

MEDICAID REFORM, PRISON HEALTHCARE, AND THE DUE PROCESS RIGHT TO A FAIR HEARING

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ABSTRACT

The healthcare provided to incarcerated individuals in the nation’s prisons falls far below that which is fair, just, or decent, and incarcerated individuals’ access to the civil justice system to demand better healthcare is fraught with restrictions and barriers. This article proposes using the opportunity provided by the expansion of Medicaid eligibility to incarcerated individuals to invoke Medicaid’s legal protections for prompt access to care. Medicaid’s legal protections may be invoked either in litigation with barriers imposed by the Prison Litigation Reform Act, or, preferably, in a Medicaid fair hearing, which is constitutionally protected under the Due Process Clause. By providing a new path to access prompt medical care, the Medicaid system will continue to play a key role in ensuring justice in the nation’s marginalized communities.

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INTRODUCTION

Later, a registered nurse noted in his medical chart that the patient’s vital signs were stable and he was in no acute distress: At that point in time, however, the patient had been dead for ten hours.

— Marc Stern, MD, MPH¹

Broken prison health care systems throughout the United States are failing to provide incarcerated individuals with a basic level of care. The issues are systemic and have been criticized at length by federal courts,² researchers,³

1. Expert Report of Marc F. Stern, MD, MPH, at 2, *Dockery v. Epps*, No. 3:13-cv-00326, Dkt. No. 179-5 (S.D. Miss. Sept. 25, 2014) [hereinafter Stern Report], https://www.aclu.org/sites/default/files/assets/expert_report_of_marc_stern_2.pdf.

2. *See, e.g.*, *Brown v. Plata*, 131 S. Ct. 1910, 1923 (2011) (“For years the medical and mental health care provided by California’s prisons has fallen short of minimum constitutional

journalists,⁴ and the media.⁵ Underfunding, understaffing, and a dearth of quality health care professionals permeate the health care systems in our nation's prisons and jails, leaving the people incarcerated in these facilities in crisis. The system's tragic dysfunction is exemplified by the experience of "Patient 1," an individual cited in a medical expert's report in *Dockery v. Epps*, a federal prison conditions lawsuit.⁶ Patient 1 was a forty-three-year-old man who suffered from a number of serious health issues, including a severe cardiac condition, damaged heart tissue, congestive heart failure, asthma, high blood pressure, anemia, and schizophrenia.⁷ He spent the last month of his life in an isolation cell of the Eastern Mississippi Correctional Facility (EMCF).⁸

During this last month, Patient 1 exhibited clear signs of serious medical distress requiring attention and hospitalization, though EMCF's medical staff ignored his symptoms.⁹ Two weeks before his death, a mental health counselor performed a routine check on Patient 1 in his isolation cell and wrote in his medical record that Patient 1 was having hallucinations, asking for medical and mental health assistance, and saying he had "nothing to live for."¹⁰ Despite Patient 1's pleas, the counselor's medical note concluded that he "did not appear to be in any distress."¹¹ Ten hours *after* Patient 1 died in his cell from heart failure,¹² a nurse even wrote in his medical note that he was still "stable" and "in

requirements and has failed to meet prisoners' basic health needs. Needless suffering and death have been the well-documented result.").

3. See, e.g., Andrew P. Wilper, Steffie Woolhandler, J. Wesley Boyd, Karen E. Lasser, Danny McCormick, David H. Bor & David U. Himmelstein, *The Health and Health Care of U.S. Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 668 (2009) [hereinafter *Nationwide Survey*], <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661478/pdf/666.pdf>; Nancy L. Winterbauer & Ryan M. Diduk, *The Ten Essential Public Health Services Model as a Framework for Correctional Health Care*, 19 J. CORRECTIONAL HEALTH CARE 43, 44 (2012) ("Public health practitioners have good reason to be concerned about incarceration.").

4. See, e.g., Editorial, *California's Prison Mess*, L.A. TIMES, Aug. 9, 2013, at A16, <http://www.latimes.com/opinion/editorials/la-ed-prison-release-california-jerry-brown-20130809-story.html>; Editorial, *Medical Inattention in New York Prisons*, N.Y. TIMES, Sept. 15, 2009, at A32, <http://www.nytimes.com/2009/09/15/opinion/15tue2.html>.

5. See, e.g., LIFE IN PRISON: THE COST OF PUNISHMENT (KBPS Jan. 25, 2010), <http://www.kpbs.org/news/envision/prisons> (documenting the California Medical Facility); *Fault Lines: Women Behind Bars* (Al Jazeera Jan. 14, 2013) (documenting inadequate prison conditions).

6. Stern Report, *supra* note 1, at 2. *Dockery v. Epps* is a class-action lawsuit brought to challenge the lack of medical and mental health treatment at the Eastern Mississippi Correctional Facility ("EMCF"). See Complaint at 1, *Dockery v. Epps*, No. 3:13-cv-00326, Dkt. No. 1 (S.D. Miss. May 30, 2013), <https://www.aclu.org/legal-document/dockery-v-epps-complaint>.

7. Stern Report, *supra* note 1, at 2.

8. *Id.*

9. See *id.*

10. *Id.*

11. *Id.*

12. *Id.* at 22.

no acute distress.”¹³ One of the plaintiffs’ litigation experts concluded, “I cannot state with certainty that the blatant and callous lack of care that this 43-year old man received during his last months at EMCF caused his death. However, I can state that it deprived him of any chance he had for continued survival.”¹⁴

Patient 1’s experience is tragic and shocking, but it is not uncommon. Prison health care systems across the United States are frequently incapable of providing necessary care to the millions of individuals currently incarcerated.¹⁵ This issue is driven in part by the tension between budget cuts for correctional facilities and the rising costs of prison health systems.¹⁶ However, the legal framework of the Eighth Amendment, under which incarcerated individuals currently challenge inadequate health care access, has also played a role in creating significant barriers to quality health care in prisons.

This article proposes looking to Medicaid law and the use of fair hearings—which are the primary forum for resolving public benefits appeals outside of the prison system¹⁷—as a more protective and efficient alternative for incarcerated individuals who wish to challenge inadequate health care access. Medicaid is the jointly-funded federal-state program that provides health insurance to individuals with low incomes and/or disabilities.¹⁸ Through this program, the federal government contributes between fifty and eighty-three percent of the costs of providing health care to Medicaid-enrolled individuals.¹⁹ Medicaid law also guarantees access to fair hearings to challenge states’ delays in providing care.²⁰

Incarcerated individuals may now access fair hearings because state governments are beginning to use Medicaid to fund prison health expenses.²¹ This change is largely due to the Patient Protection and Affordable Care Act

13. *Id.* at 2. Additionally unbelievable was the medical review of Patient 1’s case, which concluded that “nothing additional . . . could have been done,” and his treatment “appears to have been appropriate.” *Id.* at 22.

14. *Id.* at 2.

15. See *Nationwide Survey*, *supra* note 3, at 668.

16. See Victoria Law, *States Cut Prison Budgets But Not Prison Populations*, TRUTH-OUT.ORG (Feb. 14, 2013), <http://www.truth-out.org/news/item/14278-states-cut-prison-budgets-but-not-prison-populations> (describing general budget cuts); see also PEW CHARITABLE TR., *MANAGING PRISON HEALTH CARE SPENDING 2–3* (Oct. 2013) [hereinafter *PEW 2013 REPORT*], http://www.pewtrusts.org/~media/legacy/uploadedfiles/pes_assets/2014/PCTCorrectionsHealthcareBrief050814.pdf (describing rising health costs).

17. The structure, benefits, and limitations of fair hearings will be discussed in greater detail in Part III *infra*.

18. See generally 42 U.S.C. § 1396a(A) (2012). The structure and requirements of Medicaid will be discussed in greater detail *infra* Part II.

19. See 42 U.S.C. §§ 1396b(a), 1396d(b) (2012); see also *Federal and State Share of Medicaid Spending*, KAISER FAMILY FOUND. [hereinafter *KFF Federal and State Medicaid Spending*], <http://kff.org/medicaid/state-indicator/federalstate-share-of-spending> (last visited Mar. 24, 2016).

20. 42 U.S.C. § 1396a(a)(3).

21. See Erica Goode, *Little-Known Health Act Fact: Prison Inmates Are Signing Up*, N.Y. TIMES, Mar. 9, 2014, at A1, http://www.nytimes.com/2014/03/10/us/little-known-health-act-fact-prison-inmates-are-signing-up.html?_r=1.

(Affordable Care Act or ACA), which significantly expanded the number of people eligible to enroll in Medicaid,²² and provides that the federal government will pay nearly the entirety of the health costs of these newly eligible individuals.²³ Since the program's inception in 1965,²⁴ the law has prohibited federal "payments with respect to care or services for any individual who is an inmate of a public institution,"²⁵ effectively prohibiting states from enrolling incarcerated individuals in Medicaid. However, in 1997 the Centers for Medicare and Medicaid Services (CMS)—the federal agency tasked with overseeing Medicaid—interpreted the law to mean that incarcerated individuals were not "inmate[s] of a public institution" if they had been admitted to a hospital, inpatient facility, or nursing home not under the authority of the corrections agency for more than twenty-four hours.²⁶ CMS's interpretation thus allows federal Medicaid payments to reimburse states for certain health services provided to incarcerated individuals during the periods they are not considered "inmates." Though some states already seek such reimbursement, most states have not, until recently,²⁷ due to the confusion over which services are eligible for federal reimbursement and the administrative burdens of tracking and billing for these services.²⁸

This article will explore the state prison healthcare system and how Medicaid could offer new legal protections for incarcerated individuals in the coming years. Part I examines the current state of healthcare administration and funding in state prisons, as well as the significant issues with the current legal framework for challenging inadequate health services under the Eighth

22. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119, 271 (Mar. 23, 2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)).

23. See sources cited *infra* note 96.

24. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1905(a)(A), 79 Stat. 286, 352 (July 30, 1965) (codified at 42 U.S.C. § 1396d(a)(A) (2012)).

25. 42 U.S.C. § 1396d(a)(A) (2012); COUNCIL OF STATE GOV'TS JUSTICE CTR., MEDICAID AND FINANCING HEALTH CARE FOR INDIVIDUALS INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM 2 (Dec. 2013) [hereinafter CSG JUSTICE CENTER REPORT], <http://csgjusticecenter.org/wp-content/uploads/2013/12/ACA-Medicaid-Expansion-Policy-Brief.pdf>.

26. Letter from Robert A. Streimer, Dir. of Disabled & Elderly Health Programs Grp., Ctr. for Medicaid & State Operations, Health Care Fin. Admin., to Assoc. Reg'l Adm'rs (Dec. 12, 1997) [hereinafter CMS Guidance], <http://csgjusticecenter.org/wp-content/uploads/2014/06/PolicyforInmatesofPublicInst1997.pdf>; see also 42 C.F.R. § 435.1010 (2012) (defining "[i]npatient" as "[r]eceiving room, board and professional services in the institution for a 24 hour period or longer[]"). The Health Care Financing Administration was renamed the Centers for Medicare & Medicaid Services in 2001. See Press Release, U.S. Dep't of Health & Human Servs., The New Centers for Medicare & Medicaid Services (CMS) (June 14, 2001), <http://archive.hhs.gov/news/press/2001pres/20010614a.html>.

27. PEW 2013 REPORT, *supra* note 16, at 17–18 (calling states' use of Medicaid funds for prison expenses "relatively rare"); CSG JUSTICE CENTER REPORT, *supra* note 25, at 2 ("Only a few states have yet opted to take advantage of this opportunity.")

28. See Laura Morgan, *Why Do States Terminate Rather Than Suspend Inmate Medicaid Benefits?*, OPENMINDS (July 17, 2014), <https://www.openminds.com/market-intelligence/executive-briefings/states-terminate-rather-suspend-inmate-medicaid-benefits.htm/>.

Amendment's "deliberate indifference" standard. Part II describes how Medicaid impacts the issue of improving health access in prisons and explains the recent expansion of Medicaid eligibility, relevant changes in Medicaid law, and the implications for enrolling incarcerated individuals. Finally, Part III proposes two paths for using Medicaid's protections: § 1983 challenges and fair hearings. Though both paths offer an improvement to Eighth Amendment claims, this article argues that fair hearings offer the best avenue to improve conditions. This section further argues that fair hearings are not only a viable alternative forum to federal courts, but are also constitutionally protected under the Due Process Clause of the Fifth and Fourteenth Amendments.

If Patient 1 had been eligible for Medicaid, he may have been able to demand access to the hospitalization and treatment that he so critically needed, by advocating for himself in a fair hearing. Rather than suffering for months while being ignored by prison officials and administrators, he might have secured access to treatment through the quick and fair determination of a hearing officer or administrative law judge. And, ultimately, his health could have improved, and his death might have been prevented. This article advocates for the use of these new protections in order to help individuals like Patient 1, who currently wait for critical treatment from a hospital, inpatient, or nursing facility. The use of fair hearings in particular, which allow an individual to present their own case to a neutral decision-maker and fairly advocate for one's own health needs, ultimately advances the goal of health justice by enabling the self-empowerment of poor and marginalized communities.²⁹ This result allows incarcerated individuals to additionally learn to engage with the Medicaid system, which is critical for their health and the health of the communities to which they return. This article assesses these issues in order to propose a launching point for advocates, administrators, and legislators to utilize Medicaid's infrastructure to more effectively meet the health care needs of the nation's incarcerated population.

I.

THE FAILURE OF PRISON HEALTH SYSTEMS

A. *Incarcerated Individuals Currently Experience Poor Health and a Lack of Access to Care*

The millions of people incarcerated in the nation's prisons and jails are significantly less healthy than the rest of the U.S. population.³⁰ One recent study estimated that nearly forty-three percent of individuals in state prison and thirty-

29. See generally Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 84–85 (2014) (defining the nascent movement for health justice).

