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## Medicaid and the Enforceable Right to Receive Medical Assistance: The Need for a Definition of "Medical Assistance"

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# **MEDICAID AND THE ENFORCEABLE RIGHT TO RECEIVE MEDICAL ASSISTANCE: THE NEED FOR A DEFINITION OF “MEDICAL ASSISTANCE”**

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*The government of the United States has been emphatically termed a government of laws, and not of men. It will certainly cease to deserve this high appellation, if the laws furnish no remedy for the violation of a vested legal right.*<sup>1</sup>

## INTRODUCTION

Circuit courts have recently held that § 1396a(a)(8) of the Medicaid Act<sup>2</sup> grants eligible Medicaid recipients an enforceable right, under 42 U.S.C. § 1983, to receive medical assistance (Medicaid benefits) with reasonable promptness. Questions regarding the remedies available under this enforceable right to medical assistance, however, remain in contention among these courts. The United States Court of Appeals for the Third Circuit recently acknowledged a split among sister circuits as to how to define "medical assistance."<sup>3</sup> More specifically, these circuit decisions differ on the issue of whether a state must provide an eligible Medicaid recipient with the actual medical services to which she is entitled, or merely provide her with the funding for those medical services.<sup>4</sup>

Establishing an enforceable right to receive Medicaid benefits accomplishes little until courts are willing to inquire into the appropriate remedy following the breach of such a right. *Sabree v. Richman* demonstrated the inefficiency of courts not determining the appropriate remedy. In *Sabree*, a class of mentally retarded adults sued the Commonwealth of Pennsylvania for failing to provide them with intermediate care facility services for which they qualified under the Medicaid Act.<sup>5</sup> The court held that the plaintiffs

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1. *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 163 (1803).

2. 42 U.S.C. § 1396a(a)(8) (2000).

3. *Sabree v. Richman*, 367 F.3d 180, 181 n.1 (3d Cir. 2004).

4. *Id.* This Note will not discuss any cases in which courts determined that a federally enforceable right to Medicaid does not exist. It is not this Note's purpose to analyze the propriety of a federally enforceable right to Medicaid. This Note focuses solely on the remedy available to a Medicaid recipient once a court finds that such a right does exist. For an argument espousing the view that a federally enforceable right to Medicaid should not exist, see Mark Andrew Ison, Note, *Two Wrongs Don't Make a Right: Medicaid, Section 1983 and the Cost of an Enforceable Right to Health Care*, 56 VAND. L. REV. 1479 (2003).

5. *Sabree*, 367 F.3d at 181.

had an enforceable right to receive the medical assistance in question; it did not, however, grant the plaintiffs a remedy and instead remanded the case so that the district court could define "medical assistance."<sup>6</sup>

This Note explores the issue of how to interpret "medical assistance" as used in the Medicaid Act, considers the different remedies that courts have used, and, combining the differing approaches, suggests how this issue should be settled. Part I provides a brief overview of Medicaid in the United States, with a more specific discussion of the Medicaid waiver provision. Part II discusses the evolution of § 1983 jurisprudence, which established the individual right to enforce constitutional and statutory laws against the State. Part III describes two circuit court cases that held that § 1983 establishes an enforceable right to Medicaid benefits for eligible individuals, and Part IV analyzes the remedies that those two courts provided. Part V introduces the current circuit split regarding how "medical assistance"—as used in § 1396a(a)(8)—should be interpreted. This interpretation determines the ultimate remedy in cases considering the issue of individual enforceability of the Medicaid Act. Finally, Part VI explores the differing views on the proper definition of "medical assistance," and makes suggestions for how courts should ultimately decide this issue. The outcome will largely rest on the distinction between waiver and non-waiver Medicaid programs, as well as the individual facts of each case.

## I. OVERVIEW OF MEDICAID

Congress passed Title XIX of the Social Security Act, commonly known as the "Medicaid Act,"<sup>7</sup> in 1965 "as a modest legislative companion to Medicare."<sup>8</sup> Today, Medicaid is the largest means-tested entitlement law in the United States.<sup>9</sup> The purpose of the Medicaid Act was to establish "a cooperative federal-state program

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6. *Id.* at 194. "To resolve this issue we need not, and do not, address the remedy that might be available to plaintiffs, but leave that to the District Court in the first instance." *Id.* at 181 n.1.

7. *See, e.g., id.* at 182 (using the common name of the Act).

8. Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS U. L.J. 7, 8 (2001). The Medicaid Act is codified at 42 U.S.C. §§ 1396-1396v (2000).

9. Rosenbaum & Rousseau, *supra* note 8, at 16.

under which the federal government furnishes funding to states for the purpose of providing medical assistance to eligible low-income persons."<sup>10</sup> States have the option of choosing whether to participate in the program; once a state accepts federal funding through the program, however, it is required to comply with the Medicaid Act and all accompanying federal regulations.<sup>11</sup> If a state fails to abide by the rules set forth in the Medicaid Act or in the accompanying regulations, the Secretary of Health and Human Services (HHS) must discontinue all federal funding to which the state is entitled under its Medicaid program.<sup>12</sup>

There is, however, an exception to this rule of strict compliance. In 1981, Congress passed a law known as the Medicaid Waiver Provision.<sup>13</sup> Under this provision, a state can ask the Secretary of HHS for approval to include within its Medicaid program home- and community-based services—such as nursing home services, habilitation services, and respite care—that are otherwise not within the realm of the Medicaid Act.<sup>14</sup> If approved, many of the strict requirements of the Medicaid Act are waived in order to give the state flexibility in implementing the program.<sup>15</sup> More specifically, waiver programs do not have to be in place statewide or be available to all individuals equally.<sup>16</sup> For example, a state, if it wishes, may request that its waiver program be limited to twenty potential participants. The purpose of waiver programs is "to allow

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10. Pa. Pharmacists Ass'n v. Houston, 283 F.3d 531, 533 (3d Cir. 2002).

11. See §§ 1396, 1396a(a)(1); see also *Sabree*, 367 F.3d at 182; Rosenbaum & Rousseau, *supra* note 8, at 17. The applicable federal regulations are contained within Chapter 42 of the Code of Federal Regulations and were enacted by the Secretary of Health and Human Services. See, e.g., *Sabree*, 367 F.3d at 182. Every state has implemented a Medicaid program. See Cindy Mann & Tim Westmoreland, *Attending to Medicaid*, 32 J.L. MED. & ETHICS 416, 419 (2004).

