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Rachel Min Luke

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Reading Between the Lines: Medicaid, Early Periodic Screening Diagnosis and Treatment, and Section 1983

Rachel Min Luke[1]

> I am concerned about services. I don't want to lose my son. I want to get my son help now before he goes and robs a store or something and then he gets taken away. (New York)[2]

> My son didn't really get any help until I had him arrested. . . . I had to call the police on him and say he hit me, which he did. But I kind of thought to myself when I woke up that day, "Okay. Today I'm going to let him hit me. We're going to play a game." (Oregon)[3]

INTRODUCTION

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provision of the Medicaid Act provides that Medicaid-eligible children under the age of twenty-one should receive any medically necessary physical or mental health services.[4] However, many Medicaid-eligible children are left without mental health care treatment, often because they are unable to access the services to which they are legally entitled under the EPSDT provision.[5] Thus, the issue presented is twofold. First, because children's behavioral and cognitive mental health issues are not being addressed through intervention and preventative care, youth often develop behavioral problems and sometimes end up in juvenile detention centers.[6] Second, when individuals seek recourse for a state's failure to provide legally entitled mental health services, they face a difficult judicial road because the circuit courts are split as to whether individuals have a private

right of action, under 42 U.S.C. § 1983, against states that fail to provide EPSDT services.[7]

Addressing the second of these issues, I argue that the statutory language of the EPSDT provision of the Medicaid Act and underlying policies indicate that suits under § 1983 of the Medicaid Act, especially suits to enforce medically necessary mental health care for children, are appropriate private actions to bring to the federal courts. Additionally, I argue that a pragmatic textualism approach to analyzing the EPSDT provisions of the Medicaid Act is more accurate than utilizing a strict textualism approach.

In Part I, I provide a brief overview of the history of Medicaid and its role in providing mental health care services to children. In Part II, after a brief history of the Civil Rights Act of 1871, I consider the legal landscape for plaintiffs seeking to bring actions under § 1983 through the lens of existing cases. Part III discusses two approaches to the textualism analysis that the Supreme Court requires under *Gonzaga University v. Doe*[8] and *Blessing v. Freestone*[9] for potential § 1983 suits. There I argue that future courts should follow the pragmatic textualism approach for a more accurate reading of the EPSDT provisions of the Medicaid Act. Finally, Part IV concludes with a discussion of what actions the Supreme Court and Congress could take to help remedy the situation.

I. MEDICAID HISTORY

On July 30, 1965, the Medicaid Act was enacted as Title XIX of the Social Security Act.[10] The Medicaid Act committed the citizens of the United States to provide basic medical services to millions of low-income Americans.[11] Today, Medicaid covers almost sixty-one million people and is the nation's largest program financing health and mental health care.[12] In 2007, the Center for Medicare and Medicaid Services reported that 29.2 million children were enrolled Medicaid beneficiaries.[13]

Medicaid acts as a federal-state partnership in which states can choose to opt into the program that is administered by the states.[14] All fifty states, the

District of Columbia, and many U.S. territories choose to opt into the Medicaid program.[15] States must cover all medically necessary services for children, though they have considerable flexibility over eligibility and covered services for adults.[16] Eligibility is based on an individual's income and resources, but the states have discretion to establish varied eligible beneficiary groups.[17] Even so, individuals must have a low to moderate income to qualify themselves and their dependents for Medicaid.[18] If a state elects to participate in the Medicaid program, it must comply with all provisions of the federal Medicaid statute[19] and its implementing regulations, except for those individual requirements that may be waived by the federal government.[20]

A. Early and Periodic Screening, Diagnosis, and Treatment

In 1967, Congress added the EPSDT program to the Medicaid Act.[21] The EPSDT program was designed to correct or ameliorate chronic conditions.[22] The initial program was optional; however, by 1989, Congress had begun to voice concerns that given the optional nature of the EPSDT provision and the absence of a detailed statutory description of its requirements, many states chose not to provide EPSDT services and care to Medicaid-eligible children.[23]

On December 19, 1989, Congress amended the Medicaid statute's EPSDT provisions to guarantee that persons under twenty-one years of age, regardless of their ability to pay, would receive *all* medical care deemed reasonably necessary.[24] This provision is substantially different from Medicaid's coverage for adults because the EPSDT provisions are more expansive in the number and types of services available.[25] The amendment mandated that participating state agencies provide EPSDT-eligible children "[s]uch other necessary health care . . . described in [the Act's § 1396d(a) definition of 'medical assistance'] to correct or ameliorate defects and . . . illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State plan*."[26] In addition, the 1989

amendments to the EPSDT program required that the service and care provided by states include *all* twenty-eight of the types of care and services included as part of the definition of medical assistance in the revised Act.[27] These services include inpatient hospital services, outpatient hospital services, laboratory and x-ray services, any type of remedial care, home health services, preventative services, case-management services, and any other medical care.[28]

The primary purpose of EPSDT is prevention: it aims to "ensure that poor children receive comprehensive health care at an early age, so that they will develop fewer health problems as they get older."[29] The standard of coverage is necessarily broad; it provides that the standard level of medical necessity used by a state must sufficiently cover, and not merely treat, an already existing illness or injury, and it must also prevent the potential development or worsening of conditions, illnesses, and disabilities.[30] Thus, the EPSDT provisions are located in several parts of the Medicaid Act.[31] The services participating states are required to provide are found in 42 U.S.C. § 1396d(r).[32] Specifically, state Medicaid plans must provide for arranging (directly or through referral to appropriate agencies, organizations, or individuals) any necessary corrective treatment identified by health screening services.[33]

While the EPSDT provisions are meant to be preventative and expansive, children often do not receive the mental health screening or treatment to which they are entitled because services often are not available in all communities, and too few providers are available to meet the needs of those covered by Medicaid.[34] There are several reasons for this disparity in services, but two issues stand out.