30. See *Nationwide Survey*, *supra* note 3, at 668; LAURA M. MARUSCHAK, MARCUS BERZOFKY & JENNIFER UNANGST, BUREAU OF JUSTICE STATISTICS, MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONERS AND JAIL INMATES, 2011–12, at 1 (Feb. 2015), <http://www.bjs.gov/content/pub/pdf/mpsfj1112.pdf>.

nine percent in local jails have at least one chronic medical condition,³¹ and the prevalence of these conditions—including diabetes, hypertension, and asthma—is higher for individuals in prison and jail than for the general population.³² Individuals in state prisons are also thirty-one percent more likely to have asthma and ninety percent more likely to have suffered a past heart attack.³³ Over half of all individuals in prisons and jails have a mental illness,³⁴ and the prevalence of some psychotic disorders is three to five times higher among incarcerated individuals than among the overall U.S. population.³⁵ The poor health of the nation’s incarcerated population primarily derives from the fact that socioeconomic determinants of health³⁶—i.e., poverty, instability, and disempowerment—are also risk factors for being swept into the criminal justice system.³⁷

Despite their pressing need, incarcerated individuals face inadequate access to necessary health services. In a position statement, the National Commission on Correctional Health Care noted that “the lack of access to health care is a serious problem in detention and correctional institutions.”³⁸ In fact, the reality far surpasses “a serious problem.” For example, in the Eastern Mississippi

31. *Nationwide Survey*, *supra* note 3, at 668.

32. *Id.*; see also LOIS M. DAVIS, NANCY NICOSIA, ADRIAN OVERTON, LISA MIYASHIRO, KATHRYN PITKIN DEROSE, TERRY FAIN, SUSAN TURNER, PAUL STEINBERG & EUGENE WILLIAMS III, RAND CORP., UNDERSTANDING THE PUBLIC HEALTH IMPLICATIONS OF PRISONER REENTRY IN CALIFORNIA (2009) [hereinafter RAND REPORT], http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR687.pdf. For example, while approximately six percent of the U.S. population suffers from diabetes, ten percent of people in state prisons are diabetic. *Nationwide Survey*, *supra* note 3, at 669.

33. David Cecere, *Inmates Suffer From Chronic Illness, Poor Access to Health Care*, HARV. GAZETTE (Jan. 15, 2009), <http://news.harvard.edu/gazette/story/2009/01/inmates-suffer-from-chronic-illness-poor-access-to-health-care>.

34. DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (Sept. 2006), <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

35. RAND REPORT, *supra* note 32, at 27.

36. See, e.g., Ctrs. for Disease Control & Prevention, *CDC Health Disparities and Inequalities Report—United States, 2013*, 62 MORBIDITY AND MORTALITY WEEKLY REP. 1, 3–5 (Nov. 22, 2013) (providing background on social determinants of health); WORLD HEALTH ORG., REPORT NO. EB132/14: SOCIAL DETERMINANTS OF HEALTH (Nov. 23, 2012) (noting that “[t]ackling social determinants of health” is fundamental to the work of the World Health Organization).

37. See Nick de Viggiani, *Unhealthy Prisons: Exploring Structural Determinants of Prison Health*, 29 SOCIOLOGY OF HEALTH & ILLNESS 115, 115 (2007) (reporting that in the UK incarcerated individuals “come from the poorest or most socially excluded tiers of society and often have the greatest health needs”).

38. NAT’L COMM’N ON CORRECTIONAL HEALTH CARE, POSITION STATEMENT: CHARGING INMATES A FEE FOR HEALTH CARE SERVICES (Oct. 2012), http://www.ncchc.org/filebin/Positions/Charging_Inmates_a_Fee_for_Health_Care_Services.pdf. The National Commission on Correctional Health Care (“NCCHC”) is a voluntary health care accreditation organization founded in the 1970s to provide national standards and guidelines for treatment of medical conditions in detention and correctional facilities. See *When Correctional Health Administrators Need Assistance, They Turn to NCCHC*, NAT’L COMM. ON CORRECTIONAL HEALTH CARE, <http://www.ncchc.org/accreditation-facility-services> (last visited Mar. 22, 2016).

Correctional Facility (EMCF), where Patient 1 resided when he died and where “[d]irt, feces and, occasionally, blood are caked on the walls of cells,”³⁹ another patient lived with an infected sore on his leg that became gangrenous from neglect and lack of medical attention.⁴⁰ As one medical expert wrote in his report for the *Dockery v. Epps* litigation, “[t]he dysfunction in the medical care delivery system at EMCF permeates every essential aspect of the system[, and] health care operations are broken at every level”⁴¹

This damning statement about EMCF echoes the concerns with prison health across the country.⁴² A 2009 study found that twenty percent and sixty-eight percent of people in state prisons and jails, respectively, with a persistent medical problem had received *no medical examination at all* since becoming incarcerated.⁴³ The study also found that twelve percent of those individuals in state prisons and twenty-five percent in local jails with a serious injury, including knife or gunshot wounds, broken bones, or internal injuries, received no medical examination.⁴⁴ Moreover, federal judges have found prison health care to be inadequate—and unconstitutional—in states across the country.⁴⁵

B. State Funding of Current Prison Health Systems

State governments fund health care in prisons and jails through their annual budget appropriations.⁴⁶ Correctional agencies directly employ medical staff who provide health services for incarcerated individuals.⁴⁷ In order to save money, states are increasingly contracting with for-profit entities to provide

39. Erica Goode, *Seeing Squalor and Unconcern in a Mississippi Jail*, N.Y. TIMES, June 7, 2014, at A1, <http://www.nytimes.com/2014/06/08/us/seeing-squalor-and-unconcern-in-southern-jail.html>.

40. *Id.*

41. Stern Report, *supra* note 1, at 1.

42. *See, e.g.*, Expert Report of Robert L. Cohen, M.D., at 4, *Parsons v. Ryan*, Case No. 2:12-cv-00601 (D. Az. Nov. 8, 2013) [hereinafter Cohen Report], <https://www.aclu.org/legal-document/parsons-v-ryan-confidential-report-robert-l-cohen-md> (writing that the health care system of the Arizona Department of Corrections (ADOC) was “disorganized, under-resourced, understaffed, and completely lacking in the capacity to monitor itself and correct the systemic dysfunction that currently exists”).

43. *Nationwide Survey*, *supra* note 3, at 669.

44. *Id.* at 670 tbl.3.

45. *See, e.g.*, *Erickson v. Pardus*, 551 U.S. 89, 94 (2007) (Colorado); *Helling v. McKinney*, 509 U.S. 25, 35 (1993) (Nevada); *West v. Atkins*, 487 U.S. 42, 57–58 (1988) (North Carolina); *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (Texas); *Phillips v. Roane Cnty.*, Tenn., 534 F.3d 531, 539–40 (6th Cir. 2008) (Tennessee); *Hudson v. McHugh*, 148 F.3d 859, 864 (7th Cir. 1998) (Wisconsin). A more detailed discussion of constitutional litigation on prison health care is found in Part I(C) *infra*.

46. *See, e.g.*, S. 2000, 2015 Leg., 238th Sess. (N.Y. 2015) (appropriating \$377,353,000 from the “General Fund” for the Department of Corrections and Community Supervision’s “Health Services Program”); H.R. 7133, 2014 Leg., Jan. Sess. (R.I. 2014) (appropriating \$19,751,408 from “General Revenues” for “Healthcare Services” for the state prison system).

47. PEW 2013 REPORT, *supra* note 16, at 7.

medical care within prison facilities.⁴⁸ However, prisons that utilize private health contractors are held to the same constitutional standards as those that provide health care directly.⁴⁹

Despite the U.S. prison system's poor healthcare record, the nation's fifty states collectively spent \$7.7 billion on correctional healthcare in 2011.⁵⁰ The average amount that each state spent per incarcerated individual on health care costs ranged from \$2558 (Oklahoma) to \$14,495 (California).⁵¹ States spend approximately twenty percent of their correctional health care dollars on hospitalization,⁵² which, as discussed below, is the type of service Medicaid will reimburse states for.

The cost of treating older individuals in prison is particularly high and growing rapidly. The number of incarcerated individuals older than fifty-five has increased six times faster than the rest of the prison population,⁵³ increasing from 43,300 individuals in 1999 to 144,500 in 2013.⁵⁴ This rapid growth in the number of older individuals in prisons has had a corresponding impact on state spending on healthcare. For example, Michigan spends an average of \$5800 per individual on health care costs, though it spends \$11,000 per year on individuals ages fifty-five to fifty-nine, and \$40,000 per year on individuals aged eighty and

48. *Id.*

49. *See, e.g., West*, 487 U.S. at 54–57 (holding that a doctor under contract with a state to provide medical services to incarcerated individuals could be sued under § 1983); *Rosborough v. Mgmt. & Training Corp.*, 350 F.3d 459, 461 (5th Cir. 2003) (holding that “private prison management corporations and their employees may be sued under” § 1983); *Conner v. Donnelly*, 42 F.3d 220, 223 (4th Cir. 1994) (“[A] physician who treats a prisoner acts under color of state law even though there was no contractual relationship between the prison and the physician.”); *Skelton v. PriCor, Inc.*, 963 F.2d 100, 102 (6th Cir. 1991) (holding private prisons under contract with the state may be sued under § 1983); *see also* CMS Guidance, *supra* note 26, at 2 (explaining that CMS views prisons with private health contractors to be the same as public institutions).

50. PEW CHARITABLE TR, STATE PRISON HEALTH CARE SPENDING: AN EXAMINATION 3 (July 2014) [hereinafter PEW 2014 REPORT], <http://www.pewtrusts.org/~media/Assets/2014/07/StatePrisonHealthCareSpendingReport.pdf>. Though correctional health care costs grew at an average of thirteen percent each year between 2007 and 2011, the 2011 figure is actually a decline from the country's \$8.2 billion spent in 2009, attributable in part to reductions in state prison populations. *Id.*

51. *Id.* at 4 fig.1.

52. *Id.* at 7. Data was not available for all states.

53. Timothy Williams, *Number of Older Inmates Grows, Stressing Prisons*, N.Y. TIMES, Jan. 26, 2012, at A19, <http://www.nytimes.com/2012/01/27/us/older-prisoners-mean-rising-health-costs-study-finds.html>.

54. Maria Schiff, *Examining State Prison Health Care Spending: Cost Drivers and Policy Approaches*, HEALTH AFFAIRS BLOG (Nov. 4, 2014), <http://healthaffairs.org/blog/2014/11/04/examining-state-prison-health-care-spending-cost-drivers-and-policy-approaches>. Though fifty-five is not typically considered “older” in the general population, research has shown that those who are incarcerated often experience “accelerated aging,” driven by poor health, lack of access to health care, the stress of incarceration, and, often, history of substance abuse. *See* Brie A. Williams, James S. Goodwin, Jacques Baillargeon, Cyrus Ahalt & Louise C. Walter, *Addressing the Aging Crisis in U.S. Criminal Justice Healthcare*, J. AM. GERIATRICS SOC'Y 2 (June 2014) (manuscript), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923/pdf/nihms363409.pdf>.

older.⁵⁵ For off-site health care expenses—which are the services eligible for federal Medicaid reimbursement—Virginia spends an average of \$795 per year for individuals below fifty-years-old, but \$5372 for individuals older than fifty.⁵⁶ As will be addressed in Part II, these extremely high health care costs for older individuals, and for costs associated with services outside of correctional facilities, are the primary drivers for states pursuing Medicaid reimbursement for such expenses.

C. *Legal Challenges to Prison Healthcare Under the Eighth Amendment's Deliberate Indifference Standard*

Incarcerated people have brought a significant number of cases against the broken prison healthcare system. This section briefly describes the dominant legal framework for these cases, the shortcomings of that framework, and the need for alternatives where possible. The vast majority of these challenges have argued that lack of access to health services violates the Eighth Amendment of the U.S. Constitution, which prohibits “cruel and unusual punishment.”⁵⁷ In *Estelle v. Gamble*, the Supreme Court interpreted the Eighth Amendment to require that a minimum level of health care be provided to incarcerated individuals.⁵⁸ The Court articulated a “deliberate indifference” analysis to determine whether the level of health services provided is constitutionally insufficient.⁵⁹ In *Farmer v. Brennan*, the Court adopted a two-prong test to determine whether prison officials acted with “deliberate indifference.”⁶⁰ The test requires proving that: (1) the injury or deprivation experienced by the

55. HUMAN RIGHTS WATCH, OLD BEHIND BARS: THE AGING PRISON POPULATION IN THE UNITED STATES 75, 76 (Jan. 2012) (citing STEVE ANGELOTTI & SARA WYCOFF, SENATE FISCAL AGENCY, MICHIGAN'S PRISON HEALTH CARE: COSTS IN CONTEXT (2010), www.senate.michigan.gov/sfa/publications/issues/prisonhealthcarecosts/prisonhealthcarecosts.pdf), https://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0.pdf; see also Williams, Goodwin, Baillargeon, Ahalt & Walter, *supra* note 54.

56. PEW 2013 REPORT, *supra* note 16, at 11.

57. U.S. CONST., amend. VIII. (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”). A smaller portion of prison rights litigation stems from Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131–65 (2012).

