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Financial Assistance for Medicaid's Continued Existence: The Need for the United States Supreme Court to Adopt the Tenth Circuit's Definition of Medical Assistance

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FINANCIAL ASSISTANCE FOR MEDICAID'S CONTINUED EXISTENCE: THE NEED FOR THE UNITED STATES SUPREME COURT TO ADOPT THE TENTH CIRCUIT'S DEFINITION OF MEDICAL ASSISTANCE

INTRODUCTION

"Before 1965, healthcare services [in America] were described as 'dual tracked': the wealthy received care from private physicians while the poor—if they accessed service at all—received care in ambulatory clinics and emergency rooms."[1]

This perception changed in 1965 when Congress created the Medicaid program.[2] Since then, scholars and courts have examined whether Medicaid creates an individually enforceable right to health care. Courts are split on which, if any, provisions of the Medicaid statute create a federally enforceable right, but generally agree that Medicaid eligible individuals have a federally enforceable right to receive benefits with reasonable promptness, services comparable in amount, duration and scope to non-beneficiaries, and early and periodic screening, diagnostic and treatment services (EPSDT) under 42 U.S.C. § 1983.[3] While courts generally hold that there is a federally enforceable right to prompt and comparable medical assistance, courts have failed to provide a uniform remedy when that right is violated. The Medicaid statute defines the term "medical assistance" as financial assistance, however some courts interpret the statute differently.[4] Some circuits require states to provide actual medical assistance to eligible Medicaid recipients,[5] while other circuits reject the idea that states must provide actual medical services,

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1. Abigail R. Moncrieff, Comment, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 675 (2006).

2. Medicaid Statute, 42 U.S.C.A. §§ 1396a-1396v (2008). Congress created the Medicaid program by amending the Social Security Act, and as such, the program remains in the Social Security Act.

3. *See* Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 472 F.3d 1208, 1212 (10th Cir. 2007) (assuming, without deciding, that the EPSDT requirement creates a federally enforceable right); Mandy R. v. Owens, 464 F.3d 1139, 1142-43 (10th Cir. 2006) (agreeing with the Ninth and Third Circuits which have held the reasonable promptness and comparability requirements create a federally enforceable right); Doe v. Chiles, 136 F.3d 709, 719 (11th Cir. 1998) (affirming district court holding that the reasonable promptness clause of the Medicaid Act is enforceable under 42 U.S.C.A. § 1983 (2007)). *But see* Sanders *ex. rel.* Rayl v. Kan. Dep't of Soc. and Rehab. Servs., 317 F. Supp. 2d 1233, 1250 (D. Kan. 2004) (holding that the reasonable promptness requirement does not create an enforceable right).

4. § 1396d(a) (defining medical assistance as "payment of part or all of the cost of the following care and services").

5. *See* Bryson v. Shumway, 308 F.3d 79, 89 (1st Cir. 2002); *Chiles*, 136 F.3d at 719.

and instead hold that the Medicaid program requires states only to provide financial assistance to eligible Medicaid recipients.[6]

This comment addresses the differing interpretations of medical assistance as defined in the Medicaid statute. Part I begins with a brief historical analysis of public health assistance and the Medicaid program. Next, Part II examines federal circuit court opinions that interpret medical assistance. Part III then proceeds with an analysis of why the United States Supreme Court should grant certiorari to define medical assistance. The analysis concludes with an explanation of how defining medical assistance as financial assistance best serves the Medicaid eligible population and accomplishes the goals of the Medicaid program.

I. THE HISTORY OF MEDICAID AND MEDICAID TODAY

Medicaid is a federal and state partnership program that provides financial assistance for medical care to the "most vulnerable populations in society."[7] Between 37.5 million and 55 million people[8] are covered by the Medicaid program, including poor children, parents, seniors, and disabled persons.[9] The Medicaid program is an opt-in program; Congress does not mandate state participation, however all 50 states and the District of Columbia participate in the program.[10]

A. Public Health Assistance Prior to Medicaid

Prior to the creation of Medicaid, most sources of funding in the health care industry were private.[11] The creation of Medicaid began after the Second World War, when the focus on medical care in America shifted from infection and treatment to chronic disease and research.[12] Initially, federal government funding for medicine supported research and infrastructure rather than medical care.[13] However, in 1960, the Kennedy administration began to discuss community based medical services as a way to combat poverty.[14] In response to political pressure to

6. *See Mandy R.*, 464 F.3d at 1146; Westside Mothers v. Olszewski, 454 F.3d 532, 540 (6th Cir. 2006); Bruggeman v. Blagojevich, 324 F.3d 906, 910 (7th Cir. 2003).

7. HEALTH CARE FINANCE ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, A PROFILE OF MEDICAID: CHARTBOOK 2000 6 (2000), *available at* http://www.cms.hhs.gov/TheChartSeries/downloads/2Tchartbk.pdf. As evident in this definition, the Medicaid statute and agencies responsible for administering Medicaid often consider themselves responsible only for financial assistance.

8. Sidney D. Watson, *The View from the Bottom: Consumer-Directed Medicaid and Cost Shifting to Patients*, 51 ST. LOUIS U. L.J. 403, 405 (2007).

9. Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5, 5 (2006); *see also* ELICIA J. HERZ, CRS REPORT FOR CONGRESS: MEDICAID: A PRIMER 12, *available at* http://assets.opencrs.com/rpts/RL33202_20051222.pdf (last updated Jan. 24, 2007) ("In FY 2006, a total of 63.2 million people were enrolled in Medicaid at some time during the year.").

10. HERZ, *supra* note 9, at 1.

11. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 338-39 (1982).

12. *Id.* at 336-40.

13. *Id.* at 338-51.

14. *Id.* at 365-66.

provide medical care for certain vulnerable populations, Congress passed the Kerr-Mills Act.[15]

The Kerr-Mills Act established a federally funded program to provide elderly individuals with financial assistance for uncovered medical expenses.[16] Under the Act, states provided up to half of the funding for medical services for the elderly poor.[17] The Kerr-Mills program was intended to allow each state to establish a medical care program so that every aged individual could have adequate medical care.[18] The Kerr-Mills Act met opposition because of its inconsistent goals. On one hand the legislation encouraged states to create individual programs to avoid a national health care scheme, but on the other hand the legislation was a commitment to national responsibility for medical welfare.[19]

While the Kerr-Mills Act addressed the policy of providing medical services to a limited number of aged poor, it "rocked no boats" in comparison to other proposed medical welfare programs.[20] Because the Act was a moderate attempt to provide health care to individuals, neither conservatives nor liberals were happy with the policy,[21] and both political parties introduced myriad proposals to modify the Kerr-Mills Act.[22] In an effort to avoid public disappointment, Representative Mills proposed combining some of these proposals into a three-tiered medical welfare system.[23] The resulting proposal created a mandatory hospital insurance program under Social Security (Medicare Part A), government reimbursement voluntary insurance for physician bills (Medicare Part B), and expanded federal assistance to the states for medical care for the poor (Medicaid).[24]

B. The Creation of Medicaid and the Federal-State Partnership

Congress amended the Social Security Act in 1965 to adopt Representative Mills's proposal and in doing so created the Medicaid program.[25] The creation of Medicaid "reflected Congress's decision to 'liberalize and extend' [the Kerr-Mills system] of federal grants to states for specific health care purposes."[26] Additionally, the creation of the Medi-

15. *Id.* at 368; Kerr-Mills Social Security Act, Pub. L. No. 87-778, 74 Stat. 924 (1960) (codified as amended at I.R.C. § 3126 (2008)); I.R.C. § 3308 (2008); 42 U.S.C.A. § 1324 (2008); 42 U.S.C.A. § 1312 (2008).

