

No. 05-5100, 05-5107

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

OKLAHOMA CHAPTER OF THE)	
AMERICAN ACADEMY OF)	
PEDIATRICS (OKAAP), <i>et al.</i> ,)	
)	
Plaintiffs-Appellants/)	
Cross-Appellees,)	
)	
v.)	Lower Court No.
)	01-CV-0187-CVE-SAJ
)	
MICHAEL FOGARTY, Chief Executive)	
Officer of the Oklahoma Health Care)	
Authority (OHCA), <i>et al.</i> ,)	
)	
Defendants-Appellees/)	
Cross-Appellants.)	

PLAINTIFFS-APPELLANTS' SUPPLEMENTAL BRIEF

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PLAINTIFFS-APPELLANTS' SUPPLEMENTAL BRIEF

COME NOW the Plaintiffs-Appellants/Cross-Appellees (“Plaintiffs”) and, pursuant to the Court’s October 3, 2006 Order, respectfully submit their Supplemental Brief¹ regarding the impact which the Court’s recent decision in *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, No. 05-1148, 05-1150, 2006 WL 2699039, (10th Cir. (Colo.) Sep 21, 2006) (attached hereto), has on the present appeal:

¹ The arguments made in this brief are made as a supplement to the arguments previously advanced in this appeal.

INTRODUCTION

The September 21, 2006 decision of the panel in *Mandy R.* is readily distinguishable from the factual and legal issues presented by this matter. It does not preclude the panel in the instant appeal from holding that under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq (“Medicaid Act”), *children* enrolled in the Medicaid Program have an enforceable federal right to the actual provision of the care and services which are described with particular specificity in the Act. The *Mandy R.* panel, in the context of plaintiffs seeking ICF/MR services, “assume[d] that...individual plaintiffs may sue to enforce their rights under [42 U.S.C. §§ 1396a(a)(8) and (a)(10)].” *Mandy R.*, 2006 WL 2699039, *2. However, based upon the definition of “medical assistance” in § 1396d(a), the Court construed “medical assistance” as used in §§ 1396a(a)(8) and (a)(10)(B)(i) as requiring only *payment* for care and services. *Mandy R.* at *5.

Nonetheless, even if the *Mandy R.* panel’s construction of the statutory phrase “medical assistance” is accepted, the text of sections of the Medicaid Act which were not considered or examined by the *Mandy R.* panel make clear that children have an enforceable right, not only to payments for services, but to actually receive medical services. 42 U.S.C. § 1396a(a)(43) and 42 U.S.C. § 1396d(r), applicable only to children and not

considered in *Mandy R.*, demonstrate that children are entitled to the actual provision of early and periodic screening, diagnostic and treatment (“EPSDT”) services, independent of the limited definition of “medical assistance” found in *Mandy R.* These provisions make clear that when it comes to children, Congress made it explicit that “medical assistance” must be read to include the right of the child to have the state actually provide EPSDT services either directly or through referral.

Furthermore, the *Mandy R.* panel did not foreclose the enforceability of § 1396a(a)(8) in cases where payments to providers are so low as to effectively deny the right to medical assistance. *Mandy R.* at *5. This is important because the District Court in the case at bar held that Defendants had violated § 1396a(a)(8), reasoning that “[w]ithout financial assistance (provider reimbursement) sufficient to attract an adequate number of providers, reasonably prompt assistance is effectively denied.” *Oklahoma Chapter of American Academy of Pediatrics (OKAAP) v. Fogarty*, 366 F.Supp.2d 1050, 1109 (N.D.Okla. 2005).

ARGUMENT

I. The Language of 42 U.S.C. §§ 1396d(a)(43) and 1396d(r)

42 U.S.C. § 1396a(a)(43)(A)(B) and (C) contain exactly the type of “rights-creating language” called for by the Supreme Court in *Gonzaga*

University v. Doe, 536 U.S. 273, 278 (2002). The statutory language unambiguously requires states participating in the Medicaid program to provide or arrange for providing treatment, care and services to Medicaid-eligible children. Specifically, § 1396a(a)(43) states as follows:

A State plan for medical assistance must –

(43) provide for –

- (A) informing **all persons** in the State who are under the age of 21 and who have been determined to be **eligible for medical assistance *including services*** described in section 1905(r) [42 U.S.C. § 1396d(r)], of the availability of early and periodic screening, diagnostic, and treatment **services** as described in section 1905(r)j [42 USCS § 1396d(r)] and the need for age-appropriate immunizations against vaccine-preventable diseases,
- (B) **providing or arranging for** the provision of such screening *services* in all cases where they are requested,
- (C) **arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective *treatment*** the need for which is disclosed by such child health screening services...

