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An Unfulfilled Promise of The Medicaid Act: Enforcing Medicaid Recipients' Right To Health Care

By Frederick H. Cohen*

I. Introduction

The Medicaid Act ("Act") requires that states provide all Medicaid recipients with access to health care that is equal to the access enjoyed by privately insured individuals.¹ The Act requires that states go even further with respect to children, mandating that states conduct aggressive outreach and education to insure that children on Medicaid actually receive adequate and timely health care. Many states are denying these rights, leaving it to private litigants and the courts to enforce these mandates. This article describes the state of the law regarding the Medicaid Act's Equal Access provisions, including a discussion of the Act's section that grants children the right to have access to health care that is equal to that of the generally insured population. This article also explores the methods by which states should ensure that "equal access" exists. This article then discusses the children-specific Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") provisions, including the particular services that children should receive under these provisions and the methods by which states should insure that the services are provided. The article concludes with commentary on the manner in which these provisions can be and have been enforced.

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¹ 42 U.S.C. § 1396 (1965) (originally enacted as Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286).

II. The Federal Medicaid Program

The Medicaid program provides federal funds to states that choose to provide medical services to low-income individuals.² Participation in the program is voluntary, but once a state opts to participate, it must comply with the Act and with the regulations promulgated by the federal Centers for Medicare and Medicaid Services (“CMS”), a part of the United States Department of Health and Human Services (“HHS”).³ To qualify for federal reimbursement, the Act requires each state to submit its Medicaid plan to the federal government.⁴ This plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of federal law.⁵

CMS has promulgated a State Medicaid Manual that is an authoritative explanation of what the Medicaid statute and regulations require the states to do in implementing the Medicaid program.⁶ Likewise, letters written by the Director of CMS, commonly referred to as “State Medicaid Letters,” provide states with direction and interpretive guidance in the operation of state Medicaid programs.⁷ Although states may contract with private and public health care providers to deliver the panoply of services guaranteed under the Medicaid program, states retain ultimate responsibility to ensure compliance with the Medicaid Act in providing adequate health care.⁸

² 42 U.S.C. § 1396 (1965); *Harris v. McRae*, 448 U.S. 297, 308 (1980).

³ 42 U.S.C. § 301 (1965); *Wilder v. Va. Hosp. Ass’n*, 496 U.S. 498, 502 (1990).

⁴ 42 U.S.C. § 1396(a).

⁵ 42 C.F.R. § 430.10 (1988).

⁶ THE STATE MEDICAID MANUAL *available at* http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004); *see also* *Ind. Family and Social Services Admin. v. Thompson*, 286 F.3d 476, 482 (7th Cir. 2002); *Stanton v. Bond*, 504 F.2d 1246, 1249 (7th Cir. 1974).

⁷ *Slekis v. Thomas*, 525 U.S. 1098 (1999); *T.L. v. Colo. Dep’t. of Health Care Policy and Fin.*, 42 P.3d 63, 67 (Colo. Ct. App. 2001).

⁸ *See Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (Conn. Cir. Ct. 2001) (“Although the state contracts with MCO’s . . . its duties relative to ensuring that the plaintiffs receive medical services with reasonable promptness are non-delegable.”); *J.K. By and Through R.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D.Ariz. 1993) (“It is patently unreasonable to presume that Congress would permit

A. States Must Provide Medicaid Recipients With Access To Medical Care That Is Equal To The Generally Insured Population.

1. Legal Requirement For "Equal Access"

The Medicaid Act requires that individuals on Medicaid have access to care that is "equal" to the care available to individuals who have other forms of health insurance. Specifically, the Medicaid Act provides that each state's Medicaid Plan must:

[P]rovide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to . . . assure that payments are consistent with efficiency, economy, and 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.⁹

This is commonly referred to as the "Equal Access" provision.¹⁰ In passing the Equal Access provision, Congress explained that it was responding to attempts by states to improperly limit provider reimbursement rates as "one method of controlling program costs."¹¹ Congress concluded that, "[w]ithout adequate payment levels, it is simply unrealistic to expect physicians to participate in the program."¹²

a state to disclaim federal responsibilities by contracting away its obligations to a private entity. The law demands that the designated single state Medicaid agency must oversee and remain accountable for uniform statewide utilization review procedures conforming to bona fide standards of medical necessity.") (internal citations omitted).

⁹ 42 U.S.C. § 1396(a)(30)(A).

¹⁰ See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a) (codified as amended at 42 U.S.C. § 1396(a)) (adding the requirement that payments to providers 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.").

¹¹ H.R. REP. NO. 101-247 at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2116.

