

No. 05-5100, 05-5107

UNITED STATES COURT OF APPEALS  
FOR THE TENTH CIRCUIT

OKLAHOMA CHAPTER OF THE )  
AMERICAN ACADEMY OF )  
PEDIATRICS (OKAAP), *et al.*, )

Plaintiffs-Appellants/ )  
Cross-Appellees, )

v. )

MICHAEL FOGARTY, Chief Executive )  
Officer of the Oklahoma Health Care )  
Authority (OHCA), *et al.*, )

Defendants-Appellees/ )  
Cross-Appellants. )

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ANSWER AND REPLY BRIEF OF  
PLAINTIFFS-APPELLANTS/CROSS-APPELLEES, OKAAP, *et al.*

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**ANSWER AND REPLY BRIEF OF  
PLAINTIFFS-APPELLANTS/CROSS-APPELLEES, OKAAP, et al.**

COME NOW the Plaintiffs-Appellants/Cross-Appellees (“Plaintiffs”) and respectfully submit their Answer and Reply to Defendants-Appellees/Cross-Appellants’ (“Defendants”) Appeal Brief:

**INTRODUCTORY STATEMENT**

Very early on in American history, the Supreme Court recognized the sanctity of the enforceable legal right. One of the best-known passages from Justice Marshall’s opinion in *Marbury v. Madison* remains viable to this day:

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

5 U.S. 137, 164 (1803). Justice Marshall’s forewarning is as vital today as it was in the early nineteenth century. Over the decades since *Marbury v. Madison*, many great and significant jurists have built on the foundation set by Marshall, finding and enforcing the “vested legal right[s]” of the American citizenry. Indeed, the overwhelming weight of authority supports the District Court’s decision below that the statutory provisions at issue here, 42 U.S.C. §§ 1396a(a)(8) and 1396a(a)(30)(A), do in fact confer vested legal

rights on the thousands of young Medicaid beneficiaries who make up the Plaintiff Class.<sup>1</sup>

Plaintiffs have already proven through vast and powerful evidence that Defendants have violated these provisions of the Medicaid Act and that children are suffering as a result. These class members are now entitled to the remedies provided to them by the District Court. However, on appeal, contrary to numerous federal circuit court decisions spanning many years, Defendants argue that the District Court erred, and that Plaintiffs do not have any vested legal rights to enforce. Consequently, the enforceability of these statutory provisions will be **the** key issue in this appeal. Fortunately, the issue is not particularly difficult to resolve. As shown below, §§ 1396a(a)(8) and 1396a(a)(30)(A) unambiguously confer the rights to the reasonably

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<sup>1</sup> For instance see *Sabree v. Richman*, 367 F.3d 180, 192 (3<sup>rd</sup> Cir. 2004) (Barry; Alito concurring) (§ 1396a(a)(8)); *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services*, 364 F.3d 925, 930 (8<sup>th</sup> Cir. 2004) (§ 1396a(a)(30)(A)); *Bryson v. Shumway*, 308 F.3d 79, 89 (1<sup>st</sup> Cir. 2002) (§ 1396a(a)(8)); *Westside Mothers v. Haveman*, 289 F.3d 852, 862-64 (6<sup>th</sup> Cir. 2002), cert. denied *Haveman v. Westside Mothers*, 123 S.Ct. 618 (2002) (§ 1396a(a)(8) and § 1396a(a)(30)(A)); *Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 535-544 (3<sup>rd</sup> Cir. 2002) (en banc) (§ 1396a(a)(30)(A)); *Antrican v. Odom*, 290 F.3d 178, 186-87, 190-91 (4<sup>th</sup> Cir. 2002), cert. denied *Odom v. Antrican*, 123 S.Ct. 467 (2002) (§ 1396a(a)(8)); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 927-28 (5<sup>th</sup> Cir. 2000) (§ 1396a(a)(30)(A)); *Doe v. Chiles*, 136 F.3d 709, 719 (11<sup>th</sup> Cir. 1998) (§ 1396a(a)(8)); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7<sup>th</sup> Cir. 1996) (§ 1396a(a)(30)(A)); and *Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8<sup>th</sup> Cir. 1993) (§ 1396a(a)(30)(A)).

prompt provision of equal and quality health care services on the Plaintiff Class.

**PLAINTIFFS' RESPONSE TO DEFENDANTS' STATEMENT OF  
FACTS AND SUPPLEMENTAL STATEMENT OF FACTS**

**A. Defendants Have Failed to Provide the Court with an Adequate Appendix**

While Defendants provide the Court with a Statement of Facts (Dfts.' Brief at 3-20), they do not provide the Court with any of the pertinent transcripts or other necessary record materials in an appendix. As Cross-Appellants, under the Tenth Circuit Rules, Defendants were required to provide this Court with the necessary record items in an appendix. *See* 10<sup>th</sup>Cir. Rule 30.1; 10<sup>th</sup>Cir. Rule 10.1(A), *and Travelers Indemnity Co. v. Accurate Autobody, Inc.*, 340 F.3d 1118, 1120-22 (10<sup>th</sup>Cir. 2003) (applied Rule 30.1 to a cross-appeal). In particular, Tenth Circuit Rule 10.1(A)(1)(a) requires that, “[w]hen sufficiency of the evidence is raised, the entire relevant transcript **must** be provided” (emphasis added). However, contrary to these rules, Defendants failed to provide the Court with **any** of the record items they cite in their brief. Further, even though Defendants have raised sufficiency of the evidence as an issue for appeal, they have not only failed to provide the Court with the entire trial transcript, but have failed to provide the Court with **one page** of the trial transcript. In sum, Defendants’

appendix is wholly inadequate for a consideration of the sufficiency of the evidence, and the Court should summarily reject Defendants' argument that Plaintiffs' evidence was insufficient to support the District Court's ruling that Defendants have failed to comply with § 1396a(a)(30)(A).

**B. Plaintiffs' Supplemental Statement of Facts**

Plaintiffs assert that their original Statement of Facts presented in the opening brief is sufficient to support all arguments made herein. *See* Plaintiffs' Opening Brief at 4-28. Plaintiffs adopt and incorporate the Statement of Facts from their opening brief herein. However, one area which was not fully addressed in the opening brief was provider reimbursement. While Defendants have clearly failed to provide the Court with the necessary record items to judge the sufficiency of the evidence in that regard, Plaintiffs offer this Supplemental Statement of Facts to erase any doubt as to whether the District Court erred in holding that "in violation of 42 U.S.C. § 1396a(a)(30)(A), Defendants are not assuring that payments are sufficient to enlist enough providers so that care and services are available to Medicaid-eligible children to the extent that such care and services are available to the general population in the geographic areas served by the OHCA (*i.e.*, Defendants are not assuring "equal access")." *OKAAP v. Fogarty*, 366 F.Supp.2d 1050, 1119 (N.D.Okla. 2005) ("*OKAAP II*"). In

addition to the material concerning provider rates, Plaintiffs offer this Supplemental Statement of Facts to specifically address other selected “facts” set out by Defendants.

**1. Provider Reimbursement Rates**

Defendants have offered no credible evidence to contest **any** of the District Court’s many Findings of Fact pertaining to the inadequacy of Medicaid provider reimbursement rates. *OKAAP II*, 366 F.Supp.2d at 1059-61 and 1074-76. The District Court’s Findings conclusively demonstrate that provider reimbursement under Oklahoma’s Medicaid program is truly inadequate to satisfy the requirements of § 1396a(a)(30)(A) or to ensure that services are delivered with reasonable promptness as required under § 1396a(a)(8).

**a. The Reimbursement Rate System Generally**

When medical services are delivered on the basis of “fee-for-service,” physicians bill in terms of “Current Procedure Terminology” or “CPT codes.” *OKAAP II*, 366 F.Supp.2d at 1059. There are two main categories of CPT codes: (1) evaluation and management (“E and M”) codes, and (2) procedure codes. *Id.* E and M codes are essentially “office visit codes,” while procedure codes are the codes used by physicians to bill for all non-E

and M services. *Id.* For instance, all surgical and diagnostic procedures are billed under procedure codes. *Id.*

**b. Oklahoma’s Medicaid Reimbursement Rates**

At the time of trial, the Oklahoma Health Care Authority’s (“OHCA”) stated performance measure for compliance with § 1396a(a)(30)(A)’s equal access mandate was to raise provider reimbursement rates under Medicaid to 100% of the Medicare Fee Schedule. *OKAAP II*, 366 F.Supp.2d at 1074. Despite this performance measure, from 1995 through December 31, 2003, provider reimbursement rates under Oklahoma's Medicaid Fee Schedule **never exceeded 72% of Medicare.** *Id.* At the time of trial, providers were reimbursed under Oklahoma’s Medicaid fee-for-service fee schedule for “most codes,” including procedure codes, at “about 71 per cent of Medicare.” *Id.* (quoting Tr. Vol. XV, at 1949:24 – 1950:2 (Supp. App. 18 at 669-670)).

Importantly, **Defendants have repeatedly admitted that Oklahoma’s Medicaid rates are inadequate and that § 1396a(a)(30)(A)’s equal access mandate is being violated.** In its Fiscal Year 2003 Budget Request, OHCA sought from the Oklahoma Legislature an increase in physician reimbursement to “100% of the Medicare Fee Schedule” for the express purpose of complying with the federal equal access mandate.

*OKAAP II*, 366 F.Supp.2d at 1074 (citing Pl. Ex. 424, at BR-40B, at 41, 43 (Supp. App. 4 at 74, 76)). OHCA further advised the Legislature that if the reimbursement increase was not realized, it could “possibly jeopardize access to care.” *Id.* Defendant Fogarty has since admitted that the Fiscal Year 2003 Budget Request requested an increase in rates in order to comply with the law and alleviate the access problems experienced by Oklahoma’s Medicaid children:

- Q. What you’re telling the legislature is, in order to comply with the law, I need to raise rates?
- A. That’s correct.
- Q. That was truthful?
- A. That was truthful.

*Id.*; and Tr. 3/14/03, at 236:20-24 (Supp. App. 7 at 172); *see Id.* at 234:6-13 (Supp. App. 7 at 170).

In its Fiscal Year 2004 and Fiscal Year 2005 Budget Requests, OHCA again requested an increase in physician reimbursement to 100% of Medicare and **again** represented that this increase was needed in order to comply with the equal access mandate. *OKAAP II*, 366 F.Supp.2d at 1074 (citing Pl. Ex. 460 at BR-40B, at 35-36 (Supp. App. 5 at 79-80), and Ex. 461 at BR-40B, at 31-32 (Supp. App. 6 at 82-83)). Defendants have also admitted generally that these low provider reimbursement rates make it difficult to attract physicians to participate in Oklahoma’s Medicaid

program. As Defendant Fogarty admitted, and Defendant Mitchell agreed, Oklahoma's Medicaid physician reimbursement rates "are low, were low, and that this is a factor that makes it difficult to recruit physicians." *Id.* at 1075 (citing Tr. 3/14/03, at 215:25 – 216:1 (Supp. App. 7 at 151-152); quoting Agreed Pretrial Order and Statement of the Case (Aplt. App. 5, Vol. I, at 190)) (emphasis added).

