283, 293 (1996); see also Tomlinson & Mashaw, *supra* note 9, at 620 (“The posture of the federal agency toward its grantees is not generally that of a referee calling fouls, but that of a coach giving support in the form of cash and expertise.”).
13. See Key, *supra* note 12, at 292-93.

beneficiaries and as a result may prioritize good working relations with their state counterparts over the concerns of individual Medicaid enrollees.¹⁴

In the absence of an effective institutional-level remedy, individual beneficiaries seeking to force states to abide by federal Medicaid requirements historically have turned to 42 U.S.C. § 1983, a nineteenth-century civil rights measure that provides a federal cause of action against state officials who violate individual rights secured by federal statutes or the Constitution.¹⁵ The Supreme Court's decision in *Maine v. Thiboutot* first recognized the right to bring § 1983 actions against state actors to enforce federal statutory rights in 1980.¹⁶ A decade later, *Wilder v. Virginia Hospital Ass'n* expressly affirmed the applicability of § 1983 to the Medicaid statute.¹⁷ In recent decades, these actions have become a primary mechanism by which individual beneficiaries and advocacy groups have forced state Medicaid agencies to comply with federal Medicaid requirements.¹⁸ Through § 1983, Medicaid beneficiaries have been able to operate as private enforcement agents, using litigation to supplant the traditional role of federal bureaucrats in enforcing the public interest as defined by Congress.¹⁹

The importance of § 1983 for maintaining the fidelity of states to their particular Medicaid agreements extends beyond the ability of beneficiaries to obtain favorable judgments in federal court. A primary purpose of § 1983 has always been to deter states from violating federal restrictions.²⁰ So long as state

14. See *id.* at 293; Tomlinson & Mashaw, *supra* note 9, at 618-19.

15. 42 U.S.C. § 1983 (2000).

16. 448 U.S. 1 (1980).

17. 496 U.S. 498 (1990).

18. See Platt, *supra* note 5, at 276 & n.10.

19. It is not unusual for Congress to create pathways for private litigation to ensure compliance with the requirements of federal statutes. Congress frequently creates citizen-standing provisions that authorize private individuals to sue federal agencies for noncompliance with the law. See, e.g., Clean Water Act § 505, 33 U.S.C. § 1365 (2000). In areas where enforcement is particularly difficult, the government sometimes creates incentives for such lawsuits by individuals better situated than the federal government to ensure compliance with federal policy norms. See, e.g., Marc S. Raspanti & David M. Laigaie, *Current Practice and Procedure Under the Whistleblower Provisions of the Federal False Claims Act*, 71 TEMP. L. REV. 23 (1998) (discussing the development and efficacy of *qui tam* actions to incentivize whistle blowing when contractors defraud the government).

20. See *Wyatt v. Cole*, 504 U.S. 158, 161 (1992) (identifying a main animating purpose of § 1983 as “deter[ring] state actors from using the badge of their authority to deprive individuals of their federally guaranteed rights and to provide relief to victims if such deterrence fails”); see also *Richardson v. McKnight*, 521 U.S. 399, 402-03, 412 (1997); *Robertson v. Wegmann*, 436 U.S. 584, 590-91 (1978).

agencies are faced with a credible threat of being held accountable through the § 1983 mechanism, they are likely to be discouraged from moving forward with changes that contravene federal requirements.

Although the historical effectiveness of § 1983 for enforcing federal Medicaid requirements is beyond dispute, its continued legal vitality is uncertain. In 2005, Congress overhauled several provisions of the Medicaid statute. In the process, it fundamentally altered the contours of the traditional federal-state relationship, giving states for the first time ever the flexibility to restructure their benefit programs without regard to longstanding statutory rules that had previously made many aspects of the program compulsory.²¹ These major legislative modifications, when viewed in light of the movement by the Supreme Court over the last decade to narrow the scope of cognizable § 1983 claims generally, cast serious doubt on the continued viability of the provision as a functioning mechanism for ensuring state fidelity to federal Medicaid requirements, in particular with regard to Medicaid's most basic requirement that states make "available" those benefits they are obligated to provide under their state plans.²² Faced with these new legislative developments, federal courts can be expected to find that § 1983 no longer provides a cause of action for beneficiaries suing to force states to provide benefits.

With the threat of § 1983 litigation no longer serving as a deterrent to states that might feel compelled to reduce benefits during hard times, beneficiaries are likely to seek alternate means of holding states accountable. In seeking an effective substitute for § 1983, beneficiaries and advocacy groups should consider utilizing state law provisions that authorize administrative review of changes in Medicaid coverage. The Medicaid statute requires individual states to provide such "fair hearing[s]" to "any individual whose claim for medical assistance under the [state] plan is denied or is not acted upon with reasonable promptness."²³ States have great flexibility in implementing the "fair hearing" requirement, and the efficacy of these administrative actions as a replacement form of enforcement action will depend largely on the circumstances of each individual state. A thorough analysis of the minimum requirements for these hearings, along with the ways in which they vary across many jurisdictions,

21. See Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006) (codified in scattered sections of 42 U.S.C.); see also ANDY SCHNEIDER & RACHEL GARFIELD, KAISER COMM'N ON MEDICAID & THE UNINSURED, THE MEDICAID RESOURCE BOOK 49, 54-57 (2002), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14260> (describing the DRA's new benefits structure).

22. See 42 U.S.C. § 1396a(a)(10)(A) (2000).

23. *Id.* § 1396a(a)(3).

suggests that beneficiaries should be able to effectuate some amount of private enforcement of federal Medicaid requirements, including the crucial “availability” requirement, through these state administrative processes. These hearings will not, however, provide an adequate remedy in all cases.

The following examination of modern options for Medicaid beneficiary enforcement proceeds in five parts. Part I outlines the basic administrative structure of Medicaid and the processes by which states are bound to—and can subsequently modify—their individual agreements with the federal government. Part II looks at the changes to Medicaid in the Deficit Reduction Act of 2005 (DRA),²⁴ focusing in particular on the states’ new flexibility to limit or expand the provision of traditionally enumerated benefits to specific subgroups of Medicaid recipients in ways previously barred by statute. Part III examines the evolution of § 1983 jurisprudence. It argues that because of the DRA’s changes, Medicaid’s “availability” requirement will now likely fail the *Gonzaga v. Doe* standard, which requires a showing that Congress intended “unambiguously” to confer a federal right in order to sustain a § 1983 claim.²⁵

Part IV examines the extent to which state-level fair hearings can help fill the void once the federal courts begin scaling back § 1983 as a cause of action for Medicaid beneficiary enforcement claims. It focuses on the ways in which individual states implement Medicaid hearing requirements, arguing that a robust reading of that requirement can be combined with state Administrative Procedure Acts to allow individual beneficiaries to bring state-level administrative challenges to contest actions by states that violate federal Medicaid requirements. Finally, this analysis concludes by noting that although attempts at enforcement through state administrative hearings provide an incomplete substitute for § 1983 enforcement actions, they remain a practical and immediately viable alternate option for ensuring that states continue to provide those benefits they are obligated to provide under the terms of their state Medicaid agreements.

I. MEDICAID STRUCTURE AND IMPLEMENTATION

This Part briefly sketches key characteristics of the Medicaid program, focusing on how states and the federal government agree on the provision of particular benefits, as well as procedures for states to modify those agreements lawfully. At its heart, Medicaid is an optional grant program offering a massive financial subsidy to states that provide healthcare financing to low-income

24. Pub. L. No. 109-171, 120 Stat. 4 (2006) (codified in scattered sections of 42 U.S.C.).

25. See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002).

Americans. In exchange for this support, states are obligated to comply with certain federal stipulations. Historically, states participating in Medicaid have been required to provide an enumerated set of mandatory benefits to all eligible beneficiaries.²⁶ These mandatory benefits cover a broad range of medical assistance, including physicians' services,²⁷ laboratory and x-ray services,²⁸ inpatient hospital services,²⁹ and comprehensive early and periodic screening, diagnostic, and treatment services (EPSDT) for children.³⁰ The program also provides a variety of nursing facility services for adults,³¹ and as a result has seen massive growth as a source of long-term care financing.³² Beyond the mandatory benefits, which must be provided to all eligible beneficiaries as a condition of receiving any federal subsidies, states also have historically had the option of providing optional services above and beyond the base program. These optional services include, for example, prescription drugs³³ and targeted case management services.³⁴ Despite their discretionary status, optional services account for a significant portion of most states' Medicaid expenditures.³⁵

Medicaid uses both the promise of federal funds and the threat of funding withdrawal to shape the coverage provided by individual states. By reducing the costs to states to provide particular services, federal matching funds facilitate new initiatives and coverage expansions.³⁶ Despite some attempts to

-
26. The traditional Medicaid benefits are summarized in 42 U.S.C. § 1396d(a) (2000). Section 1396a(a)(10)(A) indicates those provisions of § 1396d(a) that describe mandatory services; the remainder of § 1396d(a) defines optional services. *See also* SCHNEIDER & GARFIELD, *supra* note 21, at 54-57.
 27. 42 U.S.C. § 1396d(a)(5)(A) (2000).
 28. *Id.* § 1396d(a)(3).
 29. *Id.* § 1396d(a)(1).
 30. *Id.* § 1396d(a)(4)(B).
 31. *Id.* § 1396d(a)(4)(A).
 32. *See* Jeffrey R. Brown, Norma B. Coe & Amy Finkelstein, *Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey* (2007), available at http://www.aeaweb.org/annual_mtg_papers/2007/0107_1300_0701.pdf.
 33. 42 U.S.C. § 1396d(a)(12) (2000).
 34. *Id.* § 1396d(a)(19).
 35. The Kaiser Commission on Medicaid and the Uninsured has estimated that so-called optional services now account for sixty percent of all Medicaid expenditures. KAISER COMM'N ON MEDICAID & THE UNINSURED, DEFICIT REDUCTION ACT OF 2005: IMPLICATIONS FOR MEDICAID 3 (2006) [hereinafter KAISER DRA REPORT], available at https://www.aucd.org/docs/policy/medicaid/kaiser_medicaid_dra_2005_020106.pdf.
 36. Diane Rowland & James R. Tallon Jr., *Medicaid: Lessons from a Decade*, HEALTH AFF., Jan./Feb. 2003, at 138, 140-41.

engineer the broad contours of the program from Washington, however, the existence of optional Medicaid services, combined with states' ability to roll Medicaid funds into broader statewide financing schemes, has led to a great deal of variation from state to state in the design and implementation of low-income healthcare financing.³⁷

Each state's individual Medicaid program is codified in its "state plan," a public document on file with CMS that records which optional services a state has elected to provide and stipulates how states intend to comply with the requirements of the federal Medicaid statute and any applicable supplementary regulations.³⁸ State plan documents contain the complete record of state Medicaid programs since their inception. Occasionally, states may modify their state plans beyond those options specifically authorized under current law. In those instances, they must petition the HHS Secretary for "waiver" approval.³⁹ The rest of the time, when states wish to change the terms by which they implement their programs while staying within the rules laid out by the Medicaid statute and federal regulations, they must file a State Plan Amendment (SPA) with CMS. SPAs must be filed any time a state makes "[m]aterial changes" to the law, organization, policy, or operation of its Medicaid program.⁴⁰ SPAs, which must be approved by the HHS Secretary,⁴¹ authorize state plan changes that comply with the existing statute and are presumptively accepted by CMS.⁴² Given the statutory enumeration of the grounds upon which states can modify their Medicaid programs through the SPA process, approval of amendments is generally straightforward and fairly predictable. In some cases, CMS even provides "preprint" sheets—skeleton forms that state administrators can fill in containing boxes that they can check off to indicate the options they have chosen to implement—to streamline the process.⁴³

37. See, e.g., Dayna Bowen Matthew, *The "New Federalism" Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973, 990-91 (2002) (presenting data on enrollment and expenditure disparities across sample states).

38. 42 C.F.R. § 430.10 (2007).

39. Authority is granted to the HHS Secretary for several different types of waivers. See, e.g., 42 U.S.C. §§ 1315(a), 1396n(b), 1396n(c) (2000).

40. 42 C.F.R. § 430.12(c)(ii) (2007). States are also required to submit amendments to instantiate any modifications required by changes in federal law, regulations, policy interpretations, or court decisions. *Id.* § 430.12(c)(i).

41. 42 U.S.C. § 1396a(b) (2000).

42. *Id.* § 1396a(a).

43. RUDOWITZ & SCHNEIDER, *supra* note 2, at 9.

Because they define the terms of each individual state’s obligations under Medicaid, state plans are at the center of the debate over what benefits states must provide to their Medicaid enrollees. Although the federal statute delineates between mandatory and optional benefits, once a state codifies its intent to provide an optional benefit in a state plan, it must follow through on its promise to provide those benefits as surely as if they were written into the federal statute itself as mandatory requirements.⁴⁴ The central focus of this inquiry is on how to respond effectively to actions by states that illegally violate the terms of their state plans without properly amending them.

II. THE EFFECTS OF THE DEFICIT REDUCTION ACT ON COST SHARING AND BENEFITS UNDER MEDICAID

Significant aspects of the traditional conception of Medicaid were called into question by the enactment of the Deficit Reduction Act of 2005 (DRA).⁴⁵ Signed on February 8, 2006, Congress designed the DRA to streamline existing federal spending programs and reduce net expenditures.⁴⁶ The Congressional Budget Office (CBO) roughly estimates that the legislation will reduce direct federal spending by nearly one hundred billion dollars over the next ten years.⁴⁷ Over a quarter of these savings are expected to come from decreases in Medicaid spending.⁴⁸

Title VI of the DRA deals specifically with the Medicaid program.⁴⁹ Over sixty percent of the projected savings from the DRA’s Medicaid alterations and reductions—sixteen billion dollars over ten years—is expected to come from the new benefits restrictions, cost sharing, and premiums provisions of the DRA.⁵⁰ This Part details how these three categories of provisions

44. See 42 C.F.R. § 440.230(b) (2007); see also *Alexander v. Choate*, 469 U.S. 287, 289 & n.1 (1985).

45. Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (2006) (codified in scattered sections of 42 U.S.C.).

46. In signing the DRA, President Bush noted that the bill was meant to promote restraint in federal spending through “difficult choices” made “[b]y setting priorities and making sure tax dollars are spent wisely.” President George W. Bush, Statement of the President upon Signing S.1932, Deficit Reduction Act of 2005 (Feb. 8, 2006), available at <http://www.whitehouse.gov/news/releases/2006/02/20060208-8.html>.