12. See § 1396c.

13. §§ 1315, 1396n; see also *Bryson v. Shumway*, 308 F.3d 79, 82 (1st Cir. 2002) (discussing Medicaid waiver provisions); Andrew I. Batavia, *A Right to Personal Assistance Services: "Most Integrated Setting Appropriate" Requirements and the Independent Living Model of Long-Term Care*, 27 AM. J.L. & MED. 17, 24 (2001) (discussing the adoption of Medicaid waiver programs).

14. See § 1396n(c); *Bryson*, 308 F.3d at 82.

15. See § 1396n(c); *Bryson*, 308 F.3d at 82; Batavia, *supra* note 13, at 24.

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

states to experiment with methods of care,"<sup>17</sup> and "to alter the institutional bias of the Medicaid program."<sup>18</sup>

Courts have held recently that Medicaid recipients have an enforceable right to receive the benefits entitled to them.<sup>19</sup> This enforceable right is derived from 42 U.S.C. § 1983, which was originally enacted as the Civil Rights Act of 1871. The next Part of this Note discusses § 1983.

## II. SECTION 1983 AND ENFORCEABLE INDIVIDUAL RIGHTS

### A. Civil Rights Act of 1871

After the adoption of the Thirteenth Amendment,<sup>20</sup> Congress was left with the responsibility of providing a way for the Amendment to be enforced. Congress did so by enacting the Civil Rights Act of 1871, later codified at 42 U.S.C. § 1983.<sup>21</sup> Courts, however, were slow to define the scope of § 1983.<sup>22</sup> It was ninety years before the

17. *Id.*

18. *Batavia*, *supra* note 13, at 24.

19. *See infra* Part III.

20. Section 1 of the Thirteenth Amendment states that "[n]either slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction." U.S. CONST. amend. XIII, § 1.

21. Section 1983 states:

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 ....

42 U.S.C. § 1983 (2000) (originally enacted as Civil Rights Act of 1871, ch. 22, § 1, 17 Stat. 13); *see* Christopher J. Pettit, *The Evolution of Government Liability Under Section 1983*, 24 ST. MARY'S L.J. 145, 146 (1992) (discussing Congress's motivation in the passage of the Civil Rights Act of 1871).

22. *See* Comment, *The Civil Rights Act: Emergence of an Adequate Federal Civil Remedy?*, 26 IND. L.J. 361, 363 (1950) ("The volume of private litigation under the Third Civil Rights Act and the degree of success achieved have been small until relatively recent years. From 1871 until 1920 no case involving Section 47(3) has been discovered and only twenty-one cases were decided under Section 43." [The relevant language of Section 47(3) and Section 43 of the Third Civil Rights is now reflected in § 1983.]). For a comprehensive discussion of § 1983 jurisprudence, *see* Sasha Samberg-Champion, Note, *How to Read Gonzaga: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 COLUM. L. REV. 1838, 1841-57 (2003).

Supreme Court established that states could be liable to individuals for violations of federal *constitutional* rights under § 1983.<sup>23</sup>

In 1980, the Supreme Court recognized that § 1983 may also be used against state actors to enforce rights created by federal statutes, rather than just those rights created by the Constitution.<sup>24</sup> In *Maine v. Thiboutot*, the Court justified extending the applicability of § 1983 to statutes—in this case the Social Security Act (SSA)—because “the SSA afford[ed] no private right of action against a State.”<sup>25</sup> Through a series of cases following *Maine v. Thiboutot*, the Supreme Court has developed a standard for determining when a party may hold a state liable under § 1983.

### *B. Pennhurst State School & Hospital v. Halderman*

In 1981, the Supreme Court confronted the issue of whether a developmentally disabled plaintiff could bring a cause of action under § 1983 against the State for alleged violations of the Developmentally Disabled Assistance and Bill of Rights Act.<sup>26</sup> The district court had found that the conditions at Pennhurst (a facility owned and operated by the Commonwealth of Pennsylvania)<sup>27</sup> were dangerous.<sup>28</sup> The district court ultimately held that the plaintiff had the right to sue under § 1983 to enforce his “Eighth and Fourteenth Amendment right to freedom from harm.”<sup>29</sup>

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23. *Monroe v. Pape*, 365 U.S. 167, 171-72 (1961).

It is abundantly clear that one reason the legislation was passed was to afford a federal right in federal courts because, by reason of prejudice, passion, neglect, intolerance or otherwise, state laws might not be enforced and the claims of citizens to the enjoyment of rights, privileges, and immunities guaranteed by the Fourteenth Amendment might be denied by the state agencies.

*Id.* at 180.

24. *Maine v. Thiboutot*, 448 U.S. 1, 5 (1980). *City of Greenwood v. Peacock*, 384 U.S. 808, 829-30 (1966), observed that under § 1983 state “officers may be made to respond in damages not only for violations of rights conferred by federal equal civil rights laws, but for violations of other federal constitutional and statutory rights as well.” *Id.*

25. *Thiboutot*, 448 U.S. at 6.

26. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 5-6 (1981).

27. *Id.* at 5.

28. *Halderman v. Pennhurst State Sch. & Hosp.*, 446 F. Supp. 1295, 1308 (E.D. Pa. 1977).

29. *Id.* at 1320.

The Supreme Court disagreed with the district court's decision and held that for an individual to have a private cause of action against a state under § 1983, Congress must have "unambiguously," and "with a clear voice," intended limitations on state funding for failing to meet certain standards.<sup>30</sup>

*C. Blessing v. Freestone*

In 1997, the Supreme Court revisited the issue of state liability under § 1983 in a case in which several mothers sued the State for not taking adequate steps to ensure that the fathers of their children complied with Title IV-D of the Social Security Act by paying child support.<sup>31</sup> The petitioners claimed that Title IV-D bestowed on them an individually enforceable right to receive child support.<sup>32</sup> The Supreme Court disagreed.<sup>33</sup> The Court stated that it was not enough for the petitioners to claim a violation of federal law; rather, they had to claim that their federal rights were violated.<sup>34</sup>

The Supreme Court went on to outline a three-pronged test to determine "whether a particular statutory provision gives rise to a federal right."<sup>35</sup> First, when Congress enacted a statutory provision it must have intended for the provision to benefit the plaintiff.<sup>36</sup> Second, the federal right in question must not be "so 'vague and amorphous' that its enforcement would strain judicial competence."<sup>37</sup> And third, "the statute must unambiguously impose a

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30. *Pennhurst*, 451 U.S. at 17. The Court stated that the purpose of the Developmentally Disabled Assistance and Bill of Rights Act was "to assist" the States through the use of federal grants to improve the care and treatment of the mentally retarded," not to impose an obligation on the states. *Id.* at 18.