State-wide statistics prove that these admittedly low reimbursement rates have had a negative impact on pediatrician participation in Oklahoma's Medicaid program. Approximately **ninety-three percent (93.2%)** of Oklahoma's pediatricians report that low reimbursement is a very important reason they would limit their participation in the Medicaid program. *OKAAP II*, 366 F.Supp.2d at 1075 (citing Pl. Ex. 203 (Aplt. App. 13, Vol. II, at 523)). Low reimbursement is by far the primary reason pediatricians limit participation in the Medicaid program. *Id.* Additionally, 50% of Oklahoma's pediatricians, including sub-specialists, responded they will either see few Medicaid patients or stop seeing Medicaid patients altogether if Medicaid payments remain the same. *Id.*

Moreover, as far back as 1999, the Health Care Financing Administration (“HCFA”)<sup>2</sup> identified Oklahoma’s low reimbursement rates as contributing to an identified shortage of specialists willing to accept Medicaid patients. *OKAAP II*, 366 F.Supp.2d at 1075 (citing Pl. Ex. 20, at BB.5272, BB.5287 (Supp. App. 2 at 19, 34)). In response, OHCA admitted that “... low reimbursement rates,” among other factors make it “difficult to attract additional specialists to participate in the Medicaid program.” *Id.* (quoting Pl. Ex. 20, BB.5273 (Supp. App. 2 at 20)). Likewise, HCFA found that “specialists primarily do not participate [in the now-defunct SoonerCare Plus program] because of the lack of sufficient reimbursement for specialty care and an unwillingness to participate in SoonerCare or any other type of managed care model.” *Id.* (quoting Pl. Ex. 20, BB.5287 (Supp. App. 2 at 34)).

On January 19, 2001, the HCFA Director released a memorandum regarding access to care for Medicaid children. *OKAAP II*, 366 F.Supp.2d at 1076 (citing Pl. Ex. 30 (Supp. App. 3 at 68)). In it, HCFA acknowledged the relationship between inadequate reimbursement rates and inadequate access to care and stated that:

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<sup>2</sup> HCFA, now known as the Center for Medicare and Medicaid Services (“CMS”), is the federal agency charged with overseeing the Medicaid program on behalf of the Secretary of the Department of Health and Human Services. *OKAAP II*, 366 F.Supp.2d at 1054.

One way to assess whether State payments are sufficient to enlist enough providers so that there is adequate access to services is to compare State Medicaid reimbursement rates (including fee-for-service rates and rates paid to providers by managed care organizations under contract with the State Medicaid agency) to the rates of commercial payers for comparable services in comparable geographic areas.

*Id.* (quoting Pl. Ex. 30 at BB.0028 (Supp. App. 3 at 70)). However, as the District Court correctly found, “[c]urrent Medicaid reimbursement in Oklahoma is significantly less than rates paid to physicians by private insurance plans.” *Id.* (citing Tr. Vol. V, at 580:21-25 (Supp. App. 12 at 427); Tr. Vol. VII, at 942:16 – 943:4 (Supp. App. 14 at 522-523); Tr. Vol. VIII, at 1011:11 – 1012:10 (Supp. App. 15 at 547-548); Tr. Vol. XI, at 1499:1-9 (Supp. App. 17 at 629)). Under commercial plans, Oklahoma physicians are reimbursed at rates of 130% to 180% of Medicare. *Id.* at 1060.<sup>3</sup> As OHCA’s own financial management director conceded, the **average** of the top five rates paid by private insurance companies to the university physicians is **140% of Medicare**. *Id.* (citing Tr. Vol. XV, at 1971:13 – 1972:2 (Supp. App. 18 at 691-692)).

Aside from all of this evidence of systemic deficiencies in Oklahoma’s Medicaid reimbursement rates, several physician specialists

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<sup>3</sup> Citing Tr. Vol. V, at 580:21-25 (Supp. App. 12 at 427); Tr. Vol. VII, at 942:16 – 943:4 (Supp. App. 14 at 522-523); Tr. Vol. VIII, at 1011:11 – 1012:10 (Supp. App. 15 at 547-548); Tr. Vol. XI, at 1499:1-9 (Supp. App. 17 at 609).

who treat children testified that they either do not participate in the Medicaid program or limit their participation primarily due to low reimbursement rates. These physician specialists include David Siegler, a pediatric neurologist from Tulsa, (Tr. Vol. V, at 576:23-25 (Supp. App. 12 at 423)); Joseph Leonard, an ENT specialist, (Tr. Vol. VI, at 665:9-13 (Supp. App. 13 at 465)); Edward Barns, another ENT specialist, Tr. Vol. IX, at 1052:24 – 1053:14 (Supp. App. 16 at 587-588)); Mark Capehart, a pediatric orthopedist, Tr. Vol. VIII, at 1035:12-18 (Supp. App. 15 at 571)); and Robert Lauvetz, a urologist in Stillwater, Tr. Vol. VIII, at 1007:18 – 1009:15; 1010:17 – 1011:10 (Supp. App. 15 at 543-545; 546-547)). Other physician specialists who accept all Medicaid patients testified that the low reimbursement rates have caused them financial difficulty and an inability to recruit pediatric specialists. These physician specialists include Richard Ranne, a pediatric surgeon, (Tr. Vol. VII, at 942:7-15 (Supp. App. 14 at 522)), and William Jackson, a pediatric cardiologist, Tr. Vol. XI, *Id.* at 1499:10-19; 1500:1-8 (Supp. App. 17 at 629; 630)).

## **2. Problems Experienced by Named Plaintiffs and Class Members**

Through their Statement of Facts, Defendants attempt to establish that the named Plaintiffs and class members, whose parents testified at trial, have experienced no significant problems with Oklahoma's Medicaid program.

However, Defendants have omitted crucial testimony that shows these children have experienced major difficulties that have put them at risk of great harm and even death.

**a. Jacob and Everett Hercules**

About three years prior to trial, Dr. Tawfik Ramadan came to suspect that named Plaintiff Jacob Hercules has sleep apnea. Tr. 4/15/04 at 1106:15 – 1107:23 (Supp. App. 16 at 600-601); and Tr. 4/5/04 at 164:24 – 165:24 (Supp. App. 8 at 251-252). Sleep apnea is a serious condition in children, where the child actually stops breathing for periods of time during the night. Tr. 4/15/04 at 1106:15 – 1107:23 (Supp. App. 16 at 600-601). While Dr. Ramadan had attempted for **approximately three years** to find a sleeping disorder facility to perform a necessary diagnostic sleep study on Jacob, he was unable to find a facility willing to accept Medicaid. *Id.* As such, Defendants have simply failed to provide necessary care for Jacob. Furthermore, both Jacob and his brother Everett have never had a blood lead level assessment, which is a mandatory part of an EPSDT screening. Tr. Vol. I at 169:20-22 (Supp. App.8 at 256).

**b. Mason M.**

Class member Mason M. has experienced serious problems in attempting to access pediatric neurological care and ENT care. Tr. 4/12/04

at 715-27 (Supp. App. 13 at 474-486). Mason was referred to a neurologist who has an office in Durant, Oklahoma, and in Dennison, Texas. The drive from Mason's home to Durant is about 500 miles, while the drive to Dennison is 550 miles. Mason had the option of seeing a neurologist in Oklahoma City, but it would have taken at least six to eight months to get in. *Id.* at 723-25 (Supp. App. 13 at 482-484). By contrast, a privately insured patient in the area could be seen by a pediatric neurologist "in a matter of a week." Tr. 4/8/04 at 549:6-8 (Supp. App. 11 at 397). Mason M. has also suffered developmental delays as a result of delay in receipt of necessary ENT services. Tr. 4/12/04 at 717:8-11 and 718:25 – 722:16 (Supp. App. 13 at 476 and 477-481).

**c. Ashley M.**

Class member Ashley M's Primary Care Provider ("PCP") determined that she needed a neurological evaluation of a continuing problem with "intense" headaches. Tr. 4/12/04 at 773:11 – 774:12 (Supp. App. 13 at 496-497). Ashley and her mother were forced to travel four and a half hours one way from their home in Cushing to Durant for an appointment with a pediatric neurologist. *Id.* at 774:10 – 775:4 (Supp. App. 13 at 497-498). The pediatric neurologist in Durant was the closest available neurologist at the time. *Id.* Because of the long travel time and a 9:00 a.m. appointment,

Ashley and her mother were also forced to stay the night in a motel in Durant. *Id.* at 775:20 – 776:9 (Supp. App. 13 at 498-499). In all, the trip to Durant cost Ms. McEntire “at least” \$100. *Id.* at 776:3-9 (Supp. App. 13 at 499). Due to the expense of the trip to Durant, Ashley did not make it to a follow-up appointment with the pediatric neurologist. *Id.* at 776:19 – 777:5 (Supp. App. 13 at 499-500). Had a pediatric neurologist been available in Tulsa or Oklahoma City, Ms. McEntire would not have had any problem taking Ashley in for follow-up. *Id.* at 778:8-19 (Supp. App. 13 at 501). The testimony at trial showed that pediatric neurologists in Tulsa and Oklahoma City are much more readily available to privately insured patients. Tr. 4/9/04 at 572 (Supp. App. 12 at 419); Tr. 4/7/04 at 396:6-16 (Supp. App. 10 at 354); and Tr. 4/6/04 at 214:5 – 218:13 (Supp. App. 9 at 297-301). (While Medicaid children wait months, children with private insurance are seen as quickly as “24 to 48” hours.)

**d. Chyanna W.**

Also, while Defendants would have this Court believe that class member Chyanna W. has had no problems whatsoever with Oklahoma’s Medicaid program, the Court will recall from Plaintiffs’ opening brief that young Chyanna was put at risk of death by the lack of available neurologists. The District Court took particular note of the testimony from Chyanna’s

mother who described a four-hour drive to see a pediatric neurologist and Chyanna experiencing a severe seizure en route. *OKAAP II*, 366 F.Supp.2d at 1067 (citing Tr. Vol. IX, at 1097:9 – 1098:17). Chyanna’s only two options were to wait one to two years to see a neurologist in Oklahoma City or to wait several months to see a neurologist in Durant, which is a four-hour drive from her home. Tr. Vol. IX, at 1097:7-17 (Aplt. App. 34, Vol. IV, at 1198). Chyanna’s mother chose what appeared to be the better of two bad choices, the drive to Durant. *Id.* However, the four-hour drive proved to be more than Chyanna could take:

- Q. Were there any particular difficulties in terms of taking your daughter that distance to see the neurologist?
- A. Yes, sir. My daughter goes into seizure activity if she’s on a long drive or if she gets stressed out; or if she gets overexerted, seizures come onset pretty bad and they last a while...[T]he drive [to Durant] is stressful for her because of the long hours that it takes.