47. See CONGRESSIONAL BUDGET OFFICE, CONGRESSIONAL BUDGET OFFICE COST ESTIMATE: S.1932 DEFICIT REDUCTION ACT OF 2005, at 1 (2006) [hereinafter CBO ESTIMATE].

48. *Id.* at 34.

49. Deficit Reduction Act §§ 6001-6203, 120 Stat. at 54.

50. See CBO ESTIMATE, *supra* note 47, at 40.

fundamentally alter the basic, longstanding structure of Medicaid for large swaths of current beneficiaries. Section II.A addresses the new forms of cost sharing and premiums that may be imposed on Medicaid recipients under the DRA, while Section II.B examines the DRA's provisions allowing states to radically restructure their overall Medicaid benefits packages. All of these factors combine to make much of what was once required under Medicaid a matter of state policy discretion. Part III will explain how this statutory shift from the provision of required, enumerated benefits to broad state policy discretion so fundamentally alters the basic assumptions underlying the application of 42 U.S.C. § 1983 as to render that remedy inoperable with regard to Medicaid.

A. *New Forms of Cost Sharing and Premiums*

The DRA grants significant new powers to the states to force many beneficiaries to shoulder a significant portion of their own Medicaid costs.⁵¹ The most common cost-sharing mechanisms are deductibles and various forms of copayments.⁵² Although prior Medicaid law allowed for some nominal levels of cost sharing, from 1982, such payments were limited to three dollars for the majority of Medicaid services.⁵³ Under the new, post-DRA regime, however, states have the option of implementing considerably more robust cost-sharing mechanisms for Medicaid recipients at or above the federal poverty line.⁵⁴ The DRA also grants states high levels of discretion regarding when to implement cost sharing, and precisely how much of it to employ.⁵⁵

A similar form of precision control is created by the DRA in the area of premiums. Premium provisions require Medicaid recipients to pay enrollment

51. Deficit Reduction Act § 6041, 120 Stat. at 81-82.

52. See 42 U.S.C.A. § 13960-1(a)(2)(B) (West Supp. 2007) (outlining state options for providing for these two cost-sharing mechanisms).

53. See CBO ESTIMATE, *supra* note 47, at 40. Although some states have imposed greater levels of cost sharing than these nominal limits through CMS waivers, the majority of enrollees did not pay any cost sharing prior to the DRA. *Id.*

54. See 42 U.S.C.A. § 13960-1(b) (West Supp. 2007).

55. The degree to which states are granted flexibility in distributing cost sharing across different types of services is particularly significant. While the DRA imposes caps on the total percentage of family income that can be consumed by cost sharing generally, cost sharing required for individual services can be much greater—one-tenth of the total cost per service for individuals between 100% and 150% of the federal poverty line, and one-fifth of the total cost for individuals above 150% of the federal poverty line. *Id.*

fees or equivalent charges as a condition of service.⁵⁶ Under the old rules governing Medicaid, premiums were narrowly restricted and generally allowed only by waiver.⁵⁷ The DRA, however, created a new statutory framework allowing for the imposition of significant new premiums.⁵⁸ Under the new law, states can apply different premiums to different state-defined subgroups of the eligible population at values of up to five percent of a family's total income. Although some groups of Medicaid beneficiaries are exempt under the DRA from the new premiums and cost sharing options,⁵⁹ the DRA retains the potential to affect the substantial proportion of Medicaid recipients—including many low-income adults—who are without special statutory protection.

The ability of states to impose highly specialized costs is particularly relevant for understanding the implication of these DRA provisions because there is substantial empirical evidence suggesting that, in the context of Medicaid, higher premiums and cost sharing lead to decreased enrollment and service utilization.⁶⁰ One examination of the effect of higher premiums in waiver states showed that premiums reaching five percent of income decreased enrollment of eligible beneficiaries by nearly fifty percent.⁶¹ Similar results have been found in case studies commissioned by several state governments,

56. 42 U.S.C.A. § 13960-1(a)(2)(A) (West Supp. 2007).

57. See CBO ESTIMATE, *supra* note 47, at 40.

58. States can now require premiums from individuals with incomes in excess of 150% of the federal poverty line, so long as the total cost of both premiums and cost sharing does not exceed five percent of a family's total income. 42 U.S.C.A. § 13960-1(b)(2)(A) (West Supp. 2007).

59. The imposition of both premiums and copayments is limited to certain beneficiary categories and certain types of items and services. See, e.g., *id.* § 13960-1(b)(3)(B) (exempting most eligible beneficiaries under the age of eighteen, women who are specifically guaranteed access to certain services, pregnant women, terminally ill individuals receiving hospice care, and certain categories of institutionalized patients from DRA cost sharing); *id.* § 13960-1(b)(3)(A) (exempting the same group from premiums).

60. See, e.g., SAMANTHA ARTIGA & MOLLY O'MALLEY, HENRY J. KAISER FOUND., INCREASING PREMIUMS AND COST SHARING IN MEDICAID AND SCHIP: RECENT STATE EXPERIENCES (2005), available at <http://www.kff.org/medicaid/upload/Increasing-Premiums-and-Cost-Sharing-in-Medicaid-and-SCHIP-Recent-State-Experiences-Issue-Paper.pdf> (noting that the effect of premium and cost-sharing increases via waiver increased withdrawals from state Medicaid programs in Oregon, Vermont, Rhode Island, Maryland, and Utah); LEIGHTON KU, CTR. ON BUDGET & POLICY PRIORITIES, CHARGING THE POOR MORE FOR HEALTH CARE: COST-SHARING IN MEDICAID (2003), available at <http://www.cbpp.org/5-7-03health.pdf> (surveying empirical research and concluding that premiums and cost sharing have negative effects on enrollment rates in Medicaid); see also CBO ESTIMATE, *supra* note 47, at 41.

61. Leighton Ku & Teresa A. Coughlin, *Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (2000).

including Oregon,⁶² Rhode Island,⁶³ and Utah.⁶⁴ When Oregon implemented cost sharing above nominal levels via waiver in 2003, nearly half of the enrollees targeted for increased premiums and cost sharing lost coverage within six months.⁶⁵ Over a quarter of those who withdrew from the program indicated an inability to afford cost-sharing requirements as their primary reason for losing coverage.⁶⁶ An analysis of claims before and after the implementation of higher cost-sharing requirements in Oregon showed a thirty-three percent drop in prescription drug claims and a seventeen percent increase in emergency room utilization.⁶⁷ These outcomes are consistent with results predicted by the theoretical literature on the effects of cost sharing.⁶⁸ Given that raising premiums and cost-sharing requirements can trigger substantial flight from particular programs and services, the power to impose premiums and cost sharing might well be characterized as the power to compel significant disenrollment, or to limit substantially the use of particular services, by selectively deploying these mechanisms.

Furthermore, in addition to allowing unprecedented levels of premiums and cost sharing to be imposed on Medicaid beneficiaries, the new law also provides, for the first time, a viable enforcement mechanism for inducing compliance with those cost provisions. Prior law required service providers to treat patients at the point of service even if individual recipients were unwilling or unable to pay the required cost-sharing expenses.⁶⁹ Although providers had the option of terminating service to individuals who were delinquent in their payment of nominal premiums after two months, they were prohibited from

62. JOHN MCCONNELL & NEAL WALLACE, OFFICE FOR OR. HEALTH POLICY & RESEARCH, IMPACT OF PREMIUM CHANGES IN THE OREGON HEALTH PLAN (2004), available at <http://www.oregon.gov/DAS/OHPPR/RSCH/docs/ImpactsPremiums.pdf>.

63. CTR. OF CHILD & FAMILY HEALTH, R.I. DEP'T OF HUMAN SERVS., RESULTS OF RITE CARE PREMIUM FOLLOW-UP SURVEY 1 (2003), available at http://www.ritecare.ri.gov/documents/reports_publications/ResultsRC_Prem_Surv2003.pdf.

64. OFFICE OF HEALTH CARE STATISTICS, UTAH DEP'T OF HEALTH, UTAH PRIMARY CARE NETWORK DISENROLLMENT REPORT, at ii, (2004), available at <http://health.utah.gov/hda/Reports/PCN%20Disenrollment.pdf>.

65. MATTHEW J. CARLSON & BILL WRIGHT, OFFICE FOR OR. HEALTH POLICY & RESEARCH, THE IMPACT OF PROGRAM CHANGES ON ENROLLMENT, ACCESS, AND UTILIZATION IN THE OREGON HEALTH PLAN STANDARD POPULATION 8 (2005), available at http://www.oregon.gov/OHPPR/RSCH/docs/OHREC_Cohortflwup_03_05_rpt.pdf.

66. *Id.* at 9.

67. *Id.* at 13.

68. See, e.g., Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us*, 247 *SCI.* 418, 419 (1990).

69. 42 U.S.C. § 1396o(e) (2000); see also CBO ESTIMATE, *supra* note 47, at 40.

requiring prepayment as a condition of service.⁷⁰ Under the DRA, however, states can condition service on the prepayment of premiums.⁷¹ Moreover, states are not required to enforce premium payments across all eligible beneficiaries, but rather are explicitly granted the flexibility to apply the prepayment requirement selectively to discrete subgroups of beneficiaries that the state can define in whatever manner it chooses.⁷² For cost sharing, states may now permit providers to require the payment of cost sharing “as a condition for the provision” of items or services.⁷³ Although emergency treatment is still insulated from increased cost sharing,⁷⁴ individuals who show up at an emergency room but are subsequently determined to have a nonemergency condition can now be subject to cost-sharing prepayment requirements if they elect to proceed with treatment on-site.⁷⁵ Taken as a whole, these new powers of enforcement allow states for the first time to put concerns about recouping state revenues above the interests of individual beneficiaries in receiving medical services—a stark change from the pre-DRA vision of a Medicaid program obligated to provide a large profile of benefits to all enrollees.

B. New Restrictions on Benefits

In addition to the policy discretion afforded to the states through the new premiums and cost-sharing mechanisms, the DRA for the first time allows states to limit directly access to benefits among significant subgroups of the Medicaid population. Historically, the distribution of benefits across the Medicaid population was governed by a categorical rule, known as the comparability requirement, mandating that all beneficiaries receive the same

70. 42 U.S.C. § 13960(c)(3).

71. 42 U.S.C.A. § 13960-1(d)(1) (West Supp. 2007).

72. *Id.*

73. *Id.* § 13960-1(d)(2).

74. *Id.* § 13960-1(b)(3)(B)(vi). No similar restriction, however, is found in the DRA with respect to the imposition of premiums. *See id.* § 13960-1(b)(3)(A).

75. *Id.* § 13960-1(e)(1). Cost sharing here is somewhat limited by notice requirements and the need for an alternate nonemergency services provider that is “actually available and accessible.” *Id.* § 13960-1(e)(1)(A), (B). In addition, it is limited to twice the nominal amount for individuals with family incomes between 100% and 150% of the federal poverty line, *id.* § 13960-1(e)(2)(A), and to the nominal amount in the case of individuals otherwise exempt from the new, higher limits on cost sharing. *Id.* § 13960-1(e)(2)(B). For eligible beneficiaries outside the application of the nominal cost-sharing restrictions, aggregate cost sharing remains capped at five percent. *Id.* § 13960-1(e)(2)(C).

set of benefits.⁷⁶ The required package that the state needed to make “available” was statutorily defined, albeit in broad generalities.⁷⁷ The portfolio of a given state’s required benefits included everything covered in its state plan—that is, all of the mandatory benefits required by the text of the statute, as well as any so-called optional services, like prescription drug coverage, that a state had agreed to provide.⁷⁸ Additional restrictions on state discretion even limited the ability of states to differentiate in any significant way between beneficiaries in the provision of services. For example, equality of benefits was generally held to apply across all income levels and eligibility categories.⁷⁹ States were also required by statute to provide covered services on a statewide basis and explicitly prohibited from discriminating on a geographical basis.⁸⁰ Finally, they were compelled to ensure that services were comparable across eligibility categories (e.g., children, poor families, pregnant women, etc.), guaranteeing that the method of qualification for Medicaid services did not dictate the level of care that an individual would receive.⁸¹

The DRA’s modifications to Medicaid do not explicitly repeal any of these limiting requirements.⁸² Nevertheless, the statute provides states with several new mechanisms for directly altering the provision of benefits and services to specific groups and subgroups within the population of enrolled Medicaid beneficiaries, effectively circumventing these longstanding restrictions. Under the new rules, states are no longer required to make “available” the statutorily mandated set of benefits to all enrollees, regardless of eligibility category. Instead, they may now amend their state plans to substitute “benchmark coverage” plans or “benchmark equivalent coverage” plans in place of those benefits previously enumerated by the federal statute and accompanying regulations.⁸³

“Benchmark coverage” and “benchmark-equivalent coverage” provide strikingly less in the way of required benefits than the pre-DRA version of

76. See 42 U.S.C. § 1396a(10)(A) (2000) (indicating which services under § 1396d(a) must be provided to all eligible beneficiaries); see also 42 U.S.C. § 1396a(a)(10) (2000) (defining mandatory and optional populations).

77. See, e.g., 42 U.S.C. §§ 1396a(a)(10), 1396d(a) (2000).

78. See KAISER DRA REPORT, *supra* note 35, at 2-3.

79. CBO ESTIMATE, *supra* note 47, at 41.

80. 42 U.S.C. § 1396a(a)(1) (2000).

81. *Id.* § 1396a(a)(10)(B).

82. 42 U.S.C.A. § 1396u-7(a)(1)(A) (West Supp. 2007) (indicating that state options to exercise increased discretion in the provision and structuring of benefits apply “[n]otwithstanding any other provision of this subchapter”).

83. *Id.*

Medicaid did. “Benchmark coverage” packages under the DRA may follow one of three templates. The first type of benchmark coverage is a package that corresponds to the standard Blue Cross & Blue Shield preferred-provider plan available to federal employees under the Federal Employees Health Benefit Program (FEHBP).⁸⁴ The second type is a coverage plan that is “offered and generally available” to state employees in the given state.⁸⁵ The third and final template is coverage corresponding to the benefits package offered by the HMO with the largest commercial (non-Medicaid) enrollment in the state.⁸⁶ “Benchmark-equivalent coverage” is coverage that meets certain enumerated requirements and is, in general, actuarially equivalent to one or more forms of benchmark coverage.⁸⁷

Particularly conspicuous is the additional authority of the HHS Secretary to grant “benchmark coverage” status to any plan put forward by a state in an SPA—even one that has no relation to the three templates in the statute—so long as the Secretary determines that the plan in question “provides appropriate coverage” for the population to which it is intended to apply.⁸⁸ It is worth noting that to date the majority of states to receive approval for alternative benefits packages under the DRA have utilized the “Secretary-approved” option in their reform efforts, presumably because that option offers the most flexibility to tailor state programs outside of the old Medicaid requirements.⁸⁹ This propensity to circumvent even the skeletal requirements of the three “benchmark coverage” templates or the actuarial requirements of “benchmark-equivalent coverage” in favor of plenary approval authority in the hands of the Secretary underscores the degree to which CMS can now sanction significant departures from traditionally compulsory benefits without any additional action by Congress.

