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In the Nick of Time: Using the Reasonable Promptness Provision to Challenge Medicaid Spending Cutbacks

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In the Nick of Time: Using the Reasonable Promptness Provision to Challenge Medicaid Spending Cutbacks

Jeffrey Chen

Abstract:

Because agency enforcement of the Medicaid statute against non-compliant states is utterly impractical, Medicaid providers and beneficiaries have relied on § 1983 litigation to protect themselves against the harmful effects of state cutbacks on Medicaid spending by privately enforcing two particular provisions of the Medicaid statute against the states. However, because of several legislative and judicial decisions, private litigants can no longer use these provisions to challenge low Medicaid reimbursement rates. This Note proposes and evaluates an alternative method of resisting state Medicaid spending cutbacks: enforcing the Reasonable Promptness Provision of the Medicaid statute through § 1983.

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INTRODUCTION

Much scholarly attention has been paid to the disturbing but increasingly apparent notion that Medicaid is “metamorphosing into a right without a remedy.”1 Because federal agency enforcement against the states for violations of the Medicaid statute is impractical and therefore never utilized, enforcement of the Medicaid statute has primarily been effectuated by private litigants through § 1983 suits.2 However, decisions made by Congress and the federal courts have constrained the ability of private litigants to challenge states for violating the Medicaid statute.3

Nowhere has this trend been more problematic than in the context of Medicaid reimbursement rates. The extent to which Medicaid beneficiaries can access health services depends crucially on the level of provider participation in Medicaid.4 However, Medicaid reimbursement rates are the primary determinants of provider participation levels.5 Thus, if states can cut reimbursement rates in violation of the Medicaid statute with impunity, Medicaid beneficiaries will suffer the harmful effects of impeded access to necessary health services. Currently, the ability of Medicaid providers and beneficiaries to challenge low Medicaid reimbursement levels through litigation is uncertain at best, which spells trouble for the health outcomes of our poorest and most vulnerable citizens and legal permanent residents.

This Note details how the current inability to challenge low Medicaid payment rates came about; it then identifies and evaluates a potential solution to this problem. Part I explains in more detail why private Medicaid enforcement is vital to the health and well-being of Medicaid beneficiaries. Part II discusses the ways in which prior litigants have challenged low reimbursement levels and describes how these avenues have been foreclosed by Congress and the courts. Part III provides an account of two new tactics that litigants have employed to successfully challenge low Medicaid reimbursement rates. Finally, Part IV evaluates the viability of one of those strategies: suing under the Reasonable Promptness Provision of the Medicaid statute.

2. See infra Part I.
3. See infra Part II.
5. Id.
I. MEDICAID AND SECTION 1983: THE IMPORTANCE OF PRIVATE MEDICAID ENFORCEMENT

Established in 1965 under Title XIX of the Social Security Act, Medicaid is a medical assistance program that has become the largest source of health insurance for low-income people. Medicaid currently provides services and support to sixty-six million people, including thirty-two million children and sixteen million elderly and disabled persons. The federal government and the states fund Medicaid jointly; the federal government "matches" state Medicaid expenditures according to a formula based on a state’s average personal income relative to the national average. States are not required to participate in Medicaid, but states that choose to do so must structure and administer their plans in compliance with the Medicaid statute and federal regulations. Among other things, states must cover certain populations and services in their Medicaid plans. Beyond these requirements, states are allowed flexibility in choosing additional benefits and populations to cover, as well as methods of delivery and payment.

At the federal level, the Centers for Medicaid and Medicare Services (CMS) within the Department of Health and Human Services (HHS) is responsible for overseeing and administering Medicaid. States must submit Medicaid plans to CMS for approval, and if a state wants to implement policies that deviate from federal Medicaid requirements, it must apply for a "waiver." CMS is also charged with monitoring and assuring state compliance with the federal Medicaid requirements. However, CMS’s formal oversight has not been an adequate means of ensuring that states actually comply with the requirements.
set forth in the Medicaid statute and regulations, primarily because of the limited range of enforcement mechanisms available to CMS and HHS. After CMS approves a state’s Medicaid plan, the only course of action that HHS can take if a state does not comply with federal requirements is to withhold part or all of the federal matching payment from that state.\(^{17}\) This enforcement mechanism is entirely impractical and counterproductive. States usually fail to comply with federal Medicaid requirements by cutting reimbursement rates and services because of budgetary shortfalls. Thus, withholding Medicaid funding from noncompliant states would only work to exacerbate the problem that caused the noncompliance by further diminishing the states’ ability to provide Medicaid services. This would ultimately make things worse for Medicaid beneficiaries, who are the very group of people harmed by noncompliance in the first place.\(^{18}\)

Unsurprisingly, HHS has never used this mechanism to withhold federal Medicaid funding from a noncompliant state.

The infeasibility and imprudence of HHS’s sole means of enforcing state compliance with Medicaid requirements highlights the importance of alternative enforcement mechanisms. In particular, Medicaid beneficiaries and providers have frequently resorted to federal litigation to compel states to comply with the Medicaid statute and regulations,\(^{19}\) especially under 42 U.S.C. § 1983.\(^{20}\) In *Wilder v. Virginia Hospital Association*, the Supreme Court held for the first time that a provision of the Medicaid statute created a right that was enforceable under § 1983.\(^{21}\) Since *Wilder*, federal circuit courts have found various other provisions of the Medicaid statute to confer rights to beneficiaries and providers that are enforceable under § 1983.\(^{22}\) In the past decade, suits seeking to enforce Medicaid provisions have been the most prevalent type of case brought under § 1983.\(^{23}\) In

\(^{17}\) 42 U.S.C. § 1396c (2012); see also Mark A. Ison, *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, 1511 (2003) (“[T]he sole external enforcement mechanism is the termination or reduction of federal payments to States failing to comply substantially with Medicaid provisions.”).


\(^{23}\) See Devi M. Rao, Note, “Making Medical Assistance Available”: *Enforcing the Medicaid*
the past twelve years alone, the Courts of Appeals have ruled on the enforceability of twenty-three different Medicaid provisions under § 1983 in forty-one different cases. The frequency with which Medicaid beneficiaries and providers bring § 1983 suits against states underscores the crucial role that § 1983 litigation plays in ensuring that beneficiaries obtain the care and services guaranteed to them by CMS-approved state plans and the federal Medicaid requirements.