16. HEALTH CARE FINANCE ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 7, at 6.

17. STARR, *supra* note 11, at 369.

18. ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 29 (2003).

19. *Id.*

20. *Id.* at 28.

21. *Id.* at 31.

22. STARR, *supra* note 11, at 369.

23. *Id.*

24. *Id.*

25. Medicaid Statute, 42 U.S.C.A. §§ 1396a-1396v (2008).

26. Rosenbaum, *supra* note 9, at 9.

caid program embodied Congress's intent to provide "mainstream medical services" to the poor and disabled.[27]

While Medicaid is a federal-state partnership in which states elect to participate,[28] if a state chooses to participate in the Medicaid program, it must develop a medical assistance program that complies with federal requirements.[29] The federal requirements can be split into two classifications: financial requirements and categorical requirements.[30] Some of the groups states must cover are only eligible if they meet both the financial and categorical requirements. Groups that states must provide services to because of financial requirements include poor families that qualify for the Aid to Families with Dependent Children (AFDC) cash assistance program, and families that are transitioning from welfare to work.[31] Groups that states must provide services to because of categorical requirements include some legal permanent residents like new refugees.[32] Groups that states must provide services to because of a combination of financial and categorical requirements include pregnant women and children whose families fall below at least 100 percent of the federal poverty level, poor individuals with disabilities, and poor seniors who qualify for cash benefits from the Supplemental Security Income (SSI) program.[33]

In addition, states may choose to provide Medicaid coverage to optional additional populations.[34] Optional coverage includes long-term care, care for the medically needy, care for the working disabled, and care for other poverty-related groups.[35] Long term care coverage is limited to persons who require institutional care or who require care in community settings if they fall 300 percent below the SSI income requirements.[36] The medically needy are individuals who fit into one of the categorical groups but do not meet the financial requirements.[37] The poverty related groups include pregnant women and children who do not meet the financial requirements.[38]

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27. Moncrieff, *supra* note 1, at 675.

28. *See e.g.*, KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUNDATION, MEDICAID: A TIMELINE OF KEY DEVELOPMENTS (2008), *available at* http://www.kff.org/medicaidtimeline/ (last visited Jan. 31, 2008).

29. Moncrieff, *supra* note 1, at 675.

30. *See* HERZ, *supra* note 9, at 1.

31. *Id.* at 2.

32. *Id.*

33. *Id.*

34. CENTER FOR MEDICARE & MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEDICAID PROGRAM: GENERAL INFORMATION, TECHNICAL SUMMARY 3, *available at* http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp#TopOfPage (last visited Jan. 31, 2008).

35. *Id.*

36. *See id.*

37. *Id.*

38. *Id.*

Although states must provide coverage to the federally-mandated groups, states retain much flexibility in "determining requirements for eligibility, in establishing the scope of benefits coverage, and in setting rates for reimbursement."[39] Because states retain so much flexibility, there is no typical program; rather, there are "essentially 56 different Medicaid programs—one for each state, territory and the District of Columbia."[40]

C. Medicaid Today

The joint federal-state nature of the Medicaid program requires many different agencies to administer Medicaid. On the federal level, the Centers for Medicare and Medicaid Services (CMS) administers Medicaid.[41] Each state has its own executive body to administer the state aspect of the Medicaid program.

Medicaid is jointly funded by the states and the federal government. States provide the initial funding for the program and the federal government reimburses states for a portion of the state's costs.[42] The federal government provides fifty to eighty-three percent of the state program costs.[43] The federal reimbursement funding is based on each state's average yearly per capita income. As a result, the federal reimbursement rate varies from state to state and from year to year.[44] States generally determine their own reimbursement rates for medical service providers.[45]

Currently, the federal Medicaid eligibility rules provide financial assistance to the poor, elderly, and children and parents in working families.[46] Generally, Medicaid covers "inpatient and outpatient hospital services; doctors' and nurse practitioners' services; nursing home care; rural health clinic services; home health-care services; laboratory and X-ray charges; and transportation to and from health-care providers."[47]

While states must provide the mandatory services outlined in the Medicaid statute, states also retain much flexibility to administer optional programs as well as waiver programs. Optional services include intermediate care facilities for the developmentally disabled (ICF/DD or ICF/MR).[48] Waiver programs are services not enumerated in the Medi-

39. Moncrieff, *supra* note 1, at 675-76.
40. MEDICAID PROGRAM: GENERAL INFORMATION, TECHNICAL SUMMARY, *supra* note 34.
41. 2 WEST'S ENCYCLOPEDIA OF AMERICAN LAW, CENTERS FOR MEDICAID & MEDICARE SERVICES 301 (Jeffrey Lehman & Shirelle Phelps eds., 2nd ed. 2005). The Health Care Financing Administration (HCFA) preceded CMS.
42. *See* HERZ, *supra* note 9, at 6.
43. *See id.* at 6.
44. MEDICAID PROGRAM: GENERAL INFORMATION, TECHNICAL SUMMARY, *supra* note 34.
45. *See* HERZ, *supra* note 9, at 8.
46. Watson, *supra* note 8, at 410.
47. THE AMERICAN BAR ASSOCIATION LEGAL GUIDE FOR AMERICANS OVER FIFTY 166-67 (2006).
48. Doe v. Chiles, 136 F.3d 709, 714 (11th Cir. 1998).

caid statute that states provide in order to further the goals of the Medicaid program. To provide waiver programs, states must obtain waivers from CMS.[49] Approved Medicaid waiver programs are not subject to the same requirements as mandatory or optional services.[50] In an effort to allow states to find less expensive and perhaps more effective systems of care, CMS permits waiver programs "to allow states to experiment with methods of care, or to provide care on a targeted basis, without adhering to the strict mandates of the Medicaid system."[51] A subcategory of waiver programs is the model waiver program. Model waiver programs exist as a way for states to exercise flexibility to find the best programs for the populations they treat.[52] Model waiver programs are limited to serving no more than 200 individuals at any one time.[53] A common waiver is the home and community-based service (HCBS) waiver.[54] Under HCBS waivers, "individuals who would otherwise be treated in an institutional setting" are instead treated in their homes or in small home-based facilities.[55]

States—whether they provide the minimum mandatory services, include additional services, or provide waiver programs—must follow certain federal requirements regarding the nature of care provided. The Medicaid statute provides that each state's plan for medical assistance must provide "for making medical assistance available [to all Medicaid eligible individuals]."[56] Among other requirements, states must furnish this medical assistance with "reasonable promptness to all eligible individuals"[57] and the medical assistance "shall not be less in amount, dura-

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49. HERZ, *supra* note 9, at 9.

50. Bryson v. Shumway, 308 F.3d 79, 82 (1st Cir. 2002).

51. *Id.* at 82-83.

> In theory, waiver plans are expenditure-neutral; the average estimated per capita expenditure under the waiver plans must not be more than the average estimated expenditure absent the waiver program. 42 U.S.C.A. § 1396n(c)(2)(D) (2007). In practice, the waiver programs may be costly to the states, because even though the individuals served by the waiver plan are no longer being served by nursing homes or other care facilities, other patients may take those nursing home spots. Many patients not currently being served under Medicaid may also apply for the waiver program. The states thus have a financial incentive to keep their waiver programs small, or at least, to begin with small programs and grow them incrementally.

Id. (citations omitted).

52. *See* U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *Medicaid State Waiver Program Demonstration Projects – General Information, Overview*, http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/ (last visited Jan. 31, 2008).

53. 42 C.F.R. § 441.305(b)(1) (2008).