84. *Id.* § 1396u-7(b)(1)(A). For the requirements of the FEHBP preferred provider plan, see 5 U.S.C. § 8903(1) (2000).

85. 42 U.S.C.A. § 1396u-7(b)(1)(B) (West Supp. 2007).

86. *Id.* § 1396u-7(b)(1)(C).

87. *Id.* § 1396u-7(b)(2).

88. *Id.* § 1396u-7(b)(1)(D).

89. See Ctrs. for Medicare & Medicaid Servs., Alternative Benefit Packages, http://www.cms.hhs.gov/DeficitReductionAct/21_Benefits.asp (last visited Mar. 6, 2008) (providing submissions materials from those states that have had SPAs approved to implement cost sharing, premiums, and benchmark and/or benchmark-equivalent plans under the terms of the DRA).

The DRA reforms also allow for selective application of these limited benefits packages within the Medicaid population,⁹⁰ for the first time creating a statutorily sanctioned mechanism for increasing or decreasing the benefits provided to particular subgroups of Medicaid enrollees. As with the new premiums and cost-sharing devices, some Medicaid recipients are exempt from mandatory enrollment in benchmark or benchmark-equivalent coverage.⁹¹ The statute, however, contains no restrictions on optional enrollment in the new restrictive benefits plans, and CMS allows default enrollment of “nonmandatory” beneficiaries in the new restrictive plans so long as there remains an option for these individuals to opt out of the system.⁹²

Finally, it is also significant that, like the premium and cost-sharing provisions of the DRA, the provisions regarding benefit restrictions may be applied with particular precision. Although a state cannot expand Medicaid coverage under benchmark or benchmark-equivalent plans by introducing new eligibility categories,⁹³ benefit expansions or restrictions need not be applied unconditionally across entire formal categories of eligible beneficiaries. On the contrary, benefits alterations can be applied to an “eligible individual . . . within a group,” or “within 1 or more groups of such individuals.”⁹⁴ Without further explication, states would seem to have significant freedom to include or exclude members of the mandatory population of Medicaid beneficiaries based on whatever criteria the state wishes to apply, subject to approval by CMS. Taken together, these benefits-altering provisions grant states a degree of flexibility in limiting the provision of benefits under Medicaid never before allowed in the history of the program.

III. MEDICAID ENFORCEMENT UNDER 42 U.S.C. § 1983

As discussed in the previous Part, the DRA changed the basic orientation of the Medicaid program from its historic focus on required, statutorily defined benefits toward a new focus on state policy discretion and flexibility.

90. See 42 U.S.C.A. § 1396u-7(a)(2)(A) (West Supp. 2007). Under the DRA, states can require Medicaid beneficiaries who are subject to the new benefits options to enroll in one of these benchmark or benchmark-equivalent plans and can also apply the restrictive new packages “to individuals *within* 1 or more groups of such individuals.” *Id.* (emphasis added).

91. For a list of exempt enrollee groups, see *id.* § 1396u-7(a)(2)(B) (West Supp. 2007); and *id.* § 1396u-7(a)(2)(C)(ii).

92. See Letter from Ctrs. for Medicare & Medicaid Servs. Dir. to State Medicaid Dirs., SMDL #06-008 (Mar. 31, 2006).

93. 42 U.S.C.A. § 1396u-7(a)(1)(B) (West Supp. 2007).

94. *Id.* § 1396u-7(a)(2)(A).

Commentators have noted generally that this move “takes us far in th[e] direction” of “eliminat[ing] the right of Medicaid recipients to sue the states in federal court to enforce their Medicaid entitlement.”⁹⁵ This Part explores the implications of this shift for the continued viability of § 1983 as a mechanism for enforcing the terms of state plans.

Federal grants-in-aid programs pose a crucial accountability question: how does the federal government ensure that states keep their promise to conform their administration of Medicaid to the requirements of governing federal law? This is an issue of particular concern during times of economic downturn. Enrollment in Medicaid is classically countercyclical. Because eligibility for the program is largely tethered to income, the ranks of eligible beneficiaries swell during recessions and contract during times of economic growth. Unfortunately, it is also during times of economic hardship that many states look to trim their budgets.⁹⁶ The large portion of state budgets that the Medicaid entitlement consumes⁹⁷ often makes it an attractive target for state legislators. Given that Medicaid is structured as a federal-state grant matching program, affirmative cuts in state funding trigger a concomitant drawdown in available federal money, further straining the ability of the program to meet the needs of eligible beneficiaries.⁹⁸ Particularly during times of economic growth, states have demonstrated an interest in expanding their health safety nets through aggressive augmentation of programs like Medicaid. Several such

-
95. Timothy Stolfus Jost, *Our Broken Health Care System and How To Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 614 & n.440 (2006); see also KAISER DRA REPORT, *supra* note 33, at 3 (assessing the impact of benefit reductions on millions of enrollees); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL’Y 5, 35 (2006) (“[T]he Deficit Reduction Act of 2005 marks a new chapter in the life of the Medicaid program by introducing certain fundamental changes into program design; these changes in turn hold the potential for a far-reaching re-formulation of the rules of coverage and state plan administration and, as a result, legal duties and rights.”).
96. Timothy Stolfus Jost, *The Tenuous Nature of the Medicaid Entitlement*, 22 HEALTH AFF. 145, 151 (2003). Indeed, many states are constitutionally prohibited from running deficits, forcing them to decrease expenditures at the same time that overall Medicaid costs are increasing. *Id.*; see also Rowland & Tallon, *supra* note 36, at 141-42 (“States have a love-hate relationship with their Medicaid programs—expanding them in good times and contracting them in bad times.”).
97. See NAT’L ASS’N OF STATE BUDGET OFFICERS, 2001 STATE EXPENDITURE REPORT 4 (2002), available at <http://www.nasbo.org/Publications/PDFs/nasbo2001exrep.pdf>.
98. David A. Super, *Rethinking Fiscal Federalism*, 118 HARV. L. REV. 2544, 2609-10 (2005).

prominent initiatives have been noted over the past few years.⁹⁹ The current slowdown in economic growth, however, is already generating concern about the prospects of a new round of state cuts.¹⁰⁰

Since withholding funds from recalcitrant states to induce compliance, although achievable in theory, is not a particularly viable option in practice,¹⁰¹ outside actors play an important role in enforcement. Their ability to force state implementing institutions to retain statutorily mandated benefits helps ensure the vitality of the program, especially during its most vulnerable periods. The Medicaid statute itself does not contain an express cause of action, and does not create an implied cause of action, for particularized enforcement of its provisions.¹⁰² Instead, individuals looking to compel state officials to provide required benefits have turned to 42 U.S.C. § 1983, a catch-all federal remedy designed to allow suits for “deprivation[s] of any rights, privileges, or immunities secured by the Constitution and laws” by state officials to proceed in federal court.¹⁰³

Since the 1980s, § 1983 has provided the primary legal mechanism through which individuals have worked to enforce the provision of required benefits identified in the Medicaid statute.¹⁰⁴ More recent doctrinal developments in this area, however, have begun to limit severely the reach of these lawsuits. In particular, the Court’s landmark decision in *Gonzaga v. Doe*, which required a focused inquiry into congressional intent in order to find a cognizable § 1983 claim, has narrowed the scope of such activity.¹⁰⁵ In the wake of *Gonzaga*, several circuits have begun rolling back the availability of § 1983 to enforce some types of Medicaid provisions that previously were covered by the statute.

99. See generally AM. ACAD. OF PEDIATRICS, STATE LEGISLATION REPORT (2007) (detailing legislative efforts by states toward expanding their safety nets under Medicaid and the related SCHIP program), available at <http://www.aap.org/advocacy/statelegprpt.pdf>.

100. See Letter from Sen. Barbara A. Mikulski et al. to Sen. Max Baucus, Chairman, Senate Finance Comm. and Sen. Charles Grassley, Ranking Member, Senate Finance Comm. (Jan. 29, 2008), available at <http://mikulski.senate.gov/record.cfm?id=291443> (describing an effort by Democratic senators to provide targeted increases in Medicaid funding to states on the eve of significant projected economic downturn since “Medicaid and other social programs are the first in line for cuts in cash-strapped states desperate for revenue”).

101. See *supra* notes 10-12 and accompanying text.

102. See generally *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981) (requiring that any conditions placed on the receipt of federal funds be clearly stated).

103. 42 U.S.C. § 1983 (2000).

104. See, e.g., Platt, *supra* note 5, at 276 & n.10; see also Sasha Samberg-Champion, Note, *How To Read Gonzaga: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 COLUM. L. REV. 1838, 1838 (2003).

105. 536 U.S. 273, 283-84 (2002).

For example, courts have curtailed equal access claims, once a staple of § 1983 enforcement.¹⁰⁶

To date, the specific use of § 1983 to enforce the basic “availability” of Medicaid benefits has withstood this doctrinal narrowing of the statute’s applicability. The modifications to Medicaid created by the DRA, however, seriously undermine the validity of post-*Gonzaga* § 1983 claims to force state agencies to provide statutorily mandated benefits for a substantial group of Medicaid beneficiaries. Section III.A analyzes the evolution of modern § 1983 jurisprudence. It examines the ongoing jurisprudential conflict over whether or not statutes like Medicaid confer enforceable rights and emphasizes that the touchstone of the modern *Gonzaga* inquiry is whether or not Congress intended to create an enforceable right, as determined by judicial examination of a narrow set of precise factors. Section III.B analyzes the Medicaid statute as modified by the DRA within this legal framework. It argues that the DRA’s premium, cost-sharing, and benefits substitution provisions will inevitably lead the federal courts to conclude that Congress no longer intends for the “availability” of Medicaid benefits to be enforceable through § 1983 lawsuits.

A. *Emerging Limitations on § 1983 Actions*

In order to enforce a federal statute through § 1983, plaintiffs must demonstrate that the statute confers an “individual right.”¹⁰⁷ Since the Supreme Court first began allowing plaintiffs to bring § 1983 suits against state officials to enforce federal statutory rights in *Maine v. Thiboutot*,¹⁰⁸ the federal courts have seen a steadily increasing stream of litigation designed to compel compliance.¹⁰⁹ In *Wilder v. Virginia Hospital Ass’n*, the Court specifically recognized the availability of § 1983 to challenge a (now defunct) provision of the Medicaid Act.¹¹⁰ Since the provision at issue in *Wilder* utilized the same sort of declaratory, rights-conferring language found in the current section of the

^{106.} See *infra* note 132 and accompanying text.

^{107.} See, e.g., *Gonzaga*, 536 U.S. at 284.

^{108.} 448 U.S. 1 (1979).

^{109.} See RICHARD H. FALLON, JR., DANIEL J. MELTZER & DAVID L. SHAPIRO, HART & WECHSLER’S THE FEDERAL COURTS AND THE FEDERAL SYSTEM 1082 & n.10 (5th ed. 2003) (noting a substantial increase in nonprisoner “civil rights” actions, over half of which appear to relate to rights claimed to be conferred by specific federal statutes).

^{110.} 496 U.S. 498 (1990).

Act that enumerates the program's benefits,¹¹¹ lower courts have historically been fairly solicitous of lawsuits intended to compel states to provide them.¹¹²

The *Wilder* approach to Medicaid enforcement has not been without controversy. The Supreme Court has at times exhibited skepticism toward conferring a private cause of action under § 1983 to compel state implementation of cooperative, federal-state funding programs created under the Spending Clause.¹¹³ In *Suter v. Artist M.*,¹¹⁴ the Court held that a state-federal partnership for reimbursement of state efforts to administer foster care and adoption services, with a structure analogous to that of Medicaid, conferred only the right of a state to submit a state plan—with no coincident right of beneficiaries to enforce the terms of that plan.¹¹⁵ Congressional outcry over the *Suter* decision, however, led to legislative action that severely limited its reach and clarified that state plans codifying joint federal-state funding programs like Medicaid were not per se unenforceable through § 1983.¹¹⁶ The combined effect of this congressional activity and the inconsistency of *Suter* with the balance of Supreme Court precedent created equilibrium in the 1990s whereby the judiciary continued to allow the enforcement of federal spending programs like Medicaid against the states.

In 1997, cognizant of the congressional backlash against *Suter*, the Supreme Court clarified its test for determining whether a federal statute creates a right enforceable under § 1983 in *Blessing v. Freestone*.¹¹⁷ Under the *Blessing* inquiry, for an action to be cognizable under § 1983, it must be clear that: (1) Congress intended that provision to benefit the plaintiff; (2) the asserted right is not so “vague and amorphous” that its enforcement would strain judicial competence; and (3) the statute “unambiguously impose[s] a binding

111. See 42 U.S.C. § 1396a(a)(13)(A) (1994). This provision, known as the Boren Amendment, is situated in the statute in such a way that its introductory clause— “[a] State plan for medical assistance must . . . provide”—is identical to the introductory language of § 1396a(a)(10) and the other mandatory provision components of § 1396a(a). It was repealed in 1997. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a)(1), 111 Stat. 251, 507-08.

112. See *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir. 2002); *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir. 2002); *Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993). For post-*Gonzaga* cases, see *infra* note 133 and accompanying text.

113. See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 281 (2002) (citing cases that have “rejected attempts to infer enforceable rights from Spending Clause statutes”).

114. 503 U.S. 347 (1992).

115. *Id.* at 361-63.