First, the mental health services and screenings required under EPSDT are unavailable in many communities because some agencies have elected not to offer the required substantive services. In fact, services are unavailable in so many communities that, most of the time, Medicaid-eligible children do not receive either the mental health screens or treatment

to which they are entitled.[35] This is inconsistent with federal law because under the Medicaid Act, each participating state must establish administrative mechanisms to "identify available screening and diagnostic facilities, to assure that individuals under twenty-one years of age who are eligible for medical assistance may receive the services of such facilities . . . ."[36]

Second, low fees associated with participation in Medicaid have dissuaded some practitioners from providing Medicaid services, and as a result, only a limited number of practitioners are available to EPSDT beneficiaries.[37] This has forced some practitioners to limit or deny services altogether to children enrolled in Medicaid programs.[38] As a result, children are placed on long waitlists to obtain needed treatment.[39] An Oregon woman commented: "Getting in to see a psychiatrist is impossible. You get in and there's a three-month wait for an appointment. To get her meds reevaluated another three months, and then in the meantime, she was off the deep end and out of her mind."[40]

Because mental health care services are unavailable in some communities and some practitioners have chosen not to offer these services, often, by the time a child receives treatment, he or she has already exhibited behavioral problems.[41] Many times, these children end up in the juvenile justice system.[42] This can be due to a number of complex factors, including the reality that untreated mental conditions or illness can sometimes lead to substance abuse, outbursts of anger, defiance of authority, truancy, theft, and vandalism.[43] Therefore, the consensus among mental health experts, correctional officers, and parents is that children are more effectively served in communities that are able to address mental health issues.[44] Studies suggest that more than 70 percent of children in the juvenile justice system have a mental health disorder, and approximately 20 percent have a serious mental illness.[45] Thus, the overlap between the juvenile justice and mental health populations is unavoidable when discussing issues arising from either topic. Many of the behavioral issues associated with mental illness may

have been intercepted if the children had access to the mental health services mandated by federal law.

The conclusion of Seattle-based researchers in one study is astounding. Children eligible for public mental health services were three times more likely to have contact with the juvenile justice system than a comparable sample of the general population.[46] This problem is highlighted by reports from around the country suggesting that families are encountering excessively long waitlists when seeking community-based mental health services for their children, and thus, are not receiving medically necessary mental health treatment.[47] Therefore, because of defects in state implementation of Medicaid, youth across the country are left with untreated mental health issues, and many of these youth are ultimately left to the justice system.

The effect of the lack of necessary mental health care can be devastating to families, especially when the child is left untreated. The primary purpose of the EPSDT provisions is prevention—to ensure that poor children receive comprehensive care—but it is not living up to its name.

II. THE CIVIL RIGHTS ACT OF 1871

Despite the fact that many children are not receiving the mental health treatments mandated under the EPSDT, the current legal landscape provides parents and guardians of these children a tenuous opportunity for relief through the Civil Rights Act of 1871, 42 U.S.C. § 1983.

The Civil Rights Act of 1871 was originally titled the Ku Klux Klan Act.[48] The initial purpose of the act was to protect the civil rights of freed slaves and union supporters by providing a neutral forum in which the aggrieved could bypass the biases of state courts of the Reconstruction era.[49] The statute guaranteed constitutional rights but did not refer to any statutory rights.[50] In 1884, Congress added the phrase "and laws" to section 1 of the Civil Rights Act to include a cause of action for statutory as well as constitutional rights.[51]

Since 1980, the Supreme Court has allowed § 1983 suits in cases alleging violation of constitutional rights and federal statutory rights, as well as those enforcing provisions of the Medicaid Act.[52] The relevant part of § 1983 reads,

> Every person, who, under color of any statute, ordinance, regulation, custom, or usage of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities, secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.[53]

However, in 1997, this right to bring an action in the federal court was somewhat limited in the Supreme Court case *Blessing v. Freestone*.[54] In *Blessing,* five Arizona mothers whose children were eligible for, but did not receive, state child support services filed suit against the director of the state child support agency.[55] Under the Court's reasoning, for a federal statute such as Medicaid to be enforceable under § 1983, "a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*."[56] The Court created a three-prong test to determine whether a federal right has been established. First, there must be evidence that Congress intended that the provision benefit the plaintiff.[57] Next, "the plaintiff must demonstrate that the right assertedly protected by the statute is not so 'vague and amorphous' that its enforcement would strain judicial competence."[58] Finally, the statute must unambiguously impose a binding obligation on the states.[59]

In 2002, § 1983 claims were further limited by the Supreme Court's ruling in *Gonzaga University v. Doe*.[60] In *Gonzaga*, a former university student brought an action against Gonzaga University under § 1983 alleging violations of the Family Educational Rights and Privacy Act.[61] The Court held that Congress creates an enforceable statutory right only when done "in clear and unambiguous terms—no less and no more than is required for

Congress to create new rights under an implied right of action."[62] Additionally, the *Gonzaga* Court "strongly indicated that federal statutes enacted under the Spending Clause, as Medicaid [is], are unlikely to create private enforceable rights."[63] However, the Supreme Court has found spending clause legislation enforceable under § 1983 twice; one case involved denial of Medicaid services and has yet to be overruled.[64]

A. § 1983 Suits and Medicaid

When a state that has chosen to participate in the Medicaid program does not comply with the Medicaid statute, the secretary of the U.S. Department of Health and Human Services has discretion to terminate that state's federal funds.[65] However, because this measure hurts rather than helps Medicaid recipients, this action is rarely taken.[66] Section 1983 provides an alternative mechanism for Medicaid recipients to contest a state application of Medicaid when the recipients believe that the state's implementation does not comply with the federal statute.

In a § 1983 suit contesting a state's implementation of EPSDT, the plaintiff will allege that the state violated the federal Medicaid law by failing to provide medically necessary mental health treatment for Medicaid-eligible individuals.[67] A § 1983 suit may be the last resort for families, many of whom have gone years without receiving services that a doctor has deemed to be medically necessary. Section 1983 suits regarding mental health care for children are especially crucial, because as previously discussed, without adequate mental health care, the consequences to the child, society, and the families of the children can be devastating.

B. The Evolution of the § 1983 Analysis

Wilder v. Virginia Hospital Association and *Gonzaga v. Doe*, two Supreme Court decisions, inform the way that courts analyze whether an individual has a private right of action to bring a § 1983 suit. These cases

have greatly impacted attempts at litigation to enforce provisions of the Medicaid Act.

1. Wilder v. Virginia Hospital Association Analysis[68]

In the 1990 case *Wilder v. Virginia Hospital Association*, plaintiffs brought an action pursuant to § 1983 challenging the administration of Virginia's Medicaid program.[69] The issue presented to the Supreme Court revolved around the Boren Amendment to the act, which required reimbursement according to rates that a "[s]tate finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."[70] The plaintiff, Virginia Hospital Association, a nonprofit corporation, filed suit in the U.S. District Court for the Eastern District of Virginia against several state officials including the governor, the secretary of human resources, and the members of the State Department of Medical Assistance Services (the state agency that administers the Virginia Medicaid system).[71] The plaintiff contended that Virginia's reimbursement plan violated the act because the rates were neither reasonable nor adequate to meet the needs of providing care to Medicaid patients.[72]

The *Wilder* Court examined two primary inquiries: (1) whether the Medicaid provision intended to benefit the putative plaintiff,[73] and (2) whether the Boren Amendment to the act imposed a "binding obligation" on the states that gave rise to enforceable rights.[74] The Court held that provisions intended to benefit the plaintiff created enforceable rights unless they merely reflected "congressional preference" for a certain kind of conduct rather than a binding obligation on the federal government,[75] or unless they were "too vague and amorphous" such that they were "beyond the competence of the judiciary to enforce."[76]