¹² *Id.*

The proper analysis of “Equal Access” involves a comparison of the access to care of Medicaid beneficiaries “to the access of other individuals in the same geographic area with private or public insurance coverage.”¹³ The uninsured are not part of the analysis.¹⁴

2. The Equal Access Provision Requires an Analysis of Rates And Access

The key to determining whether a state is complying with the Equal Access provision is “to check predictions against reality” by monitoring the rates and the resulting access to care and then make adjustments if the care is insufficient.¹⁵

The Equal Access provision “requires each state to produce a result.” The Seventh Circuit in *Methodist Hospitals*¹⁶ explained that

[u]nder [the equal access provision] . . . states may behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30), must) raise the price until the market clears.¹⁷

Thus, the Act requires that states monitor access after rates are set; the court noted with approval that Indiana, the defendant state, did this with “studies” and with rate-revisions to address

¹³ H.R. REP. NO. 101-247 at 390-91 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2116.

¹⁴ *See* Ark. Med. Soc’y, Inc. v. Reynolds, 6 F.3d 519, 527 (8th Cir. 1993) (“... [T]o construe the language ‘general population’ to include the uninsured members of the population would be directly contrary to the intent of the Medicaid statute To suggest that Congress appropriated vast sums of money and enacted a huge bureaucratic structure to ensure that recipients of the federal Medicaid program have equivalent access to medical services as their uninsured neighbors (i.e. close to none) is ridiculous. Congress must have meant that Medicaid recipients are entitled to access equal to that of the insured population.”); *see* Memisovski v. Patla, 2004 WL 1878332, at *42 (N.D. Ill. 2004) (in determining the level of access enjoyed by the general population, the court focuses solely on access to care by the insured).

¹⁵ *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *Am. Soc’y of Consultant Pharm. v. Garner*, 180 F. Supp. 2d 953, 973-74 (N.D. Ill. 2001).

¹⁶ *Methodist Hosps.*, 91 F.3d at 1030.

¹⁷ *Id.* (emphasis in original).

problems with access that the studies revealed.¹⁸ It suggests that evidence of the withdrawal of providers from the system and of complaints by those affected would also be persuasive.¹⁹ *Methodist Hospitals* mandates that states monitor and adjust rates according to the level of access being produced; it suggests ways of doing this and affirms that assessing the efficacy of the state's methods and results is properly within the competence of a court.²⁰

In cases where there is a challenge by recipients to the adequacy of the state's monitoring of access to care under existing rates, there are several factors a court may consider to evaluate whether a state has complied with the Equal Access provision: (a) the level of reimbursement to participating physicians in the context of the market and the cost of providing services; (b) the level of physician participation in the Medicaid program and whether providers are opting out of or restricting their Medicaid caseloads; (c) whether there is a stream of reports that recipients are having difficulty obtaining care; (d) whether the rate at which Medicaid recipients utilize healthcare services is lower than the rate at which the generally insured population uses those services; and (e) whether defendants have admitted that reimbursement rates are inadequate.²¹

In analyzing the adequacy of reimbursement levels, a court should consider the state's rate compared to what practitioners actually charge, and the adequacy of the rate to cover overhead or the cost of rendering services plus some marginal profit.²² As recognized by the *Clark* court,

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.* See generally, *Methodist Hosps.*, 91 F.3d at 1027; *Am. Soc'y*, 180 F. Supp. 2d at 956, 962-963 (involving challenges by *health care providers* to *proposed* rate decreases). In those cases, the courts were presented with only the providers' predictions of adverse impact on recipients' access to care. Neither case presented a challenge by *recipients* to the adequacy of the access to care under *existing* rates—that is, the question of whether current rates have produced the requisite equal access. Challenges to proposed rates are inherently more difficult because there is obviously less empirical evidence of the impact of the rates on access.

²¹ See *Memisovski* 2004 WL 1878332, at *76-77 (N.D. Ill. 2004); *Clark*, 758 F. Supp. at 575-78.

²² *Clark*, 758 F. Supp. at 577; see also *Rite Aid of Pa., Inc. v. Houston*, 171 F.3d 842, 854-55 (3rd Cir. 1999) (evaluating reimbursement rate levels should include consideration of whether the rate the state arrived at “would allow [providers] to maintain provision of care and earn a profit.”).

the focus of the law is on the State's ability to encourage participation by setting adequate reimbursement rates. Although other factors may affect provider participation, the statute directs the State's attention to reimbursement levels. Regardless of the interplay of other factors, if the reimbursement levels are not enough to ensure equal access to . . . care, then the State has failed in its statutory duty.²³

In measuring the level of physician participation, a court may consider: (i) the extent to which participating practitioners serve Medicaid patients; and (ii) the percentage of licensed practitioners who see every Medicaid patient who present themselves for treatment.²⁴

Separate from a showing that reimbursement rate levels are insufficient to ensure Equal Access, a violation of Equal Access can also be established where the reimbursement rates for physicians in the Medicaid program are arbitrary and capricious based on how they were adopted or their level compared to objective benchmarks.²⁵ Where a state's methodology for adopting rates is found to be arbitrary and capricious, the resulting rates may be held invalid under equal access.²⁶

Under the Equal Access provision, no particular rate-setting method or rate is mandated.²⁷ But whatever method the state employs or rate it arrives at must comply with the general obligation not to be arbitrary and capricious.²⁸ Specifically with respect to Medicaid rate-setting, factors identified by the court in *Rite Aid* appropriate for determining whether the rate is arbitrary and capricious include: (i) whether, "by considering [a] study and other sources of information,

²³ *Clark*, 758 F. Supp. at 576-77; see also *Memisovski* 2004 WL 1878332, at *77 ("Rates and equal access simply cannot be divorced.").