116. See 42 U.S.C. § 1320a-2 (2000); see also *Samberg-Champion*, *supra* note 104, at 1850-52 (2003).

117. 520 U.S. 329 (1997) (internal citations omitted).

obligation” on the state by using “mandatory, rather than precatory,” terminology.¹¹⁸ After *Blessing*, the lower federal courts treated *Suter* as an even more aberrational element of § 1983 doctrine, and continued to allow suits to compel state compliance with Medicaid requirements.¹¹⁹

In the 2002 case *Gonzaga University v. Doe*,¹²⁰ however, the Court began to inch back toward a more rigorous set of prerequisites for finding enforceable rights. Specifically, the Court established a high bar for understanding the congressional intent prong of the *Blessing* inquiry. The Court evaluated intent by focusing on the specific text of the provision at issue. In so doing, it identified three key textual factors that must be present in order for courts to find the requisite congressional intent to create an enforceable right. First, the statute must contain “‘rights-creating’ language” that focuses on individuals protected and not persons regulated.¹²¹ Second, the statute cannot have an “‘aggregate’ focus” on a class or group, but instead must be concerned with “whether the needs of any particular person have been satisfied.”¹²² Third, the ability of those implementing the statute to avoid statutory penalties through “substantial compliance,” rather than full compliance, indicates that Congress did not intend to confer an individual right.¹²³ Although the Court focused on the text of specific provisions, significantly, it noted the importance of examining the overall structure and interrelation of textual provisions of the statute.¹²⁴ Beyond the textual inquiry, the Court also briefly considered part of the provision’s legislative history in its attempt to discern the intent of Congress.¹²⁵

Congressional intent has always been particularly important when evaluating the validity of a § 1983 claim.¹²⁶ *Gonzaga*’s rejection of “anything short of an unambiguously conferred right,”¹²⁷ however, and its focus on the

118. *Id.* at 340-41.

119. See Samberg-Champion, *supra* note 104, at 1851-52.

120. 536 U.S. 273 (2002).

121. *Id.* at 287 (2002) (quoting *Alexander v. Sandoval*, 532 U.S. 275, 288 (2001)); see also *Sandoval*, 532 U.S. at 289 (“Statutes that focus on the person regulated rather than the individuals protected create ‘no implication of an intent to confer rights on a particular class of persons.’” (quoting *California v. Sierra Club*, 451 U.S. 287, 294 (1981))).

122. *Gonzaga*, 536 U.S. at 288 (quoting *Blessing*, 520 U.S. at 343).

123. *Id.* (quoting *Blessing*, 520 U.S. at 335, 343).

124. See *id.* (comparing the “text and structure” of the provision at issue to a neighboring provision in the statute).

125. *Id.* at 290.

126. See *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 505-09 (1990).

127. See *Gonzaga*, 536 U.S. at 283.

text of the provision at issue and the structure of the statute under evaluation ushered in a new era of narrow construction of this requirement. Commentators have suggested that the opinion's characterization of an unambiguously conferred right, though not explicitly endorsing the reasoning of *Suter*, nonetheless indicates significant hostility toward arguments that Spending Clause legislation confers enforceable rights under § 1983.¹²⁸ In the wake of the decision, some even suggested that the *Gonzaga* decision sub silentio overruled *Maine v. Thiboutot* and functionally foreclosed any § 1983 lawsuits to enforce Spending Clause statutes like Medicaid.¹²⁹

Decisions by the federal courts of appeals implementing *Gonzaga* have shown this concern to have been somewhat overwrought. With regard to the Medicaid statute, *Gonzaga* did occasion some decline in the reach of § 1983 enforcement actions.¹³⁰ The most extreme case is the post-*Gonzaga* treatment of Medicaid's equal access to care requirement. Although pre-*Gonzaga* federal courts generally allowed § 1983 enforcement of the equal access provision,¹³¹ four of five circuits to consider the question after *Gonzaga* have found that it does not unambiguously confer enforceable rights.¹³² For cases involving Medicaid's "availability" requirement, four circuits addressed the question after *Gonzaga* but prior to the effective date of the DRA. In each case, the court maintained fidelity to the pre-*Gonzaga* position allowing § 1983 enforcement

128. See, e.g., Bradford C. Mank, *Suing Under § 1983: The Future After Gonzaga* University v. Doe, 39 HOUS. L. REV. 1417, 1418-19 (2003); Samberg-Champion, *supra* note 104, at 1839.

129. See *The Supreme Court, 2001 Term—Leading Cases*, 116 HARV. L. REV. 200, 381 (2002); Erwin Chemerinsky, *Limiting Suits To Enforce Federal Laws*, TRIAL, Jan. 2003, at 70.

130. See Brian J. Dunne, *Enforcement of the Medicaid Act Under 42 U.S.C. § 1983 After Gonzaga* University v. Doe: *The "Dispassionate Lens" Examined*, 74 U. CHI. L. REV. 991, 1001-12 (2007); Jane Perkins, Nat'l Health Law Prog., Issue Brief: Update on § 1983 Enforcement of the Medicaid Act 3 (Jan. 2007), <http://www.healthlaw.org/library.cfm?fa=download&resourceID=94516&print>.

131. See, e.g., Pa. Pharmacists Ass'n v. Houstoun, 283 F.3d 531, 543-44 (3d Cir. 2002); Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 927-28 (5th Cir. 2000); Visiting Nurse Ass'n v. Bullen, 93 F.3d 997, 1004 n.7 (1st Cir. 1996); Ark. Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 528 (8th Cir. 1993).

132. For circuits refusing to apply § 1983 in the equal access provision context, see Mandy R. *ex rel.* Mr. & Mrs. R. v. Owens, 464 F.3d 1139 (10th Cir. 2006); Westside Mothers v. Olszewski, 454 F.3d 532 (6th Cir. 2006); Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005); Long Term Care Pharm. Alliance v. Ferguson, 362 F.3d 50 (1st Cir. 2004). This result can be compared with *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005 (8th Cir. 2006), which upheld a prior circuit ruling allowing § 1983 lawsuits under the equal access provision. For more on the efforts of the federal courts with regard to § 1983 Medicaid enforcement lawsuits, see Dunne, *supra* note 130, at 1003-11.

actions.¹³³ Central to the reasoning of these pre-DRA opinions, however, is the fact that the availability provision “requires states to provide particularly specified benefits to particularly specified types of individuals,”¹³⁴ thus presumptively meeting the requirements of *Blessing* and *Gonzaga*. The next Section illustrates how the DRA effectively eliminates that presumption.

B. The DRA and Compelling the Availability of Benefits Under § 1983

The willingness of the federal courts to allow § 1983 lawsuits to enforce state plans is a source of doctrinal tension and has been predicated historically on the fact that the language of those provisions suggests an “unambiguous” congressional intent to force all states to provide specific benefits.¹³⁵ This Section analyzes how the Deficit Reduction Act’s premium, cost-sharing, and benchmark benefits options alter the nature of Medicaid’s benefits requirements. In effect, these new options swallow the compulsory, rights-conferring aspects of Medicaid’s benefits program within a sea of state policy discretion for that substantial portion of beneficiaries who are subject to the new law. This is likely to lead the federal courts to reverse their pre-DRA positions allowing § 1983 actions in this area.

The opportunities for state flexibility created by the DRA subdivide Medicaid recipients into two broad categories. The first category is comprised of those recipients who are exempt from the compulsory application of premiums, cost sharing, and/or benchmark benefits, while the second category is comprised of those recipients who are eligible for the new measures. Recipients who are exempt from all three new types of programs will likely remain able to invoke § 1983 to force states to make “available” Medicaid benefits.¹³⁶ Those individuals who are potentially subject to DRA modifications, however, are likely to see an evaporation of their ability to bring these § 1983 suits, irrespective of whether or not their particular state chooses to exercise the flexibility afforded by the new law.

It should be noted that since the Deficit Reduction Act went into effect in February 2006, some circuits have continued to allow § 1983 to serve as a

133. See *Westside Mothers*, 454 F.3d at 532; *Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006), cert. denied sub nom. *Goldberg v. Watson*, 127 S. Ct. 598 (2006); S.D. ex rel. *Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004); *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004).

134. *Watson*, 436 F.3d at 1161.

135. See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002).

136. The statutory language regarding benefit restructuring, cost sharing, and premiums specifically states that it is inapplicable to certain beneficiaries. See *supra* notes 59, 91 and accompanying text.

vehicle for enforcing the “availability” of benefits under Medicaid.¹³⁷ That litigation, however, provides little insight into whether or not federal courts will ultimately read the DRA as rendering the provision unenforceable. This is because in each of these cases, the defending government agency failed to contest the applicability of § 1983 in light of the statutory modifications occasioned by the DRA. In three of these cases, the defending government actor failed to contest that § 1983 provided a cause of action to support the suit of the plaintiffs.¹³⁸ In the fourth, the government contested the applicability of § 1983, but not on DRA-based grounds.¹³⁹ In the final case, the court inquired as to whether or not *Gonzaga* had limited the reach of § 1983, but did not address the DRA’s modifications to the statute.¹⁴⁰ In short, the question of how the new statutory provisions affect the operation of prior Medicaid law has not yet been squarely presented to a federal appellate court. As the remainder of this Section will show, however, when the issue is ultimately briefed and argued, it appears likely that the courts will find that the new version of the Medicaid statute no longer allows for the enforcement of the program’s basic benefits requirement.

This Section proceeds in three parts. First, it compares the text and structure of the post-DRA Medicaid provisions governing the availability of benefits with the language of the court’s modern § 1983 jurisprudence and explains why these new provisions eliminate the applicability of § 1983. Next, it discusses the clear and well-documented empirical effects of premium and cost-sharing provisions like those found in the DRA, arguing that those effects have the potential to be so severe as to undermine any claim that Congress still intends to create an individual right to Medicaid benefits. The implication of these first two Subsections is that beneficiaries who are eligible for DRA-based

137. See *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007); *Katie A. ex rel. Ludin v. L.A. County*, 481 F.3d 1150 (9th Cir. 2007); *Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty*, 472 F.3d 1208 (10th Cir. 2007); *Owens*, 464 F.3d 1139; *Westside Mothers*, 454 F.3d 532.

138. See *Ludin*, 481 F.3d at 1153 n.7 (indicating that the state did not contest the applicability of § 1983 to enforce mandatory benefits). In *Fogarty*, 472 F.3d at 1212 n.1, and *Owens*, 464 F.3d at 1143, the Tenth Circuit “assume[d] without deciding” that § 1983 provided a cause of action to the Medicaid plaintiffs. Apparently, neither party contested the applicability of the statute as it applied to the benefits portion of the Medicaid statute.

139. See Brief of the Cross-Appellee at 4, *Spry v. Thompson*, 487 F.3d 1272 (9th Cir. 2007) (No. 04-35750) (arguing that § 1983 does not confer a right of action on the plaintiffs by analyzing the pre-DRA distinction between mandatory and optional benefit categories). The Ninth Circuit also referenced its pre-DRA view of the “availability” provision in dicta found in *Ball v. Rodgers*, 492 F.3d 1094, 1109 (9th Cir. 2007), again without apparent awareness of the new Medicaid framework occasioned by the DRA.

140. *Westside Mothers*, 454 F.3d at 539-41.

modifications to their Medicaid benefits will no longer be able to bring suits to enforce state plans, even if those plans do not actually incorporate DRA changes. The Section concludes with an analysis of additional reasons why beneficiaries in states that actually undertake substantive, DRA-based modifications to their benefits packages will specifically be unable to enforce the terms of those new packages using § 1983. Taken together, the analysis presents a compelling argument that most beneficiaries will no longer be able to bring § 1983 suits to force states to comply with their state plans.¹⁴¹

1. *The Text and Structure of the DRA Eliminate the Enforceability of Medicaid Under § 1983*

The fact that states under the DRA have the option of fundamentally restructuring Medicaid's basic benefit packages severely undercuts any claim to enforceability through § 1983. As previously mentioned, the enforceability of Medicaid benefits is closely tied to the required nature of those elements of the statute. Prior to the DRA, the provision of benefits under Medicaid was governed by clear, unambiguous, individual-oriented language indicating that "[a] State plan for medical assistance *must . . . provide . . . for making medical assistance available . . . to all individuals*" who are eligible for the program, with medical assistance defined as a discrete set of mandatory and optional benefits.¹⁴² This is the same sort of mandatory, individual-oriented language found in Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972, which direct that "[n]o person . . . shall . . . be subjected to discrimination,"¹⁴³ held up by *Gonzaga* as examples of rights-conferring statutes because of their "unmistakable focus on the benefited class."¹⁴⁴ Two

141. Although described in terms of congressional intent, the Court's rights inquiry under *Gonzaga*, like its inquiry in the analogous implied cause of action cases, is less about actual intent in an individual case and more about imposing a clear statement rule on Congress with respect to creating enforceable rights. See *Alexander v. Sandoval*, 532 U.S. 275, 288 (2001) (refusing to find an implied cause of action even when it seemed clear that the enacting Congress believed that contemporaneous courts would understand the statute to confer such a right). Since *Gonzaga* emphasizes that the § 1983 inquiry should "not differ from its [inquiry] in discerning whether personal rights exist in the implied right of action context," *Gonzaga Univ. v. Doe*, 536 U.S. 273, 285 (2002), courts can be expected to apply the same sort of presumption against finding a right where Congress does not clearly and unambiguously state its intent to confer one.

142. 42 U.S.C. § 1396a(a)(10)(A)(i) (2000) (emphasis added).

143. 20 U.S.C. § 1681(a) (2000); 42 U.S.C. § 2000d (2000).

144. *Gonzaga*, 536 U.S. at 284 (emphasis omitted) (quoting *Cannon v. Univ. of Chi.*, 441 U.S. 677, 691 (1979)).

substantial modifications to this framework, though, eliminate any presumption that the Medicaid statute is still intended to confer individual, enforceable rights.

First, in stark contrast to the old, mandatory language, the DRA provisions allow states simply to disregard that language for a substantial proportion of Medicaid beneficiaries. Specifically, the new statute provides that “a State, at its option as a State plan amendment, may provide for medical assistance . . . to individuals within one or more groups of individuals specified by the state through enrollment in” the broad discretionary categories of substitute benefits packages.¹⁴⁵ With the addition of this major exception to the original Medicaid language, it is obvious that the Medicaid statute no longer mandates that states provide the old, enumerated list of benefits. As such, it clearly fails the third prong of *Blessing*, requiring that the conferral of rights be couched in “mandatory, rather than precatory” language.¹⁴⁶

Second, the fact that premiums and cost sharing are now enforceable through a denial of service by providers supports a finding that Congress no longer intends to confer a right to Medicaid benefits through § 1983. As discussed in Section II.A, the Medicaid statute as written before the DRA categorically directed that “no provider participating under the State plan may deny care . . . on account of [an] individual’s inability to pay a . . . cost sharing . . . charge.”¹⁴⁷ Similarly, enforcement of premium requirements was extremely difficult.¹⁴⁸ Under the new scheme, however, Congress allows states to “condition the provision of medical assistance for an individual upon prepayment of a premium” or to “permit a provider . . . to require, as a condition for the provision of . . . medical assistance . . . the payment of any cost sharing” authorized by the DRA.¹⁴⁹ These changes represent serious structural modifications of Medicaid. The elimination of the pre-DRA focus on providing services regardless of ability to pay severely undermines any claim that the Medicaid statute still “manifests an ‘unambiguous’ intent to confer individual rights” of access to particular benefits.¹⁵⁰

145. 42 U.S.C.A. § 1396u-7(a)(1)(A) (West Supp. 2007).