31. *Blessing v. Freestone*, 520 U.S. 329, 357 (1997).

32. *Id.* at 332-33.

33. *Id.* at 333.

34. *Id.* at 340 ("In order to seek redress through § 1983, however, a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*."); see also *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989) ("Section 1983 speaks in terms of 'rights, privileges, or immunities,' not violations of federal law.").

35. *Blessing*, 520 U.S. at 340-41.

36. *Id.* at 340.

37. *Id.* at 340-41 (quoting *Wright v. Roanoke Redevelop. & Hous. Auth.*, 479 U.S. 418, 431 (1987)).



binding obligation on the States.”<sup>38</sup> The Court further explained this third prong by asserting that the federal right must be stated in “mandatory, rather than precatory,” language.<sup>39</sup>

*D. Gonzaga University v. Doe*

In 2002, the Supreme Court was faced with determining whether a provision of the Family Education Rights and Privacy Act of 1974 (FERPA), which prohibits the federal government from funding schools that release educational records to unauthorized persons, conferred a federal right upon the plaintiff.<sup>40</sup> The Court stated that its purpose for reviewing the case was to clear up “confusion [that] ha[d] led some courts to interpret *Blessing* as allowing plaintiffs to enforce a statute under § 1983 so long as the plaintiff falls within the general zone of interest that the statute is intended to protect.”<sup>41</sup> In other words, the Court refined the first prong of the *Blessing* test. Now, in addition to congressional intent to benefit the plaintiff, the rights must be “unambiguously conferred”<sup>42</sup> on the plaintiff by “rights-creating language”<sup>43</sup> comprising “individually focused terminology.”<sup>44</sup>

The Court held that FERPA did not unambiguously confer federally enforceable rights on the plaintiff under § 1983.<sup>45</sup> The Court was especially concerned with ensuring that § 1983 was only applied to situations in which a statute was written specifically to benefit the plaintiff.<sup>46</sup> The statute before the Court used the language “[n]o funds shall be made available,” rather than “individually focused terminology” such as “[n]o person ... shall ... be

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38. *Id.* at 341.

39. *Id.* For an explanation of the difference between mandatory and precatory terms, see *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 510-12 (1990) (suggesting that precatory terms are used when “Congress intend[s] only to indicate a preference for ‘appropriate treatment,’” and that mandatory terms are used when Congress “ma[kes] compliance with the provision a condition of receipt of federal funding”).

40. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 276 (2002).

41. *Id.* at 278, 283.

42. *Id.*

43. *Id.* at 274.

44. *Id.*

45. *Id.*

46. *Id.* at 283-84.

subjected to discrimination."<sup>47</sup> In other words, the language that Congress used in FERPA shows an intent to benefit a general class of people to whom the plaintiff happened to belong. It does not show an intent to unambiguously confer an individual right on the plaintiff.<sup>48</sup>

As a result of these cases, "[s]ection 1983 lawsuits have become a powerful weapon for forcing states to comply with both constitutional and statutory requirements."<sup>49</sup> Plaintiffs only recently began using § 1983 to bring claims under the Medicaid Act.

### III. MEDICAID AS AN ENFORCEABLE RIGHT UNDER § 1983

As a result of the Supreme Court cases from *Thiboutot* to *Gonzaga*, circuit courts now have clear guidance in determining whether a federally enforceable individual right exists under § 1983. Courts must decide whether the statute in question (1) unambiguously confers a right to the plaintiff, using rights-creating language comprising individually focused terminology; (2) is not vague or amorphous; and (3) imposes an unambiguous, binding obligation on the states.<sup>50</sup> Within the past several years, courts have been asked to determine whether a federally enforceable right to Medicaid exists for certain persons. This part of the Note will provide a brief discussion of two cases in which the courts found, by focusing on the above-mentioned factors, that such a right exists.

The Medicaid Act<sup>51</sup> provides in § 1396a(a)(8) that "[a] State plan for medical assistance must ... provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals."<sup>52</sup> Most plaintiffs have based their claims on the "reasonable promptness" provision; the typical theory plaintiffs advance is that they did not receive "medical assistance"—to which they are legally

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47. *Id.* at 287 (internal quotation marks omitted).

48. For a discussion on rights-creating language, see Samberg-Champion, *supra* note 22, at 1854-55.

49. *Id.* at 1841.

50. See discussion *supra* Part II.B-D.

51. Social Security Act tit. XIX, 42 U.S.C. §§ 1396-1396v (2000).

52. § 1396a(a)(8).

entitled under § 1983—with reasonable promptness.<sup>53</sup> It is important, therefore, to keep in mind when analyzing these cases that the reasonable promptness claims are based on the premise that the plaintiff is owed the medical assistance in question within a reasonably prompt time because § 1983 gives her a right to enforce § 1396a(a)(8) of the Medicaid Act.

*A. Eleventh Circuit: Doe v. Chiles*

In *Doe v. Chiles*,<sup>54</sup> a group of developmentally disabled individuals sued the State of Florida because they were not granted access to an intermediate care facility within a reasonably prompt time.<sup>55</sup> The plaintiffs were eligible Medicaid recipients who claimed they had a right to receive access to the facility based on § 1396a(a)(8), which was enforceable through § 1983.<sup>56</sup>

The facility in question was part of a program designed to provide care for individuals with “sufficiently severe mental retardation and related conditions.”<sup>57</sup> The State deemed the plaintiffs eligible to take part in the program, yet, instead of being admitted into the facility, the plaintiffs were put on a waiting list.<sup>58</sup> The plaintiffs’ complaint alleged that they had been on the waiting list for more than five years and were still being denied access to the facility.<sup>59</sup> As a result, they filed suit alleging that the State had failed to provide them with Medicaid benefits within a reasonably prompt time period.<sup>60</sup> The defendants acknowledged in their initial brief that there were serious delays getting eligible recipients admitted to the facility.<sup>61</sup> The problem was, the defendants contended, that the State of Florida was financially unable to provide access to the

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53. See, e.g., Sara Rosenbaum, Joel Teitelbaum & Alexandra Stewart, *Olmstead v. L.C.: Implications for Medicaid and Other Publicly Funded Health Services*, 12 HEALTH MATRIX 93, 127 (2002) (discussing the “reasonable promptness” standard).

