

University of Michigan Journal of Law Reform Caveat

Volume 46 | Issue 1

2012

Access to Medicaid: Recognizing Rights to Ensure Access to Care and Services

Colleen Nicholson
University of Michigan Law School

Follow this and additional works at: https://repository.law.umich.edu/mjlr_caveat



Part of the [Health Law and Policy Commons](#), [Insurance Law Commons](#), [Legislation Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

Colleen Nicholson, Comment, *Access to Medicaid: Recognizing Rights to Ensure Access to Care and Services*, 46 U. MICH. J. L. REFORM CAVEAT 22 (2012).

Available at: https://repository.law.umich.edu/mjlr_caveat/vol46/iss1/5

This Comment was originally cited as Volume 2 of the University of Michigan Journal of Law Reform Online. Volumes 1, 2, and 3 of MJLR Online have been renumbered 45, 46, and 47 respectively. These updated Volume numbers correspond to their companion print Volumes. Additionally, the University of Michigan Journal of Law Reform Online was renamed Caveat in 2015.

This Comment is brought to you for free and open access by the University of Michigan Journal of Law Reform at University of Michigan Law School Scholarship Repository. It has been accepted for inclusion in University of Michigan Journal of Law Reform Caveat by an authorized administrator of University of Michigan Law School Scholarship Repository. For more information, please contact mjlr.repository@umich.edu.

JOURNAL of LAW REFORM ONLINE

COMMENT

ACCESS TO MEDICAID: RECOGNIZING RIGHTS TO ENSURE ACCESS TO CARE AND SERVICES

Colleen Nicholson*

The Supreme Court has defined Medicaid as “a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals.”¹ In June 2012, the Court found the Patient Protection and Affordable Care Act’s (PPACA) Medicaid expansion unconstitutional.² The Court took issue with the threat to withhold all of a state’s Medicaid funding if they did not comply with the expansion, finding it coercive and a fundamental shift in the Medicaid paradigm.³ However, Medicaid in its current form may not always be effective at providing beneficiaries with timely access to the care to which they are entitled.⁴ For Medicaid to function as intended, Congress must amend the definition of “medical assistance” in the Medicaid Act and give Medicaid beneficiaries and providers an enforceable federal right to sue the states when they do not set provider reimbursement rates at levels that are adequate to attract sufficient Medicaid providers to provide enumerated services for enrollees.

Medicaid provider reimbursement rates are so low in some states that current Medicaid beneficiaries may be unable to receive covered medical care. For example, because of low reimbursement rates, at one time there were no providers of early and periodic screening, diagnostic, and treatment services

* J.D. Candidate, December 2013, University of Michigan Law School.

1. *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502 (1990); see 42 U.S.C. § 1396a (2006).

2. *See Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. ___, 132 S. Ct. 2566, 2603-04 (2012).

3. *See id.* at 2601-08.

4. *See* 76 Fed. Reg. 26342, 26344 (May 6, 2011) (to be codified at 42 C.F.R. pt. 447) (noting that access to Medicaid health care and services at the state level is in need of federal guidance).

(EPSDT) in Michigan's Upper Peninsula.⁵ EPSDT services are basic pediatric services that states are required to provide to eligible beneficiaries who request them.⁶ The current recession has exacerbated this problem, as states cut provider reimbursement rates in an attempt to cover increasing numbers of beneficiaries with dwindling state finances.⁷ Thirty-nine states cut Medicaid reimbursement rates in 2010, and fifteen of those states also reduced or eliminated benefits.⁸ If the current funding levels leave Medicaid beneficiaries without the statutorily mandated reasonable access to the medical care to which they are entitled, reforms are needed to bring Medicaid into compliance with its programmatic goals.

To strengthen Medicaid as a program that provides access to care for beneficiaries, the definition of medical assistance in the Medicaid Act should be clarified. Over the past fifteen years, a circuit split has emerged as to whether "medical assistance," a term used throughout the Act, referred to the actual provision of services, to reimbursement for services actually provided, or to both.⁹ Congress attempted to resolve the split, defining medical assistance in PPACA as both the funds provided to pay for medical care and services, and the care and services themselves.¹⁰ This amendment seemingly clarified that the states have an obligation to provide access to covered services for beneficiaries rather than merely reimburse providers for services provided. Despite rather explicit congressional intent, the circuit split persists and must be resolved.¹¹ Otherwise, the states have no obligation to ensure that

5. See *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006).

6. 42 U.S.C. § 1396d(r) (2006).

7. See OFFICE OF THE ACTUARY, CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., 2011 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID 17–18 (2011).

8. Martina Brendel, Note, *When a Door Closes, a Window Opens: Using Preemption to Challenge State Medicaid Cutbacks*, 86 CHI.-KENT L. REV. 925, 925–26 (2011).

9. Compare *Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (holding that medical assistance did not refer to actual medical services), and *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006) (holding that the Medicaid Act requires reimbursement for covered services, not the direct provision of services by the state), with *Bryson v. Shumway*, 308 F.3d 79, 81, 88–89 (1st Cir. 2002) (assuming medical assistance included services), and *Doe v. Chiles*, 136 F.3d 709, 714, 717 (11th Cir. 1998) (interpreting medical assistance as services).