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This last trip we took [to Durant], I had to literally pull off the side of the road because she was jerking, she was drooling, she was having a lot of seizure activity uncontrolled, and we had to get her under control before I could go back again and drive.

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If I cannot get [her seizures] under control, she can go comatose, and that would mean that I take a risk of losing her.

*Id.* at 1097:18 – 1098:17 (Aplt. App. 34, Vol. IV, at 1198).

## SUMMARY OF ARGUMENT

Section 1396a(a)(8) contains prototypical “rights-creating” language. This Court should follow every other federal court of appeals to have decided the issue and hold that § 1396a(a)(8) *does* confer enforceable rights. Also, contrary to Defendants’ position, § 1396a(a)(8) does, in fact, confer the right to the delivery of actual medical services on the Plaintiff Class.

Section 1396a(a)(30)(A) contains the requisite rights-creating language focused on a particular class of individuals, the Medicaid beneficiaries. Of all the many federal courts of appeals to decide whether § 1396a(a)(30)(A) is individually enforceable, only one has held that the provision does not confer rights on beneficiaries. While §§ 1396a(a)(8), 1396a(a)(10)(A), 1396d(a)(4)(B)(2) and 1336d(r) create the rights to specific services, § 1396a(a)(30)(A) assigns a duty of performance on the states which is necessary in assuring that those rights are realized.

Defendants did not raise at trial any of the evidentiary issues raised here and have failed to establish that the evidentiary issues have been preserved for appellate review. Defendants failed to provide this Court with the necessary record items in an appendix. Nonetheless, the evidence at trial was sufficient to establish a violation of § 1396a(a)(30)(A).

The Permanent Injunction entered by the District Court is narrowly tailored to address the precise statutory violations at issue here (42 U.S.C. §§ 1396a(a)(8) and 1396a(a)(30)(A)).

### **STANDARD OF REVIEW**

While Plaintiffs do not believe that Defendants' arguments regarding the sufficiency of the evidence should be considered by the Court, if the Court opts to consider these arguments, then the Court's review must be "limited to determining whether the record-viewed in the light most favorable to the prevailing party-contains substantial evidence to support the [fact-finder's] decision." *United Phosphorus, Ltd. v. Midland Fumigant, Inc.*, 205 F.3d 1219, 1226 (10<sup>th</sup>Cir. 2000) (quoting *Comcoa, Inc. v. NEC Tel., Inc.*, 931 F.2d 655, 663 (10<sup>th</sup>Cir. 1987)). Substantial evidence is "something less than the weight of the evidence, and is defined as such relevant evidence as a reasonable mind might accept as adequate to support a conclusion, even if different conclusions also might be supported by the evidence." *Webco Industries, Inc. v. Thermatool Corp.*, 278 F.3d 1120, 1128 (10<sup>th</sup>Cir. 2002). Plaintiffs easily make this standard. In the case at bar, Defendants do not even dispute the District Court's findings. Instead, Defendants claim that the findings, and underlying evidence, are insufficient

to establish a violation of law. However, there is simply no support in the record for this argument.

The remaining legal issues should be reviewed *de novo*. *Valdez v. Ward*, 219 F.3d 1222, 1230 (10<sup>th</sup> Cir. 2000).

## **ARGUMENT**

### **I. THE PROVISIONS OF 42 U.S.C. § 1396a(a)(8) DO CREATE RIGHTS WHICH ARE ENFORCEABLE UNDER § 1983**

The District Court has **twice** held that 42 U.S.C. § 1396a(a)(8) confers rights upon Plaintiffs which are enforceable under 42 U.S.C. § 1983. *OKAAP v. Fogarty*, 205 F.Supp.2d 1265, 1272 (N.D.Okla. 2002) (“*OKAAP I*”); and *OKAAP II*, 366 F.Supp.2d at 1109. In their role as Cross-Appellants, Defendants assert that the District Court erred in holding that § 1396a(a)(8) creates enforceable rights. Defendants cite three basic grounds in support of this argument: (1) that § 1396a(a)(8) is ambiguous; (2) that the focus of § 1396a(a)(8) is on “administration of the plan” and not on the provision of services; and (3) that § 1396a(a)(8) is so vague and amorphous that its enforcement would strain judicial resources. Dfts.’ Brief at 39-42. However, Defendants’ arguments in this regard are without merit. Section 1396a(a)(8) has passed all tests of enforceability which have been applied to it. Far from being ambiguous or vague, for decades, the language of §

1396a(a)(8) has proven to be a model of explicit and clear rights-creating language.

**A. Section 1396a(a)(8) Unambiguously Confers Rights on the Plaintiff Class**

There is a long and unbroken line of Supreme Court decisions, penned by ideologically diverse Justices, which uphold the enforceability of various provisions of the Social Security Act. *See King v. Smith*, 392 U.S. 309, 333 (1968) (Chief Justice Warren); *Rosado v. Wyman*, 397 U.S. 397, 412-13 (1970) (Harlan); *Wilder v. Virginia Hosp. Ass.’n*, 496 U.S. 498, 502 (1990) (Brennan). As discussed in our opening brief (at 32), another foundational case in the area of individually enforceable rights is *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981). In *Pennhurst*, Justice Rehnquist wrote the Supreme Court’s authoritative declaration of the requirement that Congress speak with a clear and unambiguous voice if it intends to impose a condition on the grant of federal monies:

Indeed, in those instances where Congress has intended the States to fund certain entitlements as a condition of receiving federal funds, it has proved capable of saying so explicitly.

*Pennhurst*, 451 U.S. at 17-18. As an example of an instance in which Congress explicitly intended to create an enforceable entitlement, the *Pennhurst* Court cited the Social Security Act provision at issue in *King v. Smith*, 392 U.S. at 333, which “creates a ‘federally imposed obligation [on

the States] to **furnish** aid to families with dependent children ... with **reasonable promptness** as to **all eligible individuals'** ..." *Id.* at 18 (emphasis added). Plainly, the key language in the provision of the Social Security Act at issue in *King v. Smith* was verbatim the same as § 1396a(a)(8), which provides:

A state plan for medical assistance must-...provide that all individuals wishing to make application for **medical assistance under the plan** shall have opportunity to do so, and that such assistance **shall be furnished with reasonable promptness to all eligible individuals.**

(emphasis added). Thus, the language of § 1396a(a)(8) is truly prototypical language in the realm of statutory rights.

Since the *King v. Smith* and *Pennhurst* decisions were handed down, several courts have had occasion to specifically decide whether § 1396a(a)(8) itself confers rights which are enforceable under 42 U.S.C. § 1983. Again, **every** federal court of appeals to have decided the issue has concluded that § 1396a(a)(8) **does** confer enforceable rights. *For instance, see Sabree v. Richman*, 367 F.3d 180, 192 (3<sup>rd</sup> Cir. 2004) (Barry; Alito concurring); *Bryson v. Shumway*, 308 F.3d 79, 89 (1<sup>st</sup> Cir. 2002); *Westside Mothers v. Haveman*, 289 F.3d 852, 862-63 (6<sup>th</sup> Cir. 2002), *cert. denied Haveman v. Westside Mothers*, 123 S.Ct. 618 (2002); *Antrican v. Odom*, 290 F.3d 178, 186-87, 190-91 (4<sup>th</sup> Cir. 2002), *cert. denied Odom v. Antrican*, 123 S.Ct. 467 (2002); and *Doe v. Chiles*, 136 F.3d 709, 719 (11<sup>th</sup> Cir. 1998). *See*

*also S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 605 (5th Cir. 2004) (citing *Sabree* and *Bryson* with approval in holding that § 1396a(a)(10)(A) confers enforceable rights). Plainly, the District Court was on firm ground in holding that § 1396a(a)(8) confers an enforceable right on the Plaintiff Class.

Two of the above-cited cases, *Sabree* and *Bryson*, were decided after the Supreme Court’s decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002). The *Gonzaga* decision did not fundamentally change the analysis of whether Congress has conferred an enforceable right and did not overrule any of the Court’s prior decisions on the issue. In *Gonzaga*, the Court simply made clear its rejection of “the notion that [the Court’s] cases permit anything short of an unambiguously conferred right to support a cause of action under § 1983.” *Gonzaga*, 536 U.S. at 283. To confer rights, Congress must use “rights-creating language.” *Id.* at 287. Such language must clearly impart an “individual entitlement” and have an “unmistakable focus on the benefitted class.” *Id.* (quoting *Blessing v. Freestone*, 520 U.S. 329, 343 (1997), and *Cannon v. University of Chicago*, 441 U.S. 677, 690-93 (1979)).

Section 1396a(a)(8) satisfies the standards for enforceability set forth in *Gonzaga*. See *Sabree*, 367 F.3d at 190-92; and *Bryson*, 308 F.3d at 88-89.

The *Sabree* Court’s analysis on this point is convincing:

The Court [in *Gonzaga*] identified the text of Titles VI and IX as exemplars of rights-creating language. *Gonzaga*, 536 U.S. at 287. Viewing Titles VI and IX, we find it difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant Title XIX language-“A State plan must provide”-from the “No person shall” language of Titles VI and IX. Just as in Titles VI and IX, the relevant terms used in Title XIX are “mandatory rather than precatory.” *Blessing*, 520 U.S. at 341. Further, the “individual focus” of Sections 1396a(a)(10), 1396d(a)(15), and 1396a(a)(8) is unmistakable. *Gonzaga*, 536 U.S. at 287. The relevant Title XIX provisions enumerate the entitlements available to “all eligible individuals.” See, e.g., 42 U.S.C. § 1396a(a)(8). The provisions do not focus on “the [entity] ... regulated rather than the individuals protected.” *Alexander v. Sandoval*, 532 U.S. [275,] 289 [(2001)]. Neither do the statutory references to the individual appear “in the context of describing the type of ‘policy or practice’ that triggers a funding prohibition.” *Gonzaga*, 536 U.S. at 288.

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In requiring states which accept Medicaid funding to provide [Intermediate Care Facility for the Mentally Retarded (“ICF/MR”)] **services** with reasonable promptness, Congress conferred specific entitlements on individuals “in terms that ‘**could not be clearer.**’” *Gonzaga*, 536 U.S. at 280 (quoting *Wright [v. Roanoke Redevelopment & Housing Authority]*, 479 U.S. [418, 430 (1987)]). **There is no ambiguity.**

*Sabree* at 190 (emphasis added). Clearly, § 1396a(a)(8) is unambiguous and unambiguously confers rights. See also *Bryson*, 308 F.3d at 89 (concluding that § 1396a(a)(8) is unambiguous); and *Doe v. Chiles*, 136 F.3d at 719

(same). Further, this Court of Appeals has previously concluded that § 1396a(a)(8) and its implementing regulations contain “specific language.” *Lewis v. New Mexico Dept. of Health*, 261 F.3d 970, 977 (10th Cir. 2001).

