

FULFILLING THE PROMISE OF THE MEDICAID ACT: WHY THE EQUAL ACCESS CLAUSE CREATES PRIVATELY ENFORCEABLE RIGHTS

INTRODUCTION

“[T]he restrictive analysis required by federal case law and the recent amendments by Congress render the Medicaid Act’s ‘equal access’ provisions merely illusory.”¹ In *Roob v. Fisher*, an Indiana Court of Appeals opinion, Judge Baker explained that preventing Medicaid recipients from enforcing their rights under these provisions (the equal access clause) of the Medicaid Act causes a result “extremely deleterious to those most in need.”² Under the equal access clause, a state must provide “methods and procedures”³ in its Medicaid plan to assure that “payments to providers produce four outcomes: (1) ‘efficiency,’ (2) ‘economy,’ (3) ‘quality of care,’ and (4) adequate access to providers by Medicaid beneficiaries.”⁴ Judge Baker’s obvious misgivings about disallowing Medicaid recipients to enforce their rights did not change the decision of the Indiana Court of Appeals: Medicaid recipients denied adequate access to healthcare because of a state’s low reimbursement rates for healthcare providers cannot enforce their rights through the equal access clause of the Medicaid Act.⁵

The purpose of the equal access clause is to protect individuals against states setting Medicaid reimbursement rates paid to healthcare providers so low that few or no providers will accept Medicaid patients, thus denying

¹ *Roob v. Fisher*, 856 N.E.2d 723, 733 (Ind. Ct. App. 2006). The equal access provisions referred to in the opinion appear in 42 U.S.C. § 1396a(a)(30)(A) (2006), referred to in this Comment as the “equal access clause.”

² *Roob*, 856 N.E.2d at 733.

³ 42 U.S.C. § 1396a(a)(30)(A).

⁴ *Pa. Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 537 (3rd Cir. 2002) (en banc) (quoting 42 U.S.C. § 1396a(a)(30)(A)).

⁵ *Id.* The court reasoned that the equal access clause creates no identifiable class of rights-holders and that there is no language demonstrating a clear congressional intent to create a right in Medicaid recipients, and thus the statute could not be enforced through a § 1983 action. *Id.* In a rehearing, the Indiana Court of Appeals granted standing to the plaintiffs because the court found that the state conceded the issue of recipient standing at the trial court level. *Roob v. Fisher*, 866 N.E.2d 781 (Ind. Ct. App. 2007).

Medicaid recipients adequate access to healthcare.⁶ While the court in *Roob* believed that congressional statutes and federal precedent forced it to rule in a way contradictory to sound public policy,⁷ several other courts have interpreted those same statutes and cases to invoke enforceable rights for Medicaid recipients.⁸ Judge Baker's opinion suggests that those other courts are employing judicial activism by misreading legal precedent and statutes to reach an agreeable policy decision.⁹ In *Roob*, the court reasoned that it was up to Congress to change the Medicaid statute and end its "apparent indifference to the plight of Medicaid . . . recipients."¹⁰ This statement suggests that Medicaid recipients lack additional ways to ensure that they are not denied access to healthcare because of a state's low reimbursement rates. However, the opinion in *Roob* and the opinions of other courts that have addressed this issue have not analyzed whether the enforcement of the equal access clause is the only way for Medicaid recipients to ensure that they receive adequate access to healthcare. Further, courts have avoided directly addressing the effect such an inquiry would have in determining whether the statute gives rise to an enforceable right under 42 U.S.C. § 1983.¹¹

The judicial split, and the confusion evident in the wide variety of reasoning used to apply the Supreme Court's test for whether a statute is enforceable through § 1983,¹² suggests that the Supreme Court should directly address the enforceability of the equal access clause. Part I of this Comment provides background information about the Medicaid Act, the equal access clause, the dilemma for Medicaid recipients created by low reimbursement rates, and how courts generally view the enforcement of federal statutory rights under § 1983.¹³ Part II explores the central reasoning from the circuits that

⁶ See H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2116 (concluding that "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program").

⁷ *Id.*

⁸ See *infra* Part II.B.1.

⁹ Judge Baker seems to suggest that judicial precedent and the statute at issue force him to come to this conclusion and, therefore, it is only the legislature that should grant enforceable rights. *Roob*, 856 N.E.2d at 733.

¹⁰ *Id.* at 734.

¹¹ 42 U.S.C. § 1983 (2000). See *infra* Part II.B (analyzing relevant case law for determining whether the equal access clause creates an enforceable right for Medicaid recipients). Section 1983 allows individuals to bring suits against local governments and state and local officers to redress violations of federal law. ERWIN CHEMERINSKY, *FEDERAL JURISDICTION* 480 (5th ed. 2007).

¹² The test for whether a statute is enforceable through a § 1983 suit has most recently been clarified by the Supreme Court in *Gonzaga University v. Doe*, 536 U.S. 273 (2002). See *infra* Part I.D.

¹³ See *infra* Part I.

allow the equal access clause to be enforceable, and examines the alternative legal reasoning employed in the circuits that have held that the right is not enforceable. This Part demonstrates that the lack of guidance from the Supreme Court to lower courts has resulted in a multitude of legal reasoning and confusion in determining whether individuals have an enforceable right under § 1983 to enforce the equal access clause of the Medicaid Act.¹⁴ Part II also examines recent judicial opinions that appear to indicate a trend toward prohibiting Medicaid recipients from enforcing equal access rights through a § 1983 suit. It ultimately explains, however, that most of those decisions occurred in circuits that historically, not just recently, ruled against allowing Medicaid recipients to enforce the equal access clause.¹⁵ This Comment argues that due to the complexity of the *Gonzaga* test, lower courts have overlooked whether alternative legal remedies exist, when determining whether the equal access clause creates an enforceable right for Medicaid recipients.¹⁶

Part III explores the various other legal avenues Medicaid recipients who are not receiving proper access to medical services can pursue.¹⁷ While these additional strategies are effective in certain situations, each has flaws that prevent it from adequately meeting the needs of all individuals suffering from insufficient access to medical services. Part IV discusses the possible implications of allowing Medicaid recipients to enforce the equal access clause through a § 1983 suit.¹⁸ This Comment concludes by arguing that the Supreme Court must address the equal access clause issue because of the judicial subjectivity and uncertainty that accompany the application of the *Gonzaga* test. Due to the lack of additional legal avenues for Medicaid recipients to pursue and the likelihood that the problem of low reimbursement rates will continue, the Court should rule in favor of allowing an enforceable right under the equal access clause to ensure that the promise of the Medicaid Act is not “merely illusory.”¹⁹

¹⁴ See *infra* Part II.B.

¹⁵ See *infra* Part II.B.3.

¹⁶ See *infra* Part II.C.

¹⁷ See *infra* Part III.

¹⁸ See *infra* Part IV.