The Court also held that the Boren Amendment was cast in mandatory rather than precatory terms, and that the provision of federal funds was expressly conditioned on compliance with the statute.[77] For these reasons,

the Court concluded that the statute imposes an obligation on states participating in the Medicaid program to adopt reasonable and adequate rates and that this obligation is enforceable under § 1983 by health care providers.[78]

Additionally, the Court did not find merit in the petitioner's argument that Congress had foreclosed enforcement of the Medicaid Act under § 1983.[79] Because the Act did not expressly preclude resort to suits under § 1983, the Court noted that there would be foreclosure only when the statute created a remedial scheme that is "sufficiently comprehensive . . . to demonstrate congressional intent to preclude the remedy of suits under § 1983."[80] The Medicaid Act contains no such scheme.[81] The Court also rejected the petitioner's argument that the existence of administrative procedures evidences intent to foreclose a private remedy in federal courts.[82] The Court held that the Medicaid Act was enforceable under § 1983.[83]

2. *Gonzaga v. Doe*'s Textualism Analysis

In 2002, § 1983 jurisprudence was forever changed with the Supreme Court's decision in *Gonzaga v. Doe*. In *Gonzaga*, the Court clarified the *Blessing* requirements. In doing so, the Court stressed that only unambiguously conferred rights, not mere benefits or interests, are enforceable under § 1983.[84] Refining the first prong of the three-part *Blessing* test, the Supreme Court engaged in a strict textualism analysis of FERPA and determined that the statute did not unambiguously confer an individual right to support a cause of action under § 1983.[85] The Court's analysis was framed by an inquiry into (1) whether Congress intended to create a private right of action by granting private rights to an identifiable class, and (2) whether the text is phrased in terms of the persons benefited.[86]

The *Gonzaga* Court rejected the student's argument that the language of FERPA unambiguously conferred a right to support a cause of action brought under § 1983.[87] The Court first determined whether Congress

"*intended to create a federal right*."[88] Where there is no indication that Congress intended to provide a private right in the text and structure, the Court held that there is no basis for a private suit under § 1983 or any other implied right of action.[89] Additionally, where a "statute *by its terms* grants no private rights to any identifiable class," the statute is not read to provide a private right.[90] To read a statute as having an implied private right of action, the Court mandated that the text of the statute must be "phrased in terms of the persons benefited."[91] Once a plaintiff has met its burden of proof by showing that the statute creates a private right, the right is presumably enforceable under § 1983.[92]

III. A PRAGMATIC TEXTUALISM ANALYSIS CREATES A PRIVATE RIGHT OF ACTION FOR EPSDT PLAINTIFFS IN § 1983 CLAIMS

Since *Gonzaga*, the circuit courts have been split over whether Medicaid confers an individual right upon its beneficiaries. Some circuits have taken a strict textualism approach, looking solely at the plain language of the statute without analyzing statutory context or purpose, to determine whether the statute grants any unambiguous rights.[93] Courts utilizing this approach have analyzed whether the provision is "phrased in terms of the person(s) benefited."[94] On the other hand, circuits utilizing a pragmatic textualism approach analyze the "meaning and importance of the provision within the purpose and structure of the [statute] as a whole."[95] Thus, those individuals who have been denied services under EPSDT are left facing an uncertain legal landscape.

The Supreme Court's *Gonzaga* decision made critical the inquiry of whether the pertinent statute contains "rights-creating" language such as that found in Title VI of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972.[96] Under *Gonzaga*, evidence of a congressional intent to create a private right of action can be found in the statute's language and its structure.[97] While the legal landscape for would-be plaintiffs is less than clear, the Supreme Court's analysis in *Gonzaga* left

plaintiffs with a clear directive to employ a textualism approach to standing questions under § 1983.[98]

A. Circuit Court Application of Gonzaga's Textualism Analysis to Medicaid Enforcement Cases

The necessary inquiry in post-*Gonzaga* cases is whether Congress intended to confer individual rights upon a class of beneficiaries.[99] Courts provide redress only for a plaintiff who asserts a "violation of a federal *right*, not merely a violation of federal *law*."[100]

To determine whether the statute has the requisite rights-creating language, strict textualism courts examine the specific language of the statute.[101] Courts that utilize a strict textualism approach to analyzing the EPSDT provisions of the Medicaid Act have not held that § 1983 provides a mechanism through which citizens can enforce federal law.[102] For example, the Sixth Circuit utilized this approach in analyzing the EPSDT provisions in *Westside Mothers v. Olszewski*.[103] Similarly, the Seventh, Ninth, and Tenth Circuits utilized this approach when analyzing other provisions of the Medicaid Act.[104] The danger of this trend is that it may be adopted by circuit courts that have been silent on whether the EPSDT provisions of the Medicaid Act grant citizens a private right of action. As of today, the Second, Fourth, and Eleventh Circuits are silent on whether EPSDT beneficiaries may bring a § 1983 action, while the Ninth and Tenth Circuits have yet to decide an EPSDT-specific § 1983 case.

In *Westside Mothers v. Olszewski*, a welfare rights organization brought a § 1983 action against state officials alleging systemic deprivation of EPSDT services.[105] The Court of Appeals for the Sixth Circuit concluded that a provision mandating that participating states provide accessible medical services for eligible beneficiaries[106] failed the first prong of the *Blessing* test[107] and did not provide Medicaid recipients or providers with an enforceable right under § 1983.[108] The court justified this finding by focusing on the aggregate focus of the provision rather than an individual

focus.[109] In its *Blessing* analysis, the court first held that the provision speaks of the state's obligation to develop "methods and procedures" rather than individual benefits.[110] Second, the court found the language of the Medicaid provision to be too "broad and nonspecific" to be suited for judicial remedy.[111] The court determined that the general objectives of the provision were too broad to identify what standards were required by terms such as "efficiency, economy, and quality of care."[112] Concluding that it had neither the expertise nor the experience to make decisions such as these, the court held that the language of the statute was ill suited for judicial remedy.[113]

Under other recent holdings, rights conferred under the EPSDT provisions of the Medicaid Act have been held to be clearly established federal rights which can be enforced under the civil rights statute.[114] These courts have utilized a different approach by analyzing the purpose and meaning of the statute as a whole.[115] Since *Gonzaga*, the First, Third, Fifth, and Eighth Circuits have applied this pragmatic textualism analysis to § 1983 suits concerning the Medicaid Act. These courts have held that the EPSDT provisions, 42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r), create enforceable federal rights and that private plaintiffs do have a private cause of action under § 1983.[116] A pragmatic approach to the textualism analysis is more appropriate than a strict textualism analysis due to the holistic nature of analyzing the statute.