While Defendants make the unsupported claim that § 1396a(a)(8) is ambiguous, and thus unenforceable, there is plainly no merit to this claim. The language unambiguously confers the right to be furnished with medical assistance on the Plaintiff Class of eligible individuals.

**B. Section 1396a(a)(8) Requires the Delivery of Medical Services and Not Merely Payment for Medical Services or Merely for Prompt Eligibility Determinations**

Defendants also argue that § 1396a(a)(8) does not require that actual medical services be furnished to any individual and, therefore, confers no enforceable right on Plaintiffs. Dfts.’ Brief at 39-40. It is Defendants’ contention that § 1396a(a)(8) only requires the State to pay for medical services and to make prompt eligibility determinations. *Id.* In Defendants’ view, the Medicaid program is a payment scheme only. *Id.* However, contrary to Defendants’ position, § 1396a(a)(8) does, in fact, confer a right to the delivery of actual medical services.

First, the plain language of the § 1396a(a)(8) and other pertinent provisions of the Medicaid Act at issue in this case evince Congress’ intent that the states *make available* actual medical services and not merely

payment. *See* §§ 1396a(a)(8) (“...[medical] assistance [under the plan] shall be furnished with reasonable promptness to all eligible individuals”); 1396a(a)(10)(A) (state plan for medical assistance must provide “for making medical assistance available, **including** at least the **care and services** listed in [§ d(a)(4)(B) and others]; 1396d(a)(4)(B) (defines “medical assistance” to include early and periodic screening, diagnosis and treatment (“EPSDT”) services); and 1396d(r) (sets out the specific “items and services,” care and treatment to be provided to eligible individuals as EPSDT). When defining EPSDT as “medical assistance,” these provisions do not advert to “payment” or “cost,” but are formulated solely in terms of care and services. In making EPSDT “available,” Plaintiffs do not suggest that the State of Oklahoma is itself required to hire doctors and employ them in state hospitals. Plaintiffs do not urge that the State must “directly provide care” as Defendants assert. Dfts.’ Brief at 40. For one, such a requirement would render superfluous the provision in Title XIX that permits a state to contract with managed care organizations to provide services, 42 U.S.C. § 1396u-2, *et seq.* Instead, the State must *provide* care and services in whatever way it chooses, including by contracting those services out to third party providers, and Defendants must act to assure that all eligible individuals actually *receive* those services.

Many courts of appeals have had little difficulty in concluding that § 1396a(a)(8) requires that states assure that beneficiaries receive services. As noted above, in *Sabree*, 367 F.3d at 189, the Third Circuit held that, “[i]n requiring states which have accepted Medicaid funding to provide ICF/MR **services** with reasonable promptness [under §§1396a(a)(8) and 1396a(a)(10)], Congress conferred specific entitlements on individuals in terms that could not be clearer” (internal quotations omitted) (emphasis added) (citing *Gonzaga*, 536 U.S. at 280). In *Bryson*, 308 F.3d at 88-9, the First Circuit held that disabled plaintiffs had an enforceable right under §1396a(a)(8) to receive home- and community-based **services** with reasonable promptness.

In *Doe v. Chiles*, 136 F.3d at 715-18, the Eleventh Circuit held that §1396a(a)(8) created a federal right in Medicaid-eligible plaintiffs to reasonably prompt provision of intermediate care facility services. In so holding, the Court relied in part on *Sobky v. Smoley*, 855 F.Supp. 1123, 1146 (E.D.Cal. 1994), where the Eastern District of California pertinently concluded that ““§1396a(a)(8) requires ‘medical assistance under the plan’ to be furnished with reasonable promptness, and **this can only mean services.**”” *Id.* at 715, n. 13 (quoting *Sobky* at 1146) (emphasis added). The *Doe v. Chiles* decision highlights the fact that “medical assistance **under the**

**plan**” is key language, for “medical assistance” under a state Medicaid plan truly can only mean services.

In *Antrican*, 290 F.3d at 187, the plaintiffs alleged that North Carolina had failed to “operate a Medicaid program under which beneficiaries can obtain ‘prompt and adequate dental **services**’...” in violation of § 1396a(a)(8) (emphasis added). In rejecting the defendants’ argument that the plaintiffs’ claims involved only the discretionary acts of State officials, the Fourth Circuit held:

...the Medicaid Act does not provide participating States with discretion to deny dental **screening** and **treatment** as specified in the Act. To the contrary, the Medicaid Act clearly mandates that a State **provide** a certain level of quality dental **care**...

*Antrican*, 290 F.3d at 191 (emphasis added). Defendants’ position that § 1396a(a)(8) only requires payment and prompt eligibility determinations is simply without merit.

Defendants’ reliance on *dicta* from the Seventh Circuit in *Bruggeman v. Blagojevich*, 324 F.3d 906 (7<sup>th</sup> Cir. 2003), is misplaced. The *Bruggeman* Court held that “the statutory entitlement to reasonable promptness of medical **services** (42 U.S.C. § 1396a(a)(8)) is not infringed by the maldistribution...of [Intermediate Care Facilities] across the state.” *Bruggeman*, 324 F.3d at 910. The Seventh Circuit’s Judge Posner also stated in passing, without holding, that the “...statutory reference to

‘assistance’ [in § 1396a(a)(8)] **appears** to have reference to *financial* assistance rather than to actual medical *services*.” *Id.* (emphasis added).<sup>4</sup> However, “appears” is the critical word in *Bruggeman*. Clearly, the commentary was tentative and indefinite, which may explain why the Court did not bother to address the actual language of the statute or regulations. With good reason, the *Bruggeman* Court is the **only** circuit court in the line of decisions on the matter which has so much as affirmatively suggested that the “medical assistance” required to be furnished under § 1396a(a)(8) is exhausted by the furnishing of money payments.<sup>5</sup>

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<sup>4</sup> The District Court’s decision is somewhat confusing in this regard. While the District Court purports to agree with the *Bruggeman dicta* concerning the meaning of “assistance,” its actual holding is that § 1396a(a)(8) requires the reasonably prompt provision of services:

Plaintiffs have offered substantial evidence that the delays in **treatment** for children with specific conditions are medically inappropriate. Importantly, plaintiffs have shown that system-wide delays in **treatment** exist and have presented convincing evidence that those delays are not reasonable. In violation of 42 U.S.C. § 1396a(a)(8), defendants are not ensuring that medical assistance is furnished with reasonable promptness to all eligible individuals.

*OKAAP II*, 366 F.Supp.2d at 1109 (emphasis added).

<sup>5</sup> The district court decision relied upon by Defendants, *Sanders v. Kansas Dept. of Social Rehabilitation Serv.*, 317 F.Supp.2d 1233, 1250 (D.Kan. 2004), merely relies on the *Bruggeman dicta* to hold that § 1396a(a)(8) does not confer a right to the provision of services. For the same reasons that the *Bruggeman dicta* is incorrect, the holding in *Sanders* is incorrect.

While the *Bruggeman* Court cites 42 C.F.R. §435.930 as supporting its position that § 1396a(a)(8) applies only to financial assistance, the regulation actually supports the opposite conclusion. Titled “[f]urnishing Medicaid,” 42 C.F.R. § 435.930 expressly governs the actual provision of services, providing:

The agency must – (a) **Furnish Medicaid** promptly to **recipients** without any delay caused by the agency’s administrative procedures; (b) Continue to **furnish Medicaid** regularly to **all eligible individuals** until they are found to be ineligible; and (c) Make arrangements to assist applicants and recipients to get emergency medical **care** whenever needed, 24 hours a day and 7 days a week.

(emphasis added). As the Supreme Court has recognized, “Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States **so that they may furnish medical care to needy individuals.**” *Wilder*, 496 U.S. at 502 (emphasis added).

This regulation clearly refers to the furnishing of services and not payment because Medicaid “recipients” and “eligible individuals” do not receive payment. Medicaid recipients receive services; Medicaid providers receive payment. Medicaid beneficiaries are not, nor have they ever been, directly compensated under the Medicaid program.

Similarly, if the word “payment” replaced the words “medical assistance” in § 1396a(a)(8), the statute would provide that a state plan would have to give “all individuals wishing to make application for

payment” “the opportunity to do so,” and further require that “such payment shall be furnished with reasonable promptness to all eligible individuals.” Again, the *Bruggeman* interpretation urged by Defendants flies in the face of common sense, and, if adopted, would require states to begin directly paying recipients with reasonable promptness, a result which Congress clearly did not intend.<sup>6</sup> Medical assistance furnished to eligible individuals “under the plan” can only mean services and cannot be limited to payment or eligibility determinations.

**C. Section 1396a(a)(8) is *Not So Vague and Amorphous* that its Enforcement Would Strain Judicial Resources**

In *Blessing*, 520 U.S. at 340-41, the Supreme Court held that one of the factors which courts should consider when determining whether a statute confers an enforceable right is whether the right assertedly protected by the statute is so “‘vague and amorphous’ that its enforcement would strain

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<sup>6</sup> Other provisions of the Medicaid Act would similarly be rendered senseless if the Court were to hold that medical assistance means only financial assistance. For instance, § 1396a(a)(23) requires that a state plan must “provide that (A) any individual eligible for **medical assistance (including drugs)** may obtain such assistance from any[one] qualified to perform the service.” 42 U.S.C. § 1396a(a)(23) (emphasis added). If “medical assistance” meant “payment,” the statute would require that states provide “payment (including drugs),” which is completely illogical. Similarly, § 1396a(a)(65) requires that a state plan must “issue provider numbers for all suppliers of **medical assistance consisting of durable medical equipment.**” 42 U.S.C. § 1396a(a)(65) (emphasis added). Suppliers of durable medical equipment are not and cannot be suppliers of Medicaid payments.

judicial competence” (citation omitted). Here, Defendants claim that § 1396a(a)(8) is so vague and amorphous that its enforcement would strain judicial resources. Dfts.’ Brief at 41-2. However, like Defendants’ other arguments against the enforceability of § 1396a(a)(8), Defendants’ “vague and amorphous” argument simply does not stand up under critical scrutiny.

First of all, Defendants do not cite any case, and Plaintiffs do not know of any case, which has held that § 1396a(a)(8) is so “vague and amorphous” that it strains judicial resources. The use of the word “reasonable” does not render § 1396a(a)(8) too vague and amorphous. *See Doe v. Chiles*, 136 F.3d at 716-18; *Sobky*, 855 F.Supp. at 1147; and *Martin v. Taft*, 222 F.Supp.2d 940, 978 (S.D.Ohio 2002). In *Doe*, the Eleventh Circuit looked to the Supreme Court’s decisions in *Wilder* and *Wright*, which both involved statutory provisions containing the term “reasonable,” in concluding that § 1396a(a)(8) is not too vague and amorphous. *Id.* As the *Doe* Court reasoned: “[I]ike the statutory provisions at issue in *Wright* and *Wilder*, section 1396a(a)(8)’s requirement that ‘assistance shall be furnished with *reasonable promptness* to all eligible individuals’ presents a sufficiently specific and definite standard readily susceptible to judicial assessment.” *Doe* at 717 (emphasis in original).