¹⁹ Cf. *Roob v. Fisher*, 856 N.E.2d 723, 733 (Ind. Ct. App. 2006) (referring to equal access clause as a “merely illusory” protection).

I. ENFORCING THE EQUAL ACCESS CLAUSE THROUGH A § 1983 SUIT

A. *The Medicaid Act*

The Medicaid Act was enacted in 1965 as Title XIX of the Social Security Act.²⁰ Congress created the Medicaid program to address the need for providing medical care to low-income individuals.²¹ Medicaid is the largest source of funding for medical and health-related services for America's poor.²² "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."²³ The four main categories of indigent individuals covered by Medicaid are pregnant women, children, individuals eligible for both Medicaid and Medicare, and the disabled.²⁴

The federal government shares the costs of Medicaid with the states that elect to participate in the program.²⁵ To qualify for federal assistance, a state must submit to and have approved by the Secretary of Health and Human Services (the Secretary) a "[s]tate plan for medical assistance"²⁶ that comprehensively describes the nature and scope of the state's Medicaid program.²⁷ Although participation is voluntary, participating states must comply with the specific requirements imposed by the Medicaid Act and the regulations of the Secretary.²⁸ A state that fails to comply with the medical assistance plan that it has submitted to the Secretary runs the risk of having its

²⁰ Grants to States for Medical Assistance Programs Act (the Medicaid Act), Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amended at 42 U.S.C. § 1396 (2006)).

²¹ See H.R. REP. NO. 89-213, at 66 (1965) (finding that the people whom Medicaid will serve are the most needy in the country and that "it is appropriate for medical care costs to be met, first, for these people").

²² See BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 772-73 (5th ed. 2004) (discussing that a Medicaid applicant must demonstrate that his or her income falls below financial eligibility requirements set by the states pursuant to broad federal guidelines); Centers for Medicare & Medicaid Services, Technical Summary (Dec. 14, 2005), http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp.

²³ *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

²⁴ FURROW ET AL., *supra* note 22, at 774-75.

²⁵ See 42 U.S.C. § 1396 (2006); see also *Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981).

²⁶ 42 U.S.C. § 1396a (describing all the requirements a state plan for medical assistance must meet to receive federal funding).

²⁷ 42 C.F.R. § 430.10 (2008).

²⁸ See *Wilder*, 496 U.S. at 502 (explaining that to qualify for federal aid, states must submit plans for approval establishing a reimbursement scheme for healthcare providers).

funding revoked.²⁹ The state plan is required to establish, among other things, a scheme describing the policy and methods used “for reimbursing health care providers for the medical services provided to needy individuals.”³⁰

B. The Equal Access Clause of the Medicaid Act

The equal access clause of the Medicaid Act requires that state plans for medical assistance “assure that payments” for care and services available under the plan “are sufficient to enlist enough providers so that care and services are available . . . at least to the extent . . . available to the general population in the geographic area.”³¹ In other words, this statutory provision requires that states pay healthcare providers adequate reimbursements for the services provided to Medicaid recipients to ensure that a sufficient number of providers enroll in the Medicaid program and accept Medicaid patients. The equal access clause was passed by Congress to prevent states from attempting to control program costs by improperly limiting provider reimbursement rates.³²

To determine whether all patients have equal access to healthcare, courts should compare the healthcare access of Medicaid beneficiaries with the access of other individuals in the same geographic area who have private insurance coverage.³³ The relevant portion of the population for comparison does not include the uninsured.³⁴

²⁹ 42 U.S.C. § 1396c. The term “medical assistance,” as used throughout the Medicaid Act, refers to the payment of all or part of the cost of the care and services specifically described in the Act. *See* Medicaid Act § 1901, 42 U.S.C. § 1396d(a).

³⁰ *Wilder*, 496 U.S. at 502; State Plan Requirements, 42 C.F.R. § 447.201(b). States are able to determine the payment levels and make payment for services directly to the individuals or entities furnishing the services. *Id.* § 430.0.

³¹ 42 U.S.C. § 1396a(a)(30)(A); *see also* Encouragement of Provider Participation, 42 C.F.R. § 447.204 (2008) (“The agency’s payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.”).

³² H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2116; *see also* Frederick H. Cohen, *An Unfulfilled Promise of the Medicaid Act: Enforcing Medicaid Recipients’ Right to Health Care*, 17 LOY. CONSUMER L. REV. 375, 378 (2005).

³³ *See Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519, 527 (8th Cir. 1993) (citing H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2116); U.S. DEP’T OF HEALTH, EDUC., & WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, SUPPLEMENT D: MED. ASSISTANCE PROGRAMS D-5340 (1966).

³⁴ *See Ark. Med. Soc’y*, 6 F.3d at 527 (finding that the belief that Congress enacted the Medicaid program so that Medicaid recipients would “have equivalent access to medical services as their uninsured neighbors . . . is ridiculous”).

Courts have looked at a variety of factors to determine whether equal access to medical services exists.³⁵ Courts often first examine the level of reimbursements that healthcare providers receive for providing services to Medicaid recipients.³⁶ Additionally, courts may examine the following considerations: the level of physician participation in the Medicaid program (as evidence that recipients have difficulty obtaining care); whether Medicaid recipients utilize healthcare services at a lower rate than the general population uses those services; and if defendants have admitted that the reimbursement rates are inadequate.³⁷ For a state to satisfy the equal access clause, it needs only to “produce a *result*, not . . . employ any particular methodology for getting there.”³⁸ Therefore, a court should not consider whether the rates are set in an arbitrary and capricious manner.³⁹

C. *The Continuing Problem of Low Healthcare Provider Participation in Medicaid*

Despite the equal access clause of the Medicaid Act, healthcare providers have continued to reject Medicaid patients because of low reimbursement rates, and this lack of participation has severely hurt the Medicaid program.⁴⁰ Healthcare provider participation in the Medicaid program is entirely optional,⁴¹ and physicians are increasingly deciding not to treat Medicaid

³⁵ See, e.g., *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332, at *42 (N.D. Ill. Aug. 23, 2004).

³⁶ See, e.g., *id.*

³⁷ See *Clark v. Kizer*, 758 F. Supp. 572, 576 (E.D. Cal. 1990), *aff'd in relevant part sub nom. Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992) (explaining that the Department of Health and Human Services uses a two-thirds physician participation ratio to gauge compliance with the equal access clause); see also *Memisovski*, 2004 WL 1878332, at *42.

³⁸ *Memisovski*, 2004 WL 1878332, at *42 (quoting *Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996)) (quotation marks omitted).