54. 136 F.3d 709 (11th Cir. 1998).

55. *Id.* at 711.

56. *Id.*

57. *Id.* at 711 n.2 (interpreting 42 C.F.R. § 483.440(a)(1)-(2) (1996)).

58. *Id.* at 711. The program was not a waiver program; the service therefore had to be “sufficient in amount, duration, and scope.” 42 C.F.R. § 440.230(b) (2004).

59. *Chiles*, 136 F.3d at 711.

60. See *id.*

61. *Id.*

facility to all of the people who qualified for such access.<sup>62</sup> The State's defense relied on the notion that the Medicaid Act does not give recipients an enforceable federal right under § 1983.<sup>63</sup>

In deciding whether the § 1396a(a)(8) requirement to provide medical assistance with reasonable promptness conferred an individually enforceable right under § 1983, the court applied the three-pronged *Blessing* test.<sup>64</sup> First, the court had to determine whether Congress "intended that the provision in question benefit the plaintiff."<sup>65</sup> It found that "[t]he plain language of the provision's reasonable promptness clause is clearly intended to benefit Medicaid-'eligible individuals'-such as the [plaintiffs] in this case."<sup>66</sup> Second, the court found that the statute was "not so vague and amorphous that its enforcement would strain judicial competence."<sup>67</sup> Third, the court determined that § 1396a(a)(8) "unambiguously impose[d] a binding obligation" on the State of Florida.<sup>68</sup> As a result, the court held that the plaintiffs "ha[d] a federal right to reasonably prompt provision of assistance under section 1396a(a)(8) of the Medicaid Act, and that this right [was] enforceable under section 1983."<sup>69</sup>

### *B. First Circuit: Bryson v. Shumway*

In *Bryson v. Shumway*,<sup>70</sup> the First Circuit was asked to decide whether § 1396a(a)(8) conferred a federal right to reasonably prompt services under § 1983.<sup>71</sup> The State of New Hampshire had

62. Reply Brief of Appellants at 19-20, *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998) (No. 96-5144).

63. *Chiles*, 136 F.3d at 712.

64. *Id.* at 715-19. This case was decided before *Gonzaga*; the Eleventh Circuit's decision, however, would not change after *Gonzaga* because the statute in question unambiguously confers a right to the plaintiff, using rights-creating language comprising individually focused terminology. "A State plan ... must ... provide ... medical assistance ... [which] shall be furnished with reasonable promptness to all eligible individuals." § 1396a(a)(8) (emphasis added).

65. *Blessing v. Freestone*, 520 U.S. 329, 340 (1997).

66. *Chiles*, 136 F.3d at 715.

67. *Id.* at 718.

68. *Id.* (quoting *Blessing*, 520 U.S. at 341).

69. *Id.* at 719.

70. 308 F.3d 79 (1st Cir. 2002).

71. *Id.* at 83-84.

created a waiver program within its Medicaid program that gave people with acquired brain disorders the option to receive specialized medical care.<sup>72</sup> The waiver program had slots available for fifteen individuals in 1993, its first year of existence.<sup>73</sup> The State increased the number of available slots each year, ultimately reaching 130 slots by the time the *Bryson* plaintiffs sued.<sup>74</sup> In each year of the program's existence, there were more applicants than slots available.<sup>75</sup>

The plaintiffs, representing a class of similarly situated individuals, had been diagnosed with acquired brain disorders and were eligible to partake in the waiver program.<sup>76</sup> Plaintiffs applied for the program and were put on the waiting list, where they remained until the time that they filed suit.<sup>77</sup> As in *Chiles*, the complaint alleged that the State failed to provide Medicaid services with "reasonable promptness" as required by § 1396a(a)(8).<sup>78</sup> The district court granted summary judgment in favor of the plaintiffs and required the State to provide the waiver services to the plaintiff class within twelve months.<sup>79</sup>

The circuit court, with *Gonzaga* in mind, applied the three-pronged *Blessing* test in a manner similar to the manner in which the *Chiles* court applied the test.<sup>80</sup> The First Circuit found that § 1396a(a)(8), "on its face, does intend to benefit the plaintiffs,"<sup>81</sup> that the "right conferred is not vague or amorphous,"<sup>82</sup> and that it "unambiguously bind[s] the states."<sup>83</sup> In fact, the court cited *Chiles* in making this determination.<sup>84</sup> In sum, the court found that the plaintiffs had an individually enforceable right to the services

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72. *Id.* at 81.

73. *Id.* at 83.

74. *Id.*

75. *Id.* ("The waiting list has ranged from 25 people in the first year to a height of 87 people in the 1997-1998 year.").

76. *Id.* at 81.

77. *Id.* at 83.

78. *Id.* at 83-84.

79. *Id.* at 84.

80. *See id.* at 88-89.

81. *Id.* at 88.

82. *Id.* at 89.

83. *Id.*

84. *Id.*

provided by the waiver program under § 1983 within a reasonably prompt time, as required by § 1396a(a)(8).<sup>85</sup>

#### IV. INITIAL REMEDIES

Both *Chiles* and *Bryson* held that the State must provide Medicaid assistance to eligible individuals within a reasonably prompt time period.<sup>86</sup> The courts were then left with the task of interpreting "assistance." There were two options they could have chosen: assistance as funding for services, or assistance as the actual provision of services. Both courts adopted the latter view.

In affirming the district court's decision,<sup>87</sup> the *Chiles* court "enjoined the [state] officials from failing to provide the assistance within a 'reasonable' time period, not to exceed ninety days."<sup>88</sup> This court clarified any confusion regarding the definition of assistance when it reiterated the district court's statement that "[m]edical assistance under the [Medicaid] plan' has been defined as medical services."<sup>89</sup> In his concurring opinion, Judge Barkett eliminated any residual ambiguity on this issue by stating that "[s]ection 1396a(a)(8) not only requires States, as a condition of federal funding, to have a plan for medical assistance providing that such assistance will be provided with reasonable promptness, it also imposes a substantive duty on States to provide medical assistance with reasonable promptness."<sup>90</sup> As a result, the State was required—within ninety days—to expand the intermediate care facilities to accommodate the eligible developmentally disabled individuals.