Courts utilizing a pragmatic approach also engage in the *Gonzaga* analysis. In the EPSDT context, the court first determines whether needy children were the specific intended beneficiaries of the provision. In *Pediatric Specialty Care v. Arkansas Department of Human Services*, plaintiffs brought a § 1983 action to enjoin proposed budget cutbacks that would allegedly violate their right to EPSDT services.[117] The Eighth Circuit held that the plaintiffs would prevail under the *Gonzaga* analytical framework because 42 U.S.C. § 1396d(a)(13) calls for state payment of costs for diagnostic, screening, preventative, and rehabilitative services

when recommended by a doctor.[118] The court found that the intended beneficiaries of this subsection are needy children as well as those who incur costs in providing those services.[119] Other circuit courts have found similarly.[120] The Eighth Circuit upheld precedent and found that the language of 42 U.S.C. § 1396a(a)(30)(A), a non-EPSDT Medicaid provision, created clearly established rights to equal access to quality medical care.[121]

Next, pragmatic courts determine whether the right is "so 'vague and amorphous' that its enforcement would strain judicial competence."[122] Some courts have gone so far as to read this factor as an insult. For example, in *Bryson v. Shumway*, the First Circuit Court of Appeals noted that "common law courts have reviewed actions for reasonableness since time immemorial."[123] This is similar to the approach the Fifth Circuit took in *S.D. ex rel. Dickson v. Hood* when it did not find the analysis interpreting the EPSDT statutes to "strain judicial competence."[124] The Fifth Circuit noted that the type of analysis that the plaintiff requested was "the type of work in which courts engage in every day."[125] Further, the court found the EPSDT provisions no more "vague and amorphous" than other statutory terms that the court has found capable of judicial enforcement.[126]

Third, pragmatic courts determine whether the statute unambiguously imposes a binding obligation on the state. In *Sabree v. Richman*, the Third Circuit held that by "requiring states which accept Medicaid funding to provide . . . services with reasonable promptness, Congress conferred specific entitlements on individuals" and there could be no ambiguity about the state's obligations.[127] Because the court found the language of the statute unambiguous when reading it as a whole, it did not look into the legislative history of the Medicaid Act.[128]

B. A More Precise Reading

Courts may also look into the statutory construction, purpose, and congressional preclusion when determining whether a plaintiff has a private

right.[129] In *Sabree*, the Third Circuit did not find any provision precluding individual actions and concluded, "Congress clearly and unambiguously conferred the rights of which plaintiffs have allegedly been deprived by Pennsylvania, and has not precluded individual enforcement of those rights."[130]

While the majority of circuit courts that have heard a Medicaid EPSDT case have found that there is a private right of action to bring a § 1983 claim, many circuits have not decided an EPSDT case. This leaves the door open for a strict textualism approach in those silent circuits for many would-be plaintiffs—an analysis which would likely bar the plaintiffs from seeking enforcement of EPSDT provisions under § 1983.

While the strict textualism approach utilizes the *Gonzaga* analysis, the more pragmatic approach provides a more accurate reading of the statute in question. For example, a strict textualism approach does not take into account that Congress amended the EPSDT portion of the Medicaid Act in 1989 so that the EPSDT provisions would be mandatory for all states opting into Medicaid. Additionally, a strict textualism approach does not recognize that the EPSDT provisions and the services to which Medicaid-eligible children are entitled are substantially different from the coverage that adults receive. Because Medicaid-eligible children are entitled to any medically necessary care, courts utilizing the pragmatic approach have held that they have a private right of action to bring a § 1983 claim. Finally, a pragmatic approach would recognize the purpose of the EPSDT provisions: to prevent future medical or mental health care issues and to decrease future costs to society.

These peripheral, but important, distinctions give the court a better, more precise understanding of the congressional intent in implementing EPSDT provisions. Courts often look to congressional intent when a statute is not clear. This analysis should be used, along with a consideration of the statutory language, in determining that the Medicaid-eligible child is the intended beneficiary, and thus has a private right of action under § 1983.

IV. CONCLUSION

Given the large number of children who are covered by Medicaid, the failure of the states to properly execute the EPSDT provisions is unjustifiable. The EPSDT provisions were adopted by Congress to prevent potential development or worsening of conditions, illnesses, and disabilities; yet despite the 1989 amendments to the Medicaid Act, states are still struggling to implement the mandatory and necessary services. This lack of mental health screenings and services can not only harm the child's wellbeing, but can lead to detrimental effects on families and society as a whole.

The legal landscape for plaintiffs seeking to enforce proper state implementation of the EPSDT provisions has a complex history beginning with the Civil Rights Act of 1871, originally enacted to protect the civil rights of freed slaves, but now allowing for § 1983 suits in cases alleging violation of constitutional rights as well as federal statutory rights. Case law has left would-be plaintiffs in a state of uncertainty; plaintiffs in some states have a right to bring a § 1983 suit in federal courts, while in other states, they have no such right. Section 1983, *Blessing*, *Wilder*, and *Gonzaga* have interwoven into a tapestry of complex litigation—litigation that is only the beginning of the road for Medicaid-eligible children who are in need of mental health care.

The Supreme Court has virtually eliminated the implied private right cause of action by demanding that the statute must contain "rights-creating" language. *Gonzaga* has likely precluded many Medicaid recipients from challenging state violations of the statute. However, the EPSDT provisions pass the *Blessing* test, even with the high threshold that *Gonzaga* has created. Furthermore, *Gonzaga* did not overrule the Supreme Court's earlier decision, *Wilder*. Congress intended the EPSDT services to be broad, preventative, and mandatory. For this reason, courts should use a pragmatic textualism analysis to determine whether § 1983 creates a private right of action in federal courts when a plaintiff wants to challenge a state's

violation of the Medicaid Act. The courts utilizing the pragmatic approach consider the provisions as a whole, including an examination of the purpose of the statute and the intent of Congress—giving the analysis a more precise reading.

The *Gonzaga* decision has complicated § 1983 jurisprudence, but has not completely precluded EPSDT-eligible children from bringing suit in federal court. While the circuits are split as to whether the Medicaid Act can survive the textualism analysis of *Gonzaga*, the EPSDT provisions provide for clear "rights-creating" language if analyzed employing the pragmatic approach. While the majority of circuits that have reviewed this issue have found that the EPSDT provisions confer an actionable individual right by utilizing a pragmatic textualism analysis, the Supreme Court should, but has yet to, clarify whether the *Gonzaga* analysis presupposes an individual right conferred under EPSDT.[131]

Another possible approach to clarify whether EPSDT recipients have an individual right to bring a § 1983 suit is further action by Congress. Congress could give the secretary of Health and Human Services multiple means to enforce state compliance with the Medicaid Act. Currently, the only power the secretary has is to terminate funds—an action that could have devastating effects for those who are receiving their necessary medical help. Allowing the secretary more options to enforce compliance with the Medicaid Act could potentially benefit those recipients not receiving the services they are entitled to without improperly removing services from an entire state's Medicaid recipients. The termination of Medicaid funds would be an extreme measure the secretary would enforce only if the state failed to take corrective action after being sanctioned for different levels of compliance violations.