³⁹ See *id.*

⁴⁰ See HEALTH & HUMAN SERVS. COMM'N, CONSOLIDATED BUDGET: FISCAL YEARS 2008–2009, at 54 (2006), http://www.hhsc.state.tx.us/about_hhsc/finance/0809_Budget/master_consolidated_budget_FY0809_101106.pdf (arguing that reimbursement increases for physicians “would promote access to care for Medicaid clients that would likely erode without the increase”); Janet D. Perloff et al., *Which Physicians Limit Their Medicaid Participation, and Why*, 30 HEALTH SERVS. RES. 7, 7–8, 22 (1995) (finding that to affect a significant change in Medicaid participation, Medicaid reimbursement rates would have to increase by approximately 60%); see also Christine M. Shaffer, *The Impact of Medicaid Reforms & False Claims Enforcement: Limiting Access by Discouraging Provider Participation in Medicaid Programs*, 58 S.C. L. REV. 995, 1002 (2007) (finding that concerns regarding Medicaid provider participation focus predominately on low Medicaid reimbursement rates).

⁴¹ The term “providers” includes individual physicians, hospitals, nursing homes, dentists, and nonphysician health practitioners such as nurses and psychologists. See 45 C.F.R. § 160.103(3) (2008)

patients.⁴² Medicaid payments to healthcare providers have historically been considerably lower than the payments received by physicians for Medicare and private insurance.⁴³ Many healthcare providers actually lose money when treating Medicaid recipients.⁴⁴ The low reimbursement rates have caused an increasing number of physicians to stop treating new Medicaid patients.⁴⁵ About five out of six physicians who stopped accepting Medicaid patients in 2004–2005 cited inadequate reimbursement as an important reason for their decision.⁴⁶ Most doctors can avoid treating Medicaid recipients because reimbursements for Medicaid patients represent only a marginal percentage of a physician's overall income.⁴⁷ The low reimbursement rates exacerbate the additional reasons why healthcare providers do not treat Medicaid recipients, such as Medicaid's complicated billing requirements, the increased cancellations often associated with Medicaid recipients, and the chronic health problems that poverty often causes.⁴⁸

Low provider reimbursement rates will continue to be a vital issue due to the steadily rising cost of healthcare in the United States.⁴⁹ In 2005, the federal government spent \$177.6 billion on the Medicaid program, while states spent

(defining healthcare provider as any "person or organization who furnishes, bills, or is paid for health care in the normal course of business").

⁴² PETER CUNNINGHAM & JESSICA MAY, CTR. FOR STUDYING HEALTH SYS. CHANGE, MEDICAID PATIENTS INCREASINGLY CONCENTRATED AMONG PHYSICIANS 1 (2006), available at <http://www.hschange.com/CONTENT/866/866.pdf>. This study found that from 2004–2005, 35.3% of physicians in solo- and two-physician practices were unavailable to provide services to new Medicaid patients. *Id.* at 2.

⁴³ *Id.* at 4. In 2003, Medicaid reimbursement rates were only 69% of Medicare reimbursement rates. *Id.* Medicare is a federal healthcare program that covers the elderly and certain disabled individuals. FURROW ET AL., *supra* note 22, at 734.

⁴⁴ For example, Georgia hospitals lost money each time they treated Medicaid patients in 2005 because they received only 80% of outpatient costs and 95% of inpatient costs. GA. HOSP. ASS'N, 2008 LEGISLATIVE AGENDA 1 (2008), <http://www.gha.org/publications/public/other/2008Agenda.pdf>. Colorado pediatricians reported that they lose \$20 to \$30 every time they treat a Medicaid recipient. THE BELL POLICY CTR., BLUEPRINT FOR OPPORTUNITY IMPLEMENTATION MEMO 2 (2007), <http://www.thebell.org/PUBS/annual/2006/ImpMemo/M16A-Eligibility.pdf> [hereinafter BELL POLICY CENTER].

⁴⁵ CUNNINGHAM & MAY, *supra* note 42, at 1. This study found that the number of physicians refusing to accept new Medicaid patients increased from 19.4% to 20.9% between 1996–1997 and 2004–2005. *Id.* This percentage increase was even higher for solo practitioners and physicians practicing with a single partner, with 35.3% of these providers no longer accepting Medicaid recipients in 2004–2005. *Id.* at 2.

⁴⁶ *Id.* at 3.

⁴⁷ Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 193 (1995).

⁴⁸ See CUNNINGHAM & MAY, *supra* note 42, at 3 (citing administrative filing difficulties and high clinical burden as reasons why physicians will not treat Medicaid patients).

⁴⁹ U.S. healthcare spending increased 6.7% in 2006. CTRS. FOR MEDICAID & MEDICARE SERVS., NATIONAL HEALTH EXPENDITURE ACCOUNTS: 2006 HIGHLIGHTS 1 (2006), <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/highlights.pdf>.

\$133.8 billion on Medicaid.⁵⁰ Recently, the federal matching rate has declined, and states have been forced to increase spending and allocate additional state funds.⁵¹ Due to the substantial amount of money states put into their Medicaid program, more and more states are reducing provider payments as a cost-saving strategy.⁵² State governments commonly freeze reimbursement rates for an extended period of time to lower costs.⁵³ Another increasingly common state response to the fiscal burden of Medicaid has been the use of managed care organizations to reduce the cost of providing healthcare to Medicaid recipients.⁵⁴ However, the use of managed care organizations has not completely alleviated the problem of low reimbursement rates to healthcare providers.⁵⁵

Low provider participation in the Medicaid program results in Medicaid recipients experiencing extended delays in receiving nonemergency treatment.⁵⁶ The limited number of physicians available in inner cities,

⁵⁰ CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTHCARE EXPENDITURE DATA tbl.3 (2006), <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

⁵¹ See KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID FACTS 1 (2007), <http://www.kff.org/medicaid/upload/7580-02.pdf> (explaining that the state share of spending increased by 3.2% in 2007, and is expected to increase by 7.8% in 2008).

⁵² See *The Medicaid Dilemma: Shrinking Budgets, Difficult Choices*, TREND WATCH (Am. Hosp. Ass'n, Washington, D.C.), June 2003, at 4, <http://www.hospitalconnect.com/ahapolicyforum/trendwatch/content/tw2003vol5no2pt1.pdf> [hereinafter HOSPITAL TREND WATCH] (finding that thirty-seven states reduced provider payments in 2003). In 2008, state Medicaid officials suggested that budget shortfalls may make targeted or across-the-board Medicaid program cuts by the end of the year. VERNON K. SMITH ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, CURRENT ISSUES IN MEDICAID: A MID-FY 2008 UPDATE 3 (2008), <http://www.kff.org/medicaid/upload/7741.pdf>.

⁵³ See AIDS DAY SERV. ASS'N, THE CASE FOR A MEDICAID REIMBURSEMENT INCREASE FOR NEW YORK'S AIDS ADULT DAY HEALTH CARE PROVIDERS 2 (2005), <http://www.adsa.net/Docs/request.pdf> (discussing how the reimbursement rates to AIDS patients in New York have been frozen from 1996 to 2005); Jeff Bell, *Medicaid Reimbursement Takes Center Stage Again*, BUS. FIRST (Columbus), Dec. 31, 2004, at A1 (revealing that hospitals have been losing money because Medicaid reimbursement rates to hospitals had been frozen for two years).