146. *Gonzaga*, 536 U.S. at 282 (quoting *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997)).

147. 42 U.S.C. § 1396o(e) (2000).

148. *Id.* § 1396o(c)(3).

149. 42 U.S.C.A. § 1396o-1(d) (West Supp. 2007).

150. *See Gonzaga*, 536 U.S. at 280.

2. *The Empirical Effects of DRA-Based Premiums and Cost Sharing Undermine Medicaid Enforceability Under § 1983*

Beyond the inquiry into the new text and structure of Medicaid’s benefits provisions, the well-documented empirical effects of premium and cost-sharing mechanisms also suggest strongly that Congress did not intend to confer a right to Medicaid benefits enforceable by § 1983. As outlined in detail in Section II.A, the experiences of several states with regard to their cost-containment mechanisms have convincingly demonstrated the degree to which such costs trigger significant disenrollment and decreased service utilization under Medicaid. Additionally, the flexibility that states have to impose these mechanisms on any arbitrary subpopulation of Medicaid enrollees so long as the HHS Secretary deems the state scheme to provide “appropriate coverage” enhances the ability of individual states to target specific types of Medicaid recipients with policies that will trigger these disenrollment effects.¹⁵¹

A judicial determination that the empirically demonstrated exclusionary effects of premiums and cost sharing at the levels allowed by the DRA indicates that Congress no longer intends to make the provision of those benefits mandatory would turn on two factors. First, it would depend on the extent to which the courts are willing to look beyond the text of the statute to its empirical policy implications. The *Gonzaga* inquiry, which emphasizes the text and structure of the provision at issue,¹⁵² may not reach this far. The *Gonzaga* Court, however, did look beyond the text of the statute to its legislative history to bolster its holding.¹⁵³ Congressional awareness of the effects of premiums and cost sharing in Medicaid would only augment the claim that Congress no longer intends to confer an enforceable right.¹⁵⁴

There would appear to be little question that Congress was aware of the effect that premiums and cost sharing would have on beneficiaries. As a general matter, given that the central debate over premiums and cost sharing is one of

151. 42 U.S.C.A. § 1396u-7(b)(1)(D) (West Supp. 2007). This flexibility would seem to be cabined only by constitutional constraints in the equal protection context.

152. See *Gonzaga*, 536 U.S. at 285-86.

153. *Id.* at 290.

154. It should be emphasized that while the *Gonzaga* Court looked to legislative history to bolster its textual claim, the primary focus of its inquiry was the text itself. In the context of these cases, the Court has “never accorded dispositive weight to context shorn of text.” *Alexander v. Sandoval*, 532 U.S. 275, 288 (2001). Insofar as the Court finds that it can “begin . . . and . . . end [its] search for Congress’s intent with the text and structure” of the DRA, *id.*, a lack of legislative history explicitly indicating Congress’s intent to abrogate the § 1983 right to enforce Medicaid benefits is unlikely to be relevant.

cost-containment versus beneficiary access,¹⁵⁵ it seems logical to conclude from these provisions that Congress opted to endorse the former value. In fact, using premiums and cost sharing as a mechanism for reducing medical services performed and trimming the Medicaid rolls seems to have been the primary way that Congress intended to save money under these provisions. The House Report of the Committee on the Budget, which accompanied the bill in the House of Representatives and contained the reports of all eight House Committees that considered the legislation, incorporated into its text the CBO estimates of how much money the federal government might be expected to save under the premium and cost-sharing provisions. The CBO is quite explicit that its estimates of ten billion dollars in savings through 2015 reflect an expectation that these provisions will have two effects—“reduced utilization of services due to higher cost-sharing requirements and decreased participation in Medicaid by individuals who would be required to pay premiums.”¹⁵⁶ And although the original House version of the bill directed the Government Accountability Office to conduct a study on the impact of premiums and cost sharing “on access to, and utilization of, services,”¹⁵⁷ that provision was stripped in conference before the bill became law.¹⁵⁸

3. *The New DRA Benefits Packages Do Not Confer Individual Rights Enforceable Under § 1983*

The previous two Subsections show that Medicaid beneficiaries who are eligible for DRA modifications will no longer be able to bring § 1983 suits to enforce the existing terms of Medicaid state plans. For two additional reasons, those enrollees whose states actually choose to implement benchmark or benchmark equivalent plans—with limited benefits—will likely be unable to bring § 1983 challenges to enforce even the limited benefits available to them.

First, as discussed in detail in Section II.B., these benefits packages contain little in the way of enforceable standards. Quite unlike the specifically enumerated list of benefits provided by the traditional Medicaid program, the new provisions allow states almost free rein to define what sorts of benefits they will offer, subject only to the administrative approval of the HHS Secretary on an amorphous finding that it provides “appropriate” coverage.¹⁵⁹

155. See, e.g., Aaron & Schwartz, *supra* note 68, at 419.

156. See H.R. REP. NO. 109-276, at 389 (2005).

157. *Id.* at 1221.

158. See Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 3 (2006).

159. 42 U.S.C.A. § 1396u-7(b)(1)(D) (West Supp. 2007).

Given the unprecedented policy discretion afforded to states by these modifications, it seems impossible for the federal courts to find that such statutory language provides anything in the way of an “unambiguous’ intent to confer individual rights” as required by *Gonzaga*.¹⁶⁰

Second, the DRA language describing these benefits packages does not communicate an “individualized right” to access the new benefits, but rather speaks “only in terms of institutional policy and practice,” articulating a process by which states may create alternate packages.¹⁶¹ The statutory language defining the benchmark benefit packages is not couched in the individual rights-creating language the Court prefers, but rather as precisely the sort of general policy directive cautioned against in *Gonzaga*.¹⁶² As such, unlike the original Medicaid availability provision, which specifically and unambiguously creates an obligation between the state and each individual beneficiary, this language does not “unmistakabl[y] focus on the benefited class.”¹⁶³ Instead, it communicates an “aggregate focus” and is “not concerned with ‘whether the needs of any particular person have been satisfied.’”¹⁶⁴ Such a focus is fatal to finding an enforceable § 1983 right under both *Blessing* and *Gonzaga*.

IV. ENFORCING FEDERAL MEDICAID REQUIREMENTS THROUGH STATE-LEVEL “FAIR HEARINGS”

The preceding Part argued that the fundamental changes to Medicaid occasioned by the passage of the DRA will lead the federal courts to foreclose the availability of § 1983 suits to compel states to provide those benefits they have agreed to provide under their state plans. The most obvious solution to this problem would be to pursue a federal legislative fix. Congressional amendment of the Medicaid statute stipulating that the law confers a right enforceable by individual beneficiaries under Medicaid, however, could prove a difficult sell, in the basic “availability” context or otherwise. For one, the establishment of a statutory right to access benefits would make it more difficult for the federal government to control costs under Medicaid, which was

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

161. *Id.* at 288.

162. See *supra* text accompanying note 145. An exception to this general finding may exist for those elements of coverage that are specifically required under benchmark-equivalent coverage. See 42 U.S.C.A. § 1396u-7 (West Supp. 2007).

163. *Gonzaga*, 536 U.S. at 283-84 (quoting *Cannon v. Univ. of Chi.*, 441 U.S. 677, 691 (1979)).

164. *Id.* (quoting *Blessing v. Freestone*, 520 U.S. 329, 343 (1997)).

a primary motivating factor underlying the enactment of the Medicaid-related DRA provisions in 2005.¹⁶⁵ For similar reasons, state opposition to enshrining a right to Medicaid enforcement in the federal statute could be expected to be significant. It is telling that Congress's last attempt at protecting beneficiary enforcement rights in the wake of the Court's *Suter v. Artist M.* decision¹⁶⁶ resulted in convoluted language that ultimately proved to be of limited utility to beneficiaries.¹⁶⁷

In the absence of decisive congressional action, then, the decline of the § 1983 remedy seems likely to shift efforts to induce compliance by states away from the federal courts and instead toward state-level mechanisms. This Part explores the degree to which enforcement actions brought through state-level administrative hearings can serve as a viable alternative to § 1983 enforcement actions.

The decline of § 1983 does not necessarily mean that states will be entirely free to deviate from the terms of their state plans. State trial courts, for example, might provide some measure of enforcement protection for beneficiaries via robust exercise of their equitable powers. As courts of general jurisdiction operating against a common law backdrop, state courts have historically exercised broad equitable discretion through robust use of the traditional prerogative writs to compel or prohibit actions by state officials.¹⁶⁸

This exercise of equitable power to remedy legal violations by state officials can take several forms. California courts, for example, are authorized to use mandamus extensively to compel administrative action by state officers.¹⁶⁹ In 2002, plaintiffs were successfully awarded mandamus relief to coerce a serious restructuring of the state's Medicaid program to bring it in line with the California courts' view of the federal Medicaid statute's requirements regarding

165. See CBO ESTIMATE, *supra* note 47, at 34.

166. 503 U.S. 347 (1992).

167. 42 U.S.C. § 1320a-2 (2000). See generally Brian D. Ledahl, *Congress Overruling the Courts: Legislative Changes to the Scope of Section 1983*, 29 COLUM. J.L. & SOC. PROBS. 411, 412, 415 (1996) (discussing "how courts should apply the new and confusing statute" and concluding that "courts should not alter their decisions on the basis of the legislative overturning of the *Suter* decision because nothing was actually overturned by the language of the statute").

168. Unlike federal courts, state trial courts are usually courts of general jurisdiction, with a lower bar for plaintiffs to hurdle in order to obtain review of an action. See Philip A. Talmadge, *Understanding the Limits of Power: Judicial Restraint in General Jurisdiction Court Systems*, 22 SEATTLE U. L. REV. 695, 709-15 (1999).

169. See CAL. R. CT. 8.490, available at http://www.courtinfo.ca.gov/rules/documents/pdfFiles/title_8.pdf.

beneficiary reimbursement.¹⁷⁰ In the wake of the decision, the California legislature amended its statute governing the state’s Medi-Cal program “to incorporate the substance and undoubtedly to facilitate the implementation of that decision.”¹⁷¹ New York has a similar history of allowing relief in state courts via prerogative writ through the so-called Article 78 procedure, which has been used several times over the last three decades to allow review of—and on occasion declaratory or injunctive relief against—state Medicaid actions as contravening federal requirements.¹⁷² Outside of places like California and New York, however, such suits can be subject to the vagaries of equitable discretion, where courts frequently invoke judicial restraint akin to that of the federal Article III requirements.¹⁷³ Such restraint may serve to limit access to the system by state Medicaid beneficiaries seeking to have a state policy declared in conflict with federal Medicaid requirements. Thus, despite occasional examples of such activity in the Medicaid context outside of California and New York,¹⁷⁴ the uncertainty of the equitable remedy in most jurisdictions renders such mechanisms unreliable for seeking enforcement of the state-federal Medicaid bargain. In addition, even where plaintiffs are able to make out a cause of action in state court, judges may invoke traditional doctrines requiring exhaustion of administrative remedies before they will consider relief.¹⁷⁵

The exhaustion requirements and the instability of the equitable remedy in most states both suggest that the logical first choice for beneficiaries seeking to constrain the unilateral revision of Medicaid by states without the availability of § 1983 is to seek state-level administrative review of such changes.

170. See *Conlan v. Bonta*, 125 Cal. Rptr. 2d 788, 803 (Ct. App. 2002) (using a writ of mandamus to compel restructuring of California’s Medicaid program to allow retroactive payments for beneficiaries determined to be within the requirements of federal Medicaid law).

171. *Conlan v. Shewry*, 32 Cal. Rptr. 3d 667, 670 (Ct. App. 2005).

172. See, e.g., *Krieger v. Krauskopf*, 503 N.Y.S.2d 418 (App. Div. 1986) (utilizing statutorily authorized prerogative writs to compel reimbursement of Medicaid plaintiffs denied funding in violation of federal requirements); see also *Martin v. Blum*, 448 N.Y.S.2d 873 (App. Div. 1982); *Seittelman v. Sabol*, 601 N.Y.S.2d 391, 394-95 (Sup. Ct. 1993) (utilizing the same procedure to grant declaratory relief to plaintiffs seeking to invalidate a state regulation on reimbursement for medical services as “irrational and inconsistent with federal law”).

173. See Talmadge, *supra* note 168, at 709-15.

174. See, e.g., *Jackson v. Millstone*, 801 A.2d 1034, 1041-44 (Md. 2002) (noting the Maryland procedure as it applies to state violations of federal Medicaid requirements).

175. See, e.g., *Del. Valley Convalescent Ctr., Inc. v. Beal*, 412 A.2d 514, 515 (Pa. 1980) (rejecting a claim that the fair hearing process can be skipped and suit can be brought directly in state court when plaintiffs make “strictly legal” claims about the illegality of state regulations under federal law).

Specifically, the federal government requires states, as a condition of their participation in Medicaid, to provide an “opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.”¹⁷⁶ This “fair hearing” requirement provides an important potential § 1983 substitute for enforcing federal Medicaid requirements against the states.

To examine the efficacy of this mechanism for holding states accountable for violations of their state plans, it is helpful to develop a taxonomy for understanding the different ways a state might alter the terms of its Medicaid program without the required consent of the federal government. Generally speaking, there are three major categories of state action that might occasion a violation of the terms of its state plan. First, a state could institute a “legislative restructuring” of its Medicaid program, whereby that state’s legislature enacts a statute that alters its benefit structure in violation of its obligations under its state plan.¹⁷⁷ Second, a state’s Medicaid implementing agency might initiate a “regulatory restructuring” of its program. Examples include issuing a new regulation or effecting a change in an existing regulation that contravenes the state plan.¹⁷⁸ Finally, a state might functionally engage in what could be called an “ad hoc restructuring” of its Medicaid program, by, for instance, implementing a facially compliant statute or regulation in a way that functionally deprives individuals of a benefit required by the original state-federal bargain. These sorts of restructurings are most likely to be found in cases of denials of individual requests for specific services.¹⁷⁹ Through the exercise of fair hearing rights, beneficiaries may be able to functionally constrain some of the ad hoc, regulatory, and legislative restructurings of state Medicaid programs in contravention of their state plan requirements.