58. *Estelle v. Gamble*, 429 U.S. 97 (1976). In the case, Gamble brought a pro se suit under 42 U.S.C. § 1983 against Texas for failing to provide adequate medical care after he was injured during a work accident. After articulating the “deliberate indifference” framework that would apply to all prisoners’ rights cases in the decades to follow, Justice Marshall ultimately held that the prison officials in the case were not deliberately indifferent to Gamble’s health needs, as the lack of performing an x-ray screening “does not constitute cruel and unusual punishment but is at most medical malpractice.” *Id.* at 97–98.

59. *Id.* at 97–98.

60. 511 U.S. 825 (1994). *Farmer* is a challenge to the conditions of confinement, though the same “deliberate indifference” standard applies to cases challenging inadequate access to health care. In this case, Dee Farmer was a transgender woman incarcerated in a men’s prison, where she was beaten and raped, leading her to file a suit arguing that the prison officials were deliberately indifferent to her safety needs. *Id.* at 825–26.

incarcerated individual is “sufficiently serious” or poses “a substantial risk of serious harm,”⁶¹ an objective standard, and (2) the prison official “knows of and disregards an excessive risk to inmate health,”⁶² a subjective inquiry.

The *Farmer v. Brennan* test poses an enormous barrier for litigants. It is almost impossible to successfully establish that prison health officials acted with deliberate indifference to their medical needs. In particular, federal courts routinely hold that delays in health treatment do not rise to the level of a sufficiently serious harm if no physical injury or pain results.⁶³ Additionally, the test’s subjective prong, which requires proof that an official knowingly disregarded the substantial risk of serious harm, has the effect of exempting medical care that might still be shockingly inadequate—including care that is otherwise negligent—so long as the litigant cannot prove that the official knew of the risk and disregarded it.⁶⁴

The Prison Litigation Reform Act (PLRA) further imposes restrictions on incarcerated individuals’ access to federal courts.⁶⁵ The PLRA requires incarcerated individuals to pay partial filing fees even if they seek to proceed *in forma pauperis*, i.e., if they move to waive filing costs because they lack the necessary funds.⁶⁶ Courts may also dismiss cases brought by incarcerated individuals if they find that the “action is frivolous [or] malicious,”⁶⁷ a standard

61. *Id.* at 834; *see also* *Erickson v. Pardus*, 551 U.S. 89, 89–90 (2007) (finding a serious medical need when prison officials prematurely stopped an individual’s year-long hepatitis C treatment, risking irreversible damage to his liver or even death); *Hathaway v. Coughlin*, 37 F.3d 63, 66 (2d Cir. 1994) (defining serious medical need as “a condition of urgency, one that may produce death, degeneration, or extreme pain”); *Carnell v. Grimm*, 872 F. Supp. 746, 755 (D. Haw. 1994) (“A ‘serious’ medical need exists if the failure to treat the need could result in further significant injury or ‘unnecessary and wanton infliction of pain.’”); *Laaman v. Helgemoe*, 437 F. Supp. 269, 311 (D.N.H. 1977) (defining serious medical need as “one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention”).

62. *Farmer*, 511 U.S. at 837.

63. *See, e.g.*, *Smith v. Carpenter*, 316 F.3d 178, 181 (2d Cir. 2003) (denial of HIV medications for days was not sufficiently serious); *Oxendine v. Kaplan*, 241 F.3d 1272, 1276 (10th Cir. 2001) (“[D]elay in medical care only constitutes an Eighth Amendment violation where the plaintiff can show that the delay resulted in substantial harm.”) (quoting *Sealock v. Colorado*, 218 F.3d 1205, 1210 (10th Cir. 2000)).

64. *Estelle*, 429 U.S. at 106 (“[A] complaint that a physician has been negligent . . . does not state a valid claim of medical mistreatment under the Eighth Amendment.”).

65. Prison Litigation Reform Act of 1995, Pub. L. No. 104-134, §§ 801–810, 110 Stat. 1321–66 (Apr. 26, 1996) (codified in scattered sections of 18 U.S.C., 28 U.S.C. and 42 U.S.C.); *see also* COLUMBIA HUMAN RIGHTS LAW REVIEW, A JAILHOUSE LAWYER’S MANUAL 288–353 (9th ed. 2011) (describing the requirements of the PLRA).

66. 28 U.S.C. §§ 1915(b)(1)–(2) (2012). The statute requires an individual to pay twenty percent of the greater of “the average monthly deposits to the prisoner’s account” or “the average monthly balance in the prisoner’s account for the 6-month period immediate preceding” the litigation. *Id.* However, if the individual has no assets, she is not completely barred from bringing litigation. *See id.*; 28 U.S.C. § 1915(b)(4) (2012) (“In no event shall a prisoner be prohibited from bringing a civil action or appealing a civil or criminal judgment for the reason that the prisoner has no assets and no means by which to pay the initial partial filing fee.”).

67. 42 U.S.C. §§ 1997e(c)(1)–(2) (2012).

not imposed on litigants under the Federal Rules of Civil Procedure.⁶⁸ An individual is not permitted to bring a case *in forma pauperis* if she has had three such suits dismissed as frivolous or malicious or for failure to state a claim, unless she is “under imminent danger of serious physical injury.”⁶⁹ Federal law further bars individuals from bringing § 1983 claims “until such administrative remedies as are available are exhausted.”⁷⁰ The administrative procedures for health grievances will be discussed further in Part III. The PLRA’s explicit purpose is to impede access to courts for incarcerated individuals, and it has been very successful.

In *Estelle*, Justice Marshall wrote that the Eighth Amendment prohibits “punishments which are incompatible with ‘the evolving standards of decency that mark the progress of a maturing society’”⁷¹ However, as described above, many of the nation’s prison health care systems fall far below any rational standards of “decency.” Moreover, the legal framework with which to challenge these systems and the PLRA together create a nearly insurmountable impediment to securing health access. The following sections describe how Medicaid potentially offers a new and stronger framework.

II.

THE EXPANSION OF MEDICAID AND THE IMPACT ON PRISON HEALTHCARE

Incarcerated individuals who qualify for Medicaid are entitled to receive a limited set of hospital-based health services under the Medicaid program, as long as states do not expressly terminate Medicaid benefits upon incarceration. This section explores the effect of the Affordable Care Act’s Medicaid reforms and the protections that Medicaid could potentially offer to incarcerated individuals. Part II(A) provides necessary background information on the structure and requirements of Medicaid, as well as the changes to eligibility that will have the effect of covering a large proportion of incarcerated individuals beginning in 2014. Part II(B) surveys how Medicaid currently interacts with prison health systems under federal and state law. It additionally describes the financial impact of Medicaid expansion on these systems.

A. *The Basics of Medicaid and the ACA’s Eligibility Expansion*

Medicaid provides health insurance coverage for Americans with low-incomes and/or disabilities. It is jointly funded by the federal and state governments. Direct administration of Medicaid programs is under the domain of state agencies, and as a result Medicaid operates as fifty-one separate state

68. *See, e.g.*, Fed. R. Civ. P. 12(b).

69. 28 U.S.C. § 1915(f)(2)(C) (2012).

70. 42 U.S.C. § 1997e(a) (2012).

71. *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)).

programs.⁷² States enter this joint partnership voluntarily,⁷³ and all fifty states plus the District of Columbia have done so.⁷⁴ To participate, states must submit to CMS an official state plan for the administration of their Medicaid program.⁷⁵ These plans are then approved or rejected by the Secretary of the U.S. Department of Health and Human Services (HHS).⁷⁶ Federal law sets extensive requirements on what these plans must contain, such as funding, eligibility, reporting, structure, administration, and the specific range of health services that must be covered.⁷⁷ Federal CMS officials regularly work with their counterparts in state health agencies to bring state plans into compliance with all requirements so they may be approved.⁷⁸ Rejection of a state plan is a drastic and undesirable option that would strip states of federal funding participation,⁷⁹ which in most states provides the majority of the funding necessary to provide coverage for individuals with low incomes or disabilities.⁸⁰

One requirement that federal law imposes on state Medicaid plans is an eligibility floor for who must be covered by the state's insurance program.⁸¹ Specifically, the law imposes an income test for eligibility and also requires states to cover, at a minimum, individuals in certain "mandatory eligibility groups,"⁸² including, among others, low-income families, pregnant women,

72. See NAT'L HEALTH LAW PROGRAM, THE ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM 2.3–2.7 (4th ed. 2011) [hereinafter NHELP MEDICAID GUIDE].

73. See *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006) ("States are not required to participate in Medicaid, but all of them do."); *Frew v. Hawkins*, 540 U.S. 431, 433 (2004) ("State participation is voluntary; but once a State elects to join the program, it must administer a state plan that meets federal requirements.").

74. See *State Medicaid & CHIP Profiles*, MEDICAID.GOV, <http://medicaid.gov/medicaid-chip-program-information/by-state/by-state.html> (last visited Apr. 12, 2015) (presenting information about the Medicaid programs of all fifty states and the District of Columbia); *Ahlborn*, 547 U.S. at 275 ("States are not required to participate in Medicaid, but all of them do.").

75. 42 U.S.C. § 1396a (2012) (state plan requirements); 42 C.F.R. § 431.10 (2014) (regulations further clarifying state plan requirements).

76. 42 U.S.C. § 1396a(b) ("The Secretary shall approve any plan . . ."); 42 U.S.C. § 1396c (2012) (describing procedures for the Secretary rejecting plans).

77. See generally § 1396a; 42 C.F.R. § 431.10.

78. See CTRS. FOR MEDICARE & MEDICAID SERVS., THE STATE MEDICAID MANUAL § 13026 [hereinafter CMS MEDICAID MANUAL], <https://www.cms.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html> ("The States are encouraged to obtain consultation of the regional staff when a plan is in process of preparation or revision."); see also NHELP MEDICAID GUIDE, *supra* note 72, at 2.3 ("CMS regional offices maintain regular contact with the state Medicaid agencies in their region and deal directly with states as they implement their state Medicaid plans.").

79. 42 U.S.C. § 1396c (granting the Secretary of HHS the authority to declare that "further payments will not be made to the State" until she "is satisfied that there will no longer be any failure to comply" with plan requirements); see *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2604 (2012) (calling the § 1396c remedy a "gun to the head").

80. For a detailed discussion of the cost-sharing between the federal and state governments, see Part II(A) *infra*.

81. 42 U.S.C. § 1396a(a)(10)(A).

82. *Id.*; see also *Eligibility*, MEDICAID.GOV, <https://www.medicicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html> (last visited Mar. 24, 2016) ("In order to

children, and individuals with disabilities receiving Supplemental Security Income (SSI).⁸³ The Affordable Care Act significantly expanded eligibility for Medicaid to all adults under a certain income threshold regardless of membership in these mandatory eligibility groups.⁸⁴ This enables all individuals with incomes below 133 percent of the Federal Poverty Line (FPL)—e.g., an income below \$15,654 for a single adult with no children—to enroll in Medicaid.⁸⁵ On top of this, the Affordable Care Act provides a “five percent disregard” when calculating eligibility income, effectively raising the income limit to 138 percent of the FPL, or \$16,242 for a single adult.⁸⁶

The Affordable Care Act initially structured the eligibility expansion as another requirement placed on state Medicaid plans, similar to those described above.⁸⁷ This meant that the states that decided not to expand eligibility would be out of compliance with the state plan requirements and could lose the entirety of their federal Medicaid funding participation if the Secretary of HHS rejected their plan.⁸⁸ However, the Supreme Court in 2012 interpreted the ACA’s eligibility expansion to have created a new and “independent” Medicaid program, and held that Congress’s conditioning of all Medicaid funding on participation in the “new” program was impermissibly coercive in violation of the Spending Clause of the Constitution.⁸⁹ Thus, if states elect not to participate in the “new” expansion program, they may still retain funding for their “original” Medicaid program. As a consequence of the Court’s ruling, thirty-one states and the District of Columbia elected to expand their Medicaid programs as of January 2016.⁹⁰ Collectively, these states have a population of approximately

participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups).”).

83. 42 U.S.C. § 1396a(a)(10)(A)(i); *see also* *List of Medicaid Eligibility Groups*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> (last visited Mar. 24, 2016).

84. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119, 271 (2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (“A State plan for medical assistance must . . . provide for making medical assistance available . . . to all individuals . . . beginning January 1, 2014, who are under 65 years of age . . . and are not described in or enrolled under a previous subclause of this clause, and whose income . . . does not exceed 133 percent of the poverty line . . .”).

85. For the Federal Poverty Line, *see* 2015 Poverty Guidelines, U.S. DEP’T OF HEALTH & HUMAN SERVS. (Sept. 3, 2015), <https://aspe.hhs.gov/2015-poverty-guidelines>.

86. *See* 42 U.S.C. § 1396a(e)(14)(I)(i). Note, this law was mistakenly enacted with two paragraph 14s.

87. Patient Protection and Affordable Care Act § 2001(a)(1) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)) (listing expansion among “state plan” requirements).

88. 42 U.S.C. §§ 1396a(b), 1396c (2012); *see also* *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2603 (2012) (“Instead of simply refusing to grant the new funds to States that will not accept the new conditions, Congress has also threatened to withhold those States’ existing Medicaid funds.”).

89. *Sebelius*, 132 S. Ct. at 2603–04, 2607.

90. *See Status of State Action on the Medicaid Expansion Decision*, KAISER FAMILY FOUND. (Jan. 12, 2016) [hereinafter *KFF Medicaid Expansion Decisions*], <http://kff.org/health->

197 million individuals, representing about sixty percent of the nation's 319 million residents.⁹¹ The remaining forty percent of the population, in the nineteen non-expansion states, must continue to live with the original Medicaid eligibility regime. However, despite this section's emphasis on Medicaid expansion, individuals in those nineteen states may still be eligible for Medicaid if they fall into any of the original eligibility groups, such as pregnant women or adults with physical or mental disabilities.