II. CHALLENGING LOW MEDICAID REIMBURSEMENT RATES: DAYS OF GLORY PAST

In particular, Medicaid providers and beneficiaries have relied on § 1983 litigation to protect themselves against the deleterious effects of state cutbacks on Medicaid spending. Recent economic downturns have caused state tax revenues to fall and Medicaid enrollments to surge. In response to this troublesome combination of events, many states have implemented Medicaid spending cutbacks, commonly in the form of reduced reimbursement rates to providers. For example, in 2009, during the most recent recession, thirty-nine states reduced or froze Medicaid reimbursement rates. Between 2001 and 2004, every state reduced or froze reimbursement rates in response to the previous economic recession. Considering the fact that Medicaid reimbursement rates have historically been significantly lower than both Medicare and private insurance rates, these rate reductions carry a substantial risk of harm to Medicaid beneficiaries because the level of provider participation in Medicaid depends crucially on reimbursement rates. The proportion of physicians who accept Medicaid patients is greater in states with higher Medicaid reimbursement rates

27. Id. at 6.
29. Id. at 30.
relative to states with lower rates, and physicians cite low reimbursement rates as the primary reason for not accepting Medicaid patients. When fewer physicians and providers participate in Medicaid, the risk of impaired access to care for Medicaid beneficiaries increases.

Many Medicaid beneficiaries and providers have brought §1983 lawsuits to challenge low reimbursement levels and rate reductions as violations of the Medicaid statute. In the past, litigants primarily utilized two specific Medicaid provisions in their attempts to force states to increase reimbursement rates: the Boren Amendment and the Equal Access Provision. However, recent decisions by Congress and the courts, respectively, have foreclosed both avenues of recourse to plaintiffs seeking to challenge low reimbursement levels.

A. The Repeal of the Boren Amendment

The Boren Amendment provided, in relevant part, that:

[A] State plan for medical assistance must . . . provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded . . . through the use of rates (determined in accordance with the methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality . . . .

Enacted in 1980, the Boren Amendment was, “in its inception and implementation, an effort to reduce federal and state expenditures.” The Boren

32. See Brietta R. Clark, Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration is Undermining its own Health Reform Goals, 55 HOW. L.J. 771, 831 (2012).
Amendment made one procedural and one substantive change to the Medicaid statute. Before 1980, the Secretary of HHS was responsible for determining whether state Medicaid payment plans satisfied federal standards (the procedural status quo), and state payment methods and standards were required to result in reasonable cost-related payments (the substantive status quo). The Boren Amendment shifted the responsibility of determining whether state payment plans complied with federal standards to the states. The Amendment also shifted the focus from payment methods to aggregate payment rates, requiring only that payment rates be reasonable and adequate and doing away with the prior requirement that they be cost-related.

Even before the Supreme Court held that § 1983 conferred Medicaid providers a private right of action to enforce the Boren Amendment, the federal circuit courts were in almost unanimous agreement that the Boren Amendment was enforceable under § 1983. Most providers who sued states under the Boren Amendment alleged both a procedural violation (that a state did not make a bona fide finding that its plan would meet federal standards before implementing the plan), and a substantive violation (that a state plan’s reimbursement rates were not reasonable and adequate). Though courts differed in their interpretations of what states were required to do to make “findings” that their plans would meet federal standards, once a court found that a state failed to make proper findings, that state’s payment methodology would almost certainly be invalidated without further inquiry into whether the reimbursement rates were ultimately reasonable and adequate. A state found to have satisfied the procedural requirement of the Boren Amendment would enjoy relatively more deferential treatment in a court’s substantive inquiries.

Providers had the burden of proving that reimbursement rates fell outside a “zone of reasonableness,” which sometimes required a showing that Medicaid payments did not cover the costs of a substantial proportion of providers.

Medicaid providers utilized the Boren Amendment to pressure states to raise their reimbursement rates with considerable success until 1997, when the

36. Id. at 169-70.
37. Id.
40. Id. at 181.
41. Id. at 182-83.
42. Id. at 183.
43. See, e.g., Portland Residence, Inc. v. Steffen, 34 F.3d 669, 672 (8th Cir. 1994).
44. See Harkins, supra note 35, at 184 n.123.
Amendment was repealed. States in general, and the National Governors Association in particular, pushed for the repeal, claiming that the Boren Amendment denied states fiscal and administrative discretion to control costs in the face of rising health care costs, and that the Amendment prevented states from exploiting market competition to secure lower prices for Medicaid services. The repeal's legislative history indicates that Congress specifically intended to take away the ability of Medicaid providers to sue states under § 1983 because of low reimbursement levels.

The Balanced Budget Act of 1997 repealed the Boren Amendment and replaced it with a requirement that states use a public process to set reimbursement rates, thereby eliminating one channel through which beneficiaries and providers could attempt to compel states to raise Medicaid payment levels.

B. The Vitiation of the Equal Access Provision

In addition to the Boren Amendment, Medicaid providers and beneficiaries also used the Equal Access Provision to bring § 1983 suits challenging low Medicaid reimbursement levels. The Equal Access Provision requires state Medicaid plans to ensure that payment rates 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.” The inclusion of this provision in the Medicaid statute suggests that Congress was specifically trying to prevent states from cutting reimbursement levels in the face of budgetary shortfalls.

In the 1990s, federal circuit courts generally allowed litigants to bring § 1983 suits to enforce the Equal Access Provision, and even some providers successfully brought § 1983 suits alleging low reimbursement rates as a violation of the Equal Access Provision.

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47. See Harkins, supra note 35, at 189.
48. See H.R. Rep. No. 105-149, at 591 (1997) (“It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of [42 U.S.C. § 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.”).
53. See, e.g., Visiting Nurse Ass'n of North Shore v. Bullen, 93 F.3d 997, 1005 (1st Cir. 2000).
claims arguing that state officials violated the Equal Access Provision by setting Medicaid reimbursement rates too low.\textsuperscript{54} Unfortunately, this mechanism for keeping states honest with regards to Medicaid payment levels has also been neutralized, primarily by two cases that are part of the Supreme Court’s recent § 1983 jurisprudence.