Fair hearing actions will be somewhat less effective at restraining state action than federal legal mechanisms like § 1983, since there is variability in the scope of the fair hearing right across the states. Since fair hearing requirements emanate from the federal Medicaid statute itself, however, some basic level of

176. 42 U.S.C. § 1396a(a)(3) (2000).

177. *See, e.g.,* Gould v. Klein, 376 A.2d 196 (N.J. Super. Ct. App. Div. 1977) (rejecting a challenge to a state statute governing reimbursement on judicial review of a fair hearing decision adverse to the beneficiary).

178. *See, e.g.,* Jacobus v. Dep’t of PATH, 857 A.2d 785, 789-91 (Vt. 2004) (holding on review of a fair hearing decision that the department’s Medicaid regulations violate Medicaid’s federal statutory and regulatory comparability requirements).

179. *See, e.g.,* G.B. v. Lackner, 145 Cal. Rptr. 555 (Ct. App. 1978) (holding that the agency’s ad hoc denial of a plaintiff’s submission for transsexual surgery reimbursement was beyond the scope of its discretion under governing federal and state law).

structural uniformity can be expected. Ultimately, an analysis of the minimum procedures mandated by the federal government, along with state-level implementation of these requirements, suggests that increased administrative activity by beneficiaries at the state level may provide a viable accountability mechanism in many states.

This Part explores the viability of the fair hearing remedy. Section IV.A examines the outer limits of the fair hearing requirement as codified in federal regulations and interpreted through a handful of relevant cases from the federal courts of appeals. Section IV.B looks at how individual states have chosen to implement the Medicaid fair hearing requirement, examining the prospects for § 1983-style activity within these existing state structures. Section IV.C concludes the discussion by examining the efficacy of the fair hearing remedy as a mechanism of enforcement as compared with a § 1983 lawsuit filed in federal court.

A. The Boundaries of the Federal Fair Hearing Requirement

Under the terms of the Medicaid statute, every state must provide in its state plan an opportunity for a “fair hearing before the State agency” to any individual whose claim for Medicaid benefits is denied.¹⁸⁰ These hearings are typically presided over by an administrative law judge (ALJ), although some states assign a more informal hearing officer to oversee the inquiry.¹⁸¹

Federal regulations issued by HHS indicate the minimum level of procedure that states must follow in providing a hearing. Opportunities for fair hearings are to be made available in the event that a state agency “takes action . . . to suspend, terminate, or reduce services.”¹⁸² Hearings can be before the agency itself or can be of an evidentiary nature at the local level with an appeal to the state agency. Along with specific procedural requirements, the hearings are required to conform to constitutional due process requirements.¹⁸³

The efficacy of the fair hearing requirement in checking the excesses of the states in their implementation of Medicaid will depend on the degree to which

180. 42 U.S.C. § 1396a(a)(3) (2000).

181. While the use of a state-level ALJ is not strictly mandated, *see* 42 C.F.R. § 431.240(a)(3) (2007), states generally choose to implement these sorts of requirements through ALJs. *See, e.g.,* KAN. STAT. ANN. 75-3306(h) (1997) (discussing the authority of ALJs in Kansas). *But see, e.g.,* 16 DEL. ADMIN. CODE § 5000 (2007), *available at* <http://regulations.delaware.gov/AdminCode> (indicating that the “hearing officer” is responsible for presiding over the Medicaid fair hearing).

182. 42 C.F.R. § 431.200(b) (2007).

183. *Id.* § 431.205(d); *see also* *Goldberg v. Kelly*, 397 U.S. 254 (1970).

beneficiaries can use hearings effectively to challenge legislative, regulatory, and ad hoc restructurings. Although the federal regulations appear to require ad hoc restructuring claims to be heard in fair hearings, they are somewhat unclear about when states must allow challenges to regulatory and legislative restructurings. This confusion results from the regulations' differing treatment of two separate categories of claims—referred to by HHS as “fact or judgment” claims on the one hand and “law or policy” claims on the other.¹⁸⁴

“Fact or judgment” questions address claims that a particular individual was erroneously denied benefits due to a state error in administering an existing law or policy. This represents the typical evidentiary inquiry common to most administrative proceedings. Examples provided by the State Medicaid Manual, which provides additional detail and direction to the states regarding the substance of the regulations (and is authored by the same HHS officials responsible for issuing the regulations),¹⁸⁵ include challenges to an agency decision that an individual is not sufficiently medically disabled to qualify for benefits or a decision that a parent works so many hours as to disqualify her family from receiving Medicaid benefits.¹⁸⁶ These questions roughly correspond to the definition of an ad hoc restructuring. Federal regulations indicate that states must provide hearings to adjudicate these “fact or judgment” challenges. As such, all states must require challenges to ad hoc restructurings through their fair hearing mechanisms.¹⁸⁷

“Law or policy” questions, by contrast, deal with the underlying state Medicaid framework and correspond to actions categorized as regulatory or legislative restructurings. Examples from the State Medicaid Manual include the elimination of eyeglasses or dental care in the list of services that beneficiaries may access under Medicaid.¹⁸⁸ The key distinction between the two categories is whether an individual alleges facts and circumstances that are in some way unique to her situation.¹⁸⁹

Although state hearings must consider “fact or judgment” issues, according to the HHS regulations, adjudicators are allowed to dismiss a hearing in the

184. STATE MEDICAID MANUAL § 2902.4 (2005), available at <http://www.cms.hhs.gov/Manuals/PBM/list.asp> (follow “Next” link; then select “The State Medicaid Manual”).

185. The Foreword of the State Medicaid Manual indicates that it “is an official medium by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.” *Id.* at i.

186. *Id.* § 2902.4(B), at 2-390.

187. 42 C.F.R. § 431.220 (2007).

188. STATE MEDICAID MANUAL, *supra* note 184, § 2902.4(A), at 2-389.

189. *Id.* § 2902.4, at 2-389 (“Issues of fact or judgment include issues of the application of State law or policy to the facts of the individual situation.”).

event that the “sole issue [contested in the hearing] is a Federal or State law requiring an *automatic change* adversely affecting some or all recipients.”¹⁹⁰ The State Medicaid Manual interprets this provision to mean that states need not grant hearings to consider claims where the “sole issue” raised is one of law or policy.¹⁹¹ As a result, HHS, at least, does not appear to require challenges to legislative and regulatory restructurings in state hearings to be heard. It is worth noting that the State Medicaid Manual represents the “official interpretations of the law and regulations, and, as such [its analyses] are binding on Medicaid State agencies.”¹⁹²

What of circumstances where the “law or policy” issue is not the “sole issue” raised in the hearing—cases where the hearing claimant challenges both the underlying policy and its application to her particular unique set of circumstances? The remainder of this Section addresses this topic by looking first at the federal requirements as augmented by HHS regulations and the State Medicaid Manual, and then at the sparse federal case law on this topic.

1. *Textual Analysis of the HHS Regulations and Supporting Materials*

Effective use of the fair hearing remedy to challenge state regulatory or legislative restructurings that violate Medicaid state plans depends on the ability of beneficiaries to compel states to hear those claims in the administrative forum. Under the terms of those federal regulations, a state “must grant” a hearing opportunity to “[a]ny recipient who requests it because he or she believes the agency has taken an action erroneously.”¹⁹³ By itself, this seems quite broad. As discussed above, however, other provisions make it clear that such requests may be dismissed when the “sole issue” raised is one of “law or policy.”¹⁹⁴ Even if all legislative or regulatory restructurings are categorized as “law or policy issues,” however, this language does not necessarily mean that challenges to these two forms of state action may be dismissed automatically by state hearing officers.

For two basic reasons, these regulations should be understood to require adjudication of “law or policy” issues when they are not the “sole issue” presented in a hearing. First, the regulations clearly contemplate that fair hearings might adjudicate issues of law or policy. They provide, for example,

190. 42 C.F.R. § 431.220(b) (2007) (emphasis added).

191. STATE MEDICAID MANUAL, *supra* note 184, § 2901.3, at 2-387 to -388.

192. *Id.* at i.

193. 42 C.F.R. § 431.220(a)(2) (2007).

194. *Id.* § 431.220(b).

several procedural instructions for handling “law or policy” questions, implying that such claims are sometimes actionable in the fair hearing context.¹⁹⁵ Second, the State Medicaid Manual directly endorses a broad reading of the hearing requirement as it relates to issues of agency policy. For instance, it expressly indicates that arguments about the “inadequacy” of a state’s program stemming from its failure to provide particular benefits are “issue[s] of agency policy [that are] grounds for requesting a fair hearing.”¹⁹⁶

Reading the regulations and attendant implementing materials as a whole thus strongly suggests that where a hearing request involves mixed questions of fact and law (i.e., when questions of law or policy are not the “sole issue” presented) states are compelled to consider “law or policy” questions in the course of fair hearings. To be sure, the regulations are murky on this issue. Federal case law is also sparse and somewhat contradictory. Ultimately, however, the three existing federal circuit court cases discussed below are not inconsistent with a reading of the regulations that requires the adjudication of “law or policy” issues so long as they are not raised in isolation from unique personal circumstances in a fair hearing.

2. *Federal Case Law on the Fair Hearing Requirement*

The federal circuit courts have provided little interpretive guidance regarding the extent to which the HHS regulations require states to allow for “law or policy” questions to be adjudicated in state Medicaid hearings. Cases addressing the issue have historically arisen out of successful actions in federal court seeking to invalidate state Medicaid legislative or regulatory restructurings due in part to the failure of the state to provide fair hearings to affected beneficiaries at the time of the change. These cases stop short of clearly articulating the view of the federal regulations discussed above, and do not expressly require consideration of “law or policy” concerns when they are not the “sole issue” raised. The case law is nonetheless consistent with such a reading. If the federal courts eventually came to this conclusion, all states would be required to allow administrative challenges to regulatory and legislative restructurings of Medicaid, so long as beneficiaries could raise specific factual claims related to their unique circumstances alongside these policy challenges.

195. *Id.* § 431.222(a), (b).

196. STATE MEDICAID MANUAL *supra* note 184, § 2902.4(A), at 2-389.

At least one federal district court has held that the refusal of a state to hear “issues of federal law in the course of administrative appeals” is a violation of the fair hearing requirement.¹⁹⁷ In *Mowbray v. Kozlowski*, the district court in the Western District of Virginia rejected a Virginia Medicaid Eligibility Appeals Board policy of refusing to hear arguments regarding issues of federal law in the course of fair hearings.¹⁹⁸ The district court noted that the federal regulations outlining the requirement “make[] the granting of a hearing mandatory at the request of an applicant or recipient aggrieved by an agency’s decision” and “do[] not limit that obligation only to those cases where the appellant raises a factual or evidentiary issue.”¹⁹⁹ The Court also suggested that a refusal by state agencies to hear issues of federal law might represent a violation of constitutional due process requirements since a right to a “fair hearing” is generally recognized as an element of due process and “[a] hearing from which a discussion of federal law is excluded, particularly where the thrust of the argument is that the state action is illegal under that law, is certainly not a ‘fair’ one.”²⁰⁰ The district court acknowledged that “administrative process, plus judicial review, may equal Due Process” – making it possible that “a system could be set up such that an agency could prevent argument on federal law and require the appellant to pursue review in federal or state court on the issue of the legality of the state rule.”²⁰¹ The court noted, however, that this was an inefficient allocation of resources:

Allowing appellants to raise the issue before the state agency gives the state the first crack at considering the issue and perhaps bringing state regulations into compliance. A hearing officer is not bound to accept the appellant’s argument; however, making the agency aware of a potential conflict, may well prevent the expense of litigation and encourage thoughtful, internal review.²⁰²

197. *Mowbray v. Kozlowski*, 724 F. Supp. 404, 417 (W.D. Va. 1989), *rev’d on other grounds*, 914 F.2d 593 (4th Cir. 1990).

198. *Id.* at 404.

199. *Id.* at 418.

200. *Id.*

201. *Id.* Even those states that expressly disallow consideration of “law or policy” questions allow the consideration of such claims on judicial review. *See generally infra* Section IV.B.

202. *Mowbray*, 724 F. Supp. at 418. The same court repeated the efficiency argument when criticizing Virginia’s post-*Mowbray* formulation of its fair hearing system as still inadequate. *See Shifflett v. Kozlowski*, 843 F. Supp. 133, 137 (W.D. Va. 1994).

Though *Mowbray* was later reversed on other grounds,²⁰³ its analysis remains the most cogent jurisprudential justification for a requirement to hear questions of “law or policy” in the context of state-level fair hearings.²⁰⁴

In 2004, the Tenth Circuit read the current HHS regulations to find that state hearings must consider challenges involving “law or policy” questions so long as those questions did not represent the “sole issue” in the case. In *Soskin v. Reinertson*,²⁰⁵ the court held that the fair hearing requirement applied to beneficiaries adversely affected by a legislative restructuring of Colorado’s Medicaid program that withdrew existing Medicaid benefits from legal aliens residing in the state. Because the Colorado statute provided a procedure for individuals to contest their imminent removal from the Medicaid rolls by arguing that they were not aliens, these individuals could “contest several factual matters” related to their individual circumstances. As a result, the Tenth Circuit found that they raised “fact or judgment” issues alongside their direct challenge to the new Colorado law itself. Thus, as a threshold matter, fair hearings were required.²⁰⁶

The Sixth Circuit has addressed this issue twice, and its holdings are not inconsistent with *Reinertson*. When dealing with the 1978 version of the federal Medicaid fair hearing requirement, the court suggested in *Benton v. Rhodes* that states were not required to provide hearings to address an issue of “law or policy.”²⁰⁷ *Rhodes* involved a regulatory restructuring whereby the Ohio Department of Public Welfare, under orders from the legislature to operate under a strict spending cap, informed Medicaid recipients that they would no longer receive a spate of previously provided benefits.²⁰⁸ In its opinion, the Sixth Circuit held that the agency’s action fell under the 1978 version of the “sole issue” provision.²⁰⁹

Although the *Rhodes* court declared in sweeping dicta that “matters of law and policy are not subject to any hearing requirements” under the terms of the HHS regulations, the holding of the case need not be read so expansively. *Rhodes* involved a pure challenge to a state regulatory restructuring; as such, it did not reach the issue of whether “law or policy” issues must be considered if

203. See *Mowbray*, 914 F.2d at 593.

204. See C. Stuart Greer, Note, *Expanding the Judicial Power of the Administrative Law Judge To Establish Efficiency and Fairness in Administrative Adjudication*, 27 U. RICH. L. REV. 103 (1992).