Like the Eleventh Circuit, the First Circuit, in *Bryson*, held that eligible individuals have an enforceable right to receive Medicaid assistance with reasonable promptness.<sup>91</sup> Unlike *Chiles*, however, *Bryson* involved a waiver program—hence giving people with

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85. *Id.*

86. *See supra* Part III.A-B.

87. *Doe v. Chiles*, 136 F.3d 709, 723 (11th Cir. 1998).

88. *Id.* at 711.

89. *Id.*

90. *Id.* at 723 (Barkett, J., concurring). This statement came after the court defined "medical assistance" as "medical services." It is clear, therefore, that "medical assistance" in this quotation refers to the provision of services.

91. *Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002).

acquired brain disorders the option to receive specialized medical care.<sup>92</sup> HHS granted New Hampshire's request that the program consist of 130 slots.<sup>93</sup> New Hampshire officials had decided, however, to fill fewer than the 130 allotted slots, leaving some vacancies.<sup>94</sup> The court ruled that the plaintiff class had a statutory right, under § 1396a(a)(8), to receive the medical services provided in the waiver program as long as slots were available.<sup>95</sup> *Bryson* interprets "medical assistance" as "medical services," although not explicitly. For example, the court did not state that the plaintiffs had a statutory right to receive medical assistance in the form of *payment* for medical services they were entitled to receive under Medicaid. Rather, it held that the plaintiffs had a right to receive medical assistance in the form of the actual services provided within the waiver program.<sup>96</sup>

Although *Bryson* involved a waiver program, the potential problems with defining "medical assistance" as "medical services" remain the same. In fact, they can be even worse. Suppose State *X* adopts a waiver program. State *X* plans on starting the program with fifty people, but in its request to HHS, it asks for a cap of 100 people. State *X* requests this limit with the hope that it will be able to find additional resources to put toward the program in order to accommodate more than fifty people. As it turns out, however, State *X* can only afford to include fifty people. The program proves to be extremely successful and leads to new and innovative ways to provide care. A plaintiff class then claims that it has a federal statutory right under § 1396a(a)(8) to receive the medical services provided in the waiver program. Under *Bryson*'s holding, State *X* would be required to fill the unused slots with these plaintiffs. The waiver program could then go bankrupt due to the price of providing these additional services. As a result of defining "medical assistance" as "medical services," the possible development of a new

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92. *See id.* at 81.

93. *See id.* at 83.

94. *See id.*

95. *Id.* at 89.

96. *See id.* at 89-90.

and innovative medical care system—under this hypothetical—would be destroyed.<sup>97</sup>

The Eleventh and First Circuits, as seen in *Chiles* and *Bryson*, applied a definition of medical assistance that required the actual provision of services, rather than the provision of funding for services. This definition seems appropriate to the facts of those cases. As will be seen in Part V, however, this will not always be the case.

## V. THE EMERGENCE OF A SPLIT

### A. *Seventh Circuit: Bruggeman v. Blagojevich*

In *Bruggeman v. Blagojevich*,<sup>98</sup> the Seventh Circuit was presented with the issue of applying § 1983 to § 1396a(a)(8). This court, however, took a different approach at the remedy stage. The court's focus, with respect to issues relevant to this discussion, was not on whether an enforceable right to Medicaid exists under § 1983,<sup>99</sup> but on the appropriate meaning of "assistance."<sup>100</sup>

In *Bruggeman*, the plaintiffs were Chicago Medicaid recipients who were developmentally disabled adults eligible to live in "Intermediate Care Facilities for the Developmentally Disabled,"<sup>101</sup> and who then lived with their parents. The problem was that most of the facilities were located far from where the plaintiffs and their parents lived.<sup>102</sup> This, the plaintiffs claimed, would cause their parents to incur extra travel expenses when their parents wished

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97. It is true in this hypothetical that in the years that State *X* wishes to expand its waiver program to more people, it could simply reapply for a new waiver program with a higher cap on the number of people that it can accommodate. This approach, however, seems impractical considering the additional administrative burdens that would be placed on the state. See 42 C.F.R. § 441.300-303 (2004).

98. 324 F.3d 906 (7th Cir. 2003).

99. In fact, the court did not look into this issue at all. Instead, its decision was based on the assumption that such a right does, in fact, exist. See *id.* at 910. "The statutory entitlement to reasonable promptness of medical services ... is not infringed by the maldistribution ... of [intermediate care facilities] across the state." *Id.*

100. See *id.*

101. *Id.* at 908.

102. See *id.*



to visit them.<sup>103</sup> The plaintiffs, therefore, sued; they asked the court to require state officials to build facilities closer to Chicago so that the plaintiffs could exercise their right to receive Medicaid.<sup>104</sup> They requested that this assistance be provided with reasonable promptness.<sup>105</sup>

The court held that the plaintiffs' right to reasonable medical assistance under the Medicaid Act was not violated by the unfavorable placement of the facilities.<sup>106</sup> The court went on to state:

[T]he 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 that they need; a requirement of prompt *treatment* would amount to a direct regulation of medical services.<sup>107</sup>

As is clear from this analysis, the court did not require the State to provide medical services to the plaintiffs. Instead, according to this decision, states are only responsible for making a prompt decision regarding a person's eligibility for Medicaid, and then for promptly providing that person with the funds necessary for her to receive the services that she needs. This approach conforms with the traditional insurance approach to Medicaid.<sup>108</sup>

There are drawbacks to this approach. Public health clinics, hospitals, or agencies could have an incentive to abuse the Medicaid system. A state, for example, could choose to open a facility that provides services that are optional under the Medicaid Act.<sup>109</sup> This

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103. *Id.* at 908-09.

104. *Id.*

105. *See id.* at 909.

106. *See id.* at 910.

107. *Id.* (citations omitted) (referring to 42 C.F.R. §§ 435.911(a), .930(a)-(b) (2004)).

108. *See infra* text accompanying note 124 (discussing characterization of Medicaid as an insurance program).