Also, contrary to Defendants’ position, Plaintiffs do not allege there are isolated delays in the provision of care, but Plaintiffs have proven there are systemic delays in the provision of care which are patently unreasonable under any credible standard. For instance, as the District Court found, OHCA’s own Care Management Director admitted at trial that Medicaid children with seizure disorders have had to wait “upwards of **six months** for an appointment with a pediatric neurologist.” *OKAAP II*, 366 F.Supp.2d at 1067. The Court further found that Medicaid patients in Oklahoma City with seizure disorders must wait “**around a year** to be seen by a pediatric neurologist.” *Id.* (emphasis added). As the Court found, some of these patients have poorly controlled seizures, and without the prompt care of a neurologist, the seizures will have a negative impact on school performance, development, behavior, and the “overall medical well-being” of these children. *Id.* (quoting from Tr. Vol. I at 54:7-16 (Aplt. App. 29, Vol. 29, at 1129)). Clearly, the Court had no difficulty determining that such delays in the provision of care are unreasonable. At the point that children are being put at risk of harm by delays in medical care, any definition of reasonableness has been violated. As the *Doe* Court put it, “[w]hile there may be a range of reasonable [time periods for the provision of assistance], there are certainly *some* [time periods] outside that range that no State could

ever find reasonable...under the [Medicaid] Act.” *Doe* at 717 (quoting *Wilder*, 496 U.S. at 519) (emphasis in original). Such is the case here.

It is also telling that Defendants rely principally on the Supreme Court’s decision in *Suter v. Artist M.*, 503 U.S. 347 (1997), in support of their “vague and amorphous” proposition. Dfts.’ Brief at 41. Notably, Defendants fail to mention the *Suter* Amendment adopted by Congress in 1992. In the *Suter* case, the Supreme Court had said, *inter alia*, that Social Security Act beneficiaries could not maintain an action to enforce a funding condition which the Act required to be set forth in a state plan. *Suter*, 503 U.S. at 348. In response to the *Suter* case, Congress amended the Act to provide:

In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan.

42 U.S.C. § 1320a-2; accord 42 U.S.C. § 1320a-10. In enacting this statute, Congress recognized the importance of suits enforcing state plan conditions:

Social Security beneficiaries, parents, and advocacy groups have brought hundreds of successful lawsuits alleging failure of the State and/or locality to comply with State plan requirements of the Social Security Act. . . .Much of this litigation has resulted in comprehensive reforms of Federal-State programs operated under the Social Security Act, and increased compliance with the mandates of the Federal statutes.

H.R. Rep. No. 102-631, at 364-65 (1992).

As a result, Congress endorsed and codified the implied cause of action analysis previously set out by the Supreme Court in *Wilder*. “The purpose of this provision is to assure that individuals who have been injured by a state’s failure to comply with the state plan requirements are able to seek redress in the federal courts to the same extent they were able to prior to the decision in *Suter v. Artist M.*” H.R. Conf. Rep. No. 102-1034 at 1304 (1992) (quoting H.R. Rep. No. 102-631 at 366 (1992)). Therefore, Congress in Section 1320a-2 has told the courts that conditions set forth as requirements of state plans shall not be considered any less worthy of enforcement. This congressional enactment defeats Defendants’ argument under *Suter* that § 1396a(a)(8) does not confer a right because its requirements are carried out as part of the state plan.<sup>7</sup>

## **II. THE PROVISIONS OF 42 U.S.C. § 1396a(a)(30)(A) DO CONFER ENFORCEABLE RIGHTS ON THE MEDICAID RECIPIENT PLAINTIFFS**

### **A. Section 1396a(a)(30)(A) Passes the *Gonzaga* Test**

Defendants argue that “recipients are [not] particularized in [§ 1396a(a)(30)(A)] to create a private right of action.” Dfts.’ Brief at 30. In

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<sup>7</sup> Also, there are dispositive distinctions between the “reasonable efforts” statutory provision at issue in *Suter* and the “reasonable promptness” statutory provision at issue here. *See Doe*, 136 F.3d at 717-18; *Sobky*, 855 F.Supp. at 1147.

support of this argument, Defendants specifically point to the phrases “methods and procedures,” “the utilization of,” and “payment for” as they are used in the provision. *Id.* at 29. According to Defendants, these phrases show that § 1396a(a)(30)(A) does not contain the necessary rights-creating language required under *Gonzaga*. *Id.* Defendants assert that, “[j]ust as in the FERPA language [which was at issue] in *Gonzaga*, the language here is broad and diffuse, requiring ‘methods and standards.’” *Id.* However, § 1396a(a)(30)(A) **does** contain the type of rights-creating language focused on a particular class of individuals, the Medicaid beneficiaries.

As established, the *Gonzaga* decision teaches that for statutory language to be deemed “rights-creating,” that language must clearly impart an “individual entitlement” and have an “unmistakable focus on the benefited class.” *Gonzaga*, 536 U.S. at 287. Section 1396a(a)(30)(A) mandates that:

A State plan for medical assistance **must**--...provide such methods and procedures relating to the utilization of, and payment for, **care and services...** to assure that payments are consistent with...quality of care and are sufficient to enlist enough providers so that **care and services are available under the plan** at least to the extent that such care and services are available to the general population in the geographic area.

(emphasis added). As the Fifth Circuit held in *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 927-28 (5<sup>th</sup> Cir. 2000), this statutory

language “**directly focuses** on [recipients’] access to medical care” and therefore “the recipient plaintiffs have an ‘**individual entitlement**’ to the equal access guarantee of section 30(A)” (emphasis added).<sup>8</sup> It should surprise no one that of all the federal courts of appeals to decide whether § 1396a(a)(30)(A) is individually enforceable, only one (*Sanchez v. Johnson*, 416 F.3d 1051, 1060 (9<sup>th</sup> Cir. 2005)) has held that the provision does not confer rights on beneficiaries. See *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services*, 364 F.3d 925, 930 (8<sup>th</sup> Cir. 2004) (post-*Gonzaga*) (§ 1396a(a)(30)(A) is a “clearly established right” enforceable by recipients and providers); *Westside Mothers*, 289 F.3d at 864, *cert. denied*, 123 S.Ct. 618 (2002) (§ 1396a(a)(30)(A) enforceable by providers); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7<sup>th</sup> Cir. 1996) (same); *Pennsylvania Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 535-544 (3<sup>rd</sup> Cir. 2002) (en banc) (§ 1396a(a)(30)(A) enforceable by recipients but not providers); *Evergreen*, 235 F.3d at 927-28 (§ 1396a(a)(30)(A)

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<sup>8</sup> *Gonzaga* has not changed the necessary underlying analysis. The Fifth Circuit held § 1396a(a)(30)(A) to be enforceable after finding that *Suter* and *Blessing* require that “Congress must unambiguously confer through Section 30(A) an ‘individual entitlement’ upon *each* of the plaintiffs in the case.” *Evergreen*, 235 F.3d at 926-27 (emphasis in original). This is consistent with *Gonzaga*’s requirement that there must be an “unambiguously conferred right” (536 U.S. at 283) to support a § 1983 claim. See also *Arkansas Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8<sup>th</sup> Cir. 1993) (concluding that § 1396a(a)(30)(a) creates a right which is “unambiguously conferred”).

enforceable by recipients); *Arkansas Med. Soc’y, Inc. v. Reynolds*, 6 F.3d 519, 528 (8<sup>th</sup> Cir. 1993) (§ 1396a(a)(30)(A) is “a right that is unambiguously conferred”). *See also Antrican*, 290 F.3d at 191, *cert. denied*, 123 S.Ct. 467 (2002) (Medicaid Act, including § 1396a(a)(30)(A), sufficiently mandatory to enforce).<sup>9</sup>

Indeed, the Medicaid Act defines § 1396a(a)(30)(A)’s “care and services” phrase as medical assistance to “**individuals**” who are eligible for coverage. 42 U.S.C. § 1396a(a)(10)(A)(i) (emphasis added). That phrase, “available under the plan,” therefore, plainly refers to the availability of medical services to which individuals (i.e., eligible Medicaid beneficiaries) must have access under a Medicaid plan. Beyond the statutory definition of “care and services,” common sense dictates that “care and services...available under the plan” can only be made “available” to Medicaid beneficiaries.<sup>10</sup> Therefore, the use of the actual word “individuals”

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<sup>9</sup> In addition, in *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 607 (5th Cir. 2004), a post-*Gonzaga* decision, the court upheld private enforcement of provisions of the Medicaid Act under § 1983. In so doing, the Fifth Circuit noted with approval its pre-*Gonzaga* decision in *Evergreen* in which it followed the lead of “many other circuits” in holding that the “equal access” mandate of § (30)(A) was “not too vague to be enforceable,” thus satisfying the *Blessing* formulation for enforceability. *S.D.*, 391 F.3d at 605.

<sup>10</sup> Section 1396a(a)(30)(A) also contains “rights-creating” language when comparing it to other “rights-creating” statutory provisions. As established above, in *Sabree*, the Third Circuit found it “difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant

or “beneficiaries” would have been superfluous and was not necessary to evince congressional intent to confer an individual right.

The *Gonzaga* decision also instructs courts to examine the “text **and structure**” of the statute at issue in determining whether “Congress intends to create new individual rights.” *Gonzaga*, 536 U.S. at 286 (emphasis added). When the text and structure of § 1396a(a)(30)(A) are taken together, as *Gonzaga* directs, again we see Congressional intent to create an enforceable right for beneficiaries. Section 1396a(a)(30)(A) cannot be read in a vacuum; it is a subpart of 1396a, which is a section of the larger Medicaid Act. Section 1396a(a)(30)(A) must be read in conjunction with the other related provisions of the Medicaid Act (§§ 1396a(a)(8), 1396a(a)(10)(A), 1396d(a)(4)(B)(2) and 1336d(r)), which unambiguously confer the right to EPSDT services on the class members. As the Supreme Court held in *Marbury v. Madison*, 5 U.S. at 166, “**...where a specific duty is assigned by law, and individual rights depend upon the performance of that duty, it seems clear that the individual who considers himself injured, has a right to resort to the laws of his country for a remedy**”

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Title XIX language – ‘A state plan must provide’ – from the ‘No person shall’ language of Titles VI and IX.” *Sabree*, 367 F.3d at 190. To be sure, § 1396a(a)(30)(A)’s “A State plan for medical assistance must--...provide” language is just the type of rights-creating language which the *Gonzaga* decision calls for.