⁵⁴ Mary E. Stuart & Michael Weinrich, *Beyond Managing Medicaid Costs: Restructuring Care*, 76 MILBANK Q. 251, 251 (1998). A managed care organization is an organization that finances medical care and delivers medical services while attempting to control the cost of healthcare services. FURROW ET AL., *supra* note 22, at 567-69. Of the total Medicaid enrollment in 2004, nearly 60% are receiving Medicaid benefits through managed care. U.S. Dep't of Health & Human Services, Ctrs. for Medicare & Medicaid Services, Medicaid Managed Care Overview (Oct. 9, 2008), <http://www.cms.hhs.gov/MedicaidManagCare/>.

⁵⁵ Under Colorado's Medicaid managed care, providers have consistently received reimbursement rates well below current market rates. BELL POLICY CENTER, *supra* note 44, at 2. Even when states utilize managed care organizations, the state still sets the Medicaid reimbursement rates paid to healthcare providers. *Id.* Therefore, this Comment does not differentiate between states using managed care for Medicaid recipients and those still using a fee-for-service system, because in both cases the reimbursement rates are set by the state.

⁵⁶ For example, the lack of dentists participating in the Medicaid program in Massachusetts forced pediatric Medicaid recipients to wait from one-and-a-half months to a year to be examined by a dentist. See,

generally home to the highest concentrations of Medicaid recipients, further inhibits Medicaid patients' access to medical services.⁵⁷ The lack of provider participation due to low reimbursement rates caused one commentator to conclude that "Medicaid has failed in its mission to care for the poor because doctors refuse to participate in the program."⁵⁸ The dilemma of low reimbursement rates and lack of provider participation is likely to continue unless Medicaid recipients can enforce their rights to equal access by ensuring that states provide adequate reimbursement to healthcare providers who treat Medicaid recipients.⁵⁹

D. Enforcing Federal Statutory Rights Under § 1983

This section explores the guidelines established by the Supreme Court for enforcing a statutory right through a § 1983 suit. The Medicaid statute does not set forth specific administrative procedures for Medicaid recipients to enforce the equal access clause; therefore, an additional legal avenue must be employed for the clause to be enforced.⁶⁰ Section 1983 enables a private action against a state official to vindicate constitutional and federal statutory rights enforceable by a plaintiff.⁶¹ To seek redress through § 1983, a plaintiff must assert a violation of an individual federal right, and not merely a violation of federal law.⁶² In *Blessing v. Freestone*, the Supreme Court set forth three factors to guide courts in determining whether a particular statutory provision

e.g., *Health Care for All, Inc. v. Romney*, No. Civ.A. 00-10833RWZ, 2005 WL 1660677 (D. Mass. July 14, 2005); *see also* Peter J. Cunningham & Len M. Nichols, *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*, 62 *MED. CARE RES. & REV.* 676, 693-94 (2005) (finding that high fee levels increase the probability that individual physicians will accept Medicaid patients, but also concluding that a broad range of factors need to be considered to obtain increased access to physicians for Medicaid enrollees).

⁵⁷ Janet B. Mitchell, *Physician Participation in Medicaid Revisited*, 29 *MED. CARE* 645, 649 (1991).

⁵⁸ Watson, *supra* note 47, at 191.

⁵⁹ A 2008 study found that state Medicaid directors expressed great concern over the lack of healthcare providers for Medicaid enrollees, particularly the lack of dental healthcare providers. SMITH ET AL., *supra* note 52, at 8-9.

⁶⁰ *See Clark v. Richman*, 339 F. Supp. 2d 631, 639 (M.D. Pa. 2004) (finding that the absence of an administrative mechanism to enforce this language indicates the intent to permit private enforcement of the provision).

⁶¹ 42 U.S.C. § 1983 (2006). The language of § 1983 has been interpreted by the Supreme Court to encompass the violations of all federal laws and not to limit suits to violations of the Constitution or statutes intended to enforce the Fourteenth Amendment. *Maine v. Thiboutot*, 448 U.S. 1, 4 (1980); *see also* *Edelman v. Jordan*, 415 U.S. 651 (1974) (reasoning that while a state official may be sued, states themselves are immune from damages under the Eleventh Amendment).

⁶² *Golden State Transit Corp. v. Los Angeles*, 493 U.S. 103, 106 (1989).

gives rise to a federal right.⁶³ First, Congress must have intended that the provision in question benefit the plaintiff.⁶⁴ Second, the plaintiff must demonstrate that the right asserted is not so vague and amorphous that its enforcement would strain judicial competence.⁶⁵ Third, the statute must unambiguously impose a binding obligation on the states, in mandatory rather than precatory terms.⁶⁶

Due to circuit and district court confusion about what statutory rights were enforceable through a § 1983 action,⁶⁷ the Supreme Court, in *Gonzaga University v. Doe*, attempted to clarify the first prong of the *Blessing* test.⁶⁸ The *Gonzaga* Court held that anything short of an unambiguously conferred right by Congress does not support an individual right of action under § 1983.⁶⁹ The statutory language must clearly demonstrate congressional intent to benefit the plaintiff individually, and may not focus solely on the aggregate practices or policies of a regulated entity.⁷⁰ The Court provided Title VI of the Civil Rights Act of 1964 and Title IX of the Education Act Amendments as examples of statutes using “rights creating” language.⁷¹ The Court’s holding, implementing a stricter standard for enforceable rights under § 1983, has resulted in several courts’ questioning whether § 1983 cases decided before the 2002 holding of *Gonzaga* are still valid as precedent.⁷² The

⁶³ *Blessing v. Freestone*, 520 U.S. 329, 340 (1997) (rejecting the § 1983 claim of five mothers whose children were eligible to receive child support services from the State of Arizona pursuant to Title IV-D of the Social Security Act).

⁶⁴ *Id.*

⁶⁵ *Id.* at 340–41.

⁶⁶ *Id.* at 341.

⁶⁷ *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282–83 (2002). The question presented in this case was whether a student may sue a private university for damages under § 1983 to enforce provisions of the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g (2006), which prohibits the federal funding of educational institutions that have a policy or practice of releasing education records to unauthorized persons. *Id.* at 276.

⁶⁸ *Gonzaga*, 536 U.S. at 283.

⁶⁹ *Id.*

⁷⁰ *Id.* at 284, 288. The *Gonzaga* Court rejected the notion that a cause of action may be inferred “so long as the plaintiff falls within the general zone of interest that the statute is intended to protect.” *Id.* at 283.