205. 353 F.3d 1242 (10th Cir. 2004).

206. *Id.* at 1263.

207. See *Benton v. Rhodes*, 586 F.2d 1, 3 (6th Cir. 1978).

208. *Id.* at 2.

209. *Id.* at 3.

they are raised alongside “fact or judgment” claims. Indeed, upon revisiting the issue in 2005, the Sixth Circuit in *Rosen v. Goetz* appeared to back off somewhat from its dicta in *Rhodes*.²¹⁰ Although the Court again refused to require states to adjudicate “sole issue” claims, it endorsed the *Reinertson* view that hearings raising “valid factual dispute[s]” alongside “law or policy” challenges should be allowed to proceed.²¹¹

Ultimately, federal doctrine in this area, though limited and underdeveloped, would be consistent with a broad rule requiring states to hear administrative challenges to “law or policy” issues, including those that manifest as state regulatory or legislative restructurings contravening federal Medicaid requirements, so long as the challenger also alleges factual issues unique to her circumstances.²¹² Unless and until courts start moving en masse toward the *Mowbray* position, however, beneficiaries looking to use fair hearings as a substitute for § 1983 will have to act within the frameworks that states have already created to implement the federal fair hearing requirement. The next Section considers those frameworks as they exist today.

B. Fair Hearings in the States

Irrespective of federal requirements, many states allow beneficiaries to challenge structural modifications to state Medicaid programs through the fair hearing requirement. The practices of individual states in determining the jurisdictional boundaries of their Medicaid hearings are varied. State implementation of Medicaid fair hearings can be divided into three broad groups—states that expressly prohibit these sorts of “law or policy” challenges, states that expressly allow these challenges, and states that simply codify the ambiguity of the federal HHS regulations. Where states in the first category are unlikely to allow these challenges, states in the second and third categories are likely to permit beneficiaries to challenge state alterations to their Medicaid programs. Note that all three categories would be expected to allow challenges to ad hoc restructurings to proceed through the fair hearing process.²¹³

210. *Rosen v. Goetz*, 410 F.3d 919, 927-28 (6th Cir. 2005).

211. *Id.* at 927.

212. For a discussion on utilizing fair hearings to challenge the legal validity of state legislative and regulatory actions under the AFDC, see Erika Geetter, *Attorney’s Fees for § 1983 Claims in Fair Hearings*, 55 U. CHI. L. REV. 1267, 1271-72 (1988).

213. See, e.g., *Hand v. State Dep’t of Human Res.*, 548 So. 2d 171, 173 (Ala. Civ. App. 1988) (“[W]here an agency prescribes rules and regulations for the orderly accomplishment of its statutory duties, its officials must vigorously comply with those requirements . . .”). For example, the Alabama Supreme Court has noted that, “[t]his principle prevents agencies

States in the first group take an expansive view of HHS's regulatory limitations on "law and policy" challenges. Under the terms of these states' implementing statutes and regulations, beneficiaries are categorically barred from making claims in a fair hearing that challenge the legal validity of a state regulation or statute.²¹⁴ For example, Alaska's Medicaid regulations expressly cabin the jurisdiction of the fair hearing authority to "the ascertainment of whether the laws, regulations, and policies have been properly applied in the case and whether the computation of the benefit amount, if in dispute, is in accordance with them."²¹⁵ These states often also have a narrow view of the scope of administrative adjudicative decision making in general. Some, like Kansas and Massachusetts, may expressly block ALJs from adjudicating the legal validity of a statute generally.²¹⁶

For the states that fall into this category, use of the fair hearing requirement to challenge ad hoc restructurings in violation of the terms of a state's Medicaid Plan are allowed to proceed since they typically implicate only questions of "fact or judgment."²¹⁷ Regulatory or legislative restructurings, however, are difficult, if not impossible, to contest through the fair hearing process. Case law from such jurisdictions appears to support this conclusion.²¹⁸ It is crucial to

from skirting their own regulations by the use of crabbed, *ad hoc* definitions of regulation terms." *Ex parte Wilbanks Health Care Servs., Inc.*, No. 1060218, 2007 WL 2966817, at *5 (Ala. Oct. 12, 2007).

214. See, e.g., Okla. Dep't of Human Servs., Office of General Counsel, Fair Hearings Information, <http://www.okdhs.org/divisionsoffices/ogc/ld/app/docs/hearappeals.htm> (Aug. 1, 2007).
215. ALASKA ADMIN. CODE tit. 7, § 49.170 (2007).
216. See, e.g., KAN. STAT. ANN. § 75-3306(h) (1997) ("The department of social and rehabilitation services shall not have jurisdiction to determine the facial validity of a state or federal statute. The hearings section of the department of social and rehabilitation services shall not have jurisdiction to determine the facial validity of an agency rule and regulation."); 130 MASS. CODE REGS. § 610.082(C)(2) (2006) ("[T]he hearing officer shall render a decision based on the applicable law or regulation as interpreted by the MassHealth agency or the Connector. . . . The hearing officer cannot rule on the legality of such law or regulation . . .").
217. See, e.g., *Ussery v. Kan. Dep't of Soc. & Rehab. Servs.*, 899 P.2d 461 (Kan. 1995) (providing judicial review of a fair hearing challenge to an agency's denial of a subsidy in violation of its own regulations).
218. See, e.g., *Americare Props., Inc. v. State Dep't of Soc. & Rehab. Servs.*, 738 P.2d 450, 453-54 (Kan. 1987) (discussing a Kansas hearing officer's unwillingness to strike down a state statute despite the fact that it "squarely defeat[ed] th[e] purpose" of a controlling federal regulation); *Salisbury Nursing & Rehab Ctr., Inc. v. Div. of Admin. Law Appeals*, 861 N.E.2d 429, 438 (Mass. 2007) (noting that the Massachusetts Division of Administrative Law Appeals does not have jurisdiction to hear "substantive" attacks on regulations governing Medicaid reimbursement rates).

note, however, that states typically allow for judicial review of administrative rulings, usually via state-level Administrative Procedure Acts.²¹⁹ Such requirements have allowed state courts the opportunity to invalidate legislative or regulatory restructurings that violate the terms of a state’s Medicaid Plan irrespective of whether or not the state agency initially declines jurisdiction to consider it.²²⁰

On the other end of the spectrum are those states that comprise the second group. These states either take a narrow view of the HHS limitations on mandatory “law and policy” adjudication, or disregard those limitations altogether. For example, Delaware allows its Medicaid hearing officers to dismiss cases where “the sole issue is one of State or federal law requiring automatic benefit adjustments for classes of . . . Medicaid recipients”²²¹ Unlike states in the first category, however, Delaware specifically authorizes its hearing officers to “issu[e] a final decision on . . . questions of law,”²²² and prohibits those officers from “apply[ing] State rules . . . to the extent they are in conflict with applicable federal regulations.”²²³ As such, a Delaware beneficiary must claim personal “fact or judgment” issues in addition to challenging a state regulatory or legislative restructuring on its face in order to avoid having her hearing request thrown out. Once a beneficiary passes that initial hurdle, however, the state hearing officer appears bound to consider whether the new state policy conflicts with federal Medicaid requirements.

Other states in this second group simply disregard the flexibility provided in the federal regulations for avoiding “law or policy” questions in state administrative hearings. After all, states are free to direct their agencies to provide hearings compulsorily in circumstances where federal regulations may not specifically require them. New York is illustrative of this phenomenon. Like Delaware, the state formally codifies the HHS exception allowing the dismissal of a hearing where the “sole issue” involved is a “Federal or State law

219. See Michele Estrin Gilman, *Legal Accountability in an Era of Privatized Welfare*, 89 CAL. L. REV. 569, 632-33 (2001).

220. See *Brewer v. Schalansky*, 102 P.3d 1145, 1154 (Kan. 2004) (reviewing the legality of a state statute governing valuation of resources for consistency with federal law and noting that “Kansas regulations cannot conflict with the federal regulations”); *Trust Co. of Okla. v. State*, 825 P.2d 1295, 1304 (Okla. 1991) (overturning a state policy regarding the treatment of trust fund assets in determining Medicaid eligibility as inconsistent with governing federal law). *But see Salisbury*, 861 N.E.2d at 429 (holding that the proper mechanism for facial challenges to Medicaid rate reimbursement schemes is the state’s Declaratory Judgment Act).

221. 16 DEL. ADMIN. CODE § 5307(2) (2007), <http://regulations.delaware.gov/AdminCode/>.

222. *Id.* § 5000 (2007).

223. *Id.* § 5406.1(1) (2007).

requiring an automatic change which adversely affects some or all recipients.”²²⁴ The state’s implementing agency, however, directs local agents to grant fair hearings even in situations where the hearing request is based only on “objection to State policy as it affects the applicant; or any other grounds affecting the applicant’s entitlement to assistance.”²²⁵ Thus, although New York state law gives the implementing agency the right to deny hearings that merely challenge the validity of a state policy, that agency specifically directs its representatives not to exercise that discretion.²²⁶

In permissive states like Delaware and New York, then, beneficiaries have a solid legal basis for using the fair hearing administrative review process to challenge ad hoc, regulatory, and legislative restructurings. Like states in the first group, these administrative decisions are also reviewable by the judiciary under state-level Administrative Procedure Acts, providing an additional level of legal oversight.²²⁷ Indeed, there are examples of state cases overturning initial agency determinations in permissive states as inconsistent with federal law.²²⁸ In addition, it is worth noting that these jurisdictions typically incorporate the HHS regulatory option allowing the consolidation of multiple hearings into a single “group hearing” in the event that they all deal with the same sole issue of law or policy.²²⁹ As a result, the sum total of regulations in these states suggests the potential for class action-style fair hearing actions challenging regulatory or legislative restructurings.²³⁰

224. N.Y. COMP. CODES R. & REGS. tit. 18, § 358-3.1(f)(4) (2006).

225. N.Y. State Dep’t of Health, Other Eligibility Requirements § 375, in MEDICAID REFERENCE GUIDE (2005), http://www.health.state.ny.us/health_care/medicaid/reference/mrg/. The purpose of the Medicaid Reference Guide is “to assist districts in determining Medicaid eligibility for applicants/recipients.” *Id.* at 10.

226. Despite this exception, there do not appear to be any readily available published cases involving judicial review of a pure challenge to a state policy in New York. This is likely because of the wide, established scope of the Article 78 equitable state remedy. *See supra* notes 172-174 and accompanying text.

227. *See, e.g.*, N.Y. A.P.A. LAW §§ 100-501 (McKinney 2007).

228. *See, e.g.*, *Urban v. Meconi*, 930 A.2d 860, 864-65 (Del. 2007) (reviewing an appeal from a Medicaid fair hearing and finding that the state’s fair hearing decision violated governing federal law).

229. *See, e.g.*, N.Y. COMP. CODES R. & REGS. tit. 18, § 358-5.10 (2006). The federal option is codified at 42 C.F.R. § 431.222 (2007).

230. Frequently, while consolidation is available to increase efficiency, individual beneficiaries have a right to withdraw and have their individual cases adjudged separately. N.Y. COMP. CODES R. & REGS. tit. 18, § 358-5.10(b)(2) (2006). This consolidation remedy, though widely codified, appears to be infrequently exercised. *But see Balino v. Dep’t of Health & Rehab. Servs.*, 348 So. 2d 349 (Fla. Dist. Ct. App. 1977).

States in the third group adopt a middle ground between those of the first and second groups. These states make no effort to expand or contract the boundaries of their local fair hearing systems outside of the basic contours of the federal HHS regulations. These statutes and regulations often explicitly state that they are meant to mirror the minimum level of procedural protection required by the federal Medicaid regulations. Utah, for example, simply “incorporate[s] by reference” the federal HHS regulations governing the operation of fair hearings.²³¹

Since ad hoc restructurings generally fall within the scope of the fair hearing requirement, challenges to such restructurings can be heard in these states. Evidence to this effect can be found in state court opinions reviewing challenges to ad hoc violations of state and federal requirements.²³² There are also examples of states in this category considering challenges to regulatory or legislative restructurings.²³³ Whether or not jurisdictions in this third group ultimately allow challenges to regulatory or legislative restructurings with any frequency, however, will be a function of two factors. First, the federal courts, which establish the baseline interpretations for the HHS regulations, are likely to define the procedural floor for the operation of fair hearings in states in this third category. Although state courts may interpret their own state regulations governing fair hearings, one would expect them to be heavily influenced by the positions taken by the federal courts. This consideration has played little role thus far in influencing agency practice since, as discussed in Section IV.A, federal case law is remarkably sparse in this area.²³⁴

Additionally, the ability to challenge legislative or regulatory restructurings in a state that falls in this third category is influenced by whether or not that state grants its ALJs the generic power to rule on questions of law that arise in the course of a proceeding initiated on the basis of specific facts or judgments. Louisiana, for example, grants all of its ALJs the authority to rule on the legality of agency policies in matters they are already adjudicating.²³⁵ As such, a

231. See, e.g., UTAH ADMIN. CODE r.414-301-6(1) (2008).

232. See, e.g., *Gustafson v. N.D. Dep’t of Human Servs.*, 712 N.W.2d 599 (N.D. 2006); *Sutherland v. N.D. Dep’t of Human Servs.*, 689 N.W.2d 880 (N.D. 2004).

233. See, e.g., *Weber Mem. Care Ctr., Inc. v. Utah Dep’t of Health*, 751 P.2d 831 (Utah 1988) (considering the legality of a duly promulgated state Medicaid regulation).

234. Cf. *Shifflett v. Kozlowski*, 843 F. Supp. 133 (W.D. Va. 1994) (discussing the changes to the Virginia fair hearing procedures with regard to hearing questions of law or policy in light of the district court’s decision five years earlier in *Mowbray v. Kozlowski*, 724 F. Supp. 404 (W.D. Va. 1989), *rev’d on other grounds*, 914 F.2d 593 (4th Cir. 1990)).