(emphasis added). While §§ 1396a(a)(8), 1396a(a)(10)(A), 1396d(a)(4)(B)(2) and 1336d(r) create the rights to specific services, § 1396a(a)(30)(A) assigns a duty of performance on the states which is necessary in assuring that those rights are realized. Without an adequate network of health care providers willing to accept Medicaid patients, recipients would not receive the services guaranteed by the other provisions of the Act; and without adequate payments to providers, there would not be enough providers willing to accept Medicaid patients. Simply put, if recipients are barred from enforcing § 1396a(a)(30)(A), then their “right” to services would be rendered a nullity.

Additionally, contrary to Defendants’ assertion that § 1396a(a)(30)(A) is too “broad and diffuse” to be enforceable, the subsection does not have the type of “aggregate focus” of the FERPA confidentiality provisions at issue in *Gonzaga*. *Gonzaga*, 536 U.S. at 275. Again, the use of the phrase “methods and procedures” does not render § 1396a(a)(30)(A) unenforceable. Defendants’ claim that § 1396a(a)(30)(A) is too broad and diffuse overlooks the similarity between § 1396a(a)(30)(A) and the now-repealed Boren Amendment, which the Supreme Court (in *Wilder*, 496 U.S. at 524) determined to create enforceable rights. *See Reynolds*, 6 F.3d at 527 (comparing § 1396a(a)(30)(A) to the Boren Amendment); and *Evergreen*,

235 F.3d at 930-31 (same). Again, the *Gonzaga* Court **did not** overrule *Wilder*. In § 1396a(a)(30)(A), states are directed to use “methods and procedures . . . as may be necessary . . .to assure that payments are consistent with . . .quality of care and are sufficient to enlist enough providers . . . .” In the Boren Amendment, states were directed to “use rates (determined in accordance with **methods and standards** developed by the State) . . . to assure that individuals have reasonable access . . .to . . .services of adequate quality.” Thus, the substantive requirement of the Boren Amendment, which the *Wilder* Court held created enforceable rights, was that Medicaid rates be sufficient to provide reasonable access and adequate quality. The similarity with § 1396a(a)(30)(A) is self-evident. The “methods and procedures” of § 1396a(a)(30)(A) and the “methods and standards” of the Boren Amendment are merely the means that the state is required to use in satisfying its basic obligation.<sup>11</sup>

Lastly, the *Gonzaga* Court held that what matters, ultimately, is whether Congress intended to create enforceable rights, and noted that “[a] court’s role in discerning whether personal rights exist in the § 1983 context

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<sup>11</sup> Further, as established above, the *Suter* Amendment directs courts to recognize that language such as “methods and procedures” in § 1396a(a)(30)(A) and “methods and standards” in the Boren Amendment does “not” render the provision “unenforceable.” 42 U.S.C. § 1320-2.

should therefore not differ from its role in discerning whether personal rights exist in the implied right of action context.” *Gonzaga*, 536 U.S. at 283-85. In light of this, it is important to review the relevant legislative history. In the Report on the bill that included what later became the relevant part of § 1396a(a)(30)(A), the House committee wrote: “[I]n instances where the States or the Secretary fail to observe these statutory requirements, **the courts would be expected to take appropriate remedial action.**” H.R. Rep. No. 97-158, 97<sup>th</sup> Cong., 1<sup>st</sup> Sess. 301 (1981) (emphasis added). As the Third Circuit has observed, “[t]his statement certainly suggests that the committee anticipated that some class of plaintiffs would be able to sue to enforce Section 30(A)...” *Pennsylvania Pharmacists*, 283 F.3d at 541.

The 1989 legislative history surrounding the codification of § 1396a(a)(30)(A)’s “equal access” mandate further demonstrates congressional intent to create an individual right. (Supp. App. 1 at 1). Specifically, the 1989 amendment added the requirement that payment to providers be “sufficient to enlist enough providers so that the care and services are available under the plan at least to the extent such services are available to the general population in the geographic area.” Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a) (codified at § 1396a(a)(30)(A)). As the legislative history shows, Congress

correctly perceived the unavoidable reality that the Medicaid eligibility and benefit expansions in the Act “will not have their **intended effect** if physicians are not willing to **treat Medicaid patients.**” H.R. Rep. No. 101-247 (1989), at 390, *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116 (Supp. App. 1 at 1) (emphasis added).

**B. Section 1396a(a)(30)(A) is Not So Vague and Amorphous that its Enforcement Would Strain Judicial Resources**

Defendants cite only one case, *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026 (7<sup>th</sup> Cir. 1996), in support of their argument that § 1396a(a)(30)(A) is too vague and amorphous to be judicially enforced. Dfts.’ Brief at 35. Quoting the decision out of context, Defendants fail to mention that the *Methodist Hospitals* Court expressly held that § 1396a(a)(30)(A) **does** create enforceable rights, and thus rejected the notion that the phrase “geographic area” as used in the provision is too vague and amorphous. *Methodist Hospitals*, 91 F.3d at 1029 (citing *Wilder*). As the Seventh Circuit stated in *Methodist Hospitals*, the meaning of “geographic area” merely depends on “what function the boundary serves.” *Methodist Hospitals*, 91 F.3d at 1029. In fact, the District Court below relied upon *Methodist Hospitals* in holding that § 1396a(a)(30)(A) is not too vague to be enforceable. *OKAAP II*, 366 F.Supp.2d at 1104. Therefore, the only authority that Defendants cite in “support” of the position that §

1396a(a)(30)(A) is too vague and amorphous actually supports the opposite position, which we advocate here. Section 1396a(a)(30)(A) is **not** so vague and amorphous that it strains judicial resources.

Like Defendants here, the defendants in *Evergreen* also argued that § 1396a(a)(30)(A) is too vague and amorphous and that neither the statute nor its underlying regulations provide any guidance to measure equal access.

The Fifth Circuit’s rationale for rejecting this argument is persuasive:

- Section 1396a(a)(30)(A) “provides the state and courts with a much less ambiguous” compliance measure than the Boren Amendment’s “reasonable access” standard which was held to create enforceable rights by the Supreme Court in *Wilder*.
- “[C]ourts are familiar with the [‘geographic area’] concept and are able to assess its meaning in a particular case.” *Id.* at 931 (citation omitted).
- “Above all, the equal access provision affords the ‘objective benchmark’ of access to medical care equal to that of the general population in the same geographic area...This finding of an ‘objective benchmark’ was critical in *Wilder*, and we conclude that it is satisfied with respect to section 30(A).”

*Evergreen*, 235 F.3d at 930-31 (citations omitted). *See also Reynolds*, 6 F.3d at 527.

Defendants also specifically chide the District Court for utilizing what they have identified as “eight decisions (sic) points.” Dfts.’ Brief at 31-33. It is apparently Defendants’ position that these “eight decisions (sic) points” require an analysis which is simply too complex for the federal courts to

handle with aptitude. Most of the decision points identified by Defendants are taken from the factors originally relied upon by the Court in *Clark v. Kizer*, 758 F. Supp. 572, 576-78 (E.D.Cal. 1990), *affirmed in part in an opinion not published*, 967 F.2d 585 (9<sup>th</sup> Cir. 1992), *explained sub.nom.*, *Clark v. Coye*, 60 F.3d 600 (9<sup>th</sup> Cir. 1995), in determining whether the State of California had violated § 1396a(a)(30)(A).<sup>12</sup> The *Clark v. Kizer* factors have subsequently been cited with approval by the District Court and by several other federal trial courts. See *OKAAP II*, 366 F.Supp.2d at 1105; *Clark v. Richman*, 339 F.Supp.2d 631, 644 (M.D.Pa. 2004); *Memisovski ex rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332 at \*42 (N.D.Ill. 2004); *Arkansas Medical Soc’y, Inc. v. Reynolds*, 834 F.Supp. 1097, 1100 (E.D.Ark. 1992). None of these Courts ever indicated that the *Clark v. Kizer* factors were excessively complex, vague or amorphous. In

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<sup>12</sup> However, Defendants misstate the District Court’s application of one of the *Clark v. Kizer* factors. Contrary to Defendants’ position, the District Court did not conclude that “two-thirds (2/3) participation was the level of participation required to” comply with § 1396a(a)(30)(A). Dfts.’ Brief at 32. Instead, the Court used the two-thirds physician participation level as a “benchmark” in determining one factor of a multi-factor approach. *OKAAP II*, 366 F.Supp.2d at 1106. This is not a bright line “requirement,” but one sub-part of the overall analysis. In any event, the uncontested evidence at trial was that only 34% of Oklahoma’s pediatricians take all Medicaid patients who present themselves for treatment, while 69% of participants take all privately insured patients. *Id.* at 1063. This is all the evidence the Court needed to determine that there is not “equal access.” For these reasons, the Court should also reject Defendants’ arguments raised at page 50 of their brief.

truth, the *Clark v. Kizer* case offers the type of legal framework which Courts routinely employ when determining whether a statute has been violated; and in the case at bar, Plaintiffs presented overwhelming evidence that each of the *Clark v. Kizer* factors had been satisfied.

It is also important to note that the *Clark v. Kizer* factors originated from an amicus brief filed by the United States Secretary of Health and Human Services (“HHS”). *Clark v. Kizer*, 758 F. Supp. at 576. The *Clark v. Kizer* Court indicated that the factors presented in the amicus brief were frequently used by the Secretary to determine compliance with the equal access mandate. *Id.* The fact that the federal government and several federal courts have utilized these factors in determining compliance with § 1396a(a)(30)(A) counteracts Defendants’ argument that enforcement of the statute strains judicial competence. The fact that the Secretary of HHS has used these factors also vitiates Defendants’ position that the federal government has provided no standard for determining compliance with § 1396a(a)(30)(A).

The remainder of Defendants’ arguments is based upon nothing but speculation and conjecture. For instance, Defendants list six additional factors which they allege trial courts “must examine” to analyze § 1396a(a)(30)(A) “completely.” Dfts.’ Brief at 33. However, Defendants

cite no authority for any of these additional factors, nor do they explain what they mean or why they are allegedly necessary.

Much as Defendants would like to complicate the issue, it is really not overly complex. And, in any event, § 1396a(a)(30)(A) is clearly not so vague and amorphous that its enforcement strains judicial resources.

### **III. DEFENDANTS' ARGUMENTS AS TO THE SUFFICIENCY OF THE EVIDENCE ARE WITHOUT MERIT**

#### **A. Defendants Did Not Raise a Sufficiency of the Evidence Argument Below**

As Cross-Appellants, Defendants now allege that Plaintiffs failed to meet their burden of proving a violation of § 1396a(a)(30)(A). Dfts.' Brief at 43-50.<sup>13</sup> More specifically, Defendants allege that: (1) the pediatric survey relied upon by Plaintiffs' statistical expert is, as an evidentiary matter, "problematic"; (2) Plaintiffs failed to present sufficient evidence as to the adequacy of reimbursement rates (by allegedly failing to provide "comparative analysis"); and (3) Plaintiffs have failed to present sufficient evidence to show state-wide access to care problems. *Id.* at 44-49. However, Defendants did not raise any of these evidentiary issues at trial and have failed to establish that the evidentiary issues have been preserved for appellate review.