⁷¹ *Id.* at 284, 287. Title VI provides that “[n]o person in the United States shall, on the ground of race, color, or national origin, be . . . subjected to discrimination under any program or activity receiving federal assistance.” 42 U.S.C. § 2000d (2006). Title IX provides that “[n]o person in the United States shall, on the basis of sex, . . . be subjected to discrimination . . .” 20 U.S.C. § 1681(a) (2006).

⁷² *E.g.*, *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004) (finding that the stricter standard set forth by the Court in *Gonzaga* forces the court to reexamine *Visiting Nurse Ass’n of North Shore v. Bullen*, 93 F.3d 997, 1003–05 (1st Cir. 1996) (holding, prior to the *Gonzaga* decision, that providers could enforce the equal access clause), *cert. denied*, 519 U.S. 1114 (2000)). *But see* *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332, at *7–8 (N.D. Ill. Aug. 23, 2004) (finding that the

flexibility and confusion that has resulted from the *Gonzaga* test are further explored in Part II.⁷³

II. PRE-GONZAGA SUPREME COURT DECISION AND THE CIRCUIT SPLIT

While the Supreme Court has not yet ruled whether a Medicaid recipient has an individualized federal right under the equal access clause to bring a § 1983 lawsuit,⁷⁴ a significant number of judicial opinions relevant to this inquiry exist.⁷⁵ This Part first explores a pre-*Gonzaga* Supreme Court decision involving a statute similar to the equal access clause.⁷⁶ Then, it analyzes the reasoning used in post-*Gonzaga* federal court opinions both allowing and disallowing an enforceable equal access right for Medicaid recipients, as well as the relevance of cases decided in 2007.⁷⁷ This Part concludes that the variety of reasoning expressed in the judicial opinions displays the lower courts' confusion in applying the *Gonzaga* test to equal access § 1983 claims, thus requiring Supreme Court clarification.⁷⁸

A. Wilder and the Boren Amendment

In *Wilder v. Virginia Hospital Ass'n*,⁷⁹ the Supreme Court confronted the question whether the Boren Amendment, a statute similar to the equal access clause,⁸⁰ was enforceable through a § 1983 suit.⁸¹ In *Wilder*, the Court considered whether the now-repealed Boren Amendment conferred enforceable rights on medical providers.⁸² The Court held that medical

pre-*Gonzaga* decision *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 512 (1990), *superseded on other grounds by statute as discussed in Memisovski*, 2004 WL 1878332, at *7 n.7, was still good law).

⁷³ See *infra* Part II.B–C.

⁷⁴ See, e.g., *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 703–04 (5th Cir. 2007).

⁷⁵ See *infra* Part II.A–C.

⁷⁶ See *infra* Part II.A.

⁷⁷ See *infra* Part II.B.

⁷⁸ See *infra* Part II.C.

⁷⁹ 496 U.S. 498 (1990).

⁸⁰ The Boren Amendment required states to pay providers rates that “the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services.” 42 U.S.C. § 1396a(a)(13)(A) (1994). The Boren Amendment is similar to the equal access clause because both employ similar language and both focus on mandatory obligations that a state plan must meet. See *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 184 (3d Cir. 2004). The Boren Amendment was repealed by Congress in 1997. See *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332, at *7 n.7 (N.D. Ill. Aug. 23, 2004).

⁸¹ *Wilder*, 496 U.S. 498.

⁸² *Id.* at 501–02.

providers could enforce their rights under the statute because the Boren Amendment was worded in mandatory rather than precatory terms and because the receipt of federal funds was expressly conditioned on compliance with the amendment.⁸³

Although *Gonzaga*, twelve years later, instituted a standard for finding enforceable rights under federal statutes that is stricter than the standard evident in *Wilder*, *Gonzaga* does not purport to overrule *Wilder*.⁸⁴ The *Gonzaga* Court reasoned that the Boren Amendment was previously found to create an enforceable right because the provision required states to pay a “monetary entitlement to individual health care providers, with no sufficient administrative means of enforcing the requirement against States that failed to comply.”⁸⁵ Several courts that examined whether the equal access clause creates enforceable rights have held *Wilder* to still be good law.⁸⁶ However, the Court in *Wilder* held that an enforceable right was created for Medicaid providers and did not address whether a right was created for Medicaid recipients.⁸⁷ Additionally, legislative history suggests that by repealing the Boren Amendment, Congress intended to prevent healthcare providers from bringing suits based on a state’s low Medicaid reimbursement rates.⁸⁸

B. *The Judicial Split*

The decisions of the lower U.S. federal courts have demonstrated a split over whether the equal access clause confers an enforceable right on Medicaid recipients.⁸⁹ Lower courts’ confusion and conflicting holdings are due to the subjective nature of the enforceable rights test developed by the Supreme

⁸³ *Id.* at 512.

⁸⁴ *E.g.*, *Pediatric Specialty Care v. Ark. Dep’t of Human Servs.*, 443 F.3d 1005, 1015 (8th Cir. 2006), *vacated in part by Selig v. Pediatric Specialty Care*, 127 S. Ct. 3000 (2007); *Sabree*, 367 F.3d at 184 (citing *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002)).

⁸⁵ *Gonzaga*, 536 U.S. at 280–81 (citing *Wilder*, 496 U.S. at 522–23).

⁸⁶ *E.g.*, *Pediatric Specialty Care*, 443 F.3d at 1015; *Sabree*, 367 F.3d at 184 (citing *Gonzaga*, 536 U.S. at 283).

⁸⁷ *Wilder*, 496 U.S. at 524.

⁸⁸ H.R. REP. NO. 105-149, at 591 (1997) (“It is the Committee’s intention that, following enactment of this Act, neither this nor any other provision of [42 U.S.C. § 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.”).

⁸⁹ *See infra* Part II.B.1–2. However, the majority of circuit courts facing the issue of whether the equal access clause creates enforceable rights for Medicaid recipients decided after *Gonzaga* have held that no such right exists. *See Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007) (noting that the Tenth, Sixth, and Ninth Circuits came to the same conclusion as it did—prohibiting Medicaid recipients from suing to enforce the equal access clause). *But see Pediatric Specialty Care*, 443 F.3d at 1016 (holding that recipients and providers can sue to enforce the equal access clause).

Court in *Gonzaga* and *Blessing*.⁹⁰ An examination of recent cases might suggest a judicial trend toward denying an enforceable equal access right.⁹¹ However, a more thorough investigation reveals that several of these recent decisions have occurred in circuits that had previously held that the equal access clause does not create an enforceable right for Medicaid recipients.⁹² Therefore, the recent cases do not necessarily indicate a trend within the judiciary away from allowing Medicaid recipients to enforce their equal access rights through a § 1983 suit.