Medicaid law requires cost-sharing between states and the federal government.⁹² The law specifies that the federal medical assistance percentage (FMAP) must be no less than fifty percent and no more than eighty-three percent.⁹³ In other words, the federal government will reimburse states for fifty to eighty-three percent of their Medicaid costs, and the percentage varies based on the state's per capita income.⁹⁴ The average federal contribution is fifty-seven percent of a state's costs.⁹⁵ The ACA set the FMAP at a much higher level for the cost of covering newly-eligible individuals, i.e., childless adults with income below 138 percent of the FPL. In 2014, 2015, and 2016, the federal government committed to pay 100 percent of the health care costs of these individuals, dropping slightly to 95 percent in 2017, then 94 percent in 2018, 93 percent in 2019, and finally 90 percent in 2020 and all years thereafter.⁹⁶

reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act. As of January 2016, these states include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, West Virginia, and the District of Columbia. *Id.* South Dakota, Virginia, and Wyoming are also reportedly considering participation in the Medicaid expansion program. *Id.*

91. See *Population Estimates – State Totals: Vintage 2015*, U.S. CENSUS BUREAU, <http://www.census.gov/popest/data/state/totals/2015/index.html> (last updated Jan. 21, 2016).

92. 42 U.S.C. § 1396b(a) (2012); 42 U.S.C. § 1396d(b) (2012) (defining “Federal medical assistance percentage”).

93. 42 U.S.C. § 1396d(b)(1).

94. More specifically, Medicaid law states that “the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii” 42 U.S.C. § 1396d(b). As a result, these percentages vary greatly between states, with states like Mississippi or West Virginia paying as little as twenty-six or twenty-seven percent of the cost, respectively, while eleven other states—Colorado, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, and Virginia—contribute close to the maximum of fifty percent. *KFF Federal and State Share of Medicaid Spending*, *supra* note 19.

95. *KFF Federal and State Medicaid Spending*, *supra* note 19.

96. Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010, 78 Fed. Reg. 19,942–43 (Apr. 2, 2013) (codified at 42 C.F.R. §§ 433.10(c)(6)(i)(A)–(E) (2014)); see also CTRS. FOR MEDICARE & MEDICAID SERVS., FREQUENTLY ASKED QUESTIONS ON EXCHANGES, MARKET REFORMS, AND MEDICAID 11–12 (Dec. 10, 2012), <https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf>.

B. *The Impact of Medicaid Eligibility Expansion on Prison Health Funding*

A large majority of the prison population has historically been excluded from Medicaid eligibility, since to qualify individuals must be within an eligibility group, such as the parent of a dependent child, a pregnant woman, or an adult with a disability.⁹⁷ These excluded individuals are now far more likely to be eligible for coverage in the twenty-eight states that have adopted Medicaid's new inclusion of childless adults earning up to 138 percent of the FPL.⁹⁸ For example, New York estimated that eighty percent of its state prison population would be newly eligible for Medicaid, and Colorado estimated ninety percent of its prison population would be.⁹⁹ The U.S. Government Accountability Office estimates that forty-five percent of individuals in prisons and forty-three percent in jails reside in states that have expanded Medicaid.¹⁰⁰ As this article will explain in Part III below, Medicaid thus potentially extends its legal protections to nearly half of the states' incarcerated populations.

However, two significant factors which pre-date the Affordable Care Act impact incarcerated individuals' ability to claim Medicaid's legal protections: (1) federal funding limitations on services to "inmates," and (2) state policies which terminate public benefits upon incarceration. These factors, as well as proposals for working around them, are addressed in the following sections.

1. *Limitations on Funding by Federal Law*

While the majority of individuals in state prisons became eligible for Medicaid enrollment after the ACA, federal law under 42 U.S.C. § 1396d(a)(A) still prohibits federal financial contributions for any Medicaid costs associated with "inmates of public institutions."¹⁰¹ HHS regulations specify that an

97. See CSG JUSTICE CENTER REPORT, *supra* note 25, at 1 ("Historically, adults who do not have dependent children or do not meet disability criteria have not been eligible for Medicaid, which has limited the extent to which the program has funded services for people involved with the criminal justice system.").

98. See NAT'L ASS'N OF COUNTIES, COUNTY JAILS AND THE AFFORDABLE CARE ACT 2 (Mar. 2012), http://www.naco.org/programs/csd/Documents/HealthReformImplementation/County-Jails-HealthCare_WebVersion.pdf. ANDREA A. BAINBRIDGE, U.S. DEP'T OF JUST., WHITE PAPER: THE AFFORDABLE CARE ACT AND CRIMINAL JUSTICE: INTERSECTIONS AND IMPLICATIONS 6 (July 2012), https://www.bja.gov/Publications/ACA-CJ_WhitePaper.pdf ("[T]here is the hypothesis that individuals involved in the criminal justice system will be among the newly eligible adults, as many jail inmates are young, low-income males who did not previously qualify for Medicaid.").

99. See U.S. GOV'T ACCOUNTABILITY OFFICE, MEDICAID: INFORMATION ON INMATE ELIGIBILITY AND FEDERAL COSTS FOR ALLOWABLE SERVICES 4 (Sept. 5, 2014) [hereinafter GAO REPORT], <http://www.gao.gov/assets/670/665552.pdf>. California estimated that seventy-two percent of its state prison would be eligible for Medicaid, and the remaining twenty-eight percent would be ineligible primarily due to the lack of a Social Security number. *Id.* at 4.

100. *Id.* These estimates are smaller than the actual percentages due to states that have expanded Medicaid since the GAO Report's publication.

101. 42 U.S.C. § 1396d(a)(A) (2012); 42 C.F.R. § 435.1009(a)(1) (2014) (stating that federal funding "is not available in expenditures for services provided to . . . [i]ndividuals who are inmates of public institutions . . .").

“[i]nmate of a public institution means a person who is living in a public institution,” and that a public institution is one “that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.”¹⁰² The law exempts medical institutions,¹⁰³ intermediate care facilities,¹⁰⁴ and publicly operated community residences, which serves no more than sixteen residents,¹⁰⁵ from the definition “public institutions.”

CMS clarified in a 1997 guidance letter that § 1396d(a)(A) does not restrict eligibility,¹⁰⁶ meaning that while states may enroll incarcerated individuals as Medicaid beneficiaries, the federal government will simply not contribute to the cost of insuring them. However, the statutory bar on funding does not apply if an individual is away from a prison-run facility for more than twenty-four hours, such as when she “is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility,”¹⁰⁷ or for outpatient

102. 42 C.F.R. § 435.1010 (2014).

103. *Id.* (defining medical institution).

104. *Id.* (adopting definition of “intermediate care facility” found in 42 C.F.R. §§ 440.140, 440.150 (2014)).

105. *Id.* (defining publicly operated community residence).

106. CMS Guidance, *supra* note 26, at 1–2.

107. *Id.* at 2. Because this limited Medicaid reimbursement for incarcerated individuals is based on an interpretation of the law by CMS, the policy is subject to change by future CMS administrators. A CMS regional administrator noted in 2008 that the interpretation “is the current policy and is subject to change based on the appropriate regulatory processes by CMS.” Letter from Richard C. Allen, Assoc. Reg’l Adm’r, Div. of Medicaid & Children’s Health Ops., to Joan Henneberry, Exec. Dir., Colo. Dep’t of Health Care Pol’y & Financing, at 2 (Dec. 2, 2008) [hereinafter CMS 2008 Letter], <https://www.colorado.gov/pacific/sites/default/files/December%20202008%20%20CMS%20Letter%20Responding%20to%20the%20Department’s%20Questions%20Regarding%20the%20Implementation%20of%20SB%2008-006.pdf>. Officials within CMS have at times given conflicting signals about the policy’s future continuation. In May 2004, a CMS official urged states to take advantage of Medicaid reimbursement for eligible services. See Memo. from Glenn Stanton, Acting Dir., Disabled & Elderly Health Programs Gr., CMS, to St. Medicaid Dirs., at 1–2 (May 25, 2004) [hereinafter CMS Homelessness Memo], <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Community-Living/Downloads/Ending-Chronic-Homelessness-SMD-Letter.pdf>. However, a month later, the Deputy Inspector General for Audit Services within HHS recommended that CMS “consider a change in policy to exclude FFP for inpatient services provided to incarcerated beneficiaries who are not in a prison setting.” OFFICE OF INSPECTOR GEN., U.S. DEP’T OF HEALTH & HUMAN SERVS., FOUR-STATE REVIEW OF MEDICAID PAYMENTS FOR INCARCERATED BENEFICIARIES, at ii (June 2004) [hereinafter HHS Four-State Review], <https://oig.hhs.gov/oas/reports/region4/40206002.pdf>. In response, CMS “agree[d] to review its current policies for incarcerated recipients.” *Id.*

An agency is entitled to change its policy views and interpretations. However, the Supreme Court has held that an “agency interpretation of a relevant provision which conflicts with the agency’s earlier interpretation is ‘entitled to considerably less deference’ than a consistently held view.” *I.N.S. v. Cardoza-Fonseca*, 480 U.S. 421, 446 n.30 (1987); see also Yehonatan Givati & Matthew C. Stephenson, *Judicial Deference to Inconsistent Agency Statutory Interpretations*, 40 J. LEGAL STUD. 85 (2011) (tracing development of Supreme Court’s treatment of agency policy changes). As an interpretation of federal statutes that was established without the force of law, CMS guidance letters or manuals are entitled “only to a level of deference commensurate with [their] inherent power to persuade.” *United States v. Mead Corp.*, 533 U.S. 218, 228 (2001) (citing *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944)). This level of review is referred to as “*Skidmore*

services provided in a non-prison health facility.¹⁰⁸ As a result, Medicaid-eligible or -enrolled individuals may be considered beneficiaries for this specific group of health services. Part III below will discuss the legal protections that can secure prompt access to these services. However, once an individual is transferred to a qualifying health facility for *inpatient* services, the stay is covered by federal funding and Medicaid does not impose a limit on the length of time that individual may stay in that facility.¹⁰⁹

Given that Medicaid covers hospital inpatient admissions and long-term nursing care for incarcerated individuals—“a relatively infrequent albeit expensive portion of prisoners’ health care”¹¹⁰—Medicaid expansion offers large potential savings for states. For example, California reported saving \$31 million in 2013,¹¹¹ and after adopting Medicaid expansion is projected to save about \$69 million in 2015.¹¹²

In states that have opted to not expand their Medicaid programs, savings may still be had from expenses such as providing hospital care to pregnant, incarcerated women; for example, North Carolina reported saving \$10 million in 2013,¹¹³ Mississippi projects saving \$6 million each year.¹¹⁴ States that currently bill Medicaid for certain health services provided to incarcerated individuals prioritize seeking federal reimbursement for hospitalization for childbirth, nursing home care for the elderly, surgery and hospital treatments for cancer, liver disease, and other serious illnesses.¹¹⁵

Thousands of Medicaid-eligible incarcerated individuals have inpatient stays each year, meaning that there are many who would benefit from the protections that will be discussed in Part III. A 2014 GAO report reviewed four states’ inpatient records from 2013 and determined that 4,328 inpatient stays that year would be Medicaid-eligible.¹¹⁶ Additionally, research into Texas’s inpatient hospitalizations among its prison population has revealed that a full ninety-four percent of inpatient stays are “medically mandatory or medically necessary,” meaning that in the face of pressure to shrink budgets, states are particularly at

deference.” See Harry T. Edwards, Linda A. Elliott & Marin K. Levy, *Federal Standards of Review* 192-193 (2d ed. 2013).

108. CMS Guidance, *supra* note 26, at 1–2.

109. CMS 2008 Letter, *supra* note 107, at 2.

110. PEW 2013 REPORT, *supra* note 16, at 18.

111. CSG JUSTICE CENTER REPORT, *supra* note 25, at 4.

112. See Christine Vestal, *Medicaid for Prisoners: States Missing Out on Millions*, USA TODAY (June 25, 2013), <http://www.usatoday.com/story/news/nation/2013/06/25/stateline-medicare-prisoners/2455201>.

113. See CSG JUSTICE CENTER REPORT, *supra* note 25, at 4.

114. Press Release, Miss. Dep’t of Corrs., *MDOC Saves \$11 Million Annually*, (Aug. 21 2012), <http://www.mdoc.state.ms.us/PressReleases/2012NewsReleases/MDOC%20Cost%20Avoidances.pdf>.

115. See Vestal, *supra* note 112.

116. See GAO REPORT, *supra* note 99, at 5. The report found 2905 Medicaid-eligible inpatient stays in California, 341 in North Carolina, 904 in Pennsylvania, and 178 in Washington.

risk of “breaching the mandate to provide an adequate level of medical care” if they do not turn to Medicaid for assistance in funding these medical costs.¹¹⁷

In particular, the costs associated with providing health care to elderly individuals in prisons and jails—already the primary driver behind many states’ use of facilities outside the prison health system¹¹⁸—will continue to strain budgets as the proportion of correctional populations over the age of fifty-five increases.¹¹⁹ As described in Part I(B) above, the number of incarcerated individuals older than fifty-five has increased six times faster than the rest of the prison population,¹²⁰ growing from 43,300 individuals in 1999 to 144,500 in 2013.¹²¹ Specialists have recommended that “aged inmates should receive special attention reflecting the physiological, psychological, and sociological effects of aging.”¹²² Indeed, in Texas in 2007, while individuals older than fifty-five accounted for only 5.8 percent of the total prison population, they accounted for 24.4 percent of inpatient health care costs.¹²³ Moreover, the average hospitalization cost in Texas for an older (above fifty-five) person is \$4040, which is six times higher than that of younger individuals.¹²⁴

As described above, the steep rise in the number of older people in prison requiring hospitalization and long-term care may result in many more prisons utilizing Medicaid to help pay for these costs.