²⁴ *Id.*

²⁵ See *Rite Aid*, 171 F.3d at 853 ("We may find that an action is arbitrary and capricious if, the agency relied on factors other than those intended by Congress, did not consider an important aspect of the issue confronting the agency, provided an explanation for its decision which runs counter to the evidence before the agency or is entirely implausible."); see also *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 40-41 (1983).

²⁶ *Id.*

²⁷ *Methodist Hosps.*, 91 F.3d at 1030.

²⁸ *Rite Aid*, 171 F.3d at 853; see also *Am. Soc'y of Consultant Pharm.*, 180 F. Supp. 2d at 976 (acknowledging that an arbitrary and capricious rate could run afoul of *Methodist Hospitals*).

[the state] made a reasonable effort to anticipate the effects of its action"; and (ii) whether the rate the state arrived at "would allow [providers] to maintain provision of care and earn a profit."²⁹

B. States Must Provide "Early And Periodic Screening, Diagnosis And Treatment"

As discussed above, Medicaid recipients have a right to Equal Access. This right is passive; although individuals on Medicaid have a right to have access to care, they must choose whether and how to take advantage of that care. Congress decided that children also should enjoy the right to Equal Access, and moreover that additional protections were necessary for children. Accordingly, Congress enacted the Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") provisions of the Medicaid Act to insure that children actually receive the care that is available to them.³⁰

1. The Medicaid Act Requires That States Provide EPSDT

The Medicaid Act and its regulations set forth a broad and detailed list of services that a state program must provide to children.³¹ Specifically, the Medicaid Act mandates that a state program provide that children receive: (i) regular healthcare screening services (i.e., well-child exams and immunizations); (ii) effective diagnosis of any conditions that need treatment; and (iii) treatment for any such conditions.³² The statute refers to these services as "early and periodic screening, diagnostic, and treatment services," and they are commonly known by their acronym, EPSDT.³³ Defined at 42 U.S.C. section 1396d(r), EPSDT includes

²⁹ *Rite Aid*, 171 F.3d at 854-55.

³⁰ See 42 U.S.C. § 1396a(a)(10)(A) ("A state plan for medical assistance must . . . provide for making medical assistance available [to eligible persons], including at least the care and services listed in paragraphs (1) through (5) . . . of section 1396(a) of this title . . ."); see also, 42 U.S.C. § 1396d(a)(4)(B) (stating that "medical assistance means . . . early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21.").

³¹ 42 U.S.C. § 1396; 42 C.F.R. § 430.

³² 42 U.S.C. § 1396a(a)(10).

³³ 42 U.S.C. § 1396d(r); 42 C.F.R. § 441.56.

several types of services.³⁴ For example, screening services include comprehensive medical and developmental histories of both physical and mental health, comprehensive unclothed examinations, immunizations, laboratory tests—including lead blood level tests—and health education.³⁵

EPSDT also includes vision, dental, and hearing screens and diagnosis. The children are entitled to age appropriate vision and hearing screening; risk assessment, such as mental health and substance abuse screening as appropriate; developmental screening and assessment as needed; and oral health screenings and referrals for dental care and other needed medical services.³⁶

2. EPSDT Services Must Be Provided On a Timely Basis

The Medicaid Act requires that EPSDT services be performed at intervals that meet reasonable standards of medical and dental practice.³⁷ The Medicaid regulations refer to this required schedule of periodic examinations, tests and services as a periodicity schedule, and they instruct the states to implement one in consultation with medical provider groups that specialize in providing healthcare to children.³⁸ The periodicity schedule must specify the screening services applicable “at each stage of the recipient’s life, beginning with a neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services.”³⁹ Services must be provided more frequently to the extent medically necessary for any individual child.⁴⁰

Illinois, for example, has adopted a periodicity schedule that tracks the recommendations of the American Academy of Pediatricians and incorporates the nationally recognized schedule for

³⁴ See generally 42 C.F.R. § 441.56 (1984) (defining EPSDT required activities).

³⁵ 42 U.S.C. § 1396d(r)(1) (1965).

³⁶ See 42 U.S.C. § 1396d(r)(2-4); 42 C.F.R. § 441.56(b)-(c).