In the 1997 case \textit{Blessing v. Freestone}, the Court held that Title IV-D of the Social Security Act, which details the eligibility requirements for child support services, does not give individuals a federal right to force a state agency to comply with its provisions.\textsuperscript{55} In reaching this holding, the Court delineated a three-part test for determining whether a federal statute creates a private right that is enforceable under § 1983: “First, Congress must have intended that the provision in question benefit the plaintiff”; second, the potential federal right must not be so “vague and amorphous” that its enforcement would strain the courts; and third, “the statute must unambiguously impose a binding obligation on the States.”\textsuperscript{56}

The Court elaborated upon this three-part test just five years later in \textit{Gonzaga University v. Doe}.\textsuperscript{57} In deciding that the Family Educational Rights and Privacy Act (FERPA) did not confer a federal right enforceable under § 1983,\textsuperscript{58} the Court attempted to clarify the first prong of the three-part test it established in \textit{Blessing}. The \textit{Gonzaga} Court stressed that only rights, and not vague “benefits” or “interests,” are enforceable through § 1983, and thus in order to satisfy the first prong of the test a statute must “unambiguously” confer a right.\textsuperscript{59} The Court applied a textual analysis for determining whether a statute confers a right, emphasizing that the statute must contain “rights-creating” language that is “phrased in terms of the person benefited”\textsuperscript{60} as opposed to language with “an aggregate, not individual, focus.”\textsuperscript{61} By setting forth a more limited set of criteria for determining the existence of statutory rights, the Court narrowed the range of statutes that confer privately enforceable rights, thereby diminishing the availability of § 1983 as a means of suing state officials for violations of federal

\textsuperscript{54} See \textit{Reynolds}, 6 F.3d at 331 (holding that a rate reduction by Arkansas’s Medicaid plan violated the Equal Access Provision).\textsuperscript{55} See \textit{Sullivan}, 91 F.3d at 1029-30 (holding that plaintiffs did not show that Indiana’s Medicaid reimbursement rates violated the Equal Access Provision).

\textsuperscript{56} \textit{Id.} at 340-41.

\textsuperscript{57} 536 U.S. 273 (2002).

\textsuperscript{58} \textit{Id.} at 276.

\textsuperscript{59} \textit{Id.} at 282-83.

\textsuperscript{60} \textit{Id.} at 284.

\textsuperscript{61} \textit{Id.} at 290.
The federal circuit courts have applied Blessing and Gonzaga to render the Equal Access Provision unenforceable. Every circuit court but one that has considered the enforceability of the Equal Access Provision under § 1983 after Gonzaga has found it unenforceable by Medicaid providers,62 and most of them have also found it unenforceable by beneficiaries.63 The circuit courts have variously held that the Equal Access Provision was not intended to benefit Medicaid providers,64 that it lacks “rights creating language,”65 and that it has an “aggregate and systemic” rather than an “individualized” focus.66 In short, the Supreme Court’s § 1983 jurisprudence has precluded enforcement of the Equal Access Provision against the states under § 1983.

Several plaintiffs have attempted to work around the § 1983 barrier by bringing federal preemption claims, alleging that state laws that conflict with the Medicaid statute violate the Supremacy Clause of the United States Constitution.67 Some circuit courts have employed the Supremacy Clause to invalidate state laws for conflicting with the Medicaid statute,68 and the Supreme Court recently assumed without explicitly stating that Medicaid beneficiaries had an implied right of action under the Supremacy Clause to enforce an anti-lien provision of the Medicaid statute.69 It looked like the Court would have the chance to decide whether the Equal Access Provision in particular could be enforced through the Supremacy Clause in Douglas v. Independent Living Center of Southern California, Inc.,70 but because of a change in circumstances,71 the

62. Equal Access for El Paso v. Hawkins, 509 F.3d 697 (5th Cir. 2007); Mandy R. ex rel. Mr. and Mrs. R. v. Owens, 464 F.3d 1139 (10th Cir. 2006); Westside Mothers v. Olszewski, 454 F.3d 532 (6th Cir. 2006); Sanchez v. Johnson, 416 F.3d 1051 (9th Cir. 2005); Long Term Care Pharm. Alliance v. Ferguson, 362 F.3d 50 (1st Cir. 2004); Pa. Pharm. Ass’n v. Houston, 283 F.3d 531 (3d Cir. 2002). But see Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs., 443 F.3d 1005 (8th Cir. 2006) (holding that the Equal Access Provision is enforceable under § 1983), vacated sub nom. Selig v. Pediatric Specialty Care, Inc., 551 U.S. 1142 (2007).

63. Equal Access for El Paso, 509 F.3d at 697; Mandy R. ex rel. Mr. and Mrs. R., 464 F.3d at 1139; Westside Mothers, 454 F.3d at 532; Sanchez, 416 F.3d at 1051. But see Pa. Pharm. Ass’n, 283 F.3d at 544 (stating in dicta that Medicaid beneficiaries are “potential private plaintiffs”).

64. See, e.g., Pa Pharm. Ass’n, 283 F.3d at 540.

65. See, e.g., Long Term Care Pharm. Alliance, 362 F.3d at 57.

66. See, e.g., Equal Access for El Paso, 509 F.3d at 704.

67. U.S. CONST. art VI, cl. 2; see Rochelle Bobroff, Medicaid Preemption Remedy Survives Supreme Court Challenge, 46 CLEARINGHOUSE REV. 35, 35 (2012) (“As access to federal courts narrows, Medicaid beneficiaries increasingly rely on preemption claims as the basis for litigation to challenge state laws that conflict with the Medicaid statute.”).

68. See Lankford v. Sherman, 451 F.3d 496 (8th Cir. 2006); Planned Parenthood of Houston & Se. Tex. v. Sanchez, 403 F.3d 324 (5th Cir. 2005).


70. 132 S. Ct. 1204 (2012).
Court avoided the issue by vacating and remanding to the Ninth Circuit. However, Chief Justice Roberts, writing for four dissenters, insisted that the plaintiffs—a group of Medicaid providers—did not have a cause of action under the Supremacy Clause to enforce the Equal Access Provision against California. The Chief Justice reasoned that, because the Medicaid statute gives CMS—and only CMS—the responsibility to enforce the requirements of the statute against the states, allowing providers to sue under the Supremacy Clause would conflict with congressional intent to vest sole enforcement authority in CMS.