(emphasis added). This language clearly imparts “individual entitlement[s]” and has an “unmistakable focus on the benefited class,” all persons under 21 who are eligible for medical assistance, including EPSDT. *Gonzaga* at 287 (quoting *Blessing v. Freestone*, 520 U.S. 329, 343 (1997), and *Cannon v.*

University of Chicago, 441 U.S. 677, 690-93 (1979)). In other words, § 1396a(a)(43) clearly confers enforceable rights on the Plaintiff Class.

The use of the words “where they are requested” in 43(B) patently indicates Congress’ intent to make the right described an individual right since the request must perforce be expressed individually. The use of the words “the need for which is disclosed by such child health screen service” even more clearly demonstrates Congress’ intent to vest an individual right in children with its focus on the particulars of the individual child’s screening. And, all of § 1396a(a)(43) must be read to be in reference to Medicaid-eligible individuals under 21.

Every post-*Gonzaga* court which has considered the matter has either assumed or expressly determined that 42 U.S.C. § 1396a(43)(A),(B) and/or (C) are enforceable by Medicaid recipients. *Clark v. Richman*, 339 F. Supp. 2d 631, 640 (M.D.Pa. 2004); *Memisovski v. Maram*, No. 92 C 1982, 2004 WL 1878332, *8-11 (N.D. Ill. 2004) (attached hereto); *Health Care for All v. Romney*, No. Civ.A. 00-10833RWZ, 2005 WL 1660677, *13 (D. Mass. 2005) (attached hereto); *Kenny A. v. Perdue*, 218 F.R.D. 277, 293-94 (N.D. Ga. 2003); *Westside Mothers v. Olszewski*, 368 F.Supp.2d 740, 769-770 (E.D. Mich. 2005), *aff’d in part and rev’d in part*; 454 F.3d 532 (6th Cir.

2006); *A.M.H. v. Hayes*, 2004 U.S. Dist. Lexis 27387, *19 (S.D. Ohio Sept. 30, 2004).

Just as important as the overall enforceability issue is the nature of the rights conferred. Section 1396a(43)(B) and (C) speak in specific terms of providing and arranging for services and treatment. The nature of the rights conferred here is plainly not monetary in nature. These provisions create enforceable rights, including the right to receive actual services. Moreover, in § 1396a(43), the only allusion to “medical assistance” is found in subsection A, which makes it clear that when it comes to children and EPSDT, “medical assistance” is more than mere payment. In the context of “medical assistance” for children, § 1396a(43)(A) uses a broad definition which includes the actual delivery of services – “medical assistance **including services** described in...” 42 U.S.C. § 1396d(r) (listing the mandatory EPSDT services) (emphasis added).² The statement “medical assistance including services” must mean that, with regard to children and

² In this regard, the language used in 43(A) is very similar to the language of 42 U.S.C. § 1396a(a)(10)(A), which again was not discussed in *Mandy R.* Congress again, when addressing the rights of children, uses an expanded definition of “medical assistance.” It requires that 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),” which describes EPSDT services (emphasis added). Given that this section of the Act was not addressed by the *Mandy R.* panel, the present panel is free to construe § 1396a(a)(10)(A) as its language makes clear that, as to children, the right to “medical assistance” includes the right to “care and services.”

EPSDT, “medical assistance” includes the provision of services. However, no matter what one’s reading of “medical assistance” is, it is evident that the rights conferred under § 1396a(43) are not limited to the mere payment for services delivered. It requires the actual delivery of specific services.

It is also apparent that 42 U.S.C. § 1396a(43)(A)(B) and (C) must be read in conjunction with the provisions of 42 U.S.C. § 1396d(r), which, with great specificity and detail, lay out exactly the content of EPSDT:

“(r) Early and periodic screening, diagnostic, and treatment services. The term ‘early and periodic screening, diagnostic, and treatment services’ means the following items and services:”

- (1) Screening services, which at a minimum must include (i) “a comprehensive health and developmental history (including assessment of both physical and mental health development)”;
 - (ii) “a comprehensive unclothed physical exam”;
 - (iii) “appropriate immunizations...according to age and health history”;
 - (iv) “laboratory tests (including lead blood level assessment appropriate for age risk factors)”;
 - and (v) “health education”;
- (2) Vision services, including diagnosis and treatment for vision defects;
 - (3) Dental services, including “relief of pain and infections, restoration of teeth, and maintenance of dental health”;
 - (4) Hearing services, including diagnosis and treatment for defects in hearing; and
 - (5) **All medically necessary health care services** “...to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, **whether or not such services are covered under the State plan.**”