235. See, e.g., LA. REV. STAT. ANN. §§ 49:963(D), 49:958 (2003) (granting ALJs in Louisiana the authority to rule on the legality of agency policies in matters they are already adjudicating).

beneficiary in Louisiana who avoids having her hearing thrown out at the initial request stage appears able to have the ALJ to consider whether a state legislative or regulatory restructuring conflicts with federal Medicaid requirements.²³⁶

Thus, an analysis of fair hearing implementation across the states suggests that all states will allow beneficiaries to contest ad hoc restructurings, and many will allow beneficiaries to contest regulatory and legislative restructurings, that contravene federal Medicaid requirements. The next Section analyzes how such administrative adjudication compares with traditional § 1983 suits in federal court.

C. The Efficacy of Fair Hearings for Enforcing the Terms of Medicaid State Plans

Assuming beneficiaries are able to sustain initially administrative challenges to legislative, regulatory, and ad hoc restructurings of state Medicaid programs through Medicaid's fair hearing requirement, the key question becomes whether or not these hearings provide an effective way to police state governments. Though ultimately not as robust a mechanism for ensuring fidelity as § 1983 actions in federal court, on balance state-level fair hearings should provide some amount of effective private enforcement of federal Medicaid requirements.

It is true that, in the main, fair hearings tend to be less formal than federal legal proceedings. Although a § 1983 suit filed in federal court would be constrained by the full panoply of the Federal Rules of Civil Procedure and could drag on for months, fair hearings under Medicaid may be conducted in a much more informal environment. In some states, hearings will occur initially at the local level, without the presence of legal counsel, and will operate on a far more expedited schedule than would a § 1983 proceeding.²³⁷ Some states, like New Jersey, apply more formal, uniform administrative procedures to their fair hearings.²³⁸ Others, like Virginia, expressly disclaim the application of formal, adversarial procedures to the fair hearing process.²³⁹ Since the focus of such

236. *King v. Sec'y of the La. Dep't of Health & Hosps.*, 956 So. 2d 666 (La. Ct. App. 2007); *Pacante v. Jindal*, 751 So. 2d 343 (La. Ct. App. 1999).

237. See generally David H. Williams, *Medicaid in Louisiana*, in *LOUISIANA LEGAL SERVICES AND PRO BONO DESK MANUAL* 515, 531-35 (Gillis W. Long Poverty Law Ctr. ed., 2005), available at http://law.loyno.edu/probono/clinic/manual/LAmanual_medicaid.pdf.

238. See N.J. ADMIN. CODE §§ 10.49-10.8 (2007).

239. See 12 VA. ADMIN. CODE § 30-110-310 (2007).

hearings is more likely to be individualized and conciliatory than federal litigation, the forum may not be well-suited to the class-wide, adversarial nature of group hearings challenging the validity of a regulatory or legislative change.

Commentators have noted, however, that the basic Medicaid fair hearing requirements enumerated in the federal regulations include all of the “major procedural safeguards” typically found in an adversarial trial.²⁴⁰ These include timely and adequate notice, opportunities to present arguments, witnesses, and evidence, to confront and cross-examine opposing witnesses, to be represented by counsel, and to be heard by an impartial decision maker, who must issue a written opinion indicating the evidence relied on in making his or her decision.²⁴¹

In addition, though the requirement that final administrative action must be taken within ninety days of the initiation of administrative review theoretically could aid a particularly recalcitrant agency in an affirmative attempt to stymie discovery,²⁴² the typical informality of Medicaid fair hearings seems likely to work to the advantage of beneficiaries in the discovery context. Unlike the highly managed, high-stakes environment that characterizes a formal § 1983 action, state witnesses will often testify at Medicaid hearings without first having been prepared by counsel. As such, they will be far more likely to make factual admissions inadvertently that might bolster a beneficiary’s legal arguments.²⁴³ The traditional conciliatory nature of these hearings means that opposing counsel may not even be present at the fair hearing. Thus, it may be much easier to establish facts through the cross-examination of state officials than in the context of formal litigation.²⁴⁴ These advantages have led one major healthcare advocacy group to conclude that fair hearings permit “more effective discovery than anything possible after filing a lawsuit.”²⁴⁵

The greatest potential drawback to using the fair hearing procedure to challenge the validity of regulatory or legislative restructurings is the

240. Mark R. Fondacaro, *Toward a Synthesis of Law and Social Science: Due Process and Procedural Justice in the Context of National Health Care Reform*, 72 DENV. U. L. REV. 303, 339 (1995).

241. *Id.* at 337-39; see also *Goldberg v. Kelly*, 397 U.S. 254, 267-71 (1970); Henry J. Friendly, “Some Kind of Hearing,” 123 U. PA. L. REV. 1267 (1975).

242. 42 C.F.R. § 431.244(f)(1) (2007).

243. SARAH SOMERS & JANE PERKINS, NAT’L HEALTH LAW PROG., MEDICAID’S AMOUNT, DURATION AND SCOPE REQUIREMENT: CHALLENGING CUTS TO SERVICES FOR ADULTS 10 (2006), available at <http://www.nls.org/conf2006/medicaid's%20amount.pdf>.

244. *Id.*

245. *Id.*

potentially low likelihood of an ALJ actually invalidating a provision of law.²⁴⁶ It is true that ALJ decisions in many states are not always subject to further review by the agency.²⁴⁷ When a claimant merely challenges the wisdom of a policy, however, agency officials often have authority to reverse the ALJ's decision.²⁴⁸ Even in circumstances where ALJs expressly are granted jurisdiction to hear law or policy claims in the first instance or to pass judgment on legal issues that may come up in the course of a "fact or judgment" proceeding, they may be reluctant to overrule controversial departmental policies. In a somewhat related vein, agency leadership may believe that they have plenary authority over ALJ rulings that implicate policy and thus may attempt to override these sorts of adverse ALJ rulings, even when the rulings are grounded in challenges to the legality of statutory or regulatory provisions.²⁴⁹

The effect of these occasional institutional constraints, however, is limited since the vast majority of states provide a right of judicial review of adverse agency hearing decisions. States typically allow for such review through their individual state Administrative Procedure Acts.²⁵⁰ The Model State Administrative Procedure Act also contains extensive judicial review provisions.²⁵¹ Of crucial importance in this regard is the fact that these courts generally utilize a *de novo* standard of review for questions of law.²⁵² Some

246. See Williams, *supra* note 237, at 530-31.

247. See Jim Flanagan, *ALJ Decisions—Final or Fallible?*, 25 J. NAT'L ASS'N ADMIN. L. JUDGES 191, 191-92 (2005) (noting that in states like South Carolina and Louisiana, ALJs make the final decision, which is then subject to review only by the judiciary, while in states like North Carolina, the ability of agencies to review ALJ decisions is so limited that in practice those decisions carry "de facto finality").

248. See STATE MEDICAID MANUAL, *supra* note 184, § 2902.4(A) (2005) (noting that a challenge to the "alleged inadequacy of the State program" cannot result in a ruling "in favor of the appellant without a change in agency policy or, in some instances, in State law").

249. See Williams, *supra* note 237, at 531.

250. See Gilman, *supra* note 219, at 632-33.

251. REVISED MODEL STATE ADMIN. PROCEDURE ACT art. 5 (Proposed Official Draft 2005).

252. See, e.g., *Chippewa County Dep't of Human Servs. v. Bush*, 738 N.W.2d 562, 565 (Wis. Ct. App. 2007) (noting that on appeal from a fair hearing decision, interpretations of state statutes and regulations governing Wisconsin's Medicaid program are "independently review[ed]" and that the court is "not bound by an administrative agency's interpretation and application of a statute"); *Webb v. Fla. Dep't of Children & Family Servs.*, 939 So. 2d 1182, 1185 (Fla. Dist. Ct. App. 2006); *Braddock v. Mo. Dep't of Mental Health*, 200 S.W.3d 78, 80 (Mo. Ct. App. 2006); *Boruch v. Neb. Dep't of Health & Human Servs.*, 659 N.W.2d 848, 852 (Neb. Ct. App. 2003) (noting that state appellate courts in Nebraska must "reach[] a conclusion independent of the lower court[]" when reviewing questions of law on appeal from agencies).

state courts exercise a more discretionary level of review of agency interpretations of law akin to the federal *Chevron* doctrine,²⁵³ while others utilize a sliding scale of discretion depending on how novel the legal claim is.²⁵⁴ Even states that appear to exercise more discretionary review, however, sometimes have found that state ALJ Medicaid decisions that apply a departmental policy in violation of federal legal requirements are by nature “unreasonable” and thus constitute an “abuse of discretion.”²⁵⁵ Ultimately, since the argument that a state restructuring violates federal Medicaid requirements will always require interpretation of the federal requirement, even beneficiaries whose states provide less than adequate procedural protections will have an opportunity to have their challenge to such an action duly considered by a state appellate court.

CONCLUSION

Federal courts have narrowed the scope of permissible § 1983 actions over the last decade, threatening the ability of individuals to bring suit to force states to comply with federal Medicaid requirements. Although there appeared to be consensus among the federal courts of appeals that the basic “availability” requirement of the original Medicaid statute remained enforceable after *Gonzaga v. Doe*, fundamental changes to Medicaid in the DRA likely signal the final end to § 1983 Medicaid benefits enforcement actions. Even when individuals seek to compel states to comply with the terms of their own negotiated agreements with the federal government, the Medicaid statute may not demonstrate the requisite congressional intent to maintain a § 1983 action.

Legal accountability through innovative use of Medicaid’s fair hearing requirement may cover some of the ground lost by the decline of § 1983. Though not all states allow for the use of this administrative review mechanism to challenge the underlying legality of a benefit cut that allegedly

253. *Mulder v. S.D. Dep’t of Soc. Servs.*, 675 N.W.2d 212, 214 (S.D. 2004) (endorsing the federal *Chevron* framework directing the court on judicial review to uphold “reasonable” interpretations by the state Medicaid agency); *see also Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984).

254. *Bezzini v. Dep’t of Soc. Servs.*, 715 A.2d 791, 793 (Conn. App. Ct. 1998) (distinguishing between issues of fact, which get very deferential review, issues of pure law, which get less deferential review, and questions of law “not previously . . . subject to judicial scrutiny,” which do not get any special deference (quoting *Conn. Light & Power Co. v. Tex.-Ohio Power, Inc.*, 708 A.2d 202, 206 (Conn. 1998))).

255. *Harrison v. Comm’r, Dep’t of Income Maint.*, 529 A.2d 188, 193 (Conn. 1987).

violates the federal Medicaid requirements, there is generally a way to have the issue adjudicated, either by a state ALJ or by a subsequent reviewing court.

The fair hearing remedy appears to be a good vehicle for addressing the accountability gap created by the decline of § 1983.²⁵⁶ Since federal regulations unambiguously require states to provide hearings to consider “fact or judgment” issues, beneficiaries challenging ad hoc restructurings can expect state Medicaid hearings across all jurisdictions to entertain their claims. Thus, state hearings can provide a viable means of enforcement in the typical ad hoc situation where a state agency denies particular benefits to a specific individual in violation of its state plan. Additionally, most jurisdictions are also likely to allow fair hearing challenges to regulatory or legislative attempts by states to restructure their Medicaid programs. Some jurisdictions, like New York, require that such claims be adjudicated by agency personnel. Others direct that such issues may be considered if they arise in conjunction with “fact or judgment” claims. Under both scenarios, savvy advocates will have a viable opportunity to obtain merits judgments in fair hearings.

To be sure, there is a subset of jurisdictions that categorically blocks its administrative hearings from determining whether a state regulation or law conflicts with a federal requirement. Even in those states, though, the typical robustness of judicial review of administrative actions may give beneficiaries a fair chance to contest the legality of these initiatives in state court. In addition, it is possible that these states have incorrectly interpreted the minimum amount of protection required by the federal government. As more beneficiaries begin to use the fair hearing system as a replacement for § 1983, the likelihood that this issue will be presented more squarely before the courts than in past litigation will increase. Future federal court litigation to determine the scope of the fair hearing requirement could well clarify that all states must, under certain circumstances, require law and policy challenges to proceed in state Medicaid hearings. There are certainly arguments grounded in existing precedent and textual analysis of the HHS regulations that suggest this requirement might exist.²⁵⁷ Should such a development occur, this group of states would be required to modify their state regulations to allow such challenges to proceed.

256. In at least one case, a state court has rejected an attempt to bind states by federal Medicaid requirements through the fair hearing process by applying § 1983 analysis of the enforceability of the beneficiary's rights. *See Keup v. Wis. Dep't of Health & Family Servs.*, 675 N.W.2d 755 (Wis. 2004).

257. *See supra* Subsection IV.A.1.

Though actual win rates associated with claimants in Medicaid hearings are currently low,²⁵⁸ the infrequent use of this mechanism to date to challenge state restructurings that violate federal Medicaid requirements render the data somewhat inapposite. Increased utilization of the fair hearing mechanism for policing state actions, which address an entirely different set of issues than the current set of cases, may result in different outcomes. Regardless, even if fair hearings ultimately prove to be less effective in obtaining favorable court judgments than § 1983 suits, the mere threat of viable legal challenges, reviewable in state courts, might well exert the same sort of deterrent effect that the threat of § 1983 litigation has in previous decades.²⁵⁹ In addition, the ability to engage in probing discovery of a type that might even be more productive than that which could be obtained in the course of ordinary federal litigation might help to facilitate compliance even more effectively than similarly situated attempts at discovery in the § 1983 context.²⁶⁰

In the end, state fair hearings as currently designed will only provide a partial substitute for § 1983 suits in federal court. The best option for the federal government to ensure compliance with federal Medicaid requirements might be a legislative fix. Congress could create an express individual cause of action in federal court for Medicaid recipients to seek state compliance with the terms of their entitlement under individual state plans, or could clearly confer a right enforceable through the § 1983 remedy. Such a provision could be modeled on the express right already found in Medicare²⁶¹ and might be the best way to protect the design flexibility afforded to states by the DRA while at the same time allowing individual beneficiaries to continue ensuring each state's fidelity to its commitment to the federal government under Medicaid. In the absence of such action, however, beneficiaries should give the fair hearing system serious consideration. Given the variation in procedures from state to state and the lack of institutional precedent defining the permissible scope of fair hearing actions, beneficiaries are likely to face a difficult and uncertain path in their attempts to enforce federal Medicaid requirements against states through this mechanism. Still, the channels for bringing such actions do appear to be open in many states. In time, beneficiaries are likely to find that given the current state of the law, state fair hearings represent their best hope at filling in the Medicaid accountability gap caused by the DRA.

258. See Williams, *supra* note 237, at 530.

259. See *supra* note 20 and accompanying text.

260. See *supra* notes 242-245 and accompanying text.

261. See 42 U.S.C. § 1395ff(b)(1)(A) (2000).