The Chief Justice’s reasoning in *Douglas* foreshadowed the ultimate demise of the Equal Access Provision as a means of challenging state Medicaid cutbacks through private rights of action. In *Armstrong v. Exceptional Child Center, Inc.*, a divided Court held that providers of residential habilitation services to Medicaid enrollees did not have a private cause of action through the Equal Access Provision to enjoin Idaho’s Department of Health and Welfare from setting Medicaid reimbursement rates at improperly low levels. Specifically, Justice Scalia, writing for the majority, explained that the Supremacy Clause itself does not contain a private right of action, and that although litigants can generally obtain private rights of action through the *equitable* power of courts to enjoin unconstitutional actions by state or federal officers, the Medicaid statute implicitly precludes equitable relief in the case of the Equal Access Provision.

Justice Scalia proffered two factors that “establish Congress’s ‘intent to foreclose’ equitable relief” in the Equal Access Provision context. First, he cited the fact that the “sole remedy Congress provided for a State’s failure to comply with Medicaid’s requirements” is the withholding of Medicaid funding by HHS. Second, he emphasized the “judicially unadministrable nature” of the Equal Access Provision’s text, asserting that it would be difficult to imagine a “broader and less specific” requirement. These two features combined constituted sufficient evidence, in the majority’s eyes, that Congress “wanted to make the agency remedy that it provided exclusive,” thereby thwarting the

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71. CMS initially disapproved of California’s State Plan Amendments (SPAs), through which California wished to implement cuts to its Medicaid reimbursement rates. However, after California withdrew some of the cuts, CMS approved the remaining cuts about one month after oral arguments. *Id.* at 1209.
72. *Id.* at 1208.
73. *Id.* at 1211-12 (Roberts, C.J., dissenting).
75. *Id.* at 1388.
76. *Id.* at 1384.
77. *Id.* at 1385.
78. *Id.* (citation omitted).
79. *Id.*
80. *Id.*
In short, it seems that the Court, through its decision in Armstrong, has all but eliminated any possibility for private litigants to utilize the Equal Access Provision to challenge state cutbacks on Medicaid reimbursement rates.

III. A NEW HOPE? TWO POTENTIAL WORKAROUNDS

With the Boren Amendment repealed and the private enforceability of the Equal Access Provision eviscerated by the Court, what other possible means do Medicaid beneficiaries or providers have to protect themselves against harmful cuts to reimbursement rates? For starters, there is a specific provision within the Medicaid statute that addresses payment methodology and reimbursement rates for services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs), and some of these providers have utilized this provision to compel states to raise reimbursement rates under § 1983. Additionally, one consumer health advocacy group was able to force a state to raise its payment rates on behalf of a set of Medicaid beneficiaries using the Reasonable Promptness Provision, another requirement in the Medicaid statute. This tactic has only been attempted once in a federal court, but it may be worthwhile to consider it as a potential alternative mechanism for suing states for higher payment levels. Thus, the bulk of the remainder of this Note will examine the Reasonable Promptness Provision as a tool for challenging state cutbacks on Medicaid reimbursement rates.

A. Section 1396a(a)(bb): Relief for FQHCs and RHCs

Section 1396a(a)(bb) sets forth the methodology that states must use to calculate payments levels to FQHCs and RHCs. The provisions under this section were introduced by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and they allow for two primary methods of reimbursement. The first is a “prospective payment system” under which states must calculate reimbursement rates based on the previous year’s average costs, augmented by the percentage increase in the Medicare

81. Id. (quoting Gonzaga University v. Doe, 536 U.S. 273, 292 (2002)).

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Economic Index and adjusted for any change in the scope of services offered by a particular clinic. The second is an “alternative payment system” that allows states more flexibility, as long as the state and the clinic agree on the system and the resulting rates are at least equal to those under the prospective payment system.

Lower federal courts have held that § 1396a(a)(bb) confers statutory rights that are enforceable under § 1983. In particular, courts have allowed FQHCs and RHCs to bring § 1983 suits challenging reimbursement rates as lower than required by § 1396a(bb). Section 1396a(bb) is very specific with regards to the methodology by which payments to FQHCs and RHCs must be calculated, rendering deviations from the required rates very clear and easy to prove. Therefore, suing states under § 1983 for violating § 1396a(bb) of the Medicaid statute seems to be an effective mechanism through which FQHCs and RHCs can ensure receipt of the federally required levels of payment for the services that they provide.

B. The Reasonable Promptness Provision

In Health Care for All v. Romney, a consumer health advocacy organization brought a § 1983 lawsuit against Massachusetts officials on behalf of a group of Medicaid beneficiaries for an alleged violation of the Reasonable Promptness Provision. This provision requires state plans to “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.” The plaintiffs successfully convinced the District Court for the District of Massachusetts that by providing insufficient reimbursement to Medicaid dental care providers, Massachusetts violated the Reasonable Promptness Provision. The court found the low payment levels to be one of the primary causes for the unreasonable delays that juvenile Medicaid beneficiaries experienced in accessing dental services.

The plaintiffs originally sued under both the Reasonable Promptness

89. See, e.g., N.J. Primary Care Ass’n. v. N.J. Dep’t of Human Servs., 722 F.3d 527 (3d Cir. 2013); Rio Grande Cnty. Health Ctr., Inc. v. Rullan, 397 F.3d 56 (1st Cir. 2005).
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Provision and the Equal Access Provision, but a previous decision handed down by the same court held that Health Care for All did not have a private cause of action to enforce the Equal Access Provision under § 1983. In the subsequent decision, the court then found that the juvenile Medicaid beneficiaries experienced “extraordinary difficulty in obtaining timely dental services” at two stages. First, the beneficiaries struggled to find dental care providers who accepted MassHealth (the Massachusetts Medicaid program) patients, in part because the MassHealth provider lists were not updated frequently enough to accurately reflect the fact that more and more dental care providers were refusing to accept MassHealth patients. In their complaint, the beneficiaries alleged that after their usual providers stopped accepting MassHealth patients, they spent many hours calling providers on the list, cold-calling other private providers, and seeking word-of-mouth referrals. Many of the beneficiaries could not locate any available providers; as a result, these beneficiaries either went without treatment or paid out-of-pocket for services that should have been covered by MassHealth. Furthermore, those beneficiaries who were fortunate enough to locate dental providers who still accepted MassHealth patients faced substantial waiting periods. The court found that beneficiaries with non-emergency conditions had to wait anywhere between two months and a year for an actual appointment after locating a participating provider.