(emphasis added). The final clause of the above language demonstrates the **emphasis** Congress placed on its mandate that all the EPSDT elements are to be provided to children, notwithstanding anything to the contrary in the “State plan” (i.e. the State plan for medical assistance, see 42 U.S.C. § 1396d(a)). This was no accident. Children have a special place under the Medicaid Act, and it is imprudent to suggest that states can exhaust their obligation to Medicaid-eligible *children* by the simple provision of payments. If, as the trial court found here, children are not *receiving* the care and services they are entitled to, then the State has failed to comply with the EPSDT mandate.³

³ Further confirming Congress’ focus on the actual provision of EPSDT services is 42 U.S.C. § 1396a(a)(43)(D) which requires states to report to the federal government, on an annual basis, specific information relating to EPSDT, including: (1) the number of children provided child health screening services, (2) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services), (3) the number of children receiving dental services, and (4) the State’s results in attaining the participation goals set for the State under § 1396d(r). Without contending that the language of 42 U.S.C. § 1396a(a)(43)(D) (unlike that of subparts A, B and C) itself creates individual rights of enforcement in children, the language of 43(D) unmistakably shows Congress’ focus on the delivery of care and services, irrespective of any construction of the term “medical assistance.”

II. An Enforceable Right to Payment in the Medicaid Act Logically Requires Minimum Standards of Amount

In *Mandy R.*, the plaintiffs sought, *inter alia*, the provision of ICF/MR services from defendants, Colorado officials. As noted above, the *Mandy R.* Court “assume[d] that...individual plaintiffs may sue to enforce their rights under [42 U.S.C. §§ 1396a(a)(8) and (a)(10)].” *Mandy R.*, 2006 WL 2699039, *2. Nonetheless, the *Mandy R.* panel narrowed the scope of these rights, without discussion of the language in § 1396a(a)(10)(A) or § 1396a(43), by holding that while the “State must pay for medical services...it need not provide them.” *Id.* at *6. *Mandy R.* says the Medicaid Act does not require states to be ICF/MR “service-providers of last resort,” even in the absence of those services in the market. *Id.* at *5.

At the same time, the *Mandy R.* panel allowed that a cause of action might be stated, should it be shown that rates are so low that they “effectively deny the right to ‘medical assistance.’” *Id.*

By contrast, the record below concerning the provision of medical and dental services to children enrolled in Oklahoma’s Medicaid program shows that while there is not a total absence of EPSDT services, children are in fact being deprived of mandated medical services and are suffering as a result due to inadequate rates:

As plaintiffs established, the lack of physician participation in Medicaid forces class members to wait for unreasonable periods of time and to receive needed care to travel long distances to find Medicaid participating providers, putting these children at risk of harm or even death. The testimony at trial also demonstrated that providers are widely opting out of the Medicaid program or restricting their Medicaid caseloads.

OKAAP, 366 F.Supp.2d at 1107. Given that the trial court found that providers who have been serving children with Medicaid are closing their doors to those children and the children are suffering as a result, the inadequacy of the financial assistance paid for these services was proven on a most fundamental level. *See OKAAP*, 366 F.Supp.2d at 1059-61 and 1074-76. Throughout the District Court's Findings is a summary of the compelling evidence put on by Plaintiffs that Medicaid-eligible children in Oklahoma are not receiving the care they need, or that the availability of providers is so limited that children are experiencing unconscionable delays in treatment, suffering unnecessary pain and having their health endangered. Importantly, the Court found a direct link between these failures in meeting the medical needs of children and provider rates.⁴ *Id.* at 1109.

⁴ There are more than 350,000 children who depend on Oklahoma's Medicaid program to meet their medical needs. Defendants' reports to the federal government reveal that during the five years before trial, during any given year, 60% or more of those children received no medical care. *Id.* at 1057 and 1082.

To put the matter starkly, if the Medicaid Act provides a right to “financial assistance” for the purchase of EPSDT services (including “corrective treatment” for all medical needs disclosed by screening under 42 U.S.C. §§ 1396a(a)(43)(C) and 1396d(r)(5)), can Oklahoma discharge its responsibilities under the statute by offering to pay a dime for a heart transplant? Since the answer must be negative, then the next question has to be, “How much ‘financial assistance’ is adequate?” The only logical answer is that “financial assistance” must be at least adequate to secure needed medical services to the extent that those services are available. Furthermore, the amount of the financial assistance must be sufficient to purchase the available service at least “promptly” enough that the child is not put at risk by the delay or required to suffer unnecessarily. This is precisely the conclusion that the District Court came to below.