109. *See infra* text accompanying notes 129-32 (discussing the optional nature of the Medicaid program).

facility could be designed so that it only accommodates a small number of people. The state would then qualify for the benefits that are provided to states under the Medicaid Act.<sup>110</sup> There could be many people, however, that qualify for this program, but who are unable to participate because of its minimal size. According to *Bruggeman*, the state's only obligation at this point would be to provide funding to these people if they are able to receive the same services elsewhere. If no other facilities exist, however, qualifying people will be left with no remedy, despite the fact that the state continues to receive federal benefits.

*B. The Third Circuit and the Recognition of the Split: Sabree v. Richman*

In *Sabree v. Richman*,<sup>111</sup> the Third Circuit held that a class of mentally retarded adults had a federal right, pursuant to § 1983, to receive medical assistance under the Medicaid Act from an intermediate care facility with reasonable promptness.<sup>112</sup> In considering a remedy for the plaintiffs, the court recognized the current circuit split regarding whether "assistance" refers to services or to payment for services.<sup>113</sup> The court decided not to resolve this issue, and clearly stated so: "[t]o resolve this issue we need not, and do not, address the remedy that might be available to plaintiffs, but leave that to the District Court in the first instance."<sup>114</sup> This statement clearly shows the inherent danger of courts failing to specify the meaning of the term "medical assistance." District courts, with nothing to guide them, are left to devise clever solutions to a problem that the circuit courts have recognized, but have walked away from. Without guiding precedent, district courts will have varying solutions. Public healthcare service

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110. See *supra* text accompanying notes 10-12 (discussing federal funding to states).

111. 367 F.3d 180 (3d Cir. 2004).

112. *Id.* at 181-82, 193-94 ("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.").

113. *Id.* at 181 n.1 ("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." (citing *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003))).

114. *Id.*

providers and Medicaid recipients could have differing rights depending upon their location.

## VI. PROPOSAL

This Part of the Note will explore how courts should handle interpreting the term "medical assistance." The *Bruggeman* court opened up the door to future inquiry about the issue; the court did not, however, offer a solution.<sup>115</sup> As a result, this issue may continually distract courts as they try to establish an appropriate standard that can be applied to similar cases. On the other hand, courts, like the *Sabree* court, may leave the issue unresolved.<sup>116</sup> This approach would ignore the fact that the plaintiffs in these cases are real people, who are eligible for Medicaid benefits, but who are not receiving the medical help that they may desperately require. Unnecessary and prolonged litigation does not serve justice to these individuals. Thus, it is important for courts to quickly resolve the issue in order to remove this debate from courtrooms.

This Part of the Note will ultimately conclude that, in the typical Medicaid scenario,<sup>117</sup> "medical assistance" should be defined as just that: medical assistance. Because cases are fact specific, courts should not try to develop a test that can be applied to all situations in which this issue arises; courts should look instead at the facts of each particular case to determine whether the plaintiffs should receive funding or be provided with services. In scenarios involving waivers, however, a state should not be required to provide medical services. Requiring the provision of services in these scenarios could counteract the very benefits that were envisioned in the creation of the waiver exception.<sup>118</sup>

### *A. Looking for the True Meaning of "Medical Assistance"*

An exhaustive search for the true definition of "medical assistance" is likely to result in disappointment. The term "true definition" is used here because one might argue that a definition

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115. See *supra* Part V.A.

116. See *supra* Part V.B.

117. "Typical Medicaid scenario" refers to non-waiver cases.

118. See *infra* Part VI.C.

does exist. The practical use of the term "medical assistance," however, has led to differing views of its meaning. "Medical assistance" is defined in the Medicaid Act as "*payment of part or all of the cost of [enumerated] care and services.*"<sup>119</sup> If, however, a state elects to participate in the Medicaid program, the state must comply with all accompanying regulatory and statutory regulations.<sup>120</sup> Chapter 42 of the Code of Federal Regulations refers to *services* that states must provide. For example, a state plan must ensure that categorically needy people receive certain services,<sup>121</sup> or if the medically needy are included within the state's plan, that they receive certain services.<sup>122</sup> It is important, therefore, to look at not only the Medicaid Act when addressing this issue, but also to look at the regulations that control the administration of the Act. By doing this, one can easily read the term "medical assistance" to encompass a requirement for the provision of services. The meaning of the phrase "medical assistance," therefore, can vary from one case to another.

Each of the two differing views of "medical assistance" possesses valuable aspects,<sup>123</sup> and arguments can be made in support of each. Medicaid is typically characterized as a medical insurance or financing program.<sup>124</sup> It is this characterization that leads many to

119. 42 U.S.C. § 1396d(a) (2000) (emphasis added).

120. See § 1396a(a)(1); 42 C.F.R. § 430.10 (2004).

121. 42 C.F.R. § 440.210. For example, "[a] State plan must specify that, at a minimum, categorically needy recipients are furnished ... [p]regnancy-related services and services for other conditions that might complicate the pregnancy." § 440.210(a)(2).

122. 42 C.F.R. § 440.220. For example, "[a] State plan that includes the medically needy must specify that the medically needy are provided, as a minimum ... [h]ome health services (§ 440.70) to any individual entitled to skilled nursing facility services." § 440.220(a)(3).

123. It is clear that the Seventh Circuit views "medical assistance" as the provision of funding for medical services. See *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003). The Eleventh and First Circuits' definition of "medical assistance" is not stated in such clear terms. See *Bryson v. Shumway*, 308 F.3d 79 (1st Cir. 2002); *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998). The logical application of their rulings, however, requires that "medical assistance" be equated with the provision of medical services. See *supra* Part IV.

124. See Lisa B. Deutsch, *Medicaid Payment for Organ Transplants: The Extent of Mandated Coverage*, 30 COLUM. J.L. & SOC. PROBS. 185, 187 (1997) ("[T]here is wide latitude for each state to determine which of its citizens qualify for this form of insurance and which services the program will provide."); Mann & Westmoreland, *supra* note 11, at 416-17 ("Medicaid is now the largest single insurer in the United States in terms of the number of beneficiaries enrolled and dollars spent.... Medicaid is also the most heterogeneous insurance program in the country."); Rosenbaum & Rousseau, *supra* note 8, at 7 ("Medicaid [is] the nation's largest means-tested health care financing program."); Rosenbaum, Teitelbaum &

the logical conclusion that Medicaid, as an insurance provider, is only meant to provide funding for services. Although this assertion is probably the most obvious way to view Medicaid (and, therefore, the most obvious way to view "medical assistance"), it is not the only way to do so. By looking at certain aspects of the Medicaid Act and applying them to real-world scenarios, one can make a strong argument in support of the idea that states should be required to provide services to eligible recipients. The two main aspects of the Medicaid Act that are referred to here are the states' receipt of federal funding and the optional nature of the Medicaid program.