Perhaps we, as a society, need to push Congress to make the EPSDT rights-creating language more explicit. While in the abstract this seems like a tenuous way to enforce state compliance with the Medicaid statute, under *Gonzaga*, it is the most obvious way for Medicaid-eligible children to be

able to bring a § 1983 action. Through grassroots efforts, we can hold Congress accountable to their goal of providing medical and mental health care to low-income children to prevent health issues as they get older.[132] The coverage that a child receives was purposefully drafted in broad terms, providing a standard of medical or mental health care beyond the standards for Medicaid-eligible adults. This should create a level of coverage that allows for screening, treatment, and prevention of conditions, illnesses, and disabilities. While Congress made the inclusion of the EPSDT provisions mandatory on all states, there has been very little enforcement. Amending the EPSDT provisions to provide for explicit rights-creating language would pass muster under both the pragmatic and strict textualism analyses.

Early intervention of mental health conditions, illnesses, and disabilities could prevent deterioration, future problems, and costs to society. Congress recognized this concept when it mandated the EPSDT provisions that have the purpose of prevention. Even President George W. Bush's Commission on Mental Health stated: "When the system fails to deliver the right types and combination of care, the results can be disastrous for our entire nation: school failure, substance abuse, homelessness, minor crime and incarceration."[133] Unfortunately, children needing mental health care will not simply grow out of their need. It is time for public systems and the community to make medically necessary mental health care a priority.

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[1] Rachel Luke is a 2009 Juris Doctorate candidate at Seattle University School of Law. Ms. Luke serves as managing editor of the *Seattle Journal for Social Justice*. She would like to thank Diana Singleton and Karen Pillar for introducing this issue to her. Additionally, Ms. Luke would like to thank Iris Tilley for her enthusiastic guidance throughout the writing process and Judge Anita Crawford-Willis for her mentorship and friendship. Ms. Luke would like to thank the SJSJ article team who worked diligently to edit her article: Jeanie Lee, Amy Pritchard, Carol Koppelman, Nicola Templeton, Douglas Cameron, Christopher Choe, and Christopher Zentz. Finally, she would like to thank her husband, Joseph Luke, who will never know how much he has helped her with this article.

[2] CHRIS KOYANAGI & RAFAEL SEMANSKY, BAZELON CTR. FOR MENTAL HEALTH LAW, NO ONE'S PRIORITY: THE PLIGHT OF CHILDREN WITH SERIOUS MENTAL

DISORDERS IN MEDICAID SYSTEMS 10 (2003), *available at* http://www.bazelon.org/issues/children/publications/focusgroups/combinedfocusgrpreport.pdf.

[3] *Id.*

[4] S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 586 (5th Cir. 2004); 42 U.S.C. §§ 1396a(a)10(A), 1396d(4)(B), 1396(d)(a), 1396d(4)(5) (West 2009).

[5] *See generally* KOYANAGI & SEMANSKY, *supra* note 2. Additionally, mental health care often carries a stigma that medical or physical care does not; often cultural and socio-economic influences can contribute to the negative connotations associated with mental health care. While these are important factors in the larger context of why children and adults are not receiving mental health care, this aspect is outside the scope of this article.

[6] *See* Melinda Bird, *Emily Q.'s Story: Using Medicaid Litigation to Expand Positive Behavior Interventions for Children in the Mental Health System*, 5 Whittier J. Child & Fam. Advoc. 87, 90 (2005); *see generally* LITTLE HOOVER COMMISSION, ST. OF CAL., YOUNG HEARTS & MINDS: MAKING A COMMITMENT TO CHILDREN'S MENTAL HEALTH (2001), http://www.lhc.ca.gov/lhcdir/161/report161.pdf.

[7] *See* Westside Mothers v. Olszewski, 454 F.3d 532 (6th Cir. 2006); Pediatric Specialty Care, Inc. v. Ark. Dept. of Human Servs., 443 F.3d 1005, 1009 (8th Cir. 2006); Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005); *Dickson*, 391 F.3d at 586; Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180, 190 (3rd Cir. 2004); Bryson v. Shumway, 308 F.3d 79, 89 (1st Cir. 2002).

[8] Gonzaga Univ. v. Doe, 536 U.S. 273, 280 (2002).

[9] Blessing v. Freestone, 520 U.S. 329, 340 (1997).

[10] 42 U.S.C. §1396 (West 2009); Rosie D. v. Romney, 410 F. Supp. 2d 18, 21–22 (D. Mass. 2006).

[11] 42 U.S.C. §1396 (West 2009); Rosie D., 410 F. Supp. 2d at 22.

[12] *See* CENTER FOR MEDICARE & MEDICAID SERVICES, 2007 EDITION OF SELECTED TABLES OF THE DATA COMPENDIUM 34, http://www.cms.hhs.gov/DataCompendium/ (follow "2007 Edition" hyperlink; then follow "Populations" hyperlink; then open 07p34).

[13] *Id.* Today, a quarter of the children in the United States are enrolled in Medicaid. OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, BUDGET OF THE U.S. GOVERNMENT: FISCAL YEAR 2003 157 (2002), *available at* http://georgewbush-whitehouse.archives.gov/omb/budget/fy2003/pdf/bud15.pdf.

[14] 42 C.F.R. §430.0 (2006); S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 585–86 (5th Cir. 2004).

[15] *See* CENTER FOR MEDICARE & MEDICAID SERVICES, 2007 EDITION OF SELECTED TABLES OF THE DATA COMPENDIUM 72, http://www.cms.hhs.gov/DataCompendium/ (follow "2007 Edition" hyperlink; then follow "State Data" hyperlink; then open 07p72).

[16] *See* BAZELON CTR. FOR MENTAL HEALTH LAW, MOVING ON: ANALYSIS OF FEDERAL PROGRAMS FUNDING SERVICES TO ASSIST TRANSITION-AGE YOUTH WITH SERIOUS MENTAL HEALTH CONDITIONS 8, 12 (2005), *available at* http://www.bazelon.org/publications/movingon/Analysis.pdf [hereinafter MOVING ON]; Technical Summary, Medicaid Program General Information, Centers for Medicare & Medicaid Services,

http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp (last visited Mar. 23, 2009).

[17] HARVEY L. MCCORMICK, MEDICARE AND MEDICAID CLAIMS AND PROCEDURES 214 (4th ed. 2005).