10. See 42 U.S.C.A. § 1396d(a) (West 2011); see also H.R. Rep. No. 111–299, pt. 1, at 649–50 (2009).

11. Compare *John B. v. Goetz*, 626 F.3d 356, 360 n.2 (6th Cir. 2010) ("The definition of 'medical assistance' has changed since we decided *Westside Mothers II*, but the new

Medicaid beneficiaries are able to receive care, seemingly frustrating Medicaid's aim. Therefore, Congress must further amend the definition of medical assistance to clarify that states have an obligation to provide Medicaid beneficiaries with access to certain covered services.

In addition to a conclusive recognition of what states' Medicaid obligations are, Medicaid beneficiaries and providers need an enforceable right to sue the states and challenge state reimbursement levels. Because states may not always set reimbursement at rates adequate to provide beneficiaries with access to care, there needs to be some legal avenue for beneficiaries to challenge the states when these rates are set at inadequate levels.¹² Possible vehicles include the reasonable promptness,¹³ availability,¹⁴ and equal access provisions of the Medicaid Act,¹⁵ but the circuits are split on whether, and for whom, these provisions create rights enforceable under 42 U.S.C. § 1983.¹⁶ Therefore, Congress must also clarify that at least one of these § 1983 avenues is available to challenge inadequate Medicaid provider reimbursement rates.

definition does not affect this holding because a state may still fulfill its Medicaid obligations by paying for services.”), *with Disability Rights N. J., Inc. v. Velez*, No. 06-4723, 2010 WL 5055820, at *3 (D.N.J. Dec. 2, 2010) (holding that because of the change in law, “it would result in manifest injustice were we to maintain our previous interpretation of ‘medical assistance’”).

12. See Sean Jessee, Comment, *Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights*, 58 EMORY L.J. 791, 811 (2009).

13. 42 U.S.C. § 1396a(a)(8) (2006) (stating that a state plan for medical assistance must provide requested assistance with reasonable promptness to all eligible individuals).

14. *Id.* § 1396a(a)(10) (describing the minimum medical services a state plan for medical assistance must make available for eligible beneficiaries).

15. *Id.* § 1396a(a)(30)(A) (requiring that a state plan assures “that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”).

16. *Compare Westside Mothers v. Olszewski*, 454 F.3d 532, 542-43 (6th Cir. 2006) (holding that the equal access provision does not create an enforceable right for Medicaid beneficiaries or providers), *and Bruggeman ex rel. Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (interpreting the reasonable promptness provision to entitle providers to reasonably prompt reimbursement for actual services provided rather than a right for beneficiaries to have reasonably prompt access to covered medical care), *with Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 192 (3d Cir. 2004) (finding that Medicaid beneficiaries have enforceable rights under the reasonable promptness and availability provisions), *Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002) (finding that the reasonable promptness provision creates a § 1983 cause of action), *and Doe v. Chiles*, 136 F.3d 709, 719 (11th Cir. 1998) (holding that Medicaid beneficiaries have a federal right enforceable under § 1983 to reasonably prompt care).

Without a concrete, universally recognized enforceable right, Medicaid beneficiaries and providers have no means of challenging the states for failing to fulfill their Medicaid responsibilities, short of calling on the Secretary of Health and Human Services to withhold some or all of the state's Medicaid funding until the Secretary is confident that the state's plan for medical assistance will comply with all of the statutory provisions.¹⁷ Such a course of action is undesirable, as it could lead to even less access to care for current Medicaid beneficiaries in the affected states. Therefore, beneficiaries should be able to bring an action against the state to challenge state provider reimbursement rates if the rates do not attract enough providers to offer care in compliance with the reasonable promptness, availability, or equal access clauses.

Congress should amend the definition of "medical assistance" in the Medicaid Act and explicitly recognize enforceable rights in the reasonable promptness, availability, and equal access provisions to clarify what states are required to do under Medicaid and allow beneficiaries to challenge states that do not meet their obligations. The Court struck down the Medicaid expansion as an irresistible "gun to the head" in *National Federation of Independent Businesses v. Sebelius* because, according to the Court, the expansion changed the fundamental nature of Medicaid and created an entirely new program.¹⁸ However, the proposed amended definition of "medical assistance," coupled with recognition of rights enforceable through § 1983, would merely further the aims of Medicaid. Medicaid was designed to "furnish medical care to needy individuals,"¹⁹ not provide reimbursement to medical providers. Therefore, providing individual Medicaid beneficiaries and providers with an enforceable right to sue the states, and giving the states a greater incentive to reign in provider reimbursement rates, would make Medicaid a program worth expanding, should Congress find a constitutional way to do so.

17. See 42 U.S.C. § 1396c (2006) (describing the Secretary of Health and Human Services' ability to withhold payments to states after finding a lack of compliance with Medicaid provisions).

18. See 132 S. Ct. 2566, 2604 (2012).

19. *Wilder v. Va. Hosp. Ass'n.*, 496 U.S. 498, 502 (1990).