The federal “inmate exclusion” thus limits Medicaid reimbursement for the majority of incarcerated individuals’ health services. However, the services covered—hospitalization, inpatient care, long-term nursing care—are those which are expensive and critically necessary. As a result, those individuals who may access Medicaid are also those individuals most in need of serious medical care.

2. State Policies Regarding Termination of Benefits

Further restrictions imposed by states themselves limit the availability of Medicaid’s legal protections for incarcerated individuals. As described above, federal law does not limit an incarcerated individual’s eligibility for Medicaid coverage, meaning that she can be enrolled during her incarceration if she meets

117. Bryan C. Schneider, Amy Jo Harzke, Lana Ivanitskaya & Owen J. Murray, *Prioritization of Inpatient Hospital Services to Prisoners: A Method for Justifying Care and Costs*, J. HEALTH CARE POOR UNDERSERVED 873 (May 2014).

118. See Vestal, *supra* note 112.

119. See, e.g., Glenda Reimer, *The Graying of the U.S. Prisoner Population*, J. CORRECTIONAL HEALTH CARE 202 (July 2008) (describing generally the impact of increases in the average sentence length, high recidivism rates, mandatory minimum sentences, and the impact of “three strikes” laws on the age of incarcerated populations).

120. Williams, *supra* note 53.

121. Schiff, *supra* note 54.

122. Reimer, *supra* note 119, at 206.

123. Schneider, Harzke, Ivanitskaya & Murray, *supra* note 117, at 864.

124. *Id.*

other eligibility requirements.¹²⁵ Upon an individual's incarceration, states either terminate enrollment in public benefits entirely or suspend it temporarily. A state's decision on whether to suspend or terminate enrollment in its Medicaid program is one part of a broader administrative complexity involving what happens to other public benefits, including SSI, Social Security Disability Income, cash assistance, and food stamps.¹²⁶ Numerous factors impact this decision, particularly in a jointly-funded program like Medicaid, including confusion over federal laws, the difficulty with administration of the program, the fear of incorrect billing, and the desire to avoid administrative fees associated with keeping individuals enrolled in Medicaid.¹²⁷ As a result, states have historically terminated Medicaid coverage, along with other public benefits, upon incarceration.¹²⁸ A 2014 study from the Center for Prisoner Health and Human Rights at Brown University determined that, of the state systems that provided Medicaid policies or practices to the researchers, twenty-eight states chose to terminate individuals from coverage, while only nine states opted to suspend coverage.¹²⁹ A 2013 briefing paper by the Council for State Governments reported that perhaps as few as twelve states have laws or administrative policies to suspend Medicaid enrollment, rather than terminate coverage.¹³⁰

The distinction between termination and suspension is significant because it impacts whether an incarcerated individual is a Medicaid beneficiary and could claim the protections of Medicaid law, which will be discussed below. If a state terminates Medicaid enrollment, it may still seek federal reimbursement from qualifying expenses, though to do so it would have to enroll an individual in coverage, seek reimbursement, and again terminate coverage each time an incarcerated individual has a qualifying expense.¹³¹ This administrative burden

125. 42 U.S.C. § 1396d(a)(A) (2012); CMS GUIDANCE, *supra* note 26, at 2; CSG JUSTICE CENTER REPORT, *supra* note 25, at 2.

126. *See, e.g., Federal Benefits for Individuals with Serious Mental Illnesses Who Have Been Incarcerated*, BAZELON CTR. FOR MENTAL HEALTH LAW, <http://www.bazelon.org/Where-We-Stand/Access-to-Services/Diversion-from-Incarceration-and-Reentry-/Federal-Benefit-Fact-Sheets.aspx> (last visited Apr. 11, 2015) (describing the varying effects of incarceration on food stamps, cash assistance, health programs, and Veterans Benefits); *Public Benefits & Reentry: New York*, PEOPLE'S GUIDE TO THE CONSEQUENCES OF CRIMINAL PROCEEDINGS, http://www.reentry.net/ny/help/item.2914-Public_Benefits_Reentry (last visited Apr. 11, 2015) (noting that in New York public assistance may be terminated, while disability benefits are only suspended).

127. Morgan, *supra* note 28.

128. CSG JUSTICE CENTER REPORT, *supra* note 25, at 3.

129. David Rosen, Dora Dumont, Andrew Cislo, Bradley Brockmann, Amy Traver & Josiah Rich, *Medicaid Policies and Practices in US State Prison Systems*, 104 AM. J. PUB. HEALTH 418, 420 tbl.2 (Mar. 2014).

130. CSG JUSTICE CENTER REPORT, *supra* note 25, at 3. These states are: California, Colorado, Florida, Iowa, Maryland, Minnesota, New York, North Carolina, Ohio, Oregon, Texas, and Washington. *Id.*

131. *See, e.g., VA. DEP'TS OF MED. ASSISTANCE & CORRS., JOINT REPORT ON INMATE MEDICAID PROGRAM 1-2* (Oct. 1, 2014) [hereinafter VA MEMO], <http://jchc.virginia.gov/3%>

is one major reason why states have avoided seeking Medicaid reimbursement for prison health costs.¹³² However, CMS encourages states to suspend coverage, rather than terminate it,¹³³ and the National Commission on Correctional Health Care recommends suspension as well.¹³⁴

Several factors may encourage states to reassess the policy of terminating of Medicaid during incarceration. Though administrative factors previously made seeking Medicaid reimbursement too burdensome, the immense cost savings for states, as described in Part II(B)(1) above, will likely be a major driver in encouraging states to change their policies. Moreover, research has shown that suspension of benefits rather than termination relieves administrative burdens.¹³⁵ Public health benefits further encourage states to both allow incarcerated people to remain in Medicaid during incarceration and actively sign up previously un-enrolled individuals. Researchers and advocates have reported that when individuals re-enter their communities without gaps in health insurance, they are more likely to be healthier and productive.¹³⁶ Additionally, continuity of Medicaid coverage enables uninterrupted access to medical and mental health care, which has been found to reduce recidivism.¹³⁷ To promote these benefits, the National Institutes of Health in 2014 issued grant funding to North Carolina to enroll incarcerated individuals in Medicaid through “Prison-Based Medicaid Enrollment Assistance Programs.”¹³⁸

As of early 2015, nine states both allow Medicaid enrollment during incarceration and offer coverage to most of their incarcerated population through

20DOC%20Report%20on%20Medicaid%20Eligibility%20Program.pdf (explaining old state procedures).

132. Morgan, *supra* note 28.

133. CMS Homelessness Memo, *supra* note 107, at 1–2. (“CMS is encouraging states with this letter to ‘suspend’ and not ‘terminate’ Medicaid benefits while a person is in a public institution . . .”).

134. See NATIONAL COMM’N ON CORR. HEALTH CARE, POSITION STATEMENT: OPTIMIZING INSURANCE COVERAGE FOR DETAINEES AND INMATES POSTRELEASE (Oct. 2014) [hereinafter NCCHC POSITION STATEMENT], http://www.ncchc.org/filebin/Positions/Optimizing_Health_Insurance_for_Detainees_and_Inmates_Postrelease.pdf.

135. CSG JUSTICE CENTER REPORT, *supra* note 25, at 3.

136. NCCHC POSITION STATEMENT, *supra* note 134; see also Evelyn Malavé, *Prison Health Care After the Affordable Care Act: Envisioning an End to the Policy of Neglect*, 89 N.Y.U. L. REV. 700, 732–34 (2014) (arguing that the significant benefits to enrolling incarcerated individuals in Medicaid pre-release might be constitutionally required).

137. See Maureen McDonnell, Laura Brookes, Arthur Lurigio & Daphne Baille, *Issue Paper: Realizing the Potential of National Health Care Reform to Reduce Criminal Justice Expenditures and Recidivism Among Jail Populations*, CMTY. ORIENTED CORR. HEALTH SYST. (Jan. 2011), <http://www.cochs.org/files/CHJFinal.pdf>.

138. *Project Information: Effectiveness of a Prison System-Based Medicaid Enrollment Program*, NAT’L INSTS. OF HEALTH, U.S. DEP’T OF HEALTH & HUMAN SERVS., RESEARCH PORTFOLIO ONLINE REPORTING TOOLS, http://projectreporter.nih.gov/project_info_description.cfm?aid=8774029&icde=21752073 (last accessed Feb. 26, 2015). The National Institute on Minority Health and Health Disparities provided the \$380,000 grant to the University of North Carolina for a three-year project to study the benefits of enrolling individuals pre-release.

the ACA's Medicaid eligibility expansion.¹³⁹ These states are California, Colorado, Iowa, Maryland, Minnesota, New York, Ohio, Oregon, and Washington.¹⁴⁰ As a result, these nine states are effective testing grounds for the protections advocated by this article. Of course, given the financial and public health benefits of enrolling incarcerated individuals in Medicaid, going forward, more states may opt to suspend coverage, rather than terminate it—and many more should do so. For example, Virginia plans to create a new Medicaid category for incarcerated individuals, which “will restrict inmate payments only to hospital claims and practitioner claims with dates of service during an inpatient hospital admission,” to ease the administrative burden of determining eligibility and to ensure that all eligible claims are submitted for Medicaid reimbursement.¹⁴¹ In this way, the legal protections discussed below could soon apply to a wider swath of the nation's incarcerated population and help ensure that those incarcerated individuals most in need of health care have access to services. The more states that pursue this path, the more their public health systems in and out of prisons will function in unison, and the more protections individuals will have.

This section presented a tangled web of new Medicaid eligibility changes after the Affordable Care Act, long-standing limitations on services covered by the federal “inmate exclusion” rule, and states' own policies regarding termination of Medicaid benefits upon incarceration. In sum, incarcerated individuals who qualify for Medicaid are entitled to be treated as Medicaid beneficiaries for a limited set of hospital- and nursing facility-based health services, as long as states do not have a policy of terminating Medicaid benefits upon incarceration.

III.

NEW AVENUES FOR CHALLENGING INADEQUATE HEALTH ACCESS UNDER MEDICAID

Federal Medicaid law offers specific legal protections to ensure that Medicaid beneficiaries receive quality health care. This section will describe how eligible individuals may invoke these protections during their incarceration to demand a more responsive prison health system and prompt access to eligible services. In particular, Medicaid requires that states create a Medicaid system in which care is “reasonably prompt.” If states fail in that duty, beneficiaries may challenge those failures. The two forums for such challenges are in civil

139. This figure was determined by cross-referencing the list of states that have expanded Medicaid with the states that do not terminate Medicaid coverage. *See* sources cited *supra* notes 25, 129.

140. As of March 2015, Florida is considering adopting Medicaid expansion. *See* KFF Medicaid Expansion Decisions, *supra* note 90. Because Florida does not terminate Medicaid benefits, the state's decision to expand Medicaid eligibility would bring this list to ten states. *See* CSG Justice Center Report, *supra* note 25, at 9.

141. *See* VA MEMO, *supra* note 131.

litigation and in administrative fair hearings. As described below, this article recommends that states, advocates, and incarcerated individuals focus their attention on expanded use of the fair hearing system.

A. *Strengthened Medicaid Protections After the Affordable Care Act: “Medical Assistance” and “Reasonable Promptness”*

In addition to expanding Medicaid eligibility, discussed above, the ACA changed a substantive aspect of Medicaid law impacting the strength and scope of the legal protections here: the definition of “medical assistance.”¹⁴² States must comply with federal requirements imposed upon their “state plan[s] for medical assistance” under 42 U.S.C. § 1396a. As explained in Part II, these plans for “medical assistance” form the basis of a state’s entire Medicaid program, and must be submitted to the Secretary of HHS for approval.¹⁴³ In fact, the term “medical assistance” is used over 225 times in § 1396a, such as in requirements for fair hearings¹⁴⁴ applications,¹⁴⁵ and covered services.¹⁴⁶ Thus, it is perhaps surprising that prior to the ACA federal courts of appeals did not agree on what “medical assistance” actually meant.¹⁴⁷

The Social Security Amendments of 1965, which established Medicaid, defined “medical assistance” as “payment of part or all of the cost of the [covered] and services.”¹⁴⁸ Courts disagreed “as to whether, pursuant to the [1965 definition], a State must merely provide financial assistance to eligible individuals to enable them to obtain covered services, or provide the services directly.”¹⁴⁹ The Sixth,¹⁵⁰ Seventh,¹⁵¹ and Tenth¹⁵² Circuits all explicitly held the statute referred only to financial assistance, while the First Circuit found that the pre-ACA definition of “medical assistance” could apply to a challenge to whether a state provided a sufficient number of slots in a home and community-based care program, suggesting it meant the provision of services themselves.¹⁵³

142. See Pub. L. No. 111-148, § 2304, 124 Stat. 296 (Mar. 23, 2010), amending 42 U.S.C. § 1396d(a).

143. 42 U.S.C. §§ 1396a(b), 1396c (2012).

144. § 1396a(a)(3).

145. § 1396a(a)(8).

146. § 1396a(a)(10)(A).

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

148. See Social Security Amendments of 1965, Pub. L. No. 89-97, § 1905(a), 79 Stat. 352 (July 30, 1965) (codified at 42 U.S.C. § 1396d(a)).

149. *Olszewski*, 454 F.3d at 540.

150. *Id.* (holding that the Medicaid law’s use of “payment” for services meant states had only a financial obligation).

151. *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (“[T]he statutory reference to ‘assistance’ appears to have reference to *financial* assistance rather than to actual medical services . . .”).