[18] Technical Summary, *supra* note 16; *see* MOVING ON, *supra* note 16, at 12, 14.

[19] 42 U.S.C. §1396 (West 2009).

[20] J.K. *ex rel.* R.K. v. Dillenberg, 836 F. Supp. 694, 694 (D. Ariz. 1993).

[21] S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 589 (5th Cir. 2004).

[22] *Id.*; *see also* Senate Finance Committee Report, 135 Cong. Rec. 24444 (1989).

[23] *Id.*

[24] Rosie D. v. Romney, 410 F. Supp. 2d 18, 22 (D. Mass. 2006). Examples of this type of health care include clinical services, such as crisis intervention, outpatient care, partial hospitalization, and day treatment. Additionally, the medical community has accepted newer, evidence-based practices such as intensive in-home services, therapeutic care, multi-systemic therapy, family psychoeducation, integrated treatments, supported education, and assertive community treatment. *See* BAZELON CTR. FOR MENTAL HEALTH LAW, FOLLOWING RULES: A REPORT ON FEDERAL RULES AND STATE ACTIONS TO COVER COMMUNITY MENTAL HEALTH SERVICES UNDER MEDICAID 17 (2008), *available at* http://www.bazelon.org/pdf/FollowingRules.pdf.

[25] *See* Dickson, 391 F.3d at 589–90.

[26] 42 U.S.C. § 1396d(r)(5) (2006) (emphasis added).

[27] *Rosie D.*, 410 F. Supp. 2d at 25; *see also* 42 U.S.C. § 1396d(a) (2006).

[28] 42 U.S.C. § 1396d(a)(xiii) (2006).

[29] Salazar v. Dist. of Columbia, 954 F. Supp. 278, 303 (D.D.C. 1996).

[30] *See, e.g.*, WASH. ADMIN. CODE § 388-534-0100 (West 2009); HEALTH & RECOVERY SERVS. ADMIN., DEP'T OF SOCIAL & HEALTH SERVS., EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM BILLING INSTRUCTIONS (2007), *available at* https://fortress.wa.gov/dshs/maa/Download/BillingInstructions/EPSDT_BI.pdf [hereninafter EPSDT BILLING INSTRUCTIONS]. In Washington, the Department of Social & Health Services' EPSDT Program Billing Instructions instruct providers that "[s]creenings *do not* result in a diagnosis. If a screen indicates a possible problem, the child is referred for an assessment where a diagnosis and plan of care are developed." EPSDT BILLING INSTRUCTIONS, *supra*, at D.1. Indicators which may prompt a screener to refer the child for an assessment include chronic physical or mental illness of parent, physical abuse or neglect, psychological abuse, domestic violence, problems with siblings, few social ties, fighting or bullying, impulsiveness, running away, defiance, lying, aggressiveness, school refusal, anxiety, depression, incoherence, self-destructive thoughts, lack of housing, frequent moves, financial problems, slow weight gain, nonorganic failure to thrive, language delay, and many other indicators. EPSDT BILLING INSTRUCTIONS, *supra*, at D.7. The Washington regional support network for community mental health and involuntary treatment programs "must demonstrate that it meets the requirements of chapters 71.05, 71.24, and 71.34 RCW, and ensure the effectiveness and cost effectiveness of community mental health services in an age and culturally competent manner." WASH. ADMIN. CODE § 388-865-0220 (West 2009). In part, the regional support network "*must*: (3) Ensure the *protection of consumer and family rights*

as described in this chapter, and chapters 71.05 and 71.34 RCW; and other applicable statutes for consumers involved in multiservice systems; (4) Collaborate with and *make reasonable efforts to obtain and use resources in the community* to maximize services to consumers; (5) Educate the community regarding mental illness to diminish stigma; (6) Maintain agreement(s) with sufficient numbers of certified involuntary inpatient evaluation and treatment facilities to *ensure that persons eligible for regional support network services have access to inpatient care*; (9) Provide orientation and ongoing training to regional support network staff in the skills pertinent to the position and the treatment population, including age and culturally competent consultation with consumers, families, and community members; (10) Identify trends and *address service gaps*." *Id.* (emphasis added).

[31] OKAAP v. Fogarty, 366 F. Supp. 2d 1050, 1110 (N.D. Okla. 2005).

[32] Under 42 U.S.C. § 1396d(r), EPSDT services must be provided to all eligible individuals under the age of twenty-one. The services are defined as screening services, which must include a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests, and health education, vision services, dental services, hearing services, and "[s]uch other necessary health care, diagnostic services, treatment, and other measures as described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r) (West 2009).

[33] 42 U.S.C. § 1396a(a)(43) (West 2009).

[34] *See generally* KOYANAGI & SEMANSKY, *supra* note 2.

[35] *See Executive Summary* to NATIONAL HEALTH LAW PROGRAM, CHILDREN'S HEALTH UNDER MEDICAID: A NATIONAL REVIEW OF THE EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM (1998) (noting that of the 22.9 million EPSDT-eligible children in 1996, only 37 percent received a medical screen). *See* BAZELON CENTER FOR MENTAL HEALTH LAW, WHERE TO TURN: CONFUSION IN MEDICAID POLICIES ON SCREENING CHILDREN FOR MENTAL HEALTH NEEDS (1999); R. Semansky et al., *Behavioral Health Screening Policies in Medicaid Programs Nationwide*, 54 PSYCHIATRIC SERVICES 736, 736 (2002). A 2001 study notes that the extent to which Medicaid-eligible children are receiving treatment is not fully known, but a comprehensive look at available evidence, including litigation, indicates that many children are not receiving these services. *See* U.S. GEN. ACCOUNTING OFFICE, MEDICAID: STRONGER EFFORTS NEEDED TO ENSURE CHILDREN'S ACCESS TO HEALTH SCREENING SERVICES 3 (2001), *available at* http://www.gao.gov/new.items/d01749.pdf.

[36] MCCORMICK, *supra* note 17, at 356.

[37] Adria N. Bullock, *The Sacrifice Wrought by a Costly and Fragmented Mental Health Care System: Parents Forced to Relinquish Custody to Obtain Care for Their Children*, 24 DEV. MENTAL HEALTH L. 17 (2005).

[38] *Child Welfare and Juvenile Justice: Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services: Hearing Before the Senate Comm. on Governmental Aff.*, 108th Cong. 2, 18 (2003) (statement of Cornelia M. Ashby, Director, Education, Workforce, and Income Security Issues), *available at* http://www.gao.gov/new.items/d03865t.pdf.

[39] Bullock, *supra* note 37; KOYANAGI & SEMANSKY, *supra* note 2, at 8 ("With my 11-year-old, I knew something was wrong with him at about six- or seven-months-old, and nothing got done until he was eight or nine. And I went through a lot of different systems and evaluations. (Oregon)").