First, states receive federal funding to help cover the costs associated with providing "medical assistance."<sup>125</sup> In fact, states receive fifty to seventy-seven percent of Medicaid benefits costs from federal funds,<sup>126</sup> with poor states receiving the most federal funds.<sup>127</sup> It is apparent that a state, especially a poor one, may have a large incentive to adopt a Medicaid program. In fact, most states depend on Medicaid funding to meet their overall cost of medical care.<sup>128</sup>

Second, Medicaid is an optional program in which states choose to participate.<sup>129</sup> Once a state decides to participate in Medicaid, it must provide certain mandatory benefits and can also choose to provide additional optional benefits.<sup>130</sup> Once a state chooses to provide an optional benefit, it must provide it equally to all of those who are eligible for the benefit.<sup>131</sup> The reason for the distinction between mandatory and optional benefits is based on financial

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Stewart, *supra* note 53, at 125 ("Medicaid functions as a health insurance program ....").

125. See *supra* Part I.

126. See Mann & Westmoreland, *supra* note 11, at 419 ("States are responsible for twenty-three to fifty percent of Medicaid benefit costs.").

127. *Id.* at 419 n.47.

128. Rosenbaum & Rousseau, *supra* note 8, at 14-15 ("Because Medicaid expenditures comprise the majority of total state spending on health care, this level of federal financial participation provides major aid to states in meeting the overall cost of medical care, which is by far the fastest growing portion of their public welfare budgets.").

129. See *supra* Part I.

130. For a list of common optional and mandatory benefits, see ANDY SCHNEIDER ET AL., THE MEDICAID RESOURCE BOOK 50, 53, 55-57 (Kaiser Comm'n on Medicaid & the Uninsured ed., 2002), available at <http://www.kff.org/medicaid/2236-index.cfm> (follow "Chapter 2: Medicaid Benefits" hyperlink) (last visited Jan. 31, 2006). See also Rosenbaum & Rousseau, *supra* note 8, at 20-21 (discussing required and optional benefits).

131. See *supra* Part I.

considerations. Some benefits—such as community-based long-term care—are optional because a state may not be able to afford to provide them to all eligible recipients.<sup>132</sup> The state, therefore, has a choice: provide optional benefits and incur the expenses that accompany them or provide no optional benefits at all.

Considering these two factors together, one could argue that it would be better to define "medical assistance" as the provision of actual services rather than as funding for those services. Because a state makes a *decision* to provide medical assistance for certain sets of benefits, coupled with the fact that it is receiving financial benefits for doing so, it should be required to provide the assistance across the board.<sup>133</sup> In other words, if 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. This would be a typical scenario in which Medicaid acts as insurance. If, however, some eligible recipients are unable to receive the benefit, then the state should be required to provide

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132. See, e.g., Mann & Westmoreland, *supra* note 11, at 419. The authors note that the lack of community-based long-term care services funded by Medicaid is a consequence of funding pressures and priorities. Medicaid law requires states to offer nursing home services to eligible beneficiaries, but home- and community-based long-term care services are not required. This imbalance between institutional and community-based services is not an oversight. It is a reflection that states believe they cannot afford the costs if these services were opened up to all who qualify.

*Id.*

133. See *id.* at 417.

There are many facets of the entitlement—consequences that flow from the simple directive that all eligible people must be enrolled. Most notable, perhaps, is Medicaid's open-ended financing structure, which is tied closely to the entitlement. The longstanding arrangement under Medicaid is that in exchange for taking on the obligation to serve all eligible people, states are guaranteed funding for the federal share of all costs that flow from that obligation. If enrollment rises, so does federal financial participation. It is difficult to imagine how an entitlement program the size of Medicaid could be maintained by the states without the open-ended federal commitment of federal funds and, at the same time, it is difficult to imagine that the federal government would continue to provide open-ended financing to states if states were not obligated to serve all eligible people.

*Id.*

the actual services—instead of mere funding—so that the benefit in question is equally available to all. If this were not the rule, then the entitlement nature of Medicaid would be irrelevant.<sup>134</sup>

A more conservative argument can also be made: states should be required to provide services, as opposed to mere funding, when there is some indication that they are manipulating the federal contribution formula in order to receive more funding, and this manipulation results in some Medicaid recipients not receiving the services for which they are eligible.<sup>135</sup> In other words, the requirement that a state provide actual services (and not merely the funding for those services) would need to be accompanied by an element of self-interest at the state level. In sum, arguments can be made supporting the definition of “medical assistance” as either the provision of funding for medical services (the insurance approach) or the provision of the actual services in question. The following sections will propose solutions that encompass aspects from both of these views.

### *B. Proposed Solution for Non-Waiver Cases*

In cases that do not involve waivers, a blanket rule should not be created. The *Bruggeman* decision provides an example of such a rule:

[T]he 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

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134. See *id.*

135. See Rosenbaum & Rousseau, *supra* note 8, at 25 (“[O]ver the years states have done a remarkable job at manipulating the federal Medicaid contribution formula to create actual federal contribution levels far higher than the level to which they might therefore be entitled under the nominal statutory formula.”).

services that they need; a requirement of prompt *treatment* would amount to a direct regulation of medical services.<sup>136</sup>

This decision attempts to establish a rule that states should be required to provide only funds, not services, under Medicaid. Although such a rule will probably apply to the majority of cases involving this issue, it could result in injustice under certain facts. For example, assume that a state decides to include the optional benefit *X* in its Medicaid program. It does so, however, with the knowledge that current medical facilities have only the capacity to accommodate two-thirds of the individuals who will be eligible for benefit *X*. The remaining one-third of those eligible are put on a waiting list for an indefinite period of time. The state has decided to include the new benefit regardless of the need for a waiting list because the federal funds that it will receive will help support its public welfare budget.<sup>137</sup> Although this in itself may be a good-faith effort by the state to deal with a genuine problem, it will result in a known inequity. The rule espoused in *Bruggeman* would not help the people who remain on the waiting list—one-third of eligible recipients—despite the fact that the state receives funds for a benefit that it is required to make available to all eligible individuals.<sup>138</sup>

In fact, under such a rule, § 1396a(a)(10)<sup>139</sup> would have no effect. Making funding available to people who are eligible for a benefit but who are unable to receive it would be useless if those individuals were never to receive the services for which the funding is designated. "Medical assistance," therefore, as used in § 1396a(a)(8) would have to be given a definition that includes "the provision of services" in order for § 1396a(a)(10) to have any effect in certain cases.