54. *See, e.g.*, Mandy R. v. Owens, 464 F.3d 1139, 1141-42 (10th Cir. 2006); *Bryson*, 308 F.3d at 82; *see also* Jane Perkins & Randolph T. Boyle, *Addressing Long Waits for Home and Community-Based Care Through Medicaid and the ADA*, 45 ST. LOUIS U. L.J. 117, 126 (2001) (explaining that in 2001 there were about 240 home and community based waiver programs nationwide).

55. *Bryson*, 308 F.3d at 82.

56. 42 U.S.C. § 1396a(a)(10)(A) (2006).

57. *Id.* § 1396a(a)(8).

tion, or scope than the medical assistance made available to any other such individual."[58]

While the Medicaid statute requires states to provide medical assistance with reasonable promptness and comparability, courts disagree as to whether the medical assistance provided must be actual medical services or financial assistance.

II. MEDICAL ASSISTANCE: ACTUAL SERVICES OR FINANCIAL SUPPORT?

The existence of a circuit split was recognized by the Third Circuit in *Sabree v. Richman*.[59] The Third Circuit remarked in a footnote that "there appears to be a disagreement among our sister courts of appeals as to whether, pursuant to Medicaid, a state must merely provide financial assistance to obtain covered services, or provide the services themselves."[60] The Third Circuit did not address whether medical assistance meant financial assistance or medical services.[61] Since the Third Circuit's observation, the Tenth Circuit has twice addressed the issue of what medical assistance means, and has concluded that medical assistance means financial assistance.[62]

A. Circuits Holding that Medical Assistance Means Actual Services

1. Eleventh Circuit: *Doe v. Chiles*[63]

The *Chiles* court's main consideration was whether the reasonable promptness requirement was a federally enforceable right.[64] The Eleventh Circuit found that the reasonable promptness requirement did create an individually enforceable right, and in its holding found that medical assistance as described in the Medicaid statute meant actual medical services.[65]

a. Facts and Procedural History

The *Chiles* plaintiffs were a group of developmentally disabled individuals on waiting lists for Intermediate Care Facilities for the Developmentally Disabled (ICF/MR).[66] The plaintiffs claimed that the Florida Department of Health and Rehabilitative Services failed to provide Medicaid assistance with reasonable promptness.[67] The plaintiffs alleged they had been waiting for over five years for the services they needed,

58. *Id.* § 1396a(a)(10)(B)(i).
59. 367 F.3d 180, 181 n.1 (3d Cir. 2004).
60. *Id.*
61. *Id.*
62. Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 472 F.3d 1208, 1214 (10th Cir. 2007); Mandy R. v. Owens, 464 F.3d 1139, 1143-44 (10th Cir. 2006).
63. 136 F.3d 709 (11th Cir. 1998).
64. *See id.* at 715-19.
65. *Id.* at 711.
66. *Id.*
67. *Id.*

and the State admitted that the waiting period was several years long.[68] The district court found for the plaintiffs and enjoined the Florida Medicaid Administrators.[69] The administrators appealed from the district court's judgment.[70]

b. Circuit Court Holding

In holding that the reasonable promptness language created a federal enforceable right under § 1983, the court used the three part *Blessing* test.[71] First, the court concluded that the plain language of the Medicaid Act, "assistance shall be furnished with reasonable promptness to all eligible individuals," demonstrated that Congress intended the provision to benefit the plaintiffs.[72] Second, the court concluded that the reasonable promptness requirement was "sufficiently specific and definite" enough for a court to evaluate.[73] The court noted "delays of 'several years' . . . are far outside the realm of reasonableness."[74] Finally, the court concluded that the language of the Medicaid statue was "cast in mandatory rather than precatory terms."[75]

After holding that the Medicaid statute did create an enforceable right under § 1983, the court noted that "'[medical] assistance under the [Medicaid] plan' has been defined as medical services. The [State] is obliged to furnish medical services . . . ."[76] The court did not provide additional reasoning as to why it interpreted medical assistance as meaning actual medical services.

2. First Circuit: *Bryson v. Shumway*[77]

The First Circuit considered whether the reasonable promptness provision required states to fill all available waiver program slots.[78] While the court did not expressly consider what medical assistance

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68. *Id.*
69. *Id.*
70. *Id.* at 712.
71. *Id.* at 713. The court explained the *Blessing* test as follows:
> In order to seek redress through § 1983, however, a plaintiff must assert the violation of a federal *right*, not merely a violation of the federal *law*. We have traditionally looked at three factors when determining whether a particular statutory provision gives rise to a federal right. First, Congress must have intended that the provision in question benefit the plaintiff. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. Third, the statute must unambiguously impose a binding obligation on the States. In other words, the provision giving rise to the asserted right must be couched in mandatory rather than precatory terms.

Id.
72. *Id.* at 715.
73. *Id.* at 717.
74. *Id.*
75. *Id.* at 718.
76. *Id.* at 711.
77. 308 F.3d 79 (1st Cir. 2002).
78. *Id.* at 81.

meant, the court's holding, in effect, implied that actual services were required when a state had unfilled waiver program slots.[79]

a. Facts and Procedural History

The plaintiffs, Bonnie Bryson and Claire Shepardson, represented a class of individuals who were being treated in New Hampshire in various treatment facilities.[80] Bryson and Shepardson were eligible for care under the Medicaid program because they both suffered from acquired brain disorders.[81]

New Hampshire Medicaid administered a model waiver program providing home and community based services (HCBS) for individuals with such acquired brain disorders.[82] New Hampshire's HCBS program initially served only 15 individuals in its first year, but the goal was to increase the number of slots up to 130.[83] There were always more applicants for the HCBS programs than available slots, so the State created a waiting list for the services. The number of eligible individuals on the waitlist ranged from 25 to 87.[84] The plaintiffs applied for the HCBS program but were never admitted and were instead placed on the waiting list.[85]

The plaintiffs sued the State administrators of the Medicaid program alleging that New Hampshire failed to fill the available HCBS slots within a reasonable time.[86] The district court granted summary judgment for the plaintiffs, finding that the state violated Medicaid's reasonable promptness requirement.[87] The State appealed the district court's ruling.

b. Circuit Court Holding

The Third Circuit applied the three-part *Blessing* test and found that the reasonable promptness provision of the Medicaid statute created a federally-enforceable cause of action under § 1983.[88] In doing so, the court noted that "[once] the waiver plan is created and approved, it be-

79. *Id.* at 89.
80. *Id.* at 81.
81. *Id.* Acquired brain disorders "manifest before age sixty, are neither congenital nor caused by birth trauma, and present 'a severe and life-long disabling condition which significantly impairs a person's ability to function in society.'" *Id.*
82. *Id.* at 82-83.
83. *Id.* at 83.
84. *Id.*
85. *Id.*
86. *Id.* at 81. Plaintiff's also alleged that "if New Hampshire set up a model program at all, Congress required that the waiver program have at least as many slots as the number of applicants, up to a limit of 200." *Id.* The court ruled that the Medicaid statute did not require states to provide services for the number of individuals who desired such services, but rather that states were free to set up model waiver programs serving as many individuals as each state desired, as long as that number did not exceed 200. *Id.* at 86. This discussion is beyond the scope of this comment.
87. *Id.* at 84.
88. *Id.* at 89.

comes part of the state plan and therefore subject to federal law; the waiver plans must meet all requirements not expressly waived."[89]

After finding a federally-enforceable right, the court considered whether New Hampshire had violated the reasonable promptness requirement by failing to fill unfilled waiver slots in a reasonable amount of time.[90] The court remanded this issue to the trial court because there was no factual record as to whether unfilled waiver slots existed.[91] While the court did not expressly decide the issue, it did discuss it. In doing so, the Third Circuit said:

> [When] an individual ceases to use the waiver plan services, there is necessarily a time gap while an individual on the waiting list is chosen to take the unfilled slot and while services are made available. Because of that lag in time, the fact that some slots are unfilled may be consistent with New Hampshire diligently filling the empty slots with reasonable promptness. It may also indicate that New Hampshire is *not being reasonably prompt in its provision of medical assistance.*[92]

The Third Circuit, then, in dicta, implied that New Hampshire must fill available slots.[93] By articulating the requirement that New Hampshire fill available slots in its waiver program, the Third Circuit indirectly held that states must provide actual medical services in order to discharge their duty of providing medical assistance with reasonable promptness.