³⁷ 42 U.S.C. § 1396d(r)(1)-(4).

³⁸ 42 C.F.R. § 441.58.

³⁹ 42 C.F.R. § 441.58(b); see also THE STATE MEDICAID MANUAL § 5140 available at http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004).

⁴⁰ 42 U.S.C. § 1396d(r)(1)(A)(ii).

immunizations.⁴¹ The Illinois periodicity schedule calls for seven appointments for health screening services in the first year of life, four appointments in the second year of life, and a decreasing number of annual appointments as a child becomes older.⁴² Under the periodicity schedule, a child should receive additional examinations if medically necessary. Illinois also calls for annual vision, hearing, and dental screens, and two blood lead screens, one at twelve and one at twenty-four months of age.

Consistent with the language of the EPSDT provisions, state law generally requires that children receive immunizations appropriate for a child's age and health history. These requirements are frequently adapted from recommendations of the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention ("CDC"), the American Academy of Pediatrics ("AAP"), and the American Academy of Family Physicians ("AAFP").⁴³

3. Children Are Entitled To Follow-Up Services

A state program also must ensure that once a screening identifies a certain condition that requires corrective services the state must provide that child with follow-up corrective services.⁴⁴ The states also must provide all care, treatment, services or other measures that are medically necessary to address any conditions that are discovered through the screening and diagnostic services under EPSDT.⁴⁵

Congress conferred the right to EPSDT services on every recipient child, and reinforced this intent by expressly instructing the Secretary of HHS to "develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening,

⁴¹ 89 Ill. Admin. Code § 140.488.

⁴² *Id.*

⁴³ *See, e.g.* 89 Ill. Admin. Code § 140.488 (adopting specific periodicity schedule based on scheduled promulgated by the American Academy of Pediatrics).

⁴⁴ *See* 42 U.S.C. § 1396a(a)(43)(C) (explaining how states are required to "arrange for (directly or through referral to appropriate agencies, organizations or individuals) corrective treatment, the need for which is disclosed by . . . child health screening services"). *See also* Bond v. Stanton, 655 F.2d 770 (7th Cir. 1981).

⁴⁵ 42 U.S.C. § 1396d(r)(5).

diagnostic, and treatment services.”⁴⁶ The Secretary established a schedule of goals in the State Medicaid Manual in 1990, directing the states to show by 1995 a “participant ratio” and a “screening ratio” of eighty percent each.⁴⁷ The “participant ratio” measures how many of the children eligible for EPSDT services in a particular year received at least one service. The “screening ratio” measures the extent to which eligible children scheduled to receive at least one service in a given year actually receive services. As noted above, young children are scheduled to receive many more than one per year.

These goals indicate that the Secretary, charged with the implementation of the statute, interprets the statute to entitle every eligible child to the full EPSDT comprehensive health program. Further, the Secretary requires, as a matter of federal-state accountability, that states evidence compliance with this entitlement by producing success in eighty percent of the cases.⁴⁸

4. States Must Actively Advance the Children’s Use of EPSDT Services

The Medicaid Act requires that the states provide information to recipients that effectively promotes the use of EPSDT services.⁴⁹ The Medicaid regulations require that the states inform recipients about the EPSDT program and its benefits using both written and oral methods.⁵⁰ States must not just perfunctorily provide information about the program; the state’s efforts must be “effective”—they must sell the plan in a way that gets children to participate in what the Act intends to be a comprehensive child health program.⁵¹

⁴⁶ 42 U.S.C. § 1396d(r)(5).

⁴⁷ THE STATE MEDICAID MANUAL § 5360(B) and (C) *available at* http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004).

⁴⁸ *See Salazar v. D.C.*, 954 F. Supp. 278, 304-06 (D.D.C. 1996) (discussing the district’s failure to achieve participation goals constituted evidence of district’s failure to deliver EPSDT services to eligible poor children).

⁴⁹ 42 U.S.C. § 1396a(a)(43)(A).

⁵⁰ 42 C.F.R. § 441.56(a)(1).

⁵¹ *Id.*; *see also Memisovski*, 2004 WL 1878332 *91 (“These EPSDT requirements differ from merely providing ‘access’ to services; the Medicaid statute places affirmative obligations on states to assure that these services are actually provided to children on Medicaid in a timely and effective manner.”); *Salazar*, 954 F. Supp. at 318-23, 333 (showing where district violated EPSDT statute by failing to provide effective notice of EPSDT to children who are eligible

Consistently, the regulations instruct the states to sell the program to its intended beneficiaries in various ways: they must use “clear, non-technical language,” inform people of the services available and where and how to obtain them, and of “the benefits of preventive health care,” and invite them to request transportation services and help with scheduling medical appointments.⁵² States must “effectively inform” those who are blind or deaf or who cannot read or understand the English language.⁵³ States must act promptly and monitor their caseloads regarding EPSDT; and they must provide assurance to CMS that “processes are in place to effectively inform individuals”⁵⁴