The Health Care for All court held that these significant obstacles and delays constituted a violation of the Reasonable Promptness Provision. Additionally, the court asserted that “the difficulties encountered by enrollees who sought dental appointments resulted from a shortage of dentists participating in MassHealth.” The plaintiffs were able to convince the court that the shortage of participating dentists was caused by low reimbursement rates, leading the court to hold that the low reimbursement rates themselves constituted a violation of the Reasonable Promptness Provision. The court then ordered the parties to

97. Id. at 12-20; see Health Care for All II, 2005 WL 1660677 at *10.
99. Id. at *10.
100. Id. at *15.
101. Id. at *11.
102. Id. ("[P]laintiffs' evidence persuasively demonstrates that MassHealth established reimbursement levels so low that private dentists could not afford to treat enrollees who, thus, either received dental care only after much delay or not at all.").
103. Id. at *15 ("Plaintiffs have demonstrated that defendants violated sections of the
IV. EVALUATING THE REASONABLE PROMPTNESS PROVISION AS A MEANS OF CHALLENGING LOW REIMBURSEMENT RATES

The success of the Health Care for All plaintiffs suggests that suing states under the Reasonable Promptness Provision may be a viable option for similarly-situated beneficiaries seeking to challenge low Medicaid reimbursement rates. One appealing feature of the Reasonable Promptness Provision is that it has been held to be enforceable under § 1983 by all federal circuit courts that have considered its enforceability, indicating that its text is sufficient to overcome the Blessing and Gonzaga hurdles. However, the fact that the Reasonable Promptness Provision has only been utilized once to challenge low Medicaid reimbursement levels in the federal courts suggests some reluctance on the part of plaintiffs to use the Reasonable Promptness Provision for this purpose. Plaintiffs may be reluctant for various reasons; there may be other barriers to deploying the Reasonable Promptness Provision, or perhaps certain uncommon or extreme conditions must exist for courts to find a violation of the provision. Below, I discuss four factors that may affect the feasibility of utilizing the Reasonable Promptness Provision to compel reimbursement rate increases.

A. The Reasonable Promptness Provision Is Only Enforceable by Medicaid Beneficiaries

One characteristic of the Reasonable Promptness Provision that might explain why it has not been used frequently to challenge low payment levels is that it only seems to confer statutory rights to Medicaid beneficiaries, and not Medicaid Act that require prompt provision of services . . . and that these violations resulted, in part, from insufficient reimbursement.


105. Romano v. Greenstein, 721 F.3d 373 (5th Cir. 2013); Doe v. Kidd, 501 F.3d 348 (4th Cir. 2007); Sabree v. Richman, 367 F.3d 180 (3d Cir. 2004); Bryson v. Shumway, 308 F.3d 79 (1st Cir. 2002); Doe v. Chiles, 136 F.3d 709 (11th Cir. 1999); see also Bertrand v. Maram, 495 F.3d 452 (7th Cir. 2007) (assuming that the Reasonable Promptness provision confers statutory rights enforceable under § 1983 without explicitly deciding the issue).
providers. To satisfy the first prong of the Blessing three-part test, the provision that confers the asserted statutory right must "benefit the plaintiff." 106 The Reasonable Promptness Provision requires states to provide medical assistance that "shall be furnished with reasonable promptness to all eligible individuals." 107 It is clear from this text that the provision confers a right to Medicaid beneficiaries only; it does not directly benefit Medicaid providers. The federal courts that have considered this issue have held that Medicaid providers cannot enforce the Reasonable Promptness Provision under § 1983. 108

If the goal is to challenge low reimbursement rates, it might be problematic if only Medicaid beneficiaries can bring § 1983 suits to enforce the Reasonable Promptness provision. Compared to health care providers, Medicaid beneficiaries are generally much less able, and therefore much less likely, to initiate lawsuits because they have relatively fewer resources. Additionally, Medicaid beneficiaries are less likely to be able to overcome the collective action problem; the "costs" of low Medicaid provider payment levels to beneficiaries (in the form of reduced access to medical services) are diffuse, so for any individual beneficiary, the cost of litigating likely outweighs the uncertain benefit of increased access to medical services. Furthermore, because a successful suit to compel increased reimbursement rates would benefit all Medicaid beneficiaries, there is also a free-rider problem. Each individual beneficiary is better off letting some other beneficiary incur the costs of litigation because, if the suit is successful, all beneficiaries who did not partake in the litigation can reap the same benefits stemming from the suit’s outcome without having incurred any litigation costs. This makes it even more unlikely that any one beneficiary will initiate a lawsuit. These obstacles highlight the importance of consumer health advocacy groups and other organizations like Health Care for All that advocate on behalf of Medicaid beneficiaries. These organizations make up for the beneficiaries’ lack of monetary resources, and they also help overcome the collective action problem by bringing beneficiaries together and lowering the litigation costs to each individual beneficiary.

On the other hand, all of the problems discussed above apply to § 1983 suits that attempt to enforce other Medicaid provisions that only confer rights to beneficiaries, as well as to Reasonable Promptness suits that are not aimed at challenging low reimbursement rates. Yet, neither of these types of suits has been

in short supply in the federal courts. For example, the Minimum Services Provision, which requires states to provide certain categories and types of "medical assistance" to Medicaid beneficiaries, has been utilized by many plaintiff beneficiaries in many federal § 1983 lawsuits to sue states for neglecting to provide required services. This disparity suggests that the infrequency with which Reasonable Promptness suits are brought to challenge low reimbursement levels is not due solely to the fact that only beneficiaries can enforce the Reasonable Promptness Provision.