1. Circuits that Have Ruled that the Equal Access Clause Creates an Enforceable Right for Medicaid Recipients

Within the Third, Seventh, Eighth, and Eleventh Circuits, there are circuit court or district court decisions holding that Medicaid recipients can sue to enforce the equal access clause.⁹³

Since the Supreme Court's ruling in *Gonzaga*, the Eighth Circuit, in *Pediatric Specialty Care v. Arkansas Department of Human Services*, is the only court of appeals that has held that the equal access clause creates an enforceable right for Medicaid recipients.⁹⁴ *Pediatric Specialty Care* was brought by service providers and parents of three recipients of the Arkansas Medicaid plan in order to enjoin proposed budget cutbacks, which the plaintiffs argued would deny them equal access to healthcare services.⁹⁵ The court first addressed the defendants' argument that *Gonzaga* requires the court to overrule previous decisions holding the equal access clause to be an

⁹⁰ See *infra* Part II.B.1–2. This Comment focuses primarily on cases that discuss the rights of Medicaid recipients, not Medicaid providers. For an analysis of case law discussing whether the equal access clause provides an enforceable right for providers, see Abigail R. Moncrieff, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673 (2006).

⁹¹ See *infra* Part II.B.3.

⁹² See *infra* Part II.B.3.

⁹³ E.g., Pa. Pharmacists Ass'n v. Houstoun, 283 F.3d 531, 543–44 (3rd Cir. 2002) (en banc); *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332, at *8 (N.D. Ill. Aug. 23, 2004); *Clark v. Richman*, 339 F. Supp. 2d 631, 639–40 (M.D. Pa. 2004); *Pediatric Specialty Care*, 443 F.3d at 1016; *Fla. Pediatric Soc'y v. Levine*, 05-23037-CIV-JORDAN (S.D. Fla. Jan. 11, 2007), available at <http://www.pilcop.org/Florida%20Order-%20Motion%20to%20Dismiss.pdf> (denying motion to dismiss Medicaid recipient's "equal access" claim because the provision creates an enforceable right).

⁹⁴ *Hawkins*, 509 F.3d at 704 (listing *Pediatric Specialty Care* as the only circuit court case to rule in favor of creating an enforceable right since *Gonzaga*).

⁹⁵ *Pediatric Specialty Care*, 443 F.3d at 1008–09. The plaintiffs also alleged that the cutbacks would violate their federal right to early and periodic screening, diagnosis, and treatment (EPSDT) services under federal Medicaid law. *Id.* at 1008.

enforceable right for Medicaid recipients.⁹⁶ Using the *Gonzaga* framework, the court found that the equal access clause is intended to benefit Medicaid recipients.⁹⁷ The court further held that the statute was designed to ensure that state reimbursements “are not too high, but yet high enough to secure the participation of enough clinics so that needy children receive equal access to quality health care.”⁹⁸

The remaining district court decisions and pre-*Gonzaga* circuit court decisions upholding the right of Medicaid recipients to bring suit under the equal access clause can be characterized by the presence of at least one of five reasons justifying the holding. The first line of reasoning is that the statute is phrased in terms that benefit recipients because its language directly focuses on Medicaid recipients’ access to medical care.⁹⁹ The language requiring a state plan to make care and services available at least to the extent they are available to insured individuals suggests that it is the Medicaid recipients’ health access which is at issue.¹⁰⁰

A second prevalent argument used to strengthen the theory that Medicaid recipients are the intended beneficiaries is that § 1320a-2 of the Medicaid Act demonstrates congressional intent to make the rights of recipients under the Medicaid statute enforceable.¹⁰¹ This argument suggests that § 1320a-2, which states that a provision “is not [to be] deemed unenforceable because of its

⁹⁶ *Id.* at 1014. The defendants in this case were the Arkansas Department of Human Services and several of its employees. *Id.* at 1006.

⁹⁷ *Id.* at 1015. The court acknowledged that “the federal government is charged with responsibility for supervising a state’s participation in the Medicaid program, a factor that *Gonzaga* normally holds indicative of no private right being created.” *Id.* However, the court reasoned that because the statute indicates both the scope of the provision and the intended beneficiary, the statute is enforceable. *Id.*

⁹⁸ *Id.* at 1015–16.

⁹⁹ *E.g.*, *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908, 927 (5th Cir. 2000), *abrogation on other grounds recognized by* *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007). Despite finding the right enforceable, the court ruled that the plaintiffs could not proceed with the equal access claim because they failed to present sufficient evidence that they would not receive equal access to medical services compared to non-Medicaid recipients. *Id.* at 933; *Ark. Med. Soc’y v. Reynolds*, 6 F.3d 519, 526 (8th Cir. 1993) (“The equal access provision is indisputably intended to benefit the recipients by allowing them equivalent access to health care services.”); *Visiting Nurse Ass’n of N. Shore v. Bullen*, 93 F.3d 997, 1004 n.7 (1st Cir. 1996) (acknowledging that Medicaid recipients “are intended beneficiaries under the ‘equal access’ requirement as it affects the availability of their medical care”).

¹⁰⁰ *Evergreen*, 235 F.3d at 931–32 (finding that providers were not the intended beneficiaries because the focus of the statute is on the recipients’ access to healthcare). The suit was brought by Medicaid beneficiaries who were seeking to prevent a proposed 7% across-the-board reduction of Medicaid reimbursement rates paid to private healthcare providers. *Id.* at 914.

¹⁰¹ *E.g.*, *Clark v. Richman*, 339 F. Supp. 2d 631, 639 (M.D. Pa. 2004). In this case, the plaintiffs alleged that they were denied access to dental services due to the low reimbursement rates set by the state. *Id.* at 634.

inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan,” is strong evidence that the equal access clause is enforceable.¹⁰² Therefore, the § 1320a-2 argument suggests that the defendants in equal access cases may not be able to rely on the provision’s “a state plan must” language to support a claim that there is no intended beneficiary.¹⁰³

The third argument supporting equal access enforceability is that the clause uses mandatory language, thus satisfying the third prong of the *Gonzaga/Blessing* test.¹⁰⁴ Section 1396a reads, “A state plan for medical assistance must—”; and then sets forth various requirements for state plans.¹⁰⁵ Courts have reasoned that Congress’s purpose in including the word “must” was to create a binding obligation on the states.¹⁰⁶ Several courts have commented on the similarity of the “A State plan . . . must” language to the “no person shall” language that the Supreme Court said created a binding obligation in *Blessing*.¹⁰⁷ Courts have also deemed the language mandatory because the equal access requirement “is not phrased in indirect terms ‘such as requiring a general policy or requiring substantial compliance.’”¹⁰⁸

A third common line of reasoning found in case law proposes that the absence of an administrative mechanism to enforce the statute suggests an intention by Congress to allow private enforcement of the equal access clause.¹⁰⁹ In *Gonzaga*, the Supreme Court held that the presence of an explicit enforcement mechanism weighs against finding an individually enforceable

¹⁰² *Id.* at 639 (quoting 42 U.S.C. § 1320a-2 (2007)); *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332, at *6–7 (N.D. Ill. Aug. 23, 2004).