[40] KOYANAGI & SEMANSKY, *supra* note 2, at 8.

[41] *Id.* at 10 ("My son didn't really get any help until I had him arrested . . . I had to call the police on him and say he hit me, which he did. But I kind of thought to myself when I woke up that day, 'Okay. Today I'm going to let him hit me. We're going to play a game.'" (Oregon) [.] . . . "I am concerned about services. I don't want to lose my son. I want to get my son help now before he goes and robs a store or something and then he gets taken away." (New York)).

[42] *Id.* at 9–10.

[43] *See* Mental Health America, Mental Illness and the Family: Recognizing Warning Signs and How to Cope, http://www.nmha.org/go/information/get-info/mi-and-the-family/recognizing-warning-signs-and-how-to-cope (last visited Mar. 23, 2009).

[44] JANE KOPPELMAN, NAT'L HEALTH POLICY FORUM, ISSUE BRIEF NO. 805: MENTAL HEALTH AND JUVENILE JUSTICE: MOVING TOWARD MORE EFFECTIVE SYSTEMS OF CARE (2005), *available at* http://www.nhpf.org/library/issue-briefs/IB805_JuvJustice_07-22-05.pdf. Furthermore, unnecessary institutionalization of disabled persons is considered a form of discrimination prohibited by Title II of the Americans with Disabilities Act. 42 U.S.C.A. § 12132 (2001); Olmstead v. L.C. *ex rel.* Zimring, 527 U.S. 581, 595 (1999).

[45] KOPPELMAN, *supra* note 44; Joseph J. Cocozza and Kathleen R. Skowyra, *Youth with Mental Health Disorders: Issues and Emerging Responses*, JUV. JUST. 6, 7 (Apr. 2000), *available at* www.ncmhjj.com/pdfs/publications/Youth_with_Mental_Health_Disorders.pdf. In 1998, the Bureau of Justice Statistics reported that an estimated 16 percent of prison and jail inmates suffered from mental health problems. *See U.S.: Number of Mentally Ill in Prisons Quadrupled*, HUMAN RIGHTS WATCH, Sept. 5, 2006, http://www.hrw.org/en/news/2006/09/05/us-number-mentally-ill-prisons-quadrupled. In 2006, the number was estimated to have quadrupled so that the rate of mental health disorders reported in the state prison population was five times greater (56.2 percent) than in the general adult population (11 percent). *Id.*

[46] Lois A. Weithorn, *Envisioning Second-Order Change in America's Responses to Troubled and Troublesome Youth*, 33 HOFSTRA. L. REV. 1305, 1351 (2005); Ann Vander Stoep et al., *Risk of Juvenile Justice System Referral Among Children in a Public Mental Health System*, 24 J. JUV. MENTAL HEALTH ADMIN. 428, 436 (1997).

[47] Weithorn, *supra* note 46, at 1363.

[48] H.R. Rep. No. 96-548, at 1 (1979), *as reprinted in* 1979 U.S.C.C.A.N. 2609, 2609.

[49] *Id.*; Mark Andrew Ison, *Two Wrongs Don't Make a Right: Medicaid, Section 1983, and the Cost of an Enforceable Right to Healthcare*, 56 VAND. L. REV. 1479, 1495 (2003).

[50] H.R. Rep. No. 96-548, at 1; Ison, *supra* note 49, at 1495.

[51] H.R. Rep. No. 96-548, at 1; Ison, *supra* note 49, at 1494.

[52] Maine v. Thiboutot, 448 U.S. 1 (1980).

[53] 42 U.S.C. § 1983 (2006).

[54] Blessing v. Freestone, 520 U.S. 329, 340 (1997) (citing Golden State Transit Corp. v. Los Angeles, 493 U.S. 103 (1939)); *accord* Gonzaga Univ. v. Doe, 536 U.S. 273 (2002).
[55] *Blessing*, 520 U.S. 329.
[56] *Id.* at 340 (citing Golden State Transit Corp. v. Los Angeles, 493 U.S. 103 (1939)); *accord Gonzaga*, 536 U.S. 273.
[57] *Blessing*, 530 U.S. at 340.
[58] *Id.* at 340–41.
[59] *Id.* at 341.
[60] *Gonzaga*, 536 U.S. at 290.
[61] *Gonzaga*, 536 U.S. 273.
[62] *Id.* at 290.
[63] SWORD AND SHIELD: A PRACTICAL APPROACH TO SECTION 1983 LITIGATION 21 (Mary Massaron Ross & Edwin P. Voss eds., 3rd ed. 2006) [hereinafter SWORD AND SHIELD].; *Gonzaga*, 536 U.S. at 290.
[64] SWORD AND SHIELD, *supra* note 63, at 21; *see* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 524 (1990); Wright v. Roanoke Redevelopment & Hous. Auth., 479 U.S. 418, 431 (1987).
[65] 42 U.S.C. §§ 1396(m)(5)(A); 1396(m)(5)(B)(ii) (West 2009).
[66] Marlaina S. Freisthler, *Unfettered Discretion: Is Gonzaga v. Doe a Constructive End to Enforcement of Medicaid Provider Reimbursement Provisions?*, 71 U. CIN. L. REV. 1397, 1416 (2003).
[67] Collins v. Hamilton, 231 F.Supp.2d 840, 841 (S.D. Ind. 2002).
[68] *Wilder*, 496 U.S. at 512 (holding that that the statute in question was cast in mandatory rather than precatory terms, and that the provision of federal funds is expressly conditioned on compliance with the amendment).
[69] *Wilder*, 496 U.S. at 500–02.
[70] *Id.*; *see* 42 U.S.C. § 1396a(a)(13)(A) (1982 ed., Supp. V). The Boren Amendment has since been repealed.
[71] *Wilder*, 496 U.S. at 503.
[72] *Id.*
[73] *Id.* at 509; Golden State Transit Corp. v. Los Angeles, 493 U.S. 103, 106 (1989).
[74] *Wilder*, 496 U.S. at 510.
[75] *Wilder*, 496 U.S. at 509; Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 19 (1981).
[76] *Wilder*, 496 U.S. at 509; *Golden State Transit*, 493 U.S. at 106 (quoting Wright v. Roanoke Redevelopment & Hous. Auth., 479 U.S. 418, 431–32 (1987).
[77] *Wilder*, 496 U.S. at 512.
[78] *Id.*
[79] *Id.* at 520.
[80] *Id.* at 521 (quoting Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n, 453 U.S. 1, 20 (1981)).
[81] *Id.* at 521.
[82] *Id.* at 523.
[83] *Id.*
[84] *Id.* at 282–83.