B. It is Difficult for Plaintiffs to Prove that Low Medicaid Reimbursement Rates Themselves Violate the Reasonable Promptness Provisions

Perhaps the potential difficulty in using the Reasonable Promptness Provision to challenge low payment levels lies not in the fact that only beneficiaries can enforce the Reasonable Promptness Provision, but rather in the difficulties that beneficiaries might face in proving that low reimbursement rates are the proximate cause of unreasonable delays in accessing Medicaid services. It might be the case that health providers, who certainly have more knowledge than beneficiaries (and perhaps consumer health advocacy groups) about the health care delivery system, would be better equipped to prove that low reimbursement rates cause more providers to refuse Medicaid patients, thereby creating barriers to accessing Medicaid services. If this is true, beneficiary plaintiffs seeking to challenge low reimbursement rates under the Reasonable Promptness Provision would probably benefit from finding ways to incorporate provider knowledge and expertise into their litigation efforts.

This is exactly what the Health Care for All plaintiffs did as part of their successful efforts to prove that low dental reimbursement rates caused the unreasonably prompt provision of juvenile dental services. First, the plaintiffs cited a 2000 Report of the Special Legislative Commission on Oral Health, which was commissioned by the Massachusetts legislature, to support the propositions that low dental provider participation in MassHealth impeded access to dental health services and that low MassHealth reimbursement rates for dental

109. See Huberfeld, supra note 1, at 445-46 (discussing how the circuit courts have handled § 1983 suits under the Minimum Services and Reasonable Promptness provisions).
111. See, e.g., Watson v. Weeks, 436 F.3d 1152 (9th Cir. 2006); S.D. ex rel. Dickson v. Hood, 391 F.3d 581 (5th Cir. 2004).
services were the primary cause of the low participation rate. Specifically, they cited the Commission's finding that only fourteen percent of the 4,500 dentists in Massachusetts accepted MassHealth, and that this proportion was likely going to shrink even further as more dentists left MassHealth due to low payment levels. They also cited the Commission's finding, regarding the shortage of MassHealth dentists, that "[o]ne of the most significant factors is the longstanding inadequacy of the MassHealth fee schedule. Present reimbursement rates are so dramatically below current market levels that dentists who choose to treat MassHealth patients receive fees that cover only about 75% of their direct costs of providing the service."  

The plaintiffs offered testimony from several dental providers to substantiate their claim that low reimbursement rates created barriers to access for beneficiaries. One provider, a former Dentist-in-Chief of the Children's Hospital Dental Clinic (CHDC), explained that CHDC operated at a loss because of low MassHealth payment levels. Another provider testified that he and the vast majority of other providers with private practices refuse to accept MassHealth patients because doing so would force them to operate at a loss. The plaintiffs' strategy worked beautifully; the court commented that the "plaintiffs' evidence persuasively demonstrates that MassHealth established reimbursement levels so low that private dentists could not afford to treat enrollees who, thus, either received dental care only after much delay or not at all." The court then held that these low reimbursement levels constituted a violation of the Reasonable Promptness Provision.

The strategies employed by the Health Care for All plaintiffs suggest a role for providers to play in challenging low payment rates as violations of the Reasonable Promptness Provision. Though they cannot personally bring § 1983 suits under the Provision, providers can assist beneficiaries by testifying about the effects of low rates on provider participation in Medicaid. Doing so would actually be in their interest, as both providers and beneficiaries would benefit from higher Medicaid reimbursement levels. However, while the Health Care for All strategy was successful, it may be quite expensive to replicate; securing extensive provider testimony may be time and resource intensive. Furthermore, Health Care for All leaves uncertain the amount of evidence that is sufficient to

114. Id.
116. Id.
117. Id. at *5.
118. Id. at *11.
119. Id.
prove causation. It is unclear whether future plaintiffs could rely solely on the testimony of providers, or whether citation to some sort of report or study is necessary. If the latter were the case, and if in a given litigation context there were no pre-existing studies to which the plaintiffs could refer, then the high burden of proof might render the Reasonable Promptness Provision infeasible as a means of challenging low reimbursement levels.

Finally, it is important to note that in order to prompt a state to raise reimbursement rates, plaintiffs do not necessarily have to prove that the state is violating the Reasonable Promptness Provision specifically by setting reimbursement rates too low. That is, as long as a plaintiff proves a Reasonable Promptness violation on the part of a state, there is some chance that the state will raise its payment levels to Medicaid providers in response. For example, if a state is ordered to remedy a Reasonable Promptness violation by decreasing wait times, the state might choose to comply with this order by raising reimbursement rates so that more providers are willing to serve Medicaid beneficiaries. However, when compared to piecemeal litigation involving scattered plaintiffs challenging long wait times for vastly different Medicaid services, a successful direct challenge increases the likelihood of system-wide changes in reimbursement rates.

C. The Definition of “Medical Assistance” in the Medicaid Statute

One relatively recent trend in some circuits regarding the interpretation of the term “medical assistance” in the Medicaid statute might have foreclosed some Reasonable Promptness suits in those circuits and caused reluctance to sue under the Reasonable Promptness Provision in others. The Reasonable Promptness Provision obliges states to provide “medical assistance” with “reasonable promptness.”120 In Bruggeman ex rel. Bruggeman v. Blagojevich,121 Judge Richard Posner understood “medical assistance” as referring to “financial assistance rather than . . . actual medical services.” In other words, Judge Posner reasoned that the Reasonable Promptness Provision only requires states to provide “funds to eligible individuals,” rather than actual medical services, promptly.122 In Judge Posner’s view, because Medicaid is “a payment scheme, not a scheme for state-provided medical assistance,” requiring states to provide prompt treatment would constitute an inappropriate “direct regulation of medical services.”123 However, this assertion was mere dicta. Judge Posner used other

121. 324 F.3d 906, 910 (7th Cir. 2003).
122. Id.
123. Id.
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reasoning to hold that Illinois’s Medicaid plan was not in violation of the Reasonable Promptness Provision, and the discussion regarding the definition of “medical assistance” was only used to bolster his position. Specifically, Judge Posner stated that “even if” his previous reasoning was not valid, the plaintiffs’ theory of the case would be “a considerable stretch” because of his view of the definition of “medical assistance.”

The Fifth, Sixth, and Tenth Circuits followed suit by holding that “medical assistance” refers only to financial assistance for medical services, and not to the medical services themselves. Some district courts in other circuits also followed this trend. Though many of these decisions cited Bruggeman, all of them relied primarily on the definition of “medical assistance” provided in the definitions section of the Medicaid statute, which states that “medical assistance means payment of part or all of the cost of the following care and services,” to reach their holdings.