152. *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139, 1146 (10th Cir. 2006) (“[T]he Medicaid statute does not require states to be service-providers of last resort The State must pay for medical services, but it need not provide them.”).

153. *Bryson v. Shumway*, 308 F.3d 79, 81–82, 88–89 (1st Cir. 2002).

The Third and Eleventh Circuits recognized but did not resolve the disagreement.¹⁵⁴ The remaining circuits appear to not have considered the question.

The section of the Affordable Care Act titled “Clarification of Definition of Medical Assistance” amended this statutory definition, which now reads: “The term ‘medical assistance’ means payment of part or all of the cost of the following care and services *or the care and services themselves*, or both.”¹⁵⁵ In the House Report for the Affordable Care Act, Congress explained:

“Medical assistance” is expressly defined to refer to payment but has generally been understood to refer to both the funds provided to pay for care and services and to the care and services themselves. . . . Some recent court opinions have, however, questioned the longstanding practice of using the term ‘medical assistance’ to refer to both the payment for services and the provision of the services themselves. . . . To correct any misunderstandings as to the meaning of the term, and to avoid additional litigation, the bill would . . . conform this definition to the longstanding administrative use and understanding of the term.¹⁵⁶

The plain language of the amended statute and its legislative history make it clear that Congress intended to strengthen the protections of Medicaid by explicitly clarifying that each time “medical assistance” is used in the statute, it refers not only to payment for health services, but to the health services themselves as well.

The significance of this expanded definition is that it triggers expansions of other protections, namely that of the reasonable promptness provision. Federal law clearly states that “such [medical] assistance shall be furnished with reasonable promptness to all eligible individuals.”¹⁵⁷ The statutory language and legislative history both direct that it is not simply payment for services that must be provided with reasonable promptness, but the healthcare services themselves. As the following two sections will explore, the budding movement towards expanding Medicaid eligibility and enrolling incarcerated individuals in Medicaid coverage offers the potential for extending this newly-strengthened “reasonable promptness” protection to the prison rights context, both through § 1983 litigation and in fair hearings.

154. *Sabree v. Richman*, 367 F.3d 180, 181 n.1 (3d Cir. 2004) (“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.” (citation omitted)); *Doe v. Chiles*, 136 F.3d 709, 717–18 (11th Cir. 1998).

155. See Pub. L. No. 111-148, § 2304, 124 Stat. 296 (Mar. 23, 2010) (amending 42 U.S.C. § 1396d(a)) (emphasis added).

156. H.R. Rep. No. 111-299, pt. 1 at 714, 2009 WL 3321420, at *694–95 (Oct. 29, 2009).

157. 42 U.S.C. § 1396a(a)(8) (2012).

B. Enforcing State Compliance with Medicaid Law Under § 1983

The aforementioned reasonable promptness provision may be enforced through individual litigation in federal court. Incarcerated individuals have the right to bring suits under 42 U.S.C. § 1983, which establishes a federal cause of action for individuals to challenge the government’s “deprivation of any rights, privileges, or immunities secured by the Constitution and laws.”¹⁵⁸ Such suits are typically brought in federal court under the federal question jurisdiction of 28 U.S.C. § 1331.

However, federal law imposes severe limitations on incarcerated individuals’ access to courts, and as a result this path is less likely to lead to greater protections or faster provision of healthcare services.

1. Using § 1983 Suits for Public Benefits Program Challenges

The Supreme Court in *Rosado v. Wyman* first held that individuals have the right to sue to force state agencies to comply with federal entitlement programs, so long as Congress did not clearly preclude that right.¹⁵⁹ In the forty-five years since *Rosado*, individuals’ ability to sue under § 1983—both to enforce Medicaid law and generally to enforce other laws—has been seriously narrowed and is now restricted to suits arising from provisions that explicitly grant an individual “right.”¹⁶⁰ Because many provisions of Medicaid law are not framed as creating specific individual rights, but instead as policy directives to states or agencies, courts often find that § 1983 is not a viable cause of action for Medicaid recipients.¹⁶¹ However, numerous federal courts of appeals, including the First, Third, Fourth, Fifth, Sixth, and Eleventh Circuits, have determined that the “reasonable promptness” provision, 42 U.S.C. § 1396a(a)(8), creates a right that is enforceable, as this provision is specifically framed around “individuals.”¹⁶² This provision is particularly applicable in the prison health

158. 42 U.S.C. § 1983 (2012).

159. 397 U.S. 397 (1970).

160. See *Gonzaga University v. Doe*, 536 U.S. 273, 286 (2002); Sara Rosenbaum, *Medicaid and Access to the Courts*, NEW ENG. J. MED. 1489, 1490 (Apr. 21, 2011).

161. For example, Medicaid’s “equal access provision,” 42 U.S.C. § 1396a(a)(30)(A) (2012), has been found to not create individual rights because it does not have individual-focused language. See, e.g., *Sanchez v. Johnson*, 416 F.3d 1051, 1068 (9th Cir. 2005) (“Congress did not unambiguously create an individually enforceable right in § 30(A) that would be remediable under § 1983 either by recipients or providers of Medicaid services.”).

162. See *Westside Mothers v. Olszewski*, 454 F.3d 532, 536–37 (6th Cir. 2006) (“First, the provisions [including 42 U.S.C. § 1396a(a)(8)] were clearly intended to benefit the putative plaintiffs Second, the provisions set a binding obligation on Michigan. They are couched in mandatory rather than precatory language, stating that Medicaid services ‘shall be furnished’ to [plaintiffs]. . . . Third, the provisions are not so vague and amorphous as to defeat judicial enforcement, as the statute and regulations carefully detail the specific services to be provided. . . . Finally, Congress did not explicitly foreclose recourse to § 1983 in this instance, nor has it established any remedial scheme sufficiently comprehensive to supplant § 1983.”); *Bryson v.*

context, as it requires Medicaid 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.”¹⁶³ Given that delays in health services are rampant in correctional health systems, such a protection is critical where a patient might wait days, weeks, or months before being transferred to a hospital or intermediate care facility for necessary treatment.¹⁶⁴ Very few courts have yet had the opportunity to analyze these changes to Medicaid law, although one federal district court addressed the new language in a summary judgment decision in *Leonard v. Mackereth*.¹⁶⁵ The facts and decision in *Leonard* are particularly applicable to potential prison litigation because the plaintiffs sought placement in an intermediate care facility, which is a type of facility eligible for federal financial assistance for incarcerated individuals. In *Leonard*, the six plaintiffs, represented by the Disability Rights Network of Pennsylvania, were Medicaid beneficiaries who were diagnosed with autism and received assistance for home-based medical care.¹⁶⁶ Seeking better health and more appropriate services for themselves, the plaintiffs requested placement in a Medicaid-eligible intermediate care facility.¹⁶⁷ However, the plaintiffs were told there were no available spaces and no plans to create more.¹⁶⁸ In response, the plaintiffs sued the state, alleging that Pennsylvania violated the reasonable promptness provision of federal Medicaid law, 42 U.S.C. § 1396a(a)(8), enforceable under 42 U.S.C. § 1983.¹⁶⁹

In analyzing the Affordable Care Act’s amendment of the reasonable promptness provision, the district judge noted that the “full extent of a state’s responsibility for providing” health services “remains unclear,” but still granted summary judgment for the plaintiffs. Thus, the court found that by not directly providing care to Medicaid beneficiaries when such care was otherwise covered by Medicaid, Pennsylvania was in violation of the reasonable promptness provision under Medicaid law.¹⁷⁰ However remarkable the judge’s ruling was,

Shumway, 308 F.3d 79, 88–89 (1st Cir. 2002); Doe 1–13 v. Chiles, 136 F.3d 709, 719 (11th Cir. 1998).

163. 42 U.S.C. § 1396a(a)(8) (emphasis added).

164. See *Nationwide Survey*, *supra* note 3, at 669.

165. *Leonard v. Mackereth*, No. 11-7418, 2014 WL 512456, at *5–8 (E.D. Pa. Feb. 10, 2014).

166. *Id.* at *1–2.

167. *Id.*

168. *Id.* at *3.

169. *Id.*

170. *Leonard*, 2014 WL 512456, at *8–9. Another district court that has considered the new definition noted that the statute’s “language cannot reasonably be construed to mean only payment for services, particularly in light of the amended definition of ‘medical assistance.’” *John B. v. Emkes*, 852 F. Supp. 2d 944, 951 (M.D. Tenn. 2012). The judge further wrote: “[T]o be clear, these provisions do not require the State to become a ‘direct medical provider’ Rather, these provisions require the State to ensure that Medicaid-eligible [individuals] receive [the covered health services] under certain circumstances. To satisfy its obligations, the State may either

the reality of the uncertainty caused by the ACA's change to the definition of medical assistance is demonstrated by the district judge's statement that the law and legislative history are "not clear enough to inform this Court what steps [Pennsylvania] is required to take under the law."¹⁷¹ As a result, the judge denied both declaratory and injunctive relief at that time.¹⁷²

As of 2015, few courts have considered the implications of the changed definition of medical assistance, and certainly none have assessed this provision in a challenge to prison health care. *Leonard* demonstrates a potential new strength of this provision's definition. Significantly, the district judge's analysis—by concluding in a summary judgment order that, because the plaintiffs had not yet received the requested health services, Pennsylvania was in violation of § 1396a(a)(8)—offers a far lower burden than the Eighth Amendment's deliberate indifference standard, described in Part I(C). Rather than being required to prove that the health officials involved had consciously disregarded a serious health risk, the plaintiffs in *Leonard* only needed to prove that they were enrolled in Medicaid, they had requested Medicaid-eligible health care, and they had not received it. In the context of prison rights litigation, such an analysis is an enormous boon.

The *Leonard* plaintiffs' attempt to seek services for which they were eligible, at a facility for which Medicaid will cover incarcerated individuals' health services, closely parallels the experience of countless Medicaid-eligible incarcerated individuals in need of hospitalization, inpatient treatment, or long-term nursing home care. While the number of potential prison rights lawsuits under this provision are limited by those who are eligible for Medicaid and whether they seek the services Medicaid will reimburse for, the provision still has immense relevance. By applying this provision's muscle to the experience of Patient 1, one of the thousands of individuals suffering inadequate health care in the nation's prisons, courts have the power to determine that states are in violation of the law for not providing the sick citizens inside their prisons with medical services.

provide services directly or hire others to do so." *Id.* at 951–52. The judge also notes that the Sixth Circuit briefly considered the new statutory definition, but was less willing to recognize the change; instead, the court dismissively said "the new definition does not affect this holding [that the state need not "ensure the reasonably prompt provision of services"] because a state may still fulfill its Medicaid obligations by paying for services." *Id.* (quoting *John B. v. Goetz*, 626 F.3d 356, 360 (6th Cir. 2010)).

171. *Leonard*, 2014 WL 512456, at *12.

172. *Id.*

2. *Limitations for Incarcerated Individuals Using § 1983 Suits*

However, as noted in Part I(C), enforcement of Medicaid law under 42 U.S.C. § 1983 requires bringing litigation, a path complicated by the PLRA.¹⁷³ In addition to filing fee requirements,¹⁷⁴ and the risk that a judge may dismiss a suit as “frivolous, malicious, [or] fail[ing] to state a claim,”¹⁷⁵ the PLRA requires incarcerated individuals to exhaust all administrative remedies prior to bringing a § 1983 suit.¹⁷⁶ For example, New York requires incarcerated individuals to file a grievance before an Inmate Grievance Resolution Committee (IGRC), a five-member body composed of two prison staff members, two incarcerated individuals selected by their peers, and a non-voting chairperson who may be a staff member, an incarcerated person, or a volunteer.¹⁷⁷ An individual filing a grievance in New York is entitled to a hearing, though presentation of evidence and witness testimony is controlled by the IGRC, which additionally makes the ultimate decision.¹⁷⁸ The state allows an appeal to the prison superintendent, followed by a subsequent appeal to a central review office.¹⁷⁹ Despite the state’s efforts to maintain a formal hearing, the decision is not made by neutral parties, and the process lacks any safeguard against bias. Other grievance procedures offer far less protection. Georgia’s grievance procedures, for example, do not allow for a hearing. Instead, an individual may submit a formal grievance on one issue only, and on one page only, for review by the Warden.¹⁸⁰ An appeal of the Warden’s decision is made to the Commissioner, and at no time is a hearing provided.¹⁸¹

Such administrative proceedings can take months and delay meaningful, fair adjudication of an individual’s lack of medical care. Moreover, given the

173. Prison Litigation Reform Act of 1995, Pub. L. No. 104-134, §§ 801–810, 110 Stat. 1321-66 (Apr. 26, 1996) (codified at 18 U.S.C. § 3626; 28 U.S.C. §§ 1915, 1915A; 42 U.S.C. § 1997e).

174. 28 U.S.C. §§ 1915(b)(1)–(2) (2012).

175. 42 U.S.C. §§ 1997e(c)(1)–(2) (2012).

176. *Id.* at § 1997e(a).

177. STATE OF N.Y. DEP’T OF CORRECTIONAL SERVS., DIRECTIVE NO. 4040: INMATE GRIEVANCE PROGRAM §§ 701.4(a)–(b) (July 12, 2006) [hereinafter NY INMATE GRIEVANCE REPORT], <https://www.prisonlegalnews.org/media/publications/NY%20DOC%20-%20Inmate%20Grievance%20Program%20and%20Revisions.pdf>. If an individual objects to any of the incarcerated individuals serving on the IGRC, there must be alternates. *Id.* at § 701.6(c). However, if she further objects to the alternates, then the IGRC will just be composed of prison staff. *Id.* There were 6362 health-related grievances filed in New York in 2012. STATE OF N.Y. DEP’T OF CORRECTIONS & COMMUNITY SUPERVISION, INMATE GRIEVANCE PROGRAM ANNUAL REPORT 2012, at § V(1), <http://www.doccs.ny.gov/Research/Reports/2014/InmateGrievanceAnnualReport2012.pdf>.