B. Circuits Holding that Medical Assistance Means Financial Support

1. Seventh Circuit: *Bruggeman v. Blagojevich*[94]

The *Bruggeman* Court also examined the issue of whether the Illinois Medicaid program violated Medicaid's statutory requirement of reasonable promptness of medical services because there were more vacancies in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) in the southern part of the state than the northern part of the state.[95]

a. Facts and Procedural History

The *Bruggeman* plaintiffs were seven developmentally disabled adults living at home with their parents in the Chicago area.[96] The par-

89. *Id.*
90. *Id.*
91. *Id.* at 89-90.
92. *Id.* at 89 (emphasis added).
93. *Id.*
94. 324 F.3d 906 (7th Cir. 2003).
95. *Id.* at 910. The court also considered whether the disproportional distribution of ICF/DD facilities violated the Rehabilitation act and the Americans with Disabilities Act. These claims are beyond the scope of this comment.
96. *Id.* at 908.

ents wanted the plaintiffs to live in ICF/DD facilities; however, the facilities with vacancies were located in the southern part of Illinois.[97] The parents did not want to send their children to those facilities because of the time and expense they would incur in traveling to visit their children.[98]

The plaintiffs brought suit against the state officials who, in their official capacity, were in charge of administering Illinois' Medicaid program. The plaintiffs argued that the defendants "prefer[red] the plaintiffs to live at home because it would cost the state more to pay for their care in an institution, and so the defendants refuse[d] to write letters urging authorization of additional ICF/DDs in the northern part of the state . . . ."[99] Without these letters from state officials, the agency responsible for authorizing additional facilities would refuse such authorizations.[100] The plaintiffs argued that by refusing to write the necessary letters, defendants violated the reasonable promptness and comparability requirements because no new facilities would be authorized. [101]

The district court dismissed the plaintiff's Medicaid claim for lack of standing, deciding "that the plaintiffs have no right to live in an ICF/DD that is near their parents' home."[102] The court found that because this right did not exist, there was no injury and thus no standing.[103]

b. Circuit Court Holding

The Seventh Circuit began by examining standing. The court found that the district court's ruling that there was no injury was based on the merits of the case rather than jurisdictional grounds.[104] Instead, the court found that "if [plaintiffs] claim a right to a wider choice of ICF/DD vacancies than the defendants are willing to permit the planning agency to authorize, then they are likely to have standing, because the absence of the plan they seek is a denial of such an entitlement."[105] After finding standing, the court moved forward and addressed the merits of the plaintiffs' claim.[106]

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97. *Id.*
98. *Id.* at 908-09.
99. *Id.* at 909.
100. *Id.*
101. *Id.* (citing 42 U.S.C. §§ 1396a(a)(1), (8), (10)(B)(i), (19), (23) (2006)).
102. *Id.*
103. *Id.*
104. *Id.* at 909-10.
105. *Id.* at 909. The court went on to note that the plaintiffs "seek merely a plan, which might not lead to the increase in the ICF/DD capacity in their immediate geographic area." *Id.* This speculative situation is what left the court to decide that Plaintiffs only *likely* had standing. The court nonetheless found standing because the possibility that new ICF/DD facilities would not increase vacancy was "not so speculative as to negate standing, which is a matter of probabilities rather than certainties." *Id.* (citing North Shore Gas Co. v. EPA, 930 F.2d 1239, 1242 (7th Cir. 1991)).
106. *Id.* at 910.

The court first addressed the statutory requirement of reasonable promptness to medical assistance. The court found that the requirement was "not infringed by the maldistribution . . . of ICF/DDs across the state."[107] The court reasoned that the plaintiffs did not require relocation to the southern part of the state because it was not "as if plaintiffs require[d] relocation to such a facility on an emergency basis, in which event the remoteness of any such facility from their homes . . . would deprive them of prompt treatment."[108] The court then considered the situation where the plaintiffs would need to be transported in an emergency situation, and in doing so, determined that the Medicaid statute only requires financial assistance.[109] The court said:

> Even if they did require emergency treatment, their theory of violation would be a considerable stretch because the statutory reference to "assistance" appears to have reference to *financial* assistance rather than to actual medical *services*, though the distinction was missed in *Bryson v. Shumway* and *Doe v. Chiles*. Medicaid is a payment scheme, not a scheme for state-provided medical assistance, as through state-owned hospitals. The regulations that implement the provision indicate that what is required is a prompt determination of eligibility and prompt provision of funds to eligible individuals to enable them to obtain the covered medical services they need . . . [A] requirement of prompt *treatment* would amount to a direct regulation of medical services.[110]

The court then addressed the Plaintiffs' claims that the State was failing to provide identical ICF/DD services because the number of vacancies in the southern part of the state "favors the people living there over those who live in the northern part."[111] To fix this problem, the plaintiffs argued there should be a ICF/DD within thirty miles from their homes, and that that ICF/DD must be specifically tailored to the Medicaid beneficiaries' needs.[112] The court concluded that the plaintiffs' desires were "[a]n unattainable goal that cannot rationally be attributed to the statute."[113]

The court also considered the plaintiffs' argument that the defendants' refusal to write the necessary letters violated the "right to obtain a needed medical service from a provider 'who undertakes to provide him such services.'"[114] The court rejected this argument, reasoning that the statutory provision exists "to give the recipient a choice among available

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107. *Id.*
108. *Id.*
109. *Id.*
110. *Id.* (internal citations omitted).
111. *Id.*
112. *Id.* at 910-11.
113. *Id.* at 911 (citing Harris v. James, 127 F.3d 993, 1011 (11th Cir. 1997)).
114. *Id.* (citing 42 U.S.C.A § 1396a(a)(23) (2008)).

facilities, *not to require the creation or authorization of new facilities.*"[115]

Overall, the court found that the Medicaid claims lacked merit, and explicitly stated that Medicaid is only a payment scheme.[116]

2. Sixth Circuit: *Westside Mothers v. Olszewski*[117]

In *Westside Mothers*, the court directly considered what medical assistance requires, and the Sixth Circuit held that medical assistance meant financial assistance.[118]

a. Facts and Procedural History

Plaintiffs, Westside Mothers, and other advocacy groups along with five Medicaid beneficiaries brought suit against the defendants—those responsible for administering Michigan's Medicaid program. The plaintiffs brought suit under § 1983 alleging that that the defendants had failed to implement an appropriate Medicaid system by (1) refusing to provide comprehensive screening to eligible individuals; (2) not requiring providers to provide diagnostic services and treatment; (3) failing to effectively inform eligible patients of the available treatment and screening; (4) failing to provide transportation to physician visits; and (5) by developing a program that lacked the capacity to provide care to eligible children.[119]

The district court granted the defendants' motion to dismiss the case, holding that Medicaid was a contract between the state and the federal government so the proper defendant was really the state instead of the state officials.[120] The court dismissed the case because the state was protected from suit by sovereign immunity.[121] The plaintiffs appealed the dismissal and the Sixth Circuit reversed and remanded the case, finding that the Medicaid statute did create an enforceable cause of action against the state officials.[122]