This definition of “medical assistance” is fatal to almost all Reasonable Promptness suits. Under this interpretation, both the level of reimbursement to Medicaid providers and the promptness with which beneficiaries receive care are wholly irrelevant; so long as a state ensures that some amount of reimbursement—even an amount below the cost of providing care—reaches providers promptly, that state will have satisfied the Reasonable Promptness requirement. Indeed, the District Court for the District of Massachusetts recognized the unsavory consequences of such an interpretation of “medical assistance” in Health Care for All v. Romney. In response to the state’s argument that “medical assistance” should be read to mean only payment for medical services, the court called the state’s reading “myopic,” asserting that “[t]imely payment for services does little to benefit enrollees who cannot find a provider willing to accept such payment. Because payment for services necessarily presumes delivery of services, state Medicaid programs may indirectly impede medical assistance through practices and protocols that delay the delivery of services.”

124. Id.
125. Equal Access for El Paso, Inc. v. Hawkins, 562 F.3d 724 (5th Cir. 2009); Mandy R. ex rel. Mr. and Mrs. R. v. Owens, 464 F.3d 1139 (10th Cir. 2006); Westside Mothers v. Olszewski, 454 F.3d 532 (6th Cir. 2006).
Fortunately, the Patient Protection and Affordable Care Act (ACA)\(^{129}\) seems to have addressed this problem by amending the definitions section of the Medicaid statute. The section now defines “medical assistance” as “payment of part or all of the cost of the following care and services or the care and services themselves, or both.”\(^{130}\) Additionally, a House Committee Report accompanying the amendment emphasized that (1) the longstanding definition of “medical assistance” has always been both payment for services and the services themselves; (2) that recent court opinions construing “medical assistance” to mean only payment for services run contrary to longstanding practice and render some sections of Title XIX absurd; and (3) that the purpose of the amendment was to “correct any misunderstandings as to the meaning of the term” and to “conform this definition to the longstanding administrative use and understanding of the term.”\(^{131}\)

Because the courts that construed “medical assistance” to mean mere payment relied primarily on the text of the definitions section of the Medicaid statute, the amendment should give plaintiffs the ability to convince those courts to overrule their erroneous constructions. In fact, one set of plaintiffs succeeded in getting a district court to change its erroneous construction after filing for reconsideration and arguing that “an intervening change in controlling law” (the amendment of the definitions section) required the court to adjust its previous interpretation of “medical assistance.”\(^{132}\) Additionally, all post-ACA federal court decisions that construed “medical assistance” to mean no more than payment did not take the amended definitions section into account.\(^{133}\) Thus, it seems likely that the ACA’s amendment to the definitions section of the Medicaid statute has revived and reinforced the viability of the Reasonable Promptness Provision as a means of challenging low Medicaid reimbursement levels.

**D. What is Reasonably Prompt?**

Finally, plaintiffs might be deterred from using the Reasonable Promptness Provision to sue states for unreasonably low payment rates by the criteria that courts use to determine what constitutes “reasonable promptness.” Perhaps a court would only find a violation of the Reasonable Promptness Provision when

delays in the delivery of services are extreme. Reluctance to bring § 1983 suits under the provision may also stem from uncertainty as to what kinds of criteria courts will utilize to decide whether services have been provided with reasonable promptness. An examination of the regulations and case law related to the Reasonable Promptness Provision suggests that the second explanation is not unreasonable.

One would think that a provision as vague and open-textured as the Reasonable Promptness Provision would be accompanied by regulations issued to clarify what constitutes “reasonable promptness,” but it turns out that there are less than a handful of regulations related to the Provision, and only one of them provides significant guidance for litigants, courts, and states. Among other requirements, 42 C.F.R. § 435.912 sets forth timeliness standards for states for determining Medicaid eligibility: it forbids states from taking longer than forty-five and ninety days to determine the eligibility of non-disabled applicants and disabled applicants, respectively, and it also forbids states from using time standards as “a waiting period before determining eligibility.” 42 C.F.R. § 435.930 requires states to “[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency’s administrative procedures” and to continue furnishing Medicaid to “all eligible individuals until they are found to be ineligible.” Finally, 42 C.F.R. § 441.56(e) requires state agencies responsible for administering Medicaid to set timeliness standards for the provision of Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services that meet “reasonable standards of medical and dental practice.” State agencies must consult with “recognized medical and dental organizations involved in child health care” before setting these standards, and must ensure timely initiation of treatment that generally does not exceed six months after a request for screening services. The dearth of regulations clarifying the meaning of “reasonable promptness” might be explained by the fact that what constitutes reasonably prompt provision of care is completely dependent on what condition the care is supposed to be treating. Because illnesses and conditions vary so widely, any set of regulations aimed at defining “reasonable promptness” would have to provide a different standard for at least every category of illness or condition.

Presumably, 42 C.F.R. § 441.56(e) provides some guidance for plaintiffs attempting to sue states for unreasonable delays in the provision of EPSDT services. If a state fails to establish timeliness standards, consult with medical

134. 42 C.F.R. § 441.56(e) (2013).
137. 42 C.F.R. § 441.56(e) (2013).
138. Id.
and dental professionals before establishing those standards, or provide initial treatment within six months of a request, then it clearly violates the regulation. However, the fact that the plaintiffs in *Health Care for All* did not invoke 42 C.F.R. § 441.56(e) is puzzling. This suggests some sort of confusion about the regulation’s role in defining “reasonable promptness” in the context of EPSDT services. Those plaintiffs brought suit because juvenile Medicaid beneficiaries faced enormous delays in receiving dental services, which fall under the EPSDT umbrella. Yet, they did not argue that Massachusetts was in violation of 42 C.F.R. § 441.56(e). It could be the case that Massachusetts did in fact set timeliness standards after consulting with the appropriate professionals, and that the plaintiffs were trying to prove that Massachusetts was violating the Reasonable Promptness Provision despite satisfying the requirements of 42 C.F.R. § 441.56(e), but none of this is explicitly discussed or addressed by either party or the court.