178. NY INMATE GRIEVANCE REPORT, *supra* note 177, at § 701.5.

179. *Id.* at §§ 701.5(c)–(d).

180. GA. DEP’T OF CORRS., STANDARD OPERATING PROCEDURES NO. IIB05-0001 6–8 (June 1, 2004), http://www.law.umich.edu/facultyhome/margoschlanger/Documents/Resources/Prison_and_Jail_Grievance_Policies/Georgia_Policy.pdf.

181. *Id.* at 8–9.

PLRA's explicit purpose of impeding access to courts for incarcerated individuals, the ability to bring a § 1983 claim to enforce Medicaid protections is greatly limited. As a result, though enforcement of Medicaid law through a § 1983 action is possible, the path to litigation is rocky and uncertain.

C. Medicaid Fair Hearings as a New Forum for Challenging Prison Health Systems' Unreasonable Delays

This section proposes the adoption of a commonly-used forum for resolving public benefits disputes outside of the prison context: fair hearings. As this section will describe, fair hearings potentially offer a forum that will address delayed access to health care fairly and efficiently. Moreover, because fair hearings are not suits under § 1983, the PLRA does not apply, and administrative grievance procedures need not be exhausted.¹⁸²

1. The Benefits of Medicaid Fair Hearings for Incarcerated Individuals

Medicaid fair hearings are an administrative forum for dispute resolution regarding benefits decisions, and are required under federal Medicaid law. States are obligated to provide a fair hearing “to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.”¹⁸³ As noted above, the statutory definition of “medical assistance” is “payment of part or all of the cost of the following care and services *or the care and services themselves*, or both,”¹⁸⁴ and therefore a fair hearing must be provided when any action or inaction affects a person's eligibility for Medicaid enrollment or the actual receipt of a particular health care service.¹⁸⁵

HHS regulations specify that patients have the right to a hearing either first before the Medicaid agency or before a local agency, with the right to appeal to the Medicaid agency.¹⁸⁶ States must also notify patients in writing of the right to obtain a hearing and the method for obtaining one after any action is taken that affects the patient's claims.¹⁸⁷ States should allow at least ten days from the date of this notice for individuals to request a hearing.¹⁸⁸ Additionally, patients have the right to “use legal counsel, a relative, a friend, or other spokesman” at

182. 42 U.S.C. § 1997e(a) (2012) (“No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.”).

183. 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.220(a)(1) (2014).

184. 42 U.S.C. § 1396d(a) (emphasis added).

185. See MARYBETH MUSUMECI, KAISER COMM'N ON MEDICAID & THE UNINSURED, A GUIDE TO THE MEDICAID APPEALS PROCESS 6 (Mar. 2012), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf> (describing Medicaid hearing requirements).

186. 42 C.F.R. §§ 431.205(b)(1)(i), (2) (2014).

187. 42 C.F.R. §§ 431.206(b)–(c).

188. CMS MEDICAID MANUAL, *supra* note 78, at § 2902.3.

hearings, and the state Medicaid agency must notify them of that right.¹⁸⁹ However, states are not required to provide legal counsel for a fair hearing.¹⁹⁰ While Medicaid hearings often follow notification from the state agency that a decision has been made to suspend or terminate benefits, individuals have the right to request a hearing if a claim for medical assistance—i.e., request for health services—is not acted upon with “reasonable promptness.”¹⁹¹

At Medicaid fair hearings, the beneficiary and a representative of the state agency engage together on the health care issues in the dispute, while a hearing officer presides over presentation of evidence and cross-examination of witnesses.¹⁹² CMS has directed state Medicaid agencies to hold hearings at locations that are convenient for beneficiaries, in the event an individual would have great difficulty traveling to government office.¹⁹³ Such accommodations include having an in-person or phone hearing at a person’s home or nursing facility; in-person and phone hearings must follow the same due process safeguards.¹⁹⁴ Given the administrative burdens and security restrictions associated with transport of incarcerated individuals, conducting a fair hearing within a prison or via phone appears to be a reasonable accommodation under this CMS guidance.

During the hearing, CMS guidance directs states to ensure certain procedural safeguards. These safeguards include having the hearing overseen by an impartial official, who “shall not have been connected in any way” to the actions being challenged in the hearing.¹⁹⁵ If a medical determination is necessary, and the beneficiary wishes for an independent medical assessment, the state agency must obtain it at the agency’s expense, if the hearing officer deems it necessary.¹⁹⁶ The beneficiary has the right to examine all materials to be used as evidence at the hearing, and if that opportunity is not provided, then those materials will not become part of the official hearing record or be used to

189. 42 C.F.R. § 431.206(b)(3).

190. CMS MEDICAID MANUAL, *supra* note 78, at § 2900.3. However, the Manual notes that “[b]ecause of the difficulties many recipients have in representing themselves in fair hearings, [state agencies] have a special responsibility to assist persons in being represented by others” *Id.* Further, states should “[a]dvise the appellant of any legal services which may be available to him . . . and any provisions [the state has] for payment of legal fees for representation at fair hearings.” *Id.*

191. 42 C.F.R. § 431.220(a)(1) (2014); *see also* Musumeci, *supra* note 185, at 6.

192. Vicki Lens, *Seeking Justice: Citizens’ Use of Fair Hearings to Correct Errors in Public Welfare Bureaucracies*, 19 J. PUB. ADMIN. RES. & THEORY 817, 829–30 (2009).

193. CMS MEDICAID MANUAL, *supra* note 78, at § 2902.6 (“There may be instances in which the claimant is housebound, hospitalized or in a nursing home, or lives far from the office in which hearings are usually held. In these and other hardship instances, make special plans, as necessary, for the convenience of the claimant.”).

194. *Id.* (“For instance, the hearing may be held in the claimant’s home. You may also conduct the hearing by telephone when the claimant is unable to attend in person. Telephone hearings must follow all of the due process required of in person hearings.”).

195. 42 C.F.R. § 431.240(a)(3) (2014); CMS MEDICAID MANUAL, *supra* note 78, at § 2902.7.

196. § 431.240(b); CMS MEDICAID MANUAL, *supra* note 78, at § 2902.8.

make a decision on an appeal.¹⁹⁷ Moreover, the beneficiary must be able to present information, witnesses, and arguments, as well as confront and cross-examine witnesses, “without undue interference.”¹⁹⁸ All requests for a hearing must be followed through to completion, and there must be a final decision within ninety days of the initial hearing request.¹⁹⁹ Decisions must be based on the evidence and testimony at the hearing, and must be written and made available to the beneficiary.²⁰⁰ The decision is then binding, requiring the state health agency to carry out the decision promptly.²⁰¹

Fair hearings must follow these procedural safeguards in accordance with due process requirements. The requirements have the secondary purpose of ensuring that individuals can effectively communicate their concerns and be heard fairly in a less formal, more understandable forum. As one academic wrote: “Fair hearings are where citizens, often the very poor, make use of the legal machinery of government to challenge perceived mistakes” and to “ensure that officials are applying the law consistently, fairly and equitably, and as intended by policy makers.”²⁰² The use of fair hearings benefits both individuals challenging their adverse decisions and the government authorities themselves, who foster trust, legitimacy, and buy-in from perceptions of procedural fairness.²⁰³ As such, CMS instructs that states “[a]llow the claimant to present his case in the way he desires,” and explicitly states: “Do not use application of the rules for the conduct of the hearing to suppress the appellant’s claim.”²⁰⁴

A guide to fair hearings by the Legal Aid Society encourages individuals to not “be afraid to ask questions and tell the judge if you disagree” with the state’s arguments.²⁰⁵ Framed in this way, fair hearings offer individuals a real chance to secure the relief they seek, with procedures that help, rather than impede, their access to justice. Moreover, for correctional departments allegedly frustrated by high numbers of pro se complaints filed in federal and state courts relating to health care,²⁰⁶ fair hearings offer the opportunity to right the ship and create a

197. CMS MEDICAID MANUAL, *supra* note 78, at § 2902.9; *see also* §§ 431.242(a)(1)–(2) (2014).

198. §§ 431.242(b)-(d); CMS MEDICAID MANUAL, *supra* note 78, at § 2902.9.

199. CMS MEDICAID MANUAL, *supra* note 78, at § 2902.10.

200. *Id.* at § 2903.1.

201. § 431.244(f) (2014); CMS MEDICAID MANUAL, *supra* note 78, at § 2903.3.

202. Lens, *supra* note 192, at 817.

203. *Id.* at 819.

204. CMS MEDICAID MANUAL, *supra* note 78, at § 2902.9.

205. LEGAL AID SOC’Y, HOW TO WIN YOUR FAIR HEARING 17 (Sept. 2002), <http://www.legal-aid.org/media/40735/fairhearing.pdf>.

206. *See, e.g.*, 141 Cong. Rec. 26467, 26548(1995) (statement of Sen. Dole) (“This legislation is . . . to address the alarming explosion in the number of frivolous lawsuits filed by State and Federal prisoners.”).

fair forum for individuals to raise these issues.²⁰⁷ The opportunity to participate in a fair hearing enables incarcerated individuals to engage responsibly and affirmatively in their health care decision-making. This further serves to provide experience with, trust in, and knowledge about the Medicaid system for when they are released into the community.

2. *Due Process and the Right to a Fair Hearing*

a. *Individuals Have a Property Interest in Medicaid Benefits, Subject to Constitutional Due Process Protections*

The Due Process Clause of the Fifth and Fourteenth Amendments to the Constitution additionally protects individuals' right to a fair hearing. The Due Process Clause protects all individuals' "property interests" and "liberty interests."²⁰⁸ Property interests are grounded in entitlements to wealth under statutes and regulations, and liberty interests stem primarily from the freedoms protected the Constitution, though also from statutes and regulations.²⁰⁹ The Supreme Court, in *Board of Regents of State Colleges v. Roth*,²¹⁰ noted that "the range of interests protected by procedural due process is not infinite," and thus created a framework from which to determine whether a property interest or liberty interest is protected and, if so, what procedures are required under the Constitution.²¹¹

The first question under the *Roth* analysis is whether "the interest is within the Fourteenth Amendment's protection of liberty and property."²¹² In the context of public benefits, the Supreme Court in *Goldberg v. Kelly* directly answered this question in the affirmative and held that individuals have a property interest in statutorily-provided entitlement benefits.²¹³ In the decades following *Goldberg*, numerous federal courts have found that adverse decisions specifically affecting a person's Medicaid benefits trigger these same due process protections.²¹⁴ Importantly for this article, while the Supreme Court has

207. Lens, *supra* note 192, at 819–20 (noting that researchers frequently find that individuals prefer procedural fairness—to ensure that they are respectfully heard by a neutral decision-maker—to substantive fairness).

208. U.S. CONST. amends. V, XIV.

209. Susan N. Herman, *The New Liberty: The Procedural Due Process Rights of Prisoners and Others Under the Burger Court*, 59 N.Y.U. L. REV. 482, 485 (1984); *see also* Sandin v. Conner, 515 U.S. 472, 497–98 (1995) (Breyer, J., dissenting) (noting that the Due Process Clause protects "reliance upon an 'entitlement' that local . . . law itself has created or helped to define," but in the liberty context, it protects "not this kind of reliance upon a government-conferred benefit, but rather an absence of government restraint, the very absence of restraint that we call freedom").

210. 408 U.S. 564 (1972).

211. *Id.* at 570.

212. *Id.* at 571.

213. 397 U.S. 254, 262 n.8, 266 (1970).

214. *See, e.g.*, Hamby v. Neel, 368 F.3d 549, 559 (6th Cir. 2004) (holding that individual has a property interest in Medicaid benefits); Catanzano v. Dowling, 60 F.3d 113, 117 (2d Cir. 1995)

not yet addressed whether mere applicants, as opposed to those already receiving benefits, have a property interest in an entitlement program such as Medicaid, the leading circuit case on the question, *Griffeth v. Detrich*, as well as several others, has determined that applicants may have a legitimate expectation of benefits in nondiscretionary benefits programs, triggering the same property interest held by those already receiving benefits.²¹⁵ Because no incarcerated individual is likely to already be a Medicaid recipient at the time they need health services, these cases importantly establish that their status as mere applicants does not diminish their expectation of benefits and property interest.

Once this interest has been established, courts proceed to the second step of the *Roth* analysis and look to the magnitude of due process protections that that interest triggers. In *Goldberg*, the Court noted that the “extent to which procedural due process must be afforded” depended on “the extent to which [an individual] may be condemned to suffer grievous loss.”²¹⁶ Accordingly, “the crucial factor” for the Court was that the benefits termination “may deprive an eligible recipient of the very means by which to live.”²¹⁷ As a result, individuals have the right to notice of changes to their benefits and a hearing in which they can present evidence.²¹⁸ In this second step, courts often apply the Supreme Court’s balancing test established in *Mathews v. Eldridge*, a case determining what procedural protections are due prior to termination of Social Security benefits.²¹⁹ *Mathews* directs courts to consider and balance three factors: (1) the

(holding that an individual has the right to a fair hearing before termination of Medicaid benefits); *Lewis v. Rendell*, 501 F. Supp. 2d 671, 692 (E.D. Pa. 2007) (“The Court concludes that plaintiffs receiving Medicaid benefits have a constitutionally protected property interests [sic] in those benefits.”); *Ladd v. Thomas*, 962 F. Supp. 284, 289 (D. Conn. 1997) (“The plaintiffs have a protectable ‘property interest’ in their Medicaid benefits under the Fourteenth Amendment.”); *Greenstein ex rel. Horowitz v. Bane*, 833 F. Supp. 1054, 1076 (S.D.N.Y. 1995) (“The recipient’s property interest, therefore, is the necessary health care that is provided or that should have been provided free of charge under the state’s Medicaid program.”).