On remand, the district court granted in part the defendant's motion to dismiss for failure to state a claim.[123] In doing so, the court concluded that the Medicaid Act "[requires] the State to pay some or all of the costs of certain medical services available to eligible individuals, but [does

115. *Id.* (emphasis added).
116. *Id.* at 910-11.
117. Westside Mothers v. Olszewski, 454 F.3d 532 (6th Cir. 2006).
118. *Id.* at 539-40.
119. *Id.* at 536.
120. *Id.*
121. *Id.*
122. *Id.* at 536-37.
123. *Id.* at 537.

not] require the State provide the services directly."[124] The plaintiffs again appealed from the district court's dismissal.

b. Circuit Court Holding

The Sixth Circuit considered "whether the individual rights to 'medical assistance' . . . [impose] an obligation on the State to provide services directly."[125] The court recognized that while other courts interpreted the medical assistance provision differently, the statute clearly provided a definition. "Medical assistance" the court wrote, "means 'payment of part or all of the cost of the [enumerated] services' to eligible individuals.'"[126] The plaintiffs encouraged the court to adopt a broader interpretation of medical assistance, but the court relied on the language and structure of the Medicaid statute to reject the plaintiffs' suggestion.[127] In rejecting a broader interpretation of the statute, the Sixth Circuit wrote:

> The most reasonable interpretation of [the reasonable promptness requirement] is that all eligible individuals should have the opportunity to apply for medical assistance, i.e., financial assistance, and that such medical assistance, i.e., financial assistance, shall be provided to the individual with reasonable promptness. The most reasonable interpretation of [the comparability requirement] is that medical assistance, i.e., financial assistance, must be provided for at least the [mandatory] care and services listed in [various] paragraphs [of the Medicaid statute].[128]

The Sixth Circuit's explicit holding set the stage for the Tenth Circuit's consideration of the same issue.

3. Tenth Circuit: *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*[129]

The *Mandy R.* court considered three issues associated with the Medicaid Act: reasonable promptness, comparability, and sufficient payments.[130] The court held that the Medicaid requirements of reasonable promptness and comparability did not require the state to provide actual medical services to Medicaid recipients.[131] The court discussed the suf-

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124. *Id.* at 539.
125. *Id.* at 539-40.
126. *Id.* at 540 (citing 42 U.S.C.A § 1396d(a) (2008)).
127. *Id.*
128. *Id.* The court also addressed whether 42 U.S.C.A § 1396a(a)(30) (2008), the requirement that state Medicaid programs must provide access to eligible children and § 1396a(a)(43)(A), the requirement that States provide notice to eligible individuals about certain programs, created federally enforceable rights. *Id.* at 541. The court concluded that § 1396a(a)(30) did not create a federally enforceable right but that § 1396a(a)(43)(A) may. *Id.* at 544. Further discussion about these arguments is beyond the scope of this comment.
129. Mandy R. v. Owens, 464 F.3d 1139 (10th Cir. 2006).
130. *Id.* at 1141.
131. *Id.*

ficient payments requirement separately, and this comment does not address that analysis.

a. Facts and Procedural History

Colorado offers a number of Medicaid-funded services for developmentally disabled persons. The services at issue here were Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community Based Services (HCBS).[132] Colorado had three ICF/MR facilities, which are larger institutional settings "generally reserved for persons with extreme needs."[133] ICF/MRs in Colorado served, at the time of suit, approximately 86 individuals.[134] HCBS programs, in contrast, were smaller waiver programs that served between one and eight people per program.[135] HCBS programs are less isolating and less expensive than ICF/MR programs.[136] At the time of the trial, approximately 3,800 developmentally disabled individuals were being treated in HCBS programs.[137]

During the same time, approximately 733 individuals were waiting for enrollment in HCBS programs, but the services were unavailable.[138] In contrast, only 21 individuals were waiting for enrollment in an ICF/MR program.[139]

The plaintiffs, six developmentally disabled individuals seeking ICF/MR services (an association of service providers), brought suit against the state alleging that it violated the Medicaid Act by failing to provide the developmentally disabled with comprehensive residential services that meet the statutory "requirements of *reasonable promptness* and *comparability*."[140] The district court held a four day bench trial and found for the state.[141] The plaintiffs appealed.[142]

b. Circuit Court Holding

The court began by assuming that the statutory requirements of reasonable promptness and comparability conferred a federally-enforceable right because the district court did not consider the point and because

132. *Id.*
133. *Id.*
134. *Id.*
135. *Id.*
136. *Id.* at 1142.
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.* at 1142-43 (emphasis added).
141. *Id.* at 1142.
142. *Id.*

other circuit courts that addressed the issue found a private right existed.[143]

The court characterized the plaintiffs' claims that the state was not providing medical assistance with reasonable promptness and comparability as one problem: "that the individual plaintiffs are not receiving the comprehensive residential services they need."[144] In order to determine the merits of the claim, the court began by asking "[w]hat is the 'medical assistance' that the state must provide promptly and equally?"[145] In defining medical assistance, the court considered the statutory definition, statutory "contextual clues," and policy rationale.[146] This analysis led the court to conclude that the Medicaid Act required states to provide financial assistance rather than actual medical services.[147]

First, the court looked at the definition of medical assistance as defined in the Medicaid Act. The Act "defines 'medical assistance' as '*payment* of part of all of the cost of the [described] care and services.'"[148] The court reasoned that because the definition provided in the statute "mention[ed] payment for, but not provision of services" that medical assistance only included financial assistance.[149] Thus, the court concluded, the Medicaid Act only requires participating states to "pay promptly and evenhandedly for medical services when the state is presented a bill" rather than provide medical services promptly and evenhandedly.[150]

In reaching its conclusion based on the statutory definition, the court relied on the Seventh Circuit's interpretation of medical assistance and recognized the potential circuit split.[151] In a footnote, the Tenth Circuit recognized that while there may be a circuit split, it is not explicit. It noted "two circuits have held that 'medical assistance' requires only financial assistance . . . . Another circuit has reserved the question . . . . Without expressly addressing the issue, two other circuits appear to have treated the statute as requiring the provision of actual services."[152]

Second, the court quickly rejected each of the plaintiffs' arguments that five specific "contextual clues" in the Medicaid Act pointed to the

143. *Id.* at 1142-43 ("Since the Supreme Court clarified when a statute creates an enforceable private right in *Gonzaga University v. Doe*, 536 U.S. 273 (2002) . . . several courts have considered whether one or both of these subsections [42 U.S.C.A § 1396a(a)(8) (2008) reasonable promptness and § 1396a(a)(10) comparability] creates an enforceable private right. Each has concluded that the provision in question does.").

144. *Id.*

145. *Id.*

146. *Id.* at 1143-45.

147. *Id.*

148. *Id.* at 1143 (quoting 42 U.S.C.A § 1396d(a)) (emphasis added).

149. *Id.*

150. *Id.*

151. *Id.* at 1143 n.2.