Adding to this confusion, at least one federal district court has applied the 42 C.F.R. § 441.56(e) requirements to the provision of non-EPSDT services. In that case, the District Court for the Eastern District of Pennsylvania acknowledged that the regulation only specifically implements EPSDT services. It does not cover behavioral health rehabilitative (BHR) services, which were the services at issue. But the court then decided that “in the absence of another guide by which to base timeliness, the Court may compare the Defendant's provision of services against this standard,” and found the state to be in violation of the Reasonable Promptness Provision because it did not establish timeliness standards for BHR services after adequate consultation with medical providers.

Another federal district court made a similarly odd move by applying the ninety-day limit on eligibility determinations for disabled Medicaid applicants found in 42 C.F.R. § 435.911 to the actual provision of care to disabled Medicaid recipients. In *Boulet v. Celluci*, the District Court for the District of Massachusetts explicitly stated that “[w]hile this regulation is focused on eligibility determinations rather than the actual provision of services, it still gives some guidance to courts attempting to decide what time periods may be considered reasonably prompt in the larger context.” The court went on to find that Massachusetts violated the Reasonable Promptness Provision by subjecting Medicaid enrollees to unreasonably long waiting periods, and ordered the state to provide the services to each beneficiary no later than ninety days after the beneficiary was placed on the waiting list. However, in a later decision, the

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140. *Id.* at *2-3.
142. *Id.* at 80.
District Court for the Eastern District of New York declined to follow Boulet’s application of the regulation’s ninety-day limit, asserting that applying this limit would be “completely arbitrary because the record contains no information suggesting that the magic number ninety bears any relation to what is reasonable in this case.”

The Reasonable Promptness case law that does not involve federal rules and regulations is just as haphazard and, ultimately, unilluminating. Some early court decisions held that any delay in the provision of services, or any use of waiting lists, constituted a violation of the Reasonable Promptness Provision. In the case that is most often cited for this proposition, Sobky v. Smoley, the District Court for the Eastern District of California applied the borrowed statute doctrine to reach this conclusion. The court first observed that the Reasonable Promptness Provision was borrowed from a similar provision with almost the exact same wording in the Aid to Families with Dependent Children (AFDC) portion of the Social Security Act. The court then pointed to the Supreme Court’s decision in Jefferson v. Hackney, which construed the borrowed provision in the AFDC program to forbid waiting lists. The Supreme Court relied on legislative history to hold that “the statute was intended to prevent the States from denying benefits, even temporarily, to a person who has been found fully qualified for aid.” Finally, the Sobky court reasoned from this chain of events that the Reasonable Promptness Provision in the Medicaid statute must also prohibit states from implementing any waiting lists or delays.

More recent court decisions have also held that waiting periods of several years or longer are obvious violations of the Reasonable Promptness Provision. Recently, courts seem to be more reluctant to construe the Reasonable Promptness Provision as prohibiting all delays or waiting lists. Few of the recent cases even cite Sobky, let alone use its reasoning. Perhaps courts or litigants have come to think that the Medicaid program is so different from the AFDC program.
that their respective "reasonable promptness" provisions are not in pari materia. One district court made this point explicitly; in refusing to apply the borrowed statute doctrine to construe the Reasonable Promptness Provision to prohibit any delay, the court observed that "[a]lthough distribution of welfare money, which was an issue in Jefferson, can be expected to occur without delays, immediate placement in [residential treatment facilities] upon finding of eligibility does not appear to be reasonable or practical."

The courts seem to have developed a separate set of criteria for determining whether "waiver" services are being provided with reasonable promptness. Unlike the services that the Medicaid statute requires states to provide, "waiver" services—like Home and Community-Based Services (HCBS) programs for beneficiaries with developmental disabilities—are allowed to have a "cap." This means that states are allowed to establish a fixed number of "slots" to allocate among the entire beneficiary population, so long as that fixed number is above a minimum number specified by CMS. Each beneficiary who gets a slot receives the services provided by the waiver program. Beneficiaries who do not receive slots are put on a waiting list. Thus far, the courts have held that in order to comply with the Reasonable Promptness Provision in the context of waiver services, states must allocate empty slots without delay and provide waiver services to those who receive slots without delay. In other words, states are under no obligation to increase the number of slots for waiver services, nor are they required to shorten the waiting periods of those waiting for waiver slots—even if the waiting periods span multiple years.

As demonstrated above, the regulations and case law related to the Reasonable Promptness Provision do not provide a clear answer to the question of what constitutes a violation of reasonable promptness. Perhaps the case law suggests that a plaintiff's best bet is to draw upon specific numbers from objective and minimally relevant sources, like the ninety-day figure from the eligibility determination regulation. However, one district court opinion suggests another strategy. In Oklahoma Chapter of American Academy of Pediatrics (OKAAP) v. Fogarty, the District Court for the Northern District of Oklahoma found that the plaintiffs offered "substantial evidence that the delays in treatment
for children with specific conditions are medically inappropriate."¹⁵⁶ This evidence convinced the court that the system-wide delays constituted a violation of the Reasonable Promptness Provision.¹⁵⁷ OKAAP, along with the timeliness standards based on "reasonable standards of medical and dental practice" required by 42 C.F.R. § 441.56(e), suggest that a plaintiff might be able to convince a court that a state is violating the Reasonable Promptness Provision by proving that beneficiaries are having to endure delays that are medically inappropriate. This standard could be the most commonsensical and thus intuitively appealing one to judges. It also offers flexibility, as it can be applied to all conditions and illnesses. Finally, the "medically inappropriate" standard would create another role for providers to play in suits aimed at forcing states to raise their Medicaid reimbursement rates: they could provide testimony regarding the medical consequences of the delays stemming from low reimbursement levels, thereby helping plaintiffs prove that those delays, and by extension those low reimbursement rates, constitute violations of the Reasonable Promptness Provision.

CONCLUSION

In today’s economic climate, as Medicaid enrollment expands and state coffers dwindle, finding a way to prevent states from skimping on Medicaid is crucial for the health and well-being of our most vulnerable and politically powerless citizens and residents. Given the current status of § 1983 jurisprudence and the uncertainty surrounding Medicaid preemption claims, utilizing the Reasonable Promptness Provision to challenge low Medicaid reimbursement rates may be just the workaround the doctor ordered.

¹⁵⁷. Id.