The court's statement in *Bruggeman*,<sup>140</sup> however, contains some valid concerns regarding a universal definition of "medical assistance" that *requires* the provisions of services. The "direct regula-

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136. *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (citations omitted).

137. See *supra* notes 125-28 and accompanying text.

138. See 42 U.S.C. § 1396a(a)(10) (2000) ("A State plan for medical assistance must ... provide ... for making medical assistance available ... to ... all [eligible] individuals....").

139. *Id.*

140. See *supra* text accompanying note 107.



tion of medical services," or the necessity of state-owned hospitals, could be the unintended result of a rule that requires the definition of "medical assistance" to always include the provision of services.<sup>141</sup> A definition of "medical assistance" that requires the provision of services, therefore, should not be applied in *all* cases. As a result of these two competing definitions—each with valid support and each with valid concerns—courts should adopt a rule for defining "medical assistance" in cases that involve non-waiver Medicaid programs that focuses on the individual facts of each case. The state should have the burden of establishing that it would be substantially more demanding for it to provide the necessary services than it would be for the plaintiff to remain on the waiting list. This rule would encompass both the entitlement nature of Medicaid because it would presume that the plaintiff is entitled to the medical assistance at issue, and *Bruggeman's* concern for not imposing an unintended hardship on the state.

### *C. Proposed Solution for Waiver Cases*

In cases that involve a Medicaid waiver provision (waiver programs),<sup>142</sup> the distinction between the two views of "medical assistance" becomes vital. Courts should not require states to provide services for benefits that are included within a waiver provision, absent fraud or intentional misconduct. It is important for states to be able to maximize the potential benefits that may result from waiver programs.<sup>143</sup> Requiring a state to provide these services could cause the program to go bankrupt, eliminating any possible health care advances that may have been discovered or created.<sup>144</sup>

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141. See *Bruggeman*, 324 F.3d at 910.

142. See 42 U.S.C. § 1396n(c) (describing Medicaid waiver program procedures and requirements).

143. See, e.g., *Bryson v. Shumway*, 308 F.3d 79, 82 (1st Cir. 2002) ("The waiver program is designed 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.").

144. For a discussion of current problems with waiver programs, see Mann & Westmoreland, *supra* note 11, at 422-23.

Also, courts should not require states under a waiver program to fill any vacancies that have been approved but not filled.<sup>145</sup> For example, if a state applies for a program that allows 150 people to participate, but chooses to accept only 100 people into the program, it should not be required to provide services to the additional fifty people. Doing so would dissuade states from setting high goals. In other words, if a state would prefer to eventually include 150 people in the program, but currently has the financial ability to provide the services to only 100 people, it should be allowed to serve those 100 people without the fear of being forced to fill the program. In fact, this type of behavior should be encouraged, not punished.<sup>146</sup> By requiring the state to provide the service to all 150 individuals, a court may end up causing the entire program to end. This is exactly the risk that the court created in *Bryson v. Shumway*.<sup>147</sup>

If a court determines that a state has abused the Medicaid waiver provisions, then it should require the state to take appropriate measures to correct the abuse. The plaintiff, however, should bear the burden of proving the abuse. Again, this test is in line with the view that waiver programs should be encouraged and supported.

### CONCLUSION

The issue of individual enforceability of Medicaid benefits under § 1983 is not likely to disappear any time soon. Indeed, there has been much debate on whether such a right should exist in the first place.<sup>148</sup> When courts do decide that an individually enforceable right to Medicaid exists, they also need to decide what remedy that enforceable right provides. Awarding a plaintiff "medical assistance" is of little use without guidance as to what that phrase means. Recent circuit court decisions are likely to spark further debate on this topic; a resolution, however, is needed. Courts must

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145. An example of this requirement is seen in *Bryson v. Shumway*, 308 F.3d 79, 81 (1st Cir. 2002). See *supra* Part III.B.

146. See, e.g., *Bryson*, 308 F.3d at 82-83 (noting that states possess economic reasons for creating and slowly developing waiver programs). "[W]aiver programs may be costly to the states .... 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.*

147. See *supra* Part III.B.

148. See *supra* note 4 and accompanying text.

develop a standard that defines the scope of "medical assistance." Without such a standard, courts will be distracted by this issue, litigation will be prolonged, and Medicaid recipients may not receive the assistance to which they are entitled.

A blanket rule that defines "medical assistance" as the provision of services or as the provision of funding for services is not practical. This is because the facts of each case presenting this issue will not be the same, and it is likely that a court will use a definition that may apply to one set of facts, but may not fit as well to another set of facts. Such a situation is demonstrated by comparing *Doe v. Chiles* and *Bryson v. Shumway* with *Bruggeman v. Blagojevich*. Courts, therefore, should develop a standard that considers the individual facts of each case. The burden should then be placed upon the state to prove that it would be more taxing for it to provide actual services than it would be for the plaintiff to remain on the waiting list.

On the other hand, when a state adopts a waiver program that has been approved by the appropriate regulatory body, the court should grant wide latitude concerning how that program is administered. Absent fraud or intentional misconduct, states should not be required to provide eligible Medicaid recipients with services under these programs. Doing so would only frustrate the purpose for which the programs were created, thus slowing the possible progression in health care that may result. As society advances, so should the quality and breadth of treatment options for America's poor.

In the end, this Note does not suggest that the proposals made herein are the only possible ways to address this issue. Rather, the important lesson is that courts, in the absence of further congressional action on this issue, need to adopt standards that give rightful plaintiffs some direction. Considering that plaintiffs in these cases qualify for Medicaid, it can be assumed that they do not have the means to pursue lengthy litigation. In addition to an initial trial, possibly followed by an appeal, the plaintiffs, without the guidance of any uniform standard, might subsequently be forced to pursue additional litigation in order to find out their exact remedy under an enforceable right to Medicaid. This surely cannot be what Congress envisioned when it created the Medicaid Act.

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