As established above, the District Court ultimately held that Defendants have violated 42 U.S.C. § 1396a(a)(8) under any construction of the term “medical assistance,” because “[w]ithout financial assistance (provider reimbursement) sufficient to attract an adequate number of providers, reasonably prompt assistance is effectively denied.” *OKAAP*, 366 F.Supp.2d at 1109. *Mandy R.* does not invalidate the District Court’s holding in this regard. The *Mandy R.* Court left open the question of

whether the inadequate payments could effectively deny recipients their right to “medical assistance” as conferred under § 1396a(a)(8) and (a)(10). *Mandy R.* at *5 (citing *Westside Mothers v. Olszewski*, 454 F.3d 532, 541 (6thCir. 2006)). In this case, the District Court found that children were being denied meaningful “medical assistance” as a result of low provider rates. Thus, the panel’s decision in *Mandy R.* in no way can be read to require reversing the District Court’s decision that Defendants must provide prompt and sufficient “financial assistance” to the Plaintiff Class so that the services actually meet their needs.

III. Congress Has Manifested Clear Intent that Rates Paid to Providers of Medical Assistance Be High Enough to Deliver Care and Services at Least to the Extent that Care and Services are Delivered to the Privately Insured Population

In § 6402(a) of the Omnibus Budget Reconciliation Act of 1989, Congress added the language underlined below to 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act. That section, after its amendment in 1989, provides in pertinent part:

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).

The legislative history of the Budget Reconciliation Act of 1989 emphatically and clearly demonstrates that these enactments were designed to remedy a past failure by states to pay Medicaid providers (particularly physicians) enough to get care and services delivered and to assure that recipients, particularly children, actually receive the mandated services. As this legislative history shows, Congress correctly perceived the unavoidable reality that the expanded benefits in the Act (which notably included EPSDT) “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 (Plfs. Supp. App. 1 at 1) (emphasis added).

Even though *Mandy R.* holds that, in the context of the ICFMR program, 42 U.S.C. § 1396a(a)(30)(A) is unenforceable by Medicaid providers and recipients (*Mandy R.* at *8),⁵ the statutory language quoted and underlined above, as well as the legislative history, shows congressional intent to establish that, at a minimum, states must pay Medicaid providers rates at a sufficient level to provide Medicaid recipients access to providers’ services equal to those of the population generally in the same area. This

⁵ Plaintiffs strongly believe that the *Mandy R.* panel erred in deciding that § 1396a(a)(30)(A) is unenforceable. However, Plaintiffs recognize that unless and until *Mandy R.* is overturned, it is binding in the present appeal.

standard, even if not separately enforceable under § 1983, must inform the court in determining the minimum rate states must pay providers in order to carry out the enforceable mandates of 42 U.S.C. § 1396a(a)(8), a(a)(10)(A) and a(43)(A), (B) and (C), to assure that EPSDT care and services, as defined in § 1396(r), are delivered promptly to recipients.

In this sense, § 1396a(a)(30)(A) fits perfectly within the language from *Marbury v. Madison*, 5 U.S. 137, 166 (1803), which we quoted in our Reply Brief, “**...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**” (emphasis added). While §§ 1396a(a)(8), 1396a(a)(10)(A), 1396a(43)(B) and (C) and 1396d(r) define and create enforceable rights, at the very least, § 1396a(a)(30)(A) assigns a specific duty. It is the duty of states to pay rates sufficient to assure that children covered by Medicaid can actually receive needed medical services to the same extent as other children. Congress recognized that, in order for children to enjoy the right to necessary medical services, this duty must be performed by the states. Without adequate payments to health care providers, there will not be enough providers willing to treat Medicaid recipients. As the District Court’s Findings in this case demonstrate, without

an adequate network of health care providers willing to treat Medicaid recipients, those recipients will be, and in fact are, denied their right to medical services guaranteed by the other provisions of the Act. Simply put, if recipients are barred from seeking a remedy consistent with § 1396a(a)(30)(A), then their “right” to EPSDT services can be made meaningless, and children will needlessly suffer as a result.

Respectfully submitted,

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On this 18th day of October, 2006, I did cause a true and correct copy of this document to be served, by U.S. Mail, postage prepaid, and by electronic mail, upon the following counsel of record:

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s/Louis W. Bullock