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<sup>13</sup> Notably, Defendants do not assert that the evidence was insufficient to establish a violation of § 1396a(a)(8).

“Generally, an appellate court will not consider an issue raised for the first time on appeal.” *Tele-Communications, Inc. v. Commissioner of Internal Revenue*, 104 F.3d 1229, 1232 (10<sup>th</sup> Cir. 1997) (citation omitted). As the *Tele-Communications* Court reasoned, “[r]eview of issues not raised below would require us frequently to remand for additional evidence gathering and findings; would undermine the need for finality in litigation and conservation of judicial resources; would often have this court hold everything accomplished below for naught; and would often allow a party to raise a new issue on appeal when that party invited the alleged error below.” *Tele-Communications, Inc. v. Commissioner of Internal Revenue*, 104 F.3d at 1232 (citing *Lyons v. Jefferson Bank & Trust*, 994 F.2d 716, 721 (10<sup>th</sup> Cir. 1993)). All of these rationales are present in the case at bar. Defendants should not be permitted to essentially retry this case before the Circuit when they failed to even raise these evidentiary issues below.

**B. Defendants Have Failed to Provide the Court with Any of the Pertinent Record Materials in their Appendix**

As established above, Defendants were required to provide this Court with the necessary record items in an appendix. *See* 10<sup>th</sup> Cir. Rule 30.1; 10<sup>th</sup> Cir. Rule 10.1(A), *and Travelers Indemnity Co. v. Accurate Autobody, Inc.*, 340 F.3d 1118, 1120-22 (10<sup>th</sup> Cir. 2003) (applied Rule 30.1 to a cross-appeal). Defendants failed to do so. As such, the Court is simply without

the needed record items to even consider Defendants' sufficiency of the evidence arguments on appeal.

**C. Even If the Court Determines that the Issue Has Been Properly Raised and/or that Defendants Have Presented an Adequate Appendix, Defendants' "Sufficiency of the Evidence" Arguments Are Without Merit**

As part of the Pretrial Order filed with the District Court below, Defendants made several key admissions with regard to Plaintiffs' claim under § 1396a(a)(30)(A):

- "OHCA's stated performance measure for compliance with the equal access mandate is to raise provider reimbursement rates under Medicaid to '100% of the Medicare Fee Schedule.'"
- "From 1995 through December 31, 2003, provider reimbursement under Oklahoma's Medicaid Fee Schedule never exceeded 72% of Medicare."
- "Low reimbursement rates make it difficult for Defendants to attract physicians to participate in the Medicaid program."
- "In OHCA's Fiscal Year 2003 Budget Request, Defendants informed the Oklahoma Legislature that Medicaid physician rates needed to be raised to 100% of Medicare **in order to comply with the equal access mandate.**"

(Aplt. App. 5, Vol. I, at 188-89) (emphasis added).

The District Court's Findings of Fact reflect additional admissions by Defendants that Oklahoma's Medicaid reimbursement rates were too low and that the equal access mandate was being violated:

At the class certification hearing, defendant Fogarty confirmed that the Fiscal Year 2003 Budget Request essentially requested an increase in rates [to 100% of Medicare] in order to comply with the law and alleviate the access problems experienced by Oklahoma's Medicaid children.

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In its Fiscal Year 2004 and Fiscal Year 2005 Budget Requests, OHCA again requested an increase in physician reimbursement to 100% of Medicare and again represented [to the Oklahoma Legislature] that this increase was needed **in order to comply with the equal access mandate.**

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As defendant Fogarty testified, and defendant Mitchell agreed, Medicaid physician reimbursement rates are low, were low, and that this is a factor that makes it difficult to recruit physicians [to participate in the Medicaid program].

*OKAAP II*, 366 F.Supp.2d at 1074-75 (quotations and citations to the record omitted) (emphasis added). The District Court's Findings of Fact, and our Supplemental Statement of Facts above, also show that at the time of trial, most physician services were reimbursed under Oklahoma's Medicaid Fee Schedule at a rate of about 71% of Medicare, and that no physician services were reimbursed at a rate equivalent to 100% of Medicare. *Id.* at 1059. On appeal, Defendants do not contest *any* of these Findings of Fact. Thus, there is no controversy that Defendants admitted their Medicaid reimbursement rates were insufficient to allow for compliance with § 1396a(a)(30)(A)'s equal access mandate.

Despite their clear admissions, which go to the very core of Plaintiffs' claims under § 1396a(a)(30)(A), Defendants now assert that the evidence submitted by Plaintiffs at trial was insufficient to establish a violation of § 1396a(a)(30)(A). While it is somewhat surprising that Defendants would even attempt to make such an assertion considering their own admissions that the equal access mandate was being violated, Plaintiffs are happy to demonstrate that Defendants' position in this regard is without merit.

First, Defendants' criticism of the pediatrician survey is unwarranted. Defendants begin their criticism by misrepresenting what the survey questionnaire called for. Dfts.' Brief at 47. Specifically, Defendants incorrectly claim that the survey questionnaire "simply" asked survey participants, "“Would you like more money to provide services. (sic)”” *Id.* By using the word "simply" and by using quotation marks around the alleged survey question, Defendants give the impression that this was the only question on the survey and that this was the exact question asked. However, unfortunately, Defendants have given the Court a patently **false** impression with regard to the pediatrician survey. The actual survey questionnaire was comprised of 22 questions, with many of the questions containing multiple parts. Pl. Ex. 203 (Aplt. App. 13, Vol. II, at 532-36). Further, the questionnaire includes several reimbursement-related questions

in order to get a full picture of how Medicaid reimbursement impacts pediatrician participation. *Id.* at 534-35. However, the question, “[w]ould you like more money to provide services[?]” does not appear anywhere in the questionnaire. *Id.*

In any event, the most important aspect of the pediatrician survey is that it shows the level of participation by pediatricians in Oklahoma’s Medicaid program compared to the level of participation in commercial insurance on a state-wide level. Pl. Ex. 203 (Aplt. App. 13, Vol. II, at 509). The District Court relied on the survey to find that “only 34% of Oklahoma’s pediatricians participate fully in the Medicaid program by accepting all new Medicaid patients...[while] 69% of Oklahoma’s pediatricians accept all new privately-insured patients.” *OKAAP II*, 366 F.Supp.2d at 1063. Defendants have never raised any credible argument that these figures are incorrect or inadmissible. In fact, Defendants could not contest these numbers at trial because, as the District Court found, “defendants have no system to identify specialists who have stopped accepting Medicaid patients or who have limited their Medicaid practice.” *Id.* at n. 5. These uncontested state-wide statistics demonstrate the fallacy of Defendants’ argument that Plaintiffs offered only anecdotal evidence at trial. The testimony of individual physicians only strengthened Plaintiffs’

statistical evidence. Taken together, the evidence unquestionably showed a crisis in physician participation in Oklahoma's Medicaid program.

Defendants also criticize Plaintiffs for an alleged failure to offer comparative analysis of what private insurance pays for services. Dfts.' Brief at 47. However, this is simply not the case. As shown above, the Court relied upon vast uncontested evidence comparing Oklahoma's Medicaid rates to Medicare rates. *For instance see OKAAP II*, 366 F.Supp.2d at 1059-61. It is generally known that Medicare rates are less than commercial or private insurance rates. However, lest there be any doubt, the District Court found that under commercial plans, Oklahoma physicians are reimbursed at rates of 130% to 180% of Medicare. *Id.* at 1060 (citing Tr. Vol. V, at 580:21-25 (Supp. App. 12 at 427); Tr. Vol. VII, at 942:21 – 943:4 (Supp. App. 14 at 522-523); Tr. Vol. VIII, at 1012:2-10 (Supp. App. 15 at 548)). Further, the District Court relied on testimony from the OHCA's own rate specialist to find that "[t]he average of the top five rates paid by private insurance companies to the [Oklahoma] university physicians is 140% of Medicare." *Id.* (Citing Tr. Vol. XV, at 1971:13 –

1972:2 (Supp. App. 18 at 691-692)).<sup>14</sup> Again, Defendants do not contest any of these findings.

#### **IV. THE STATES' FUNCTION OF DETERMINING RATES HAS NOT BEEN "IMPROPERLY SEIZED" BY THE FEDERAL COURT**

Defendants also raise a federalism argument on appeal which they did not raise below. Dfts.' Brief at 49-50. For this reason, the Court should refuse to consider Defendants' federalism argument. *Tele-Communications, Inc.*, 104 F.3d at 1232.

However, even if the Court opts to consider Defendants' federalism argument, it should be rejected. The Permanent Injunction entered by the District Court requires Defendants to contract with a "nationally recognized economic consulting firm" to conduct a study to determine the Medicaid provider reimbursement rates which are necessary "to assure reasonably prompt access to health care for minor children in the Oklahoma Medicaid Program." (Aplt. App. 9, Vol. I, at 423). The Injunction also requires that Defendants update the reimbursement study "as needed" in order to ensure compliance with the Medicaid Act. *Id.* Defendants argue that this aspect of the Court's Permanent Injunction violates principles of federalism.

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<sup>14</sup> Defendants also claim that Medicaid pays more for psychiatric services than does the average private insurance plan. Dfts.' Brief at 47. However, Defendants offer absolutely no evidentiary support for this contention.

The principal federalism decision cited by Defendants, *Miliken v. Bradley*, 433 U.S. 267, 282 (1977), provides that “federal-court decrees must directly address and relate to the constitutional violation itself.” While the case at bar is not a constitutional case, Plaintiffs concede that the same principle applies in cases involving a federal statute. However, the reimbursement rate study at issue is narrowly tailored to address the precise statutory violations here (42 U.S.C. §§ 1396a(a)(8) and 1396a(a)(30)(A)). The rate study is explicitly concerned with determining the appropriate reimbursement rates to assure compliance with the Medicaid Act provisions. This is an appropriate remedy which does not violate federalism concerns.

**V. “SUBSTANTIAL COMPLIANCE” WITH THE STATUTE AND REGULATIONS IS *NOT* THE PROPER STANDARD TO BE APPLIED WHEN DETERMINING WHETHER DEFENDANTS HAVE VIOLATED THE EPSDT MANDATE**

Defendants’ fourth proposition is that the “District Court Correctly Concluded Oklahoma to be in Compliance with the Federal EPSDT Requirements.” Dfts.’ Brief at 51. However, the District Court **did not** conclude that Defendants are in compliance with the EPSDT mandate. Instead, the District Court held that Defendants are in “**substantial compliance** with all EPSDT provisions of the Medicaid Act other than the requirement set forth in 42 U.S.C. § 1396d(r)(1)(A)(i)...” *OKAAP II*, 366 F.Supp.2d at 1119. In so holding, the District Court applied the incorrect

legal standard. Of course, the District Court's application of the "substantial compliance" standard is the one of primary bases of Plaintiffs' appeal. Plaintiffs' Opening Brief at 34-43. As such, it seems that Defendants have misapprehended the District Court's holding and the subject of our appeal.