215. 603 F.2d 118, 121–22 (9th Cir. 1979) (finding that applicants for welfare benefits had a legitimate expectation of entitlement because the statute creating the benefit program gave little to no discretion to individuals to determine whether to grant or deny benefits if eligibility requirements were met); *see also* Nat’l Ass’n of Radiation Survivors v. Derwinski, 994 F.2d 583, 588 n.7 (9th Cir. 1992) (affirming that “both applicants for and recipients of [service-connected death and disability] benefits possess a constitutionally protected property interest in those benefits”); *Cushman v. Shinseki*, 576 F.3d 1290, 1298 (Fed. Cir. 2009) (“A veteran is entitled to disability benefits upon a showing that he meets the eligibility requirements set forth in the governing statutes and regulations. We conclude that such entitlement to benefits is a property interest protected by the Due Process Clause of the Fifth Amendment to the United States Constitution.”).

216. *Goldberg*, 397 U.S. at 263.

217. *Id.* at 264.

218. *Id.* In 1978, HHS affirmed *Goldberg*’s significance by explicitly incorporating the decision into federal Medicaid regulations, which now state: “The hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970). . . .” Fair Hearings for Applicants and Recipients, 44 Fed. Reg. 17,932 (Mar. 23, 1979) (codified at 42 C.F.R. § 431.205(d)).

219. 424 U.S. 319, 335 (1975); *see also* *Greenstein*, 833 F. Supp. at 1076 (noting that analysis under *Mathews* is the second step of the due process analysis).

plaintiff's interests that will be affected by the state's action; (2) the risk of harm to the plaintiff if certain procedural protections are not adopted and the value added of those safeguards if used; and (3) the potential administrative and fiscal burdens to the government that the procedural safeguards would entail.²²⁰

As a threshold issue, due process considerations are only triggered by state action, rather than the actions of private parties. The Second Circuit has stated that "due process fair hearing rights required by the statute and regulations are triggered only when the adverse actions are implemented through *state action*."²²¹ There is therefore a potential question of statutory interpretation, as well as constitutional law,²²² about what "state action" is.²²³ The Supreme Court in *Blum v. Yaretsky* wrote that in the Medicaid context, "a State normally can be held responsible for a private decision only when it has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State."²²⁴ While a state-employed prison health official would certainly qualify as state action when depriving an incarcerated individual of their property interest in Medicaid health benefits, a private prison health contractor acting in the same capacity would likely trigger the same due process protections under *Blum*. This is in accordance with CMS's own treatment of private prison health contractors being held to the same standards as state-operated facilities,²²⁵ as well as courts' determination that the Eighth Amendment's obligations are imposed on private prison health contractors as well.²²⁶

b. The Potential Impact of Sandin v. Conner on Incarcerated Individuals' Right to a Fair Hearing

As potential Medicaid beneficiaries, incarcerated individuals have the same property interests in receiving health benefits as citizens in the general population, and thus have a constitutionally-protected right to a fair hearing if those rights are at risk of being deprived. The Supreme Court has declared that

220. *Id.*

221. *Catanzano ex rel. Catanzano v. Dowling*, 60 F.3d 113, 117 (2d Cir. 1995) (emphasis added) (finding that decisions made by certified home health care agencies were sufficiently controlled by the state to constitute state action).

222. *See, e.g., State Action and the Public/Private Distinction*, 123 HARV. L. REV. 1248 (2010) (discussing the constitutional state action doctrine).

223. Determining what is an "action" is an easier question. Federal Medicaid law grants individuals the right to a hearing when a "claim for medical assistance . . . is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3) (2012). HHS regulations further specify that notice and the opportunity for a hearing must be provided after "any action affecting" a person's claim, 42 C.F.R. § 431.206(c)(2) (2014), and define "action" as "a termination, suspension, or reduction of Medicaid eligibility or covered services." 42 C.F.R. § 431.201.

224. 457 U.S. 991, 1004 (1982) (holding that a discharge or transfer by a private nursing home does not require notice and an opportunity to be heard in a hearing).

225. *See* CMS GUIDANCE, *supra* note 26, at 2.

226. *See* cases cited *supra* note 49.

“[t]here is no iron curtain drawn between the Constitution and the prisons of this country.”²²⁷ As such, incarcerated individuals “may also claim the protections of the Due Process Clause [and] may not be deprived of life, liberty, or property without due process of law.”²²⁸ However, incarcerated individuals face enormous restrictions on their individual rights and liberties, and courts engage in a different analysis when assessing their legal claims. In considering whether incarcerated individuals may claim that their right to a Medicaid fair hearing is protected by the Due Process Clause, it must be established that they have a property interest in Medicaid enrollment and their interests and potential harms under the *Mathews v. Eldridge* balancing test are sufficiently strong to require access to hearings.

A key issue in determining whether incarcerated individuals have a Due Process right to fair hearings lies in the differences between property and liberty interests, as described below. In the prison context, courts have tended to conflate these types of interests and determined that the analysis for whether the Due Process Clause requires procedural safeguards is the same for both types.²²⁹ The Supreme Court in *Sandin v. Conner*,²³⁰ a significant case involving an individual’s liberty interest in avoiding placement in an isolation cell, created a new test for assessing an incarcerated person’s right to Due Process protections. The Court, without distinguishing between property and liberty interests, held that an incarcerated individual’s Due Process rights were only triggered upon a showing that the prison’s actions threatened to impose “atypical and significant hardship on the inmate in relation to the ordinary incidents of prison life.”²³¹ This “atypical and significant” test creates a very burdensome and subjective standard, and it remains unclear how the denial of a property interest might rise to the high level of an “atypical” hardship that the Court would decide is significant when compared with “the ordinary incidents of prison life.” In layman’s terms, the Court appears to be saying to most potential plaintiffs: “Prison is tough, and don’t look to us for help.”

However, despite *Sandin* failing to distinguish between property and liberty interests, six federal courts of appeals have not applied *Sandin*’s nearly impossible “atypical and significant hardship” standard to property interest cases. The Fifth, Second, and Third Circuits explicitly have held that *Sandin* does not apply to property interest analysis.²³² Notably, the Fifth Circuit stated

227. *Wolff v. McDonnell*, 418 U.S. 539, 555–56 (1974).

228. *Id.* at 556.

229. *Id.* at 557 (determining that the Due Process “analysis as to liberty parallels the accepted due process analysis as to property”); Herman, *supra* note 209, at 506–10; Kaitlin Cassel, *Due Process in Prison: Protecting Inmates’ Property After Sandin v. Conner*, 112 Colum. L. Rev. 2110, 2110–11 (2012).

230. *Sandin v. Conner*, 515 U.S. 472 (1995).

231. *Id.* at 484.

232. *See Burns v. Penn. Dep’t of Corrections*, 544 F.3d 279, 290–91 n.8 (3d Cir. 2008); *Handberry v. Thompson*, 446 F.3d 335, 353 n.6 (2d Cir. 2006) (“*Sandin* was concerned with the

that *Sandin* failed to provide “the correct methodology for determining when prison regulations create a protected property interest.”²³³ The Sixth, Eighth, and Ninth Circuits have also expressed the opinion that *Sandin* does not apply to property interest cases.²³⁴ In contrast, the Tenth Circuit held the opposite, stating explicitly that the “Supreme Court mandate since *Sandin* is that henceforth we are to review property and liberty interest claims arising from prison conditions” under the “atypical and significant hardship” test.²³⁵ The Seventh Circuit has also expressed support for the Tenth Circuit’s position.²³⁶

The majority of circuits that rejected *Sandin*’s application to cases involving due process protections of property interests have instead turned to the Supreme Court’s decision in *Hewitt v. Helms*.²³⁷ The Court in *Hewitt* created a two-part analysis that considers first whether the statutes or regulations at issue create “unmistakably mandatory language”—demonstrated by words like “shall,” “will,” or “must”—and second use “specific substantive predicates” to establish due process protections.²³⁸ Applying the first step, section 1396a(a)(10)(A) of the Medicaid Act provides explicitly that states “must” provide the health services listed in the statute “to all individuals” who qualify.²³⁹ The Medicaid statute’s language is thus “unmistakably mandatory” under *Hewitt*. Further, for this second step, the Medicaid statute must provide substantive predicates for due process protections. Again, the statute does so explicitly. Section 1396a(a)(8) states that a state “must” provide a hearing when an individual’s “claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.”²⁴⁰ Under *Hewitt*’s two-part test, incarcerated individuals thus have an established property interest in Medicaid benefits, which stems directly from the federal statute.

Once a court establishes the existence of a property interest, it must turn to the balancing test of *Mathews v. Eldridge*. As the *Hewitt* Court articulated, under the *Mathews* test, courts “consider the private interests at stake in a governmental decision, the governmental interests involved, and the value of procedural requirements in determining what process is due under the Fourteenth

proper definition of liberty interests, not property interests.”); *Bulger v. U.S. Bureau of Prisons*, 65 F.3d 48, 50 (5th Cir. 1995) (stating that *Sandin* failed to “instruct on the correct methodology for determining when prison regulations create a protected property interest”).

233. *Bulger*, 65 F.3d at 50.

234. See *Woodward v. Ohio Adult Parole Auth.*, 107 F.3d 1178, 1184 (6th Cir. 1997); *Jennings v. Lombardi*, 70 F.3d 994, 995 (8th Cir. 1995).

235. See *Cosco v. Uphoff*, 195 F.3d 1221, 1223 (10th Cir. 1999) (applying *Sandin* test to property interest).

236. *Abdul-Wadood v. Nathan*, 91 F.3d 1023, 1025 (7th Cir. 1996).

237. 459 U.S. 460, 471–72 (1983).

238. *Id.*

239. 42 U.S.C. § 1396a(a)(10)(A) (2012) (stating that states must provide certain services); § 1396(d)(1) (listing “inpatient hospital services” among services that must be provided to beneficiaries).

240. § 1396a(a)(3) (2012).

Amendment.”²⁴¹ Though the Court in *Hewitt* found that the plaintiff’s interest in not being placed in administrative segregation was “not one of great consequence” because it was substituting one restrictive environment for another,²⁴² access to health care services cannot be said to have such little significance. As described in Part II(B)(1), the relevant eligible health services for incarcerated individuals are significant, including hospital admission, inpatient care, and residence in a long-term care facility. Relatedly, while correctional departments have an interest in maintaining prison security,²⁴³ the financial benefits of Medicaid covered services, constitutional obligation to provide medical care, and complaints about excessive § 1983 litigation give prison administrators strong incentives to provide access both to Medicaid services and fair hearings. Finally, the courts must consider the value of the procedural requirements. To this question, federal Medicaid regulations requiring states to follow the Supreme Court precedent in *Goldberg*,²⁴⁴ and the Supreme Court’s statement that the right to a fair hearing is “paramount,”²⁴⁵ together clearly demonstrate that the opportunity for a hearing is extremely important in the context of adverse decisions regarding health care benefits.

This analysis demonstrates that incarcerated individuals can establish that they have a property interest in Medicaid coverage, and they have a corresponding constitutionally-protected right to a fair hearing if a prison official deprives them of that interest through a failure to provide services with reasonable promptness.

CONCLUSION

Consider again the experience of Patient 1, the forty-three-year-old patient who suffered tremendously before he died of heart failure while incarcerated in a Mississippi prison. Patient 1 spent the last months of his life in pain, asking for help, and suffering from severe heart conditions, asthma, and high blood pressure.²⁴⁶ Instead of undergoing hospitalization and treatment, he spent those last months in solitary confinement, with his requests for treatment ignored. The current framework for challenging inadequate health care in prisons requires years of federal litigation, payment of filing fees, and an evidentiary burden that is often impossible to satisfy. This article proposes a new way forward by embracing the emerging trend of prison officials seeking Medicaid reimbursement for prison health expenses and invoking Medicaid’s legal protections for eligible incarcerated individuals.

241. *Hewitt*, 459 U.S. at 473.

242. *Id.*

243. *Id.* at 473–74 (stating government’s interests).

244. 42 C.F.R. § 431.205(d) (2014).

245. *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 570 (1971).

246. Stern Report, *supra* note 1, at 2.

The clear failures of prison health systems across the country have left the health of millions of incarcerated individuals, and the communities to which they will return, in peril. The passage of the Affordable Care Act and the dramatic expansion of Medicaid eligibility, complemented by the significant strengthening of Medicaid beneficiaries' protections, offers the potential to expand the rights of incarcerated individuals in a meaningful way. These protections might have been enough to save Patient 1's life, and they may potentially allow individuals in circumstances like that of Patient 1 to demand prompt access to extremely critical care.

The goal of health justice, advanced through greater autonomy and power redistribution to poor and marginalized communities, is furthered by the use of the fair hearings. These hearings grant incarcerated individuals a fair forum to tell their story and advocate for their own needs, thus preserving the dignity and voice of individuals across the country like Patient 1. The ability to demand these constitutionally-protected hearings enables the self-empowerment of people ignored, dismissed, and marginalized by the modern legal system. Medicaid's protections further offer an additional tool to assist incarcerated individuals to become healthy and to be able to return to healthy communities. While state correctional departments might currently be paying attention only to the influx of federal funding for Medicaid-eligible individuals, advocates and incarcerated individuals should charge ahead and embrace the use of fair hearings and the Affordable Care Act's strengthening of Medicaid's legal protections.