152. *Id.*

interpretation that medical assistance means actual medical services.[153] Plaintiffs first alleged that section 1396a(a)(2) of the Act, which requires states to "assure that lack of adequate *funds* from local sources" will not decrease the quality of care under Medicaid, meant states must provide medical assistance.[154] The court rejected this argument, noting that the provision only mentions funding and "says nothing about providing the services themselves."[155] Secondly, plaintiffs alleged the comparability requirement requires states to provide beneficiaries with actual medical services because the provision requires that the "'medical assistance' [] be the same 'in amount, duration or scope.'"[156] The court found that the comparability provision did not indicate which meaning should be given to medical assistance because the provision "can apply to the payment for services no less logically than to the provision of services."[157] Third, the plaintiffs argued that the requirement that states provide care and services "'in a manner consistent with simplicity of administration in the best interests of the recipients'" required the state to provide actual medical services.[158] The court declined to adopt this argument because it saw "no logical end" to state provided care if the state was required to provide all actual medical services that were in the best interest of the recipients.[159] Fourth, plaintiffs argued that the language in the state's waiver application promised to provide ICF/MR services "with 'No Limitations.'"[160] The court rebuffed this argument, noting that by choosing the "no limitations" language, "the State was abjuring limits such as length of ICF/MR services for which it would pay, but there [was] no indication that . . . the State promised to build, staff, and maintain as many ICFs/MR as would be needed to meet the demand in Colorado."[161] Lastly, the court rejected the plaintiffs' argument that the waiver program was a "commitment to ensuring that every eligible patient receive[d] services either from ICFs/MR or HCBS."[162] The court reasoned that the waiver application did not confer responsibility upon the state to ensure that ICF/MR or HCBS are available for every individual who desired such a program.[163]

Third, the court rejected plaintiffs' public policy argument for defining medical assistance as actual medical services.[164] Plaintiffs argued that by accepting federal funds for Medicaid, the state was "promising to

153. *Id.* at 1144.
154. *Id.* (emphasis added).
155. *Id.*
156. *Id.* (quoting 42 U.S.C.A. § 1396a(a)(10)(B)(i) (2008)).
157. *Id.*
158. *Id.* (quoting § 1396a(a)(19)).
159. *Id.*
160. *Id.*
161. *Id.* at 1145.
162. *Id.*
163. *Id.*
164. *Id.*

pay for services for the developmentally disabled and then suppressing the supply of these services."[165] The plaintiffs' only argument supporting the assertion that the state was suppressing the supply of ICF/MR facilities was that the state "ha[d] discouraged efforts to build new ICFs/MR by responding coolly to initial inquiries."[166] The court found this "too nebulous a basis to support a legal claim" and refused to honor plaintiffs' suggestions that the state become the hospital of last resort or that the state include a good faith requirement in the medical assistance requirement.[167]

After analyzing the statutory definition, contextual clues from the statute, and policy considerations, the Tenth Circuit adopted the conclusion of the Seventh Circuit by holding that the definition of medical assistance in the Medicaid Act referred solely to financial assistance, not actual medical services.

4. Tenth Circuit: *Oklahoma Chapter of the American Academy of Pediatrics (OKAAP) v. Fogarty*[168]

The *OKAAP* court considered three provisions of the Medicaid Act: early and period screening, diagnostic and treatment services (EPSDT), providing necessary care and services with reasonable promptness, and provider reimbursements.[169]

a. Facts and Procedural History

Two non-profit organizations, the OKAAP and the Community Action Project of Tulsa County, Inc. (CAPTC), along with thirteen individual children, brought suit against the State of Oklahoma and the Oklahoma Health Care Authority (OHCA).[170] OHCA implements and administers Oklahoma's Medicaid program.[171] The plaintiffs alleged that the policies and procedures of the administration of Oklahoma's Medicaid program "denied or deprived eligible children . . . of the health and medical care to which they were entitled under federal law."[172]

The district court conducted a bench trial and dismissed OKAAP's claim for lack of standing.[173] In its holding, the district court found that

165. *Id.*
166. *Id.* at 1145-46.
167. *Id.* at 1146.
168. Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 472 F.3d 1208, 1208 (10th Cir. 2007).
169. *Id.* at 1210. Provider reimbursement is beyond the scope of this comment, so the case discussion focuses on the first two issues raised by the Plaintiffs.
170. *Id.*
171. *Id.*
172. *Id.*
173. *Id.* On appeal *OKAAP* contended that the district court erred in dismissing the group for lack of standing. The appeals court did not consider the issue because the court's "conclusion on the parties' other issues, which necessitate reversal of the district court's judgment, have rendered this issue moot." *Id.* at 1216.

the State and OHCA violated the Medicaid Act by failing to ensure that physician reimbursements for care were sufficient and by failing to furnish medical assistance with reasonable promptness.[174] In reaching its conclusion, the district court noted that the plaintiffs demonstrated that children who needed care were not receiving it and that "system-wide delays in treatment exist and have presented convincing evidence that those delays are not reasonable. In violation of [the reasonable promptness requirement], defendants are not ensuring that medical assistance is furnished with reasonable promptness to all eligible individuals."[175]

The court noted that the Seventh Circuit interpreted medical assistance to mean financial assistance, but distinguished the OKAAP claims from the claims the Seventh Circuit considered.[176] In doing so, the district court held that while the Medicaid statute only required financial assistance, the state could still have violated the Medicaid statute's reasonable promptness requirement by not providing sufficient financial assistance.[177] The court reasoned that failing to provide sufficient financial reimbursement would mean fewer providers would accept Medicaid, and thus effectively deny reasonably prompt medical assistance."[178]

The district court ordered the plaintiffs and defendants to meet and submit a proposed injunctive order to remedy the violations of the Medicaid statute on which the court would base its final order.[179] After the court received the proposed injunctive order, the district court issued a permanent injunction. The injunction and final judgment outlined how the state must create and comply with a new payment scheme to "assure reasonably prompt access to health care for minor children."[180] Both parties appealed.[181]

b. Circuit Court Holding

The Tenth Circuit reversed and remanded the district court's holding.[182] The court held that Oklahoma's Medicaid program did not violate the '"reasonable promptness' requirement by allowing system-wide delays in treatment of Medicaid beneficiaries . . . ."[183] Additionally, the Tenth Circuit concluded that the comparability requirement "requires a

174. *Id.* at 1210. While the district court considered the reimbursement issue, reimbursement is beyond the scope of this comment.

175. *Id.* at 1213-14 (quoting Okla. Chptr. of the Am. Acad. of Pediatrics v. Fogarty, 366 F. Supp. 2d 1050, 1109 (D. Okla. 2005) [hereinafter *OKAAP II*].

176. *Id.* at 1214.

177. *Id.*

178. *Id.* (quoting *OKAAP II*, 366 F. Supp. 2d at 1109).

179. *Id.* at 1210.

180. *Id.* at 1210-11 (citing Aplt. App. at 422-25).

181. *Id.* at 1211.

182. *Id.* at 1216.

183. *Id.* at 1209 (citing 42 U.S.C.A. § 1396a(a)(8) (2008)).

state Medicaid plan to pay for, but not to directly provide, the specific medical services listed in the Medicaid Act."[184]

The Tenth Circuit reaffirmed its holding from *Mandy R.* that medical assistance as provided in the Medicaid statute refers only to financial reimbursement and not actual medical services.[185] In doing so, the Tenth Circuit rejected the district court's ruling that the state must conduct a study of rates and reimbursements.

In rejecting the need for a study, the Tenth Circuit noted that the reasonable promptness requirement does not make a state Medicaid program "directly responsible for ensuring that the medical services enumerated in the Medicaid Act (i.e. those that are reimbursable) are actually provided to Medicaid beneficiaries in a reasonably prompt manner."[186]

The Tenth Circuit recognized the district court's conclusion that low reimbursement rates result in fewer providers which in turn creates a longer wait time for Medicaid beneficiaries, but made an important distinction. The court noted that while reduced rates of reimbursement may increase the time a Medicaid beneficiary must wait for treatment, that "does not mean that defendants failed (or will fail in the future) to be reasonably prompt in paying for services actually rendered by available providers, as required by [the reasonable promptness requirement]."[187]

Following the discussion of reasonable promptness, the Tenth Circuit rejected plaintiffs' argument that the statute created a federally enforceable right to receive EPSDT services. The court considered the EPSDT argument separately because the *Mandy R.* court did not address an EPSDT claim. The court again reasoned that the Medicaid Act required Oklahoma's Medicaid plan to pay for EPSDT services rather than ensure such services were being provided or directly provide such medical services.[188]

III. WHY COURTS SHOULD INTERPRET MEDICAL ASSISTANCE AS FINANCIAL ASSISTANCE

The United States Supreme Court denied certiorari of the two Tenth Circuit cases that held medical assistance meant financial assistance, *Mandy R.* and *OKAAP*, and denied certiorari in the Eleventh Circuit case that held medical assistance meant actual medical services, *Doe v.*

184. *Id.* at 1209-10.
185. *Id.* at 1214.
186. *Id.*
187. *Id.*
188. *Id.* at 1215.