¹⁰³ See *Memisovski*, 2004 WL 1878332, at *6. For a more detailed explanation of the relevance that § 1329a-2 has on equal access clause cases, see *infra* notes 153–58 and accompanying text.

¹⁰⁴ See *infra* notes 106–07 and accompanying text. The third prong of the *Blessing* test requires a statute to impose a binding obligation on the states, in mandatory rather than precatory terms. *Blessing v. Freestone*, 520 U.S. 329, 341 (1997).

¹⁰⁵ 42 U.S.C. § 1396a(a) (2006).

¹⁰⁶ See, e.g., *Evergreen*, 235 F.3d at 931.

¹⁰⁷ E.g., *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir. 2004) (finding 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”); *Memisovski*, 2004 WL 1878332, at *8 (suggesting that mandatory language connotes an intent to permit private enforcement of provision).

¹⁰⁸ *Memisovski*, 2004 WL 1878332, at *7 (quoting *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1122 (E.D. Cal. 2003)).

¹⁰⁹ E.g., *Clark v. Richman*, 339 F. Supp. 2d 631, 639 (M.D. Pa. 2004); *Clayworth*, 295 F. Supp. 2d at 1123 (finding that unlike the statute in *Gonzaga*, California’s Medicaid program did not provide for an administrative procedure to which beneficiaries could resort in seeking quality of care or equal access).

private right.¹¹⁰ Because there is no administrative remedy for Medicaid recipients who have been denied access to health services because reimbursement rates for healthcare providers are too low, some courts have assumed that Congress intended § 1983 suits to be available.¹¹¹

A final common holding in equal access judicial decisions suggests that the structure of § 1396a prevents Congress from using the exact types of rights-creating language of which the *Gonzaga* Court provided examples.¹¹² Section 1396a is structured in a way that lists dozens of requirements that a state plan must meet, all of which are preceded by the clause, “A State plan for medical assistance must”¹¹³ This structure makes it difficult for Congress to include rights-creating language that the Supreme Court has specifically accepted as satisfying the first prong of the *Gonzaga/Blessing* test, such as “no person shall.”¹¹⁴

2. *Circuits that Have Held that the Equal Access Clause Does Not Create an Enforceable Right for Medicaid Recipients*

The Fifth, Sixth, Ninth, and Tenth Circuits have all held that the equal access clause does not create an enforceable right for Medicaid recipients.¹¹⁵ Additionally, a First Circuit opinion has also strongly suggested in dicta that Medicaid recipients cannot enforce the equal access clause.¹¹⁶

The opinions denying Medicaid recipients the right to enforce the equal access clause rely on four central reasons. The first and most prevalent line of reasoning suggests that the equal access clause has an aggregate, rather than an individual focus.¹¹⁷ Courts reaching this conclusion reason that the statute

¹¹⁰ *Gonzaga Univ. v. Doe*, 536 U.S. 273, 289–90 (2002).

¹¹¹ *Clark*, 339 F. Supp. 2d at 639.

¹¹² *Memisovski*, 2004 WL 1878332, at *7 (quoting *Clayworth*, 295 F. Supp. 2d at 1122). In *Memisovski*, the plaintiffs alleged that a reimbursement cut, the State of Illinois’s schedule for reimbursement of healthcare providers, and the lengthy payment cycle were denying their children equal access to medical services. *Id.* at *1, *11–*13.

¹¹³ See 42 U.S.C. § 1396a(a) (2006).

¹¹⁴ *Memisovski*, 2004 WL 1878332, at *7.

¹¹⁵ See *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1060 (9th Cir. 2005).

¹¹⁶ *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57 (1st Cir. 2004).

¹¹⁷ *E.g.*, *Westside Mothers*, 454 F.3d at 542 (finding that the focus of the equal access clause is “on ‘the aggregate services provided by the State,’ rather than ‘the needs of any particular person’” (quoting *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282 (2002))); *Sanchez*, 416 F.3d at 1059 (noting the aggregate focus of the statute); *Mandy R.*, 464 F.3d at 1148 (same).

refers not to individual benefits, but rather to a state's obligation to develop methods and procedures.¹¹⁸ According to judicial opinions utilizing this argument, the equal access clause does not identify a discrete class of beneficiaries and only refers to recipients in the "aggregate, as members of 'the general population in the geographic area.'"¹¹⁹ The lack of individual entitlement means that the statute fails the first prong of the *Gonzaga/Blessing* test, which requires that anything short of an unambiguously conferred right does not support enforcement under § 1983.¹²⁰

A second common reason in the cases denying a § 1983 equal access right is that the statute's language is ill-suited for a judicial remedy.¹²¹ One court reasoned that the provision sets forth only general objectives such as "efficiency, economy, and quality of care," which are ill-suited for a judicial remedy and "would involve making policy decisions for which th[e] court has little expertise."¹²² These objectives are held to be broad and nonspecific descriptions that do not relate to definite services.¹²³ Courts also note the difficulty judges would have trying to balance the potential tensions between the statutory objectives of "quality" care and "efficient and economical" medical care.¹²⁴ A provision that is ill-suited for a judicial remedy fails the second prong of the *Gonzaga/Blessing* test, and is therefore unenforceable through a § 1983 suit.¹²⁵

¹¹⁸ *Westside Mothers*, 454 F.3d at 542 (stating that the equal access clause has an aggregate focus because it speaks "not of individual benefits, but rather of the State's obligation to develop 'methods and procedures'"); *Sanchez*, 416 F.3d at 1059 (concluding that a clear congressional intent to create a private action is not reflected when the statute only refers to the individual in the context of describing the necessity of developing statewide policies and procedures); *Long Term Care Pharmacy Alliance*, 362 F.3d at 57 (suggesting that the statute does not suggest an intent to confer rights on a particular class of persons, or at least not to providers).

¹¹⁹ *Sanchez*, 416 F.3d at 1059 (quoting 42 U.S.C. § 1396a(a)(30)(A)); *Mandy R.*, 464 F.3d at 1148 (same).

¹²⁰ See *Gonzaga*, 536 U.S. at 283; *Westside Mothers*, 454 F.3d at 542 (finding that the equal access clause fails the standard set forth by the Court in *Gonzaga*).

¹²¹ E.g., *Westside Mothers*, 454 F.3d at 543 (stating that a judicial remedy is poorly suited for statutory provisions with broad and nonspecific language).

¹²² *Id.* at 543 (citing *Sanchez*, 416 F.3d at 1060).

¹²³ *Id.* (finding that the language is broad and nonspecific and that the provision is not confined to particular services).

¹²⁴ *Sanchez*, 416 F.3d at 1059–60 (reasoning that that "[t]he most efficient and economical system of providing care may be one that benefits taxpayers to the detriment of medical providers and recipients" and that quality of care may conflict with such a system); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 58 (1st Cir. 2004) (finding the objectives to be generally and potentially in tension).