The State Medicaid Manual provides further prescriptions about the “informing” requirement in 42 U.S.C. section 1396a(a)(43)(A). It instructs the states to “[u]se methods of communication that recipients can clearly and easily understand to ensure that they have the information they need to utilize services to which they are entitled.”⁵⁵ Oral methods are expressly required by the Medicaid Act, and these methods include face-to-face communications from eligibility workers, health aides, and providers,

for those services, failing to monitor whether social services staff inform patients about EPSDT services or take other appropriate action to ensure that eligible families are informed about EPSDT); *Stanton*, 504 F.2d at 1250 (“The mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue those problems with the needed treatment is made unambiguously clear by the 1967 act and by the interpretative regulations and guidelines.”); *see also* 42 C.F.R. § 441.56(a)(1) (“The [state] agency must—(1) Provide for a combination of written and oral methods designed to inform *effectively* all EPSDT eligible individuals (or their families) about the EPSDT program.”) (emphasis added).

⁵² *See* 42 C.F.R. § 441.56(a)(2); 42 C.F.R. § 441.62 (requiring the provision of transportation and scheduling services); *see also* THE STATE MEDICAID MANUAL § 5150 available at http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004) (“To ensure that recipients obtain needed Medicaid services, offer and provide, if requested and necessary, assistance with transportation and scheduling appointments Offer both transportation and scheduling assistance prior to each due date of a child’s periodic examination. Provide this assistance if requested and necessary.”).

⁵³ 42 C.F.R. § 441.56(a)(3); *see also Salazar*, 954 F. Supp. at 320 (declaring that written forms available only in English were inadequate notice to illiterate and non-English speaking recipients).

⁵⁴ 42 C.F.R. § 441.56(a)(4).

⁵⁵ THE STATE MEDICAID MANUAL § 5121(A) available at http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004).

plus public service announcements, community awareness campaigns and audio and visual methods.⁵⁶ It is “effective and efficient” to tailor these methods to particular at-risk groups.⁵⁷

The State Medicaid Manual sums up its result-oriented set of “informing” duties in this way: “[States] have the flexibility to determine how information may be given most appropriately while *assuring* that every EPSDT eligible receives the basic information necessary to gain access to EPSDT services.”⁵⁸

Whether the informational strategies a state employs comply with the practical, result-oriented “informing” requirements of the EPSDT scheme is properly measured not only by the objective reasonableness of each strategy but ultimately by the overall results. Eligible children are not being “effectively” informed—even if they receive a few flyers in the mail—if significant numbers of them are not accessing services according to the periodicity schedule (or at all).⁵⁹

5. States Must Follow-Up With Those Children Who Are Not Receiving Care

The states are obligated to increase their efforts for any families that “have not used services.”⁶⁰ This necessarily requires that the states monitor the healthcare provided to each child and that the states follow-up with every child that does not receive services. The states have an obligation to monitor the level of healthcare actually provided to help them improve their performance.⁶¹ If states do not know how the program is performing with respect to individual

⁵⁶ See THE STATE MEDICAID MANUAL, *supra* note 55; 42 U.S.C § 1396a(a)(43)(A).

⁵⁷ 42 U.S.C § 1396a(a)(43)(A).

⁵⁸ THE STATE MEDICAID MANUAL § 5121(C) *available at* http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004) (emphasis added).

⁵⁹ See *Salazar*, 954 F. Supp. at 320 (declaring that low percentage of recipients who expressed desire for EPSDT services was evidence that District’s use of recertification form was an ineffective tool for informing Medicaid recipients about EPSDT).

⁶⁰ 42 C.F.R. § 441.56(a)(4).

⁶¹ See *Salazar*, 1997 WL 306876, at *10-11 (requiring the district to establish a tracking system to assure that all Medicaid-eligible children receive all age-appropriate screens, services and follow-up treatment).

recipients of EPSDT services, the failure to monitor the program is itself a violation of the EPSDT requirements.⁶²

To achieve an “effective child health program” the states are required to take a practical, pro-active and result-oriented approach to the screening requirements of the EPSDT program. According to the State Medicaid Manual, the initial EPSDT examination

[M]ay be requested at any time, and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Sound medical practice requires that when children first enter the EPSDT program you [the state] encourage and promote that they receive the full panoply of screening services available under EPSDT. It is desirable that a parent or other responsible adult accompany the child to the examination. When this is not possible or practical, arrange for a follow-up worker, social worker, health aide, or neighborhood worker to discuss the results in a visit to the home or in contacts with the family elsewhere.⁶³

The Seventh Circuit has held that a technical and bureaucratic approach to the concept of a “request” for services is inconsistent with the result-oriented and practical approach embodied in the Medicaid Act.⁶⁴ According to the court:

Indiana's somewhat casual approach to EPSDT hardly conforms to the aggressive search for early detection of child health problems envisaged by Congress. It is difficult enough to activate the average affluent adult to seek medical assistance until he is virtually laid low. It is utterly

⁶² See *Bond*, 655 F.2d at 770-771 (showing where the state violated EPSDT statute in failing to monitor whether complete screening services are being performed on EPSDT-eligible children); see also *Salazar*, 954 F. Supp. at 329 (noting the agency's failure to respond to parental requests for EPSDT services for their children, failure to conduct site visits to monitor providers serving EPSDT-eligible children, and lack of data collection requirements or organized system for receiving feedback from providers and for enforcing those requirements evidenced district's failure to monitor whether EPSDT-eligible children receive complete screening services).

⁶³ THE STATE MEDICAID MANUAL § 5123.1(B) available at http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004).

⁶⁴ *Stanton*, 504 F.2d at 1251.

beyond belief to expect that children of needy parents will volunteer themselves or that their parents will voluntarily deliver them to the providers of health services for early medical screenings and diagnosis. By the time an Indiana child is brought for treatment it may too often be on a stretcher. This is hardly the goal of 'early and periodic screening and diagnosis.'⁶⁵

In this context, case management services are a key strategy states should employ to achieve the results required in EPSDT. Case management "centers on the process of collecting information on the health needs of the child, making—and following up on—referrals as needed, maintaining a health history, and activating the examination/diagnosis/treatment loop."⁶⁶ It "provides the difference" in achieving the goal of the program: instead of fragmentation and children falling through cracks, there is "a comprehensive program based on the concept of getting children into the existing mainstream system of health care delivery."⁶⁷

Case management is particularly effective in helping the state to accomplish the "integral responsibility" of notifying recipients each time they are due to receive an EPSDT screening.⁶⁸ While case management is not in itself specifically mandated by the statute, its absence or under-use in a state that has significant numbers of children not receiving EPSDT services according to the periodicity schedule or at all is evidence of a program that does not comply with the result-oriented requirements of the statute.⁶⁹

⁶⁵ See *Frew v. Gilbert*, 109 F. Supp. 2d 579, 606-12 (E.D. Tex. 2000), *vacated on other grounds sub nom. Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002), *cert. granted in part sub nom. Frew ex rel. Frew v. Hawkins*, 123 S.Ct. 1481 (U.S. 2003) (rejecting state's argument that state is responsible for providing EPSDT services to only those Medicaid recipients' who technically request them; recipients' entitlement to services is not dependent upon a formalized type of request).

⁶⁶ THE STATE MEDICAID MANUAL § 5310(D) *available at* http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004).

⁶⁷ *Id.*

⁶⁸ THE STATE MEDICAID MANUAL § 5310(D) *available at* http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004).

⁶⁹ See *Id.* § 5010(B) ("Although 'case management' does not appear in statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that

The “arranging for treatment” component of the EPSDT program in 42 U.S.C. § 1396a(a)(43)(C) is also result-oriented. The states must provide any and all diagnostic and treatment services allowed under the federal Medicaid scheme to address needs indicated by the screens, regardless of whether the state has opted to provide those services to adult Medicaid recipients.⁷⁰ To ensure that treatment is provided according to this requirement, states are instructed to “[t]ake advantage of all resources available. Make arrangements with providers, including physicians practicing in individual or group settings, for the delivery of EPSDT services.”⁷¹ There is no limitation with respect to specialists. If treatment services are indicated based on the screens and among those provided for in the federal Medicaid scheme, the state must provide them to children.

States may contract with HMOs to provide EPSDT services to eligible children enrolled with the organization.⁷² To the extent a state contracts with an HMO, the contract must provide for certain quality assurance measures including “maintenance of sufficient patient encounter data to identify the physician who delivers services to patients.”⁷³ States also must ensure through their contracts that each MCO maintain a “health information system” that collects data on enrollee and provider characteristics and on “services furnished to enrollees through an encounter data system.”⁷⁴ Ultimately, however, the states remain accountable for the provision of EPSDT services, and must monitor these activities and enforce these contractual provisions in order to assure that they are fully carried out.⁷⁵

duplicated and unnecessary services are avoided.”); *see also Bond*, 655 F.2d at 771; *John B. v. Menke*, 176 F. Supp. 2d 786, 802-803 (M.D. Tenn. 2001) (stating emphatically: “Without proper outreach, EPSDT is worthless.”).

⁷⁰ 42 C.F.R. § 441.56(c) (2005).

⁷¹ THE STATE MEDICAID MANUAL § 5220(A) available at http://www.cms.hhs.gov/manuals/45_smm/pub45toc.asp? (last modified Sept. 16, 2004).

⁷² 42 U.S.C. § 1396b(m)(1)(A)(i) (2000).