Chiles.[189] Thus, the Supreme Court has, in effect, accepted both interpretations. However, because Medicaid is a federally-funded program, and because federal circuits interpret the Medicaid statute inconsistently, the United States Supreme Court should grant certiorari to define medical assistance.

The reasons for this circuit split are somewhat puzzling for a number of reasons, and the circuits holding that Medicaid programs require actual medical services do a poor job of explaining away the disparities. The most logical interpretation of the medical assistance provision is provided in the Tenth Circuit's analysis in *Mandy R.* concluding that medical assistance means financial assistance.

This part addresses why the financial assistance interpretation of medical assistance is more persuasive than the actual medical services interpretation, and why future courts should reject the notion that the Medicaid statute requires states to provide actual medical services to Medicaid beneficiaries. First, the legislative history behind the creation of Medicaid points to the idea that Congress intended for Medicaid to serve as a type of health insurance program by providing financial assistance to those who could not afford medical care on their own.[190] The language of the Medicaid statute and explanations about what Medicaid is by CMS describe the program as a financial assistance program.[191] Second, and more compelling, the problems facing Medicaid are vast and best alleviated by only requiring states to provide financial assistance.

A. Legislative History and Statutory Language

When Congress passed the Medicaid program, it defined medical assistance "to mean payment of all or part of the cost of care and services for [eligible] individuals."[192] This definition only requires states to provide payment for the costs of care and services rather than provide actual medical services. Had Congress intended for states to provide the actual

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189. Mandy R. v. Ritter, 127 S. Ct. 1905 (2007); Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 128 S. Ct. 68 (2007); Kearney v. Does 1-13, 534 U.S. 1104 (2002). The *Mandy R. v. Ritter* plaintiffs asked the Court to consider whether:

> federal Medicaid law, which requires that medical assistance be furnished with reasonable promptness to all eligible individuals and may not be less in amount, duration, and scope to the medical assistance made available to similarly situated others, impose on a state an obligation to ensure that the care and assistance specified in the state's Medicaid plan is promptly furnished . . . . Or may the state discharge its federal Medicaid obligation by merely making prompt payment when presented with a charge for such care and assistance . . . ?

Petition for Writ of Certiorari at *i, Mandy R. v. Ritter, 127 S. Ct. 1905 (2007) (No. 06-1002), 2007 WL 178418.

190. *See generally* STEVENS & STEVENS, *supra* note 18.

191. *See* 42 U.S.C.A. § 1296 d(1) (2008); *see also* Centers for Medicare & Medicaid Services, *Medicaid Eligibility – Overview*, http://www.cms.hhs.gov/MedicaidEligibility/ (last visited Feb. 1, 2008) ("Medicaid is health insurance that helps many people who can't afford medical care pay for some or all of their medical bills.").

192. S. REP. NO. 89-404 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 2020.

medical care, surely it was familiar enough with the legislative process to write such a requirement into the bill.

In addition, CMS recognizes that "Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements . . . ."[193] Because CMS is the agency charged with administering the Medicaid program, it is a logical conclusion that CMS's understanding of how the Medicaid program is run is accurate.

Examining the history surrounding the creation of the Medicaid statute enhances the statutory language and agency interpretation of the Medicaid statute. The Medicaid program was an expansion of the Public Assistance Acts of 1960, which implemented a national vendor payment system for elderly who could not pay for their medical care.[194] Scholars have long recognized that Medicaid is a vendor payment system and that under the program states are responsible for providing direct reimbursement to medical providers.[195] By creating the Medicaid program, Congress shifted public medical assistance from "a series of vendor payment programs . . . to . . . one (Medicaid)."[196] In creating Medicaid, Congress gave states "a green light to reorganize and expand their vendor payment schemes."[197] Had Congress intended for states to actually provide the medical services, there would be no need for a vendor payment system. Instead, states would use the federal matching funds to supplement the state budget and provide additional infrastructure.

The legislative history of Medicaid, combined with the statutory language, illustrates that Congress intended Medicaid to serve needy individuals by providing financial assistance. The statutory language does not require states to provide actual medical assistance, and interpreting the Medicaid statute as such ignores Congress's intent.

B. Lessening the Burdens on the Medicaid Program

Limited financial resources and administrative burdens are two of the major problems facing Medicaid today.[198] Not only do these problems create challenges for the agencies administering Medicaid, but more importantly they create access issues for eligible Medicaid beneficiaries. As fewer physicians accept Medicaid patients because of low reim-

193. MEDICAID PROGRAM: GENERAL INFORMATION, TECHNICAL SUMMARY, *supra* note 34.
194. *See* STEVENS & STEVENS, *supra* note 18, at 61.
195. *Id.* at 66.
196. *Id.* at 69.
197. *Id.* at 73.
198. Another problem plaguing the Medicaid program is fraud and abuse. A discussion of fraud and abuse is beyond the scope of this comment. For a discussion of agency measures in place to help combat Medicaid fraud, *see generally* 42 C.F.R. § 455 (2008), *available at* http://www.cms.hhs.gov/MDFraudAbuseGenInfo/.

bursement payments, beneficiaries are forced to wait longer and travel further for care. Interpreting the medical assistance language to mean financial assistance will help lessen the impact of these challenges facing Medicaid. If this interpretation does not increase access to care, it will at least help prevent access from continuing to decline.

1. Limited Financial Resources

One of the biggest financial concerns of states in 2005 was Medicaid spending. In fact, "[i]n their 2005 fiscal outlooks, thirty states listed spiraling Medicaid costs as one of their top three fiscal priorities, and sixteen states anticipated Medicaid-induced spending overruns in 2005."[199] In 2003, the House Energy and Commerce Committee Subcommittee on Health held a hearing about problems facing Medicaid ("Medicaid Hearings"). Florida Governor Jeb Bush, Former Connecticut Governor John Rowland, and New Mexico Governor Bill Richardson testified about the fiscal challenges their states were facing as a result of Medicaid. Governor Richardson testified "[f]rom my new vantage point, I can tell you that the costs of this program can and do produce great challenges for my State and all States."[200]

The fiscal challenges have led many states to reduce the scope of their Medicaid programs.[201] States have been forced to reduce benefits and eligibility to Medicaid beneficiaries. At the 2003 Medicaid Hearings, former Governor John Rowland testified that "in 22 states, including my own, Medicaid eligibility has been reduced. Medicaid benefits have been reduced in 22 states, and many others are seeking to implement premiums, co-payments, preferred drug lists, and other techniques routinely applied in the private sector to contain health care costs."[202]

Requiring states to provide actual medical services as opposed to financial assistance for Medicaid beneficiaries would increase the already cumbersome financial burdens on states. If states were forced to provide medical care services, they would be "required to pay millions in construction for publicly funded facilities."[203] The resources already allocated to Medicaid beneficiaries would be redistributed to pay for new hospitals and treatment centers instead of paying for the medical treat-

199. Moncrieff, *supra* note 1, at 673.

200. *Medicaid Today: The States' Perspective: Hearing Before the Subcomm. on Health*, 108th Cong. (2003), *available at* http://energycommerce.house.gov/reparchives/108/Hearings/03122003hearing815/print.htm (statement of Honorable Bill Richardson, Governor, State of New Mexico).