Even so, it is apparently Defendants' argument as Appellee that the evidence introduced by Plaintiffs was insufficient to establish a violation of the EPSDT mandate. For one, this argument should be rejected because, again, Defendants have failed to provide the Court with any of the record items it relies upon in arguing that evidence was not sufficient. *See* 10<sup>th</sup> Cir. Rule 30.1; 10<sup>th</sup> Cir. Rule 10.1(A). Nonetheless, as chronicled in our opening brief, the District Court's own Findings of Fact comprehensively set out Defendants' continuing, serious and knowing failures to comply with the EPSDT mandate, including the outreach requirements. Plaintiffs' Opening Brief at 9-26.

It is Plaintiffs' position on appeal that if the District Court would have applied the correct legal standard of full compliance, then the ultimate holding on the EPSDT issue would have necessarily been different. Defendants have offered this Court absolutely nothing to counter this aspect

of Plaintiffs' appeal.<sup>15</sup> Indeed, Defendants do not even argue that Plaintiffs' core position is incorrect: that a "substantial" compliance standard cannot be applied when the rights of individuals are at stake. *See Withrow v. Concannon*, 942 F.2d 1385, 1388 (9<sup>th</sup> Cir. 1991); *Sabree*, 367 F.3d at 192-93 (A "substantial compliance" standard cannot be read into the "discrete, rights-creating" language of §§ 1396a(a)(8) or (a)(10)).<sup>16</sup> Defendants have

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<sup>15</sup> While Defendants argue that the EPSDT mandate is satisfied by substantial compliance with the outreach requirements of 42 U.S.C. § 1396a(a)(43)(B), this is clearly not the case. The EPSDT mandate requires not only aggressive outreach, but also the provision of actual services. *See* 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(10)(A), 1396d(a)(4)(B) and 1396d(r). Overall, "EPSDT programs **provide** health care services to children to reduce lifelong vulnerability to illness or disease." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004) (emphasis added). In other words, "[t]he purpose of the EPSDT program is to ensure that poor children **receive comprehensive health care** at an early age, so that they will develop fewer health problems as they get older." *Salazar v. District of Columbia*, 954 F.Supp. 278, 303 (D.D.C. 1996) (emphasis added).

<sup>16</sup> Contrary to Defendants' position, Plaintiffs have not argued that *any* authority requires that "every Medicaid child be **forced** to the doctor's office each time a scheduled EPSDT [screening] is due." Dfts.' Brief at 53 (emphasis added). This is a truly absurd distortion of fact. Defendants should not, nor could they, "force" class members to do anything. However, what Plaintiffs must do is everything they can to assure that all eligible individuals are receiving EPSDT. Yet, Defendants have not even scratched the surface. As established in our opening brief, the uncontested evidence in the case at bar shows that Defendants do almost nothing to even monitor Oklahoma's EPSDT performance. Plaintiffs' Opening Brief at 23-6. Therefore, Defendants have not even attempted to learn the extent of the many failures with the EPSDT program, let alone devise a plan to address those failures.

given this Court no good reason to uphold the District Court's application of a substantial compliance standard.

Lastly, Defendants make some totally unsubstantiated claims in support of their EPSDT-related arguments. For instance, Defendants assert that the HCFA 416 form "has been judged a poor tool" for measuring EPSDT compliance. Dfts.' Brief at 52. However, Defendants cite no authority for this claim. Also, Defendants make the outlandish allegation that Plaintiffs failed to offer any first-hand testimonial evidence of an EPSDT service being denied or of a class member suffering as a result of a failure in the Medicaid system. In fact, the testimony of the parents and physicians of Plaintiffs alike showed that necessary medical care is denied and/or severely delayed causing these children to suffer. Much of this testimony was detailed in Plaintiffs' opening brief. *See* Plaintiffs' Opening Brief at 15-22. *See also* Supplemental Statement of Facts, above at 11-15.

This testimonial evidence gives a human voice to Defendants' own reports and statistics which show that children are being denied EPSDT on a grand scale. *See* Plaintiffs' Opening Brief at 9-15 and 23-26. Defendants do not credibly contest any of this evidence, which shows that Oklahoma's EPSDT performance is consistently sub-par by any reasonable measure. For the seven years contemplated by the trial record (1995-2001), the percentage

of EPSDT-eligible children who received at least one required initial or periodic screening service **never exceeded 40%**, with a low of 27%. *OKAAP II*, 366 F.Supp.2d at 1082. Findings of Fact at 55 (Aplt. App. 6, Vol. I, at 329). This is not compliance. However, it will be the District Court's duty on remand to determine whether this constitutes compliance with the mandate.

## **VI. OKAAP HAS THIRD PARTY STANDING TO RAISE THE FEDERAL RIGHTS OF RECIPIENTS**

Defendants' last proposition is that the District Court correctly dismissed OKAAP because OKAAP does not have third party standing to assert the rights of recipients. Dfts.' Brief at 54-6. In order to achieve third party standing, an organization like OKAAP must establish that the following three factors have been satisfied:

1. the plaintiff must suffer injury;
2. the plaintiff and the third party must have a "close relationship"; and
3. the third party must face some obstacles that prevent it from pursuing its own claims.

*Pennsylvania Psychiatric Soc'y v. Green Springs Health Serv., Inc.*, 280 F.3d 278, 288-89 (3<sup>rd</sup> Cir. 2002) (citing *Campbell v. Louisiana*, 523 U.S. 392, 397 (1972)). Defendants argue that OKAAP does not meet these requirements because: (1) OKAAP has suffered no injury because, "as ruled by the District Court," the Medicaid "regulations" at issue have "no

applicability” to the member pediatricians; (2) OKAAP does not have a sufficiently close relationship with the class because “not all” OKAAP members have a contract with OHCA to see Medicaid patients; and (3) the class members do not face obstacles which would prevent them from pursuing their own claims. *Id.* Defendants’ arguments in this regard are easily overcome.

First, while Defendants assert that the District Court “ruled” that the Medicaid “regulations” have no applicability to OKAAP member pediatricians, they fail to cite any actual order of the District Court. *Id.* at 55. In truth, the District Court **did not** hold that the Medicaid “regulations” at issue are inapplicable to the OKAAP pediatricians. The District Court held that “OKAAP, as it represents Medicaid providers, does not have **enforceable rights** under § 1396a(a)(30)(A)...” *OKAAP II*, 366 F.Supp.2d at 1103 (emphasis added). Clearly, the lower court did not make any ruling with regard to “regulations,” and, more importantly, only held that § 1396a(a)(30)(A) does not confer enforceable rights on providers. There is a significant difference between ruling that a statute does not apply to a group of individuals and ruling that a statute does not confer individual rights on a group of individuals. Clearly, § 1396a(a)(30)(A) does apply to the OKAAP

pediatricians, as the statute explicitly requires that Medicaid payments be sufficient to enlist enough “providers.”

Plaintiffs need not prove that § 1396a(a)(30)(A) confers an individual right on providers. If that were the case, then third party standing would be superfluous. As the Court concluded in *Pennsylvania Psychiatric Soc’y*, the issue of whether the plaintiff organization has suffered direct injury “is not relevant to the issue of the [member providers’] standing to bring the patients’ claims.” 280 F.3d at 289 n. 11. Instead, the Court found that the first element had been satisfied because the organizational plaintiff there had “properly pleaded that defendants’ policies and procedures have economically injured its member psychiatrists and undermined their ability to provide quality health care.” *Id.* at 289. Here, OKAAP has not only “properly pleaded” that its members have been economically impacted by Defendants’ low Medicaid reimbursement rates and that Defendants’ acts and omissions have compromised its members’ ability to provide quality health care, OKAAP has presented overwhelming evidence which has proved these claims. This is more than enough to satisfy the “injury” prong of the third party standing test.

Secondly, the fact that not all OKAAP members have signed Medicaid contracts does preclude OKAAP from third party standing status.

Defendants cite no authority which holds that **every** member of an organization must have a sufficiently close relationship with the party litigants. Many of the OKAAP members do treat Medicaid patients, and even those who do not see Medicaid patients advocate for them to receive the care to which they are entitled. The Supreme Court has noted that the “closeness” between physician and patient is “patent.” *Singleton v. Wulff*, 428 U.S. 106, 117 (1976). The District Court in this case has previously found that “OKAAP’s purpose is to foster improvements in the health and welfare of infants, children and adolescents in the State of Oklahoma.” *OKAAP I*, 205 F.Supp.2d at 1272-73. The OKAAP members’ relationship with the class members is sufficiently “close” to satisfy the second prong of the third party standing test.

Finally, the fact that the parents of a handful of class members testified at trial does not mean that OKAAP fails to satisfy the third prong of the third party standing test. As a general matter, patients face obstacles in bringing suit on their own. *See Powers v. Ohio*, 499 U.S. 400, 411 (1991) (outlining three requirements); *Wauchope v. U.S. Dep’t. of State*, 985 F.2d 1407, 1411 (9<sup>th</sup> Cir. 1993) (same). Medicaid recipients, like the class members here, are hindered from bringing suit because they lack information about the effect of reimbursement rates or rate cuts on provider

participation. Another obstacle is that an individual Medicaid recipient has a transitory need for access to quality medical care in a given instance, whereas physicians have long-term interests in securing the rights of their many patients. *See Singleton*, 428 U.S. at 117. These hindrances to bringing suit are not any less real because a few parents of class members testified at trial. Indeed, even those few class members who had parents to testify on their behalf do not have access to that kind of information, nor do they have the type of special expertise possessed by the pediatricians. The pediatricians are in a special position to act in a representative capacity for these children who normally would have no voice.

### **CONCLUSION**

WHEREFORE, premises considered, the Plaintiffs respectfully request that this Court affirm the District Court's conclusions that: (1) in violation of 42 U.S.C. 1396a(a)(30)(A), Defendants are not assuring that payments are sufficient to enlist enough providers so that care and services are available to Medicaid-eligible children to the extent that such care and services are available to the general population in the geographic areas served by the OHCA; and (2) in violation of 42 U.S.C. 1396a(a)(8), Defendants are not furnishing medical assistance with reasonable promptness to all eligible individuals. Plaintiffs further request that the

Court reverse: (1) the District Court’s conclusion that Defendants are in “substantial compliance” with all EPSDT provisions of the Medicaid Act except for the provision requiring consultation with recognized medical and dental organizations involved in child health care prior to establishing the periodicity schedule; and (2) the District Court’s dismissal of Plaintiff OKAAP from the case for lack of standing.

Respectfully submitted,

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On the 30<sup>th</sup> day of December, 2005, I did cause a true and correct copy of this document to be mailed, postage prepaid, to the following counsel of record:

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s/ Louis W. Bullock