⁷³ 42 U.S.C. § 1396b(m)(1)(A)(xi).

⁷⁴ 42 C.F.R. § 438.242(a) (2005); 42 C.F.R. § 438.242(b)(1).

⁷⁵ *See John B.*, 176 F. Supp. 2d at 801-802 (stating that state contractors’ failure to follow federal EPSDT requirements did not relieve State of its responsibilities; “EPSDT cannot be simply relinquished to the MCOs, as the State remains ultimately bound by the EPSDT regulations.”); *see supra* Part I(A).

III. Many States Are Violating the Rights of Health Care Consumers on Medicaid

In order to comply with the Medicaid Act, including the Equal Access and EPSDT provisions, states must devote significant resources to the poor. Many states, however are under-funding their Medicaid programs. While one cannot judge a state's compliance with the Medicaid Act solely by reference to the reimbursement rates that the state pays to medical providers, those rates are an objective indicator of a state's commitment to complying with its obligations under the Equal Access and EPSDT provisions. The rate structure of many states is dramatically below any applicable market rates.

In *Memisovski v. Patla*, a recent Equal Access and EPSDT case, Illinois took the position that it was complying with the Medicaid Act because its results were no worse than other industrial states. In its court filings, Illinois made no effort to analyze whether those other states were complying with the Medicaid Act, but instead argued solely that its results were not out of line with the nation. While the Court had little difficulty in barring Illinois from even presenting evidence to support this argument, based on the fact that Illinois did not analyze whether these other states were, in fact, complying with the Medicaid Act, this type of argument suggests that states will not always employ a rigorous and proper analysis of their compliance with the Medicaid Act.

IV. The Medicaid Act Should Be Enforceable Under Section 1983

Plaintiffs have attempted to enforce the Equal Access and EPSDT Provisions in cases across the country.⁷⁶ One of the more hotly-contested issues is whether recipients can enforce these provisions under Section 1983. The better conclusion is that

⁷⁶ See *Memisovski ex rel. v. Patla*, No. 92 C 1982, 2001 WL 1249615, at *11-13 (N.D. Ill. 2001)(asserting violations of equal access and EPSDT); see also *Methodist Hosp. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996) (asserting violations of equal access); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908 (5th Cir. 2000) (asserting violations of equal access); *Miller by Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993) (asserting violations of EPSDT); *Westside Mothers et al. v. Haveman*, 289 F.3d 852 (6th Cir. 2002) (asserting violations of equal access and EPSDT), *cert. denied*, 537 U.S. 1045 (2002); *Bond v. Stanton*, 655 F.2d 766 (7th Cir. 1981) (asserting violations of EPSDT); *Clark v. Kizer*, 758 F. Supp. 572 (E.D.Cal 1990) (asserting violations of equal access and EPSDT); *Salazar v. D.C.*, No. CA-93-452, 1997 WL 306876 (D.D.C. 1997) (asserting violations of EPSDT).

recipients can do so.⁷⁷ Congress clearly intended to benefit Medicaid recipients when it enacted the EPSDT and equal access provisions.⁷⁸

States have argued that the Supreme Court ruling in *Gonzaga University v. Doe*,⁷⁹ bars private citizens from bringing any claim under Section 1983 to enforce their rights under the Medicaid Act.⁸⁰ This argument would require a significant expansion of the actual holding of *Gonzaga*.

The Supreme Court expressly upheld the enforceability of rights under the Medicaid Act through Section 1983 in *Wilder v. Virginia Hospital Association*.⁸¹ In *Wilder*, the Supreme Court held that the now repealed "Boren Amendment" to Section 1396a of the Medicaid Act did provide health care providers with enforceable rights that could be enforced pursuant to Section 1983, and strongly rejected the contention that "Congress has foreclosed enforcement of the Medicaid Act under § 1983."⁸² The Boren Amendment is analogous to the Equal Access provision, and the Boren Amendment required states to set reimbursement rates for certain institutional medical providers which were "reasonable and adequate to meet the costs" of operating such facilities.⁸³ The *Wilder* Court held that this provision created rights enforceable under Section 1983 because it was (1) clearly intended to benefit the specified institutional providers, (2) phrased in mandatory terms, and (3) sufficiently

⁷⁷ See *Memisovski*, 2001 WL 124615, at *5 (stating that the provisions satisfy the traditional three-factor test that gives rise to a federal right, and citing case law holding that "violations of the statutory provisions requiring EPSDT services are redressable through 1983").