[85] *Id.* at 285; Freisthler, *supra* note 66, at 1409.
[86] *Gonzaga*, 536 U.S. at 283–84; Brian J. Dunne, *Enforcement of the Medicaid Act Under 42 U.S.C. Section 1983 After Gonzaga University v. Doe: The "Dispassionate Lens" Examined*, 74 U. CHI. L. REV. 991, 999 (2007) (noting that the *Gonzaga* decision focusing on a provision's text was "a marked departure from the more broad-based inquiry into legislative intent demonstrated in *Wilder* and other Court precedent").
[87] *Gonzaga*, 536 U.S. at 283.
[88] *Id.* (emphasis in orginal).
[89] *Id.* at 286.
[90] *Id.* at 284 (emphasis added); Touche Ross & Co. v. Redington, 442 U.S. 560, 576 (1979).
[91] *Gonzaga*, 536 U.S. at 284; Cannon v. Univ. of Chicago, 441 U.S. 677, 692, n.13 (1979).
[92] *Gonzaga*, 536 U.S. at 284.
[93] Dunne, *supra* note 86, at 1008.
[94] *Id.*
[95] *Id.* at 1004.
[96] *Gonzaga*, 536 U.S. at 284, 287. Title VI provides: "*No person* in the United States *shall* . . . be subjected to discrimination under any program or activity receiving Federal financial assistance" on the basis of race, color or national origin. 42 U.S.C. § 2000d (2006) (emphasis added). Title IX provides: "*No person* in the United States *shall*, on the basis of sex, . . . be subjected to discrimination under any education program or activity receiving Federal financial assistance." 20 U.S.C. § 1681(a) (2006) (emphasis added).
[97] *Gonzaga*, 536 U.S. at 286.
[98] *See* Freisthler, *supra* note 66, at 1416.
[99] Westside Mothers v. Olszewski, 454 F.3d 532, 542 (6th Cir. 2006).
[100] *Id.* at 541 (emphasis in original); Blessing v. Freestone, 520 U.S. 329, 340 (1997); *see also* Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 508 (1990).
[101] *See Gonzaga*, 536 U.S. at 287.
[102] *Westside Mothers*, 454 F.3d at 543; Mandy R. v. Owens, 464 F.3d 1139, 1148 (10th Cir. 2006); Sanchez v. Johnson, 416 F.3d 1051, 1060 (9th Cir. 2005).
[103] *Westside Mothers*, 454 F.3d 532.
[104] In *Sanchez*, the Ninth Circuit held that the state Medicaid plan to provide efficient, economical, quality medical care and adequate access to providers did not create an enforceable right under § 1983. *Sanchez*, 416 F.3d at 1058–59. The court found that the provision in question did not employ the "no person shall" language cited by the Court in *Gonzaga* as the ultimate rights-creating language. *Id.* Additionally, the court held that the Medicaid statute had an aggregate focus on beneficiaries rather than a focus on individual rights. *Id.*; *accord Mandy R.*, 464 F.3d at 1146. However, in dicta, the *Sanchez* court does mention that the EPSDT language may allow a plaintiff to bring a § 1983 claim. *Sanchez*, 416 F.3d at 1061.
[105] *Westside Mothers*, 454 F.3d 532.
[106] 42 U.S.C. § 1396a(a)(30) (West 2009).
[107] Blessing v. Freestone, 520 U.S. 329, 340–41 (1997). The first prong of the *Blessing* test is whether Congress intended that the provision benefits the plaintiff. The second

prong is whether the right is so vague and amorphous that enforcement would strain judicial competence. The final prong is whether the statute unambiguously imposes a binding obligation on the state.

[108] *Westside Mothers*, 454 F.3d at 542.

[109] *Id.*

[110] *Id.*; Long Term Care Pharm. Alliance v. Ferguson, 362 F.3d 50, 58 (1st Cir. 2004) (noting that "[t]he criteria (avoiding overuse, efficiency, quality of care, geographic equality) are highly general . . . ."); *see also* 42 U.S.C. § 1396a(a)(30)(A) (West 2009).

[111] *See Westside Mothers*, 454 F.3d at 543; Sanchez v. Johnson, 416 F.3d 1051, 1060 (9th Cir. 2005).

[112] *Westside Mothers*, 454 F.3d at 543.

[113] *Id.*

[114] Carson P. *ex rel.* Foreman v. Heineman, 240 F.R.D. 456, 545 (D. Neb. 2007); S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 603–07 (5th Cir. 2004) ("[W]e conclude that the EPSDT treatment provisions of the Medicaid Act contains the 'rights-creating language critical to showing the requisite congressional intent to confer a new right.'"); OKAAP v. Fogarty, 366 F. Supp. 2d 1050, 1110–11 (N.D. Okla. 2005); Memisovski *ex rel.* Memisovski v. Maram, No. 92 C 1982, 2004 WL 1878332 at *8–11 (N.D. Ill. Aug. 23, 2004); Winn v. Perdue, 218 F.R.D. 277, 293–95 (N.D. Ga. 2003).

[115] Dunne, *supra* note 86, at 1008.

[116] *OKAAP*, 205 F. Supp. 2d at 1272.

[117] Pediatric Specialty Care, Inc. v. Ark. Dep't. of Human Servs., 443 F.3d 1005 (8th Cir. 2006).

[118] *Id.* at 1015.

[119] *Id.*

[120] S.D. *ex rel.* Dickson v. Hood, 391 F.3d 581, 603 (5th Cir. 2004) (recognizing a private right to "all individuals" who meet the Medicaid plan's ESPSDT eligibility requirements); Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180 (3rd Cir. 2004) (examining statutory language to determine that terms such as "a state must provide" is rights-creating language); Bryson v. Sumway, 308 F.3d 79 (1st Cir. 2002).

[121] *Pediatric Specialty Care*, 443 F.3d at 1013.

[122] Blessing v. Freestone, 520 U.S. 329, 340–41 (1997).

[123] Bryson v. Shumway, 308 F.3d 79, 89 (1st Cir. 2002); *see e.g.*, 1 WILLIAM BLACKSTONE, COMMENTARIES *77 (analyzing the reasonableness of customs).

[124] *Dickson*, 391 F.3d at 605.

[125] *Id.*

[126] *Id.*

[127] Sabree *ex rel.* Sabree v. Richman, 367 F.3d 180, 190 (3rd Cir. 2004).

[128] *Id.*

[129] *Id.* at 190–93.

[130] *Id.* at 193–94.

[131] Pediatric Specialty Care, Inc. v. Ark. Dep't. of Human Servs., 443 F.3d 1005, 1009 (8th Cir. 2006).

[132] Salazar v. Dist. of Columbia, 954 F. Supp. 278, 303 (D.D.C. 1996).

[133] KOYANAGI & SEMANSKY, *supra* note 2, at 15.