201. Moncrieff, *supra* note 1, at 673.

202. *Medicaid Today*, *supra* note 200 (statement of Honorable John G. Rowland, Governor, State of Connecticut).

203. Press Release, Attorney General of Colorado, Attorney General Suthers Comments on U.S. Supreme Court Decision in Medicaid Case (Mar. 26, 2007), *available at* http://www.ago.state.co.us/press_detail.cfm?pressID=846.

ment beneficiaries need. The existing funding problems inherent in the Medicaid structure are not because of a lack of infrastructure.

Furthermore, it is reasonable to conclude that the costs of requiring public facilities would greatly outweigh the benefits such a policy would provide. Medicaid beneficiaries do not live in one specific area in any state. Rather, beneficiaries are spread out across cities and counties. Building one Medicaid public facility in each state would not be sufficient. In Colorado, for example, if only one facility was built in Denver, Medicaid beneficiaries who did not reside in the surrounding areas, for example a resident in Grand Junction, would have to travel for hours to get to the public facility. Instead, if states decided to build a few facilities throughout the state, the financial resources spent on infrastructure would rise with each new facility.

2. Administrative Burdens

It has been suggested that in place of the black and white approach of either requiring actual medical services or financial assistance courts should instead consider the facts of each case individually "to determine whether the plaintiffs should receive funding or be provided with services."[204] This alternate idea to take into account a number of issues facing Medicaid. First, the case-by-case approach ignores the financial burdens of providing actual medical services. Second, it also fails to take into account the already existing administrative burdens facing the Medicaid program, and instead, it creates more hurdles for the already vulnerable Medicaid eligible population. Finally, this approach assumes that courts have an in depth understanding of the administration of Medicaid and what is best for each beneficiary.

The case-by-case approach is founded on the reasoning that:

> [I]f a state chooses to include a certain benefit under its Medicaid program and accepts federal funds for doing so, then it should ensure that all eligible recipients receive that benefit. When all recipients are able to receive the benefit by obtaining required services from a public or private source, the state would then merely have to provide the funding for that benefit . . . . If, however, some eligible recipients are unable to receive the benefit, then the state should be required to provide the actual services—instead of mere funding—so that the benefit in question is equally available to all . . . .[205]

At first impression this reasoning seems logical. If a state provides Medicaid services for a beneficiary, then it should ensure that all beneficiaries receive the same service. However, requiring a state to provide

204. Kenneth R. Wiggins, Note, *Medicaid and the Enforceable Right to Receive Medical Assistance: The Need for a Definition of "Medical Assistance,"* 47 WM. & MARY L. REV. 1487, 1504 (2006).

205. *Id.* at 1507-08.

the actual medical care is not a fiscally responsible way of implementing Medicaid. As discussed in depth above, the financial burdens associated with providing infrastructure for public facilities outweigh the benefits of such a requirement.[206]

Secondly, a case-by-case approach would impose administrative burdens on courts and Medicaid administrators. Congress foresaw that administrative proceedings may hinder the administration of Medicaid, and required that state plans include safeguards to assure that Medicaid would be provided "in a manner consistent with the simplicity of administration."[207] Administrative burdens already plague the Medicaid system. In the Medicaid Hearings, Florida Governor Jeb Bush described the bureaucratic problems already facing the Medicaid program. Governor Bush testified:

> [B]ureaucracy is also isolating our patients from care. Providers constantly complain about the difficulty of navigating patients through the current system—with its paperwork and low fees. Patients also must maneuver the system, and are equally discouraged. There are costs associated with time delays, approvals, needless paperwork, and processes for monitoring each individual component of our state program.[208]

Adding courts to the administration of Medicaid would add another hurdle to a system that is already difficult to maneuver. Requiring individuals to argue in front of the court is a cost that many could not incur—both in terms of finances and in terms of time. Forcing an individual to wait for his day in court may not be reasonable if he needs immediate medical assistance. Additionally, waiting for courts to rule on whether actual services or financial assistance was the proper remedy for each particular individual may violate the statutory reasonable promptness requirement.

The Medicaid statute requires that states promptly administer Medicaid. Corresponding federal regulations require states to create timetables for informing applicants of their eligibility.[209] Another regulatory requirement is that the state Medicaid administrative body must "furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures."[210] Even circuits holding that medical assistance means actual medical services recognize and endorse this administrative requirement.[211] Requiring courts to hear fact specific

206. *See supra* Section III.B.1.
207. S. REP. NO. 89-404, *reprinted in* 1965 U.S.C.C.A.N. 1943, 2016.
208. *Medicaid Today*, *supra* note 200 (statement of Honorable Jeb Bush, Governor, State of Florida).
209. 42 C.F.R. § 435.911(a) (1996); Doe v. Chiles, 136 F.3d 709, 714 (11th Cir. 1998).
210. 42 C.F.R. § 435.930(a) (2008).
211. *Chiles*, 136 F.3d at 714.

situations on case-by-case bases adds another administrative procedure to the Medicaid program, and would create additional delay. Doing so would violate the reasonable promptness requirement of Medicaid.

Thirdly, while the case-by-case approach strives to provide a fairer atmosphere for eligible Medicaid recipients, surely courts would not be able to prevent discrepancies in their rulings. This approach forces courts to become experts on a detailed statute that is over 200 pages long, and then apply consistent rulings affecting the medical treatment of individuals. As the system operates today, litigation about scope and access to care already affects each Medicaid beneficiary. One scholar notes that while litigated Medicaid cases often reflect disputes over a national health care policy, "the outcome of each legal skirmish [affects], immediately and substantially, the lives of Medicaid beneficiaries . . . ."[212] If courts adopted the case-by-case approach, each individual health and funding-related question would result in a litany of consequences for beneficiaries who were not a party to the decision. The largest of these consequences is perhaps inconsistency. As evident from the circuit court split on the interpretation of medical assistance, courts are likely to interpret provision of the Medicaid statute differently and often come to different results. Different courts that come to different conclusions about beneficiaries who face the same or similar circumstances would not only create unfairness, but beneficiaries would likely appeal the court's decision, leading to more and more expensive, needless litigation. Requiring courts to become experts on the intricacies of a detailed statute and uniformly apply it provides another unnecessary administrative burden.

CONCLUSION

By denying certiorari on the issue of whether medical assistance means medical services or financial assistance, the United States Supreme Court leaves the Medicaid program disjointed among the states. While each state creates its own Medicaid program, states in the Eleventh and First Circuits are required to provide actual medical assistance to Medicaid beneficiaries, while states in the Sixth, Seventh and Tenth Circuits may continue their practice of providing financial services for Medicaid beneficiaries. This circuit split creates a disparity of how federal Medicaid funds can be used in states. Some states need only provide financial assistance with the federal funds, while other states may be required to use the federal Medicaid funds to create public hospitals.

An analysis of the legislative history, statutory language, and problems currently plaguing Medicaid demonstrates how the program goals are better served when medical assistance is defined as financial assistance. Requiring the state to be the "service-provider of last resort"

212. Ann B. Lever, *"Shake It up in a Bag": Strategies for Representing Beneficiaries in Medicaid Litigation*, 35 ST. LOUIS U. L.J. 863, 863 (1991).

would create additional burdens to an already drained system and undermine the Medicaid drafters' intention.[213]

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213. Mandy R. v. Owens, 464 F.3d 1139, 1145 (10th Cir. 2006).

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