⁷⁸ *Id.* at *11-13. See also *Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996) (analyzing § 1396a(a)(30)); *Evergreen Presbyterian Ministries, Inc. v. Hood*, 235 F.3d 908, 924 (5th Cir. 2000) (analyzing § 1396a(a)(30)); *Miller by Miller v. Whitburn*, 10 F.3d 1315, 1316 (7th Cir. 1993) (analyzing § 1396a(a)(43)); *Westside Mothers et al. v. Haveman*, 289 F.3d 852, 862-63 (6th Cir. 2002), *cert. denied*, 537 U.S. 1045 (2002) (analyzing § 1396a(a)(43) and 1396d(r)); *Bond v. Stanton*, 655 F.2d 766, 767-768 (7th Cir. 1981) (enforcing predecessor provision to § 1396a(a)(43)); and *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980) (*quoting* *Rosado v. Wyman*, 397 U.S. 397 (1970) ("[S]uits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States.")).

⁷⁹ 536 U.S. 271 (2002).

⁸⁰ See *e.g.* *Memisovski v. Patla*, No. 92 C 1982, 2004 WL 1878332.

⁸¹ *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 524 (1990).

⁸² *Id.* at 520, 524.

⁸³ See *id.* at 503 (citing 42 U.S.C. § 1396a(a)(13)(A)).

definite to be judicially enforceable.⁸⁴ This three-part test was further established by *Blessing v. Freestone*,⁸⁵ which rejected certain Section 1983 suits brought under Title IV-D of the Social Security Act, and has since been known as the “*Blessing* test.”

As noted by the Third Circuit in *Sabree v. Richman*,⁸⁶ the *Gonzaga* decision “carefully avoided disturbing, much less overruling” cases such as *Wilder*.⁸⁷ As such, an assessment of whether rights are enforceable under Section 1983 must still include an evaluation of the three-part test set forth in *Wilder* and *Blessing*, as further construed by *Gonzaga*. What *Gonzaga* clarified within that test was that it is not sufficient that a plaintiff fall “within the general zone of interest that the statute is intended to protect,” but rather the statute must set forth an “unambiguously conferred right” to be protected pursuant to Section 1983.⁸⁸ This involves an assessment of the text and structure of the statute to determine whether the statute in question contains, e.g., “rights-creating language.”⁸⁹

Recent cases, such as *Sabree*, have made clear that even under the heightened standard articulated by *Gonzaga*, the provisions of Section 1396a of the Medicaid Act continue to be enforceable through Section 1983 actions. In *Sabree*, the Third Circuit engaged in an extensive examination of 42 U.S.C. Sections 1396a(a)(8), 1396a(a)(10), and 1396d(a)(15) in light of *Gonzaga*, and concluded that these sections did include “unambiguously conferred rights,” enshrined within the statute by “rights-creating language” with an “unmistakable” individual focus on Medicaid-eligible individuals.⁹⁰

Both of the specific provisions of the Medicaid Act at issue here pass this test. More recently, in *Memisovski v. Patla*, Judge Lefkow conducted an extensive analysis of the Equal Access and EPSDT provisions in light of *Gonzaga*. She concluded that, after

⁸⁴ *Wilder*, 496 U.S. at 510-520.

⁸⁵ *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997).

⁸⁶ *Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004).

⁸⁷ *Id.* at 184; *see also* *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280-81 (noting that *Wilder* addressed a provision of the Medicaid Act as to which “Congress left no doubt of its intent for private enforcement”); *see also id.* at 290 (noting that FERPA’s administrative enforcement procedures “squarely distinguish this case from . . . *Wilder*”).

⁸⁸ *See Gonzaga Univ.*, 536 U.S. at 283.

⁸⁹ *Id.* at 286-87.

⁹⁰ *See Sabree*, 367 F.3d at 190-92.

Gonzaga, 42 U.S.C. section 1396a(a)(30)(A), and the EPSDT provisions unambiguously confer rights on plaintiffs supporting a cause of action brought under Section 1983.⁹¹ There is no reason to believe that *Gonzaga* implicitly overruled the consistent line of authority holding that the EPSDT provisions of the Medicaid Act create rights enforceable under Section 1983.⁹²

V. Conclusion

Millions of children and adults are entitled to benefits under the Medicaid Act. Congress has mandated that these individuals have access to medical care that is equal to the access enjoyed by the general population in the applicable geographic region. The general population for these purposes consists of persons with private health insurance. In virtually all cases, reimbursement rates are a critical factor in providing such access.

Congress also has mandated that with respect to children, states must go further than providing access. States must employ effective notification techniques and outreach so that they *succeed* in providing children with a full set of health care services. To the extent that a state fails to comply with these mandates, Section 1983 should provide an appropriate vehicle for pursuing a remedy.

⁹¹ *Memisovski*, No. 92 C 1982, 2004 WL 1878332, at *5 (2004).

⁹² *See, e.g.,* *Pediatric Specialty Care, Inc. v. Ark. Dep't. of Human Servs.*, 293 F.3d 472, 479 (8th Cir. 2002); *Westside Mothers et al.*, 289 F.3d at 863, *cert. denied*, 537 U.S. 1045 (2002).