¹²⁵ *Blessing v. Freestone*, 520 U.S. 329, 340–41 (1997) (requiring the plaintiff to demonstrate that the right asserted is not so vague and amorphous that its enforcement would strain judicial competence). This Comment proposes that those courts that have found the equal access clause to be ill-suited for a judicial remedy are using flawed reasoning. See *infra* notes 160–64 and accompanying text.

A third argument advanced by courts that deny an enforceable right for Medicaid recipients is that the central means of enforcement of the equal access clause is plan review by the Secretary and regional administrators.¹²⁶ This reasoning is based on the belief that the equal access clause is only relevant to the state and the Secretary when a state Medicaid plan is adopted and approved.¹²⁷ The Court in *Gonzaga* found that the presence of an administrative enforcement mechanism weighs against enforceability under § 1983.¹²⁸ The generality of the statute, according to one court, is evidence that Congress intended the Secretary's review to be the "central means of enforcement" against a state.¹²⁹

A final counterargument used by courts is that simply because Medicaid recipients benefit from the equal access clause does not mean that they have a right to enforce it.¹³⁰ This argument seems to be a direct rebuttal to the pre-*Gonzaga* courts that found an enforceable right due to the statute clearly benefiting Medicaid recipients.¹³¹ One court reasoned that while recipients may benefit from the efficient care requirement of the statute, so do all taxpayers because of the lower costs of more efficient administration.¹³² The court found the only relevant factor to be not who benefits from the statute but whether the statute creates "an 'identifiable class' of rights-holders."¹³³

3. *Recent Equal Access Decisions*

All three equal access cases decided by circuit courts in 2007 ruled against recognizing an enforceable right for Medicaid recipients.¹³⁴ The holdings in these cases could be read as a circuit court trend toward a rejection of a Medicaid recipient's enforceable right to equal access of medical services.

¹²⁶ *Long Term Care Pharmacy*, 362 F.3d at 58. The Secretary and regional administrators can enforce compliance with the Medicaid Act by disapproving a state plan, 42 C.F.R. § 430.15 (2006), or by cutting off funds to a state. 42 U.S.C. § 1396c (2006); 42 C.F.R. § 430.35.

¹²⁷ *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 703 (5th Cir. 2007).

¹²⁸ *Gonzaga Univ. v. Doe*, 536 U.S. 273, 289–90 (2002).

¹²⁹ *Long Term Care Pharmacy*, 362 F.3d at 58.

¹³⁰ For examples of circuit court cases using this argument, see *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1148 (10th Cir. 2006); *Westside Mothers v. Olszewski*, 454 F.3d 532, 543 (6th Cir. 2006).

¹³¹ Judicial opinions arguing that the statute clearly benefits Medicaid recipients are analyzed *supra* notes 99–100.

¹³² *Mandy R.*, 464 F.3d at 1148.

¹³³ *Id.* (citing *Gonzaga*, 536 U.S. at 283–84).

¹³⁴ *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 703–04 (5th Cir. 2007); *Ball v. Rodgers*, 492 F.3d 1094, 1102 (9th Cir. 2007); *Okla. Chapter of the Am. Acad. of Pediatrics (OKAAP) v. Fogarty*, 472 F.3d 1208, 1215 (10th Cir. 2007).

However, a closer examination reveals that only one case overruled a previous decision that recognized an enforceable right for Medicaid recipients.¹³⁵ Additionally, these cases demonstrate that the lack of provider participation in the Medicaid program due to low reimbursement rates continues to affect Medicaid recipients negatively due to the number of suits still being brought on their behalf.

Prior to the Supreme Court's ruling in *Gonzaga*, the Fifth Circuit held, in *Evergreen Presbyterian Ministries v. Hood*, that Medicaid beneficiaries had an enforceable right in the equal access clause.¹³⁶ However, in December of 2007, the Fifth Circuit overruled this previous holding in *Equal Access for El Paso v. Hawkins*.¹³⁷ The plaintiffs in *Hawkins* consisted of Medicaid recipients who alleged that the Texas set deficient Medicaid reimbursement and capitation rates, resulting in inadequate access to medical services for Medicaid recipients compared to individuals covered by private insurance.¹³⁸ The court held that the equal access clause does not confer on individuals private rights enforceable through § 1983.¹³⁹ The court reasoned that the provision's language does not demonstrate the requisite congressional intent for individual rights because the provision only speaks to the state and the Secretary in their functions of proposing and approving a state plan.¹⁴⁰ According to the opinion, *Gonzaga* disallows the essential inference from *Evergreen* that Congress meant to enforce the provision in private suits because of the overall purpose of the Medicaid Act.¹⁴¹ The court concluded that the equal access clause only "invests the Secretary with the exclusive power and duty of carrying [a state plan] into effect."¹⁴²

¹³⁵ *Hawkins*, 509 F.3d at 704 (overruling *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908 (5th Cir. 2000)).

¹³⁶ *Evergreen*, 235 F.3d at 931.

¹³⁷ *Hawkins*, 509 F.3d at 704.

¹³⁸ *Id.* at 700–01. The plaintiffs argued that "inadequate reimbursement and capitation rates, . . . combined with the relatively high percentage of Medicaid recipients in the El Paso area," created incentives for physicians either to relocate or seek out patients covered by employer-sponsored insurance. *Id.* at 701.

¹³⁹ *Id.* at 703–04.

¹⁴⁰ *Id.* at 703. The court also found that the equal access clause speaks only in terms of institutional policy and practice, further supporting an aggregate, as opposed to an individual, focus. *Id.*

¹⁴¹ *Id.* at 704. The essential inference in *Evergreen* was the following: "[B]ecause Congress's aim in the Medicaid Act was to protect the interests of health care recipients as its primary, ultimate beneficiaries, Congress necessarily meant for recipients to enforce the Equal Access provision in private suits . . ." *Id.*

¹⁴² *Id.*

The two remaining circuit court equal access cases decided in 2007 relied on precedent when they disallowed an equal access claim. In *Ball v. Rodgers*, the Ninth Circuit Court of Appeals dismissed the equal access claim without discussion because it had previously decided in *Sanchez v. Johnson* that the equal access clause does not provide enforceable rights through § 1983.¹⁴³ The Tenth Circuit Court of Appeals in *Oklahoma Chapter of the American Academy of Pediatrics (OKAAP) v. Fogarty* similarly held that the equal access clause was not enforceable due to its recent decision in *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*.¹⁴⁴

Consequently, *Ball* and *OKAAP* offer no insight into a possible judicial shift against enforcing the equal access clause. Both were decided in circuits that have consistently held that the clause is not enforceable for Medicaid recipients, and both offered little explanation for their holdings.¹⁴⁵ While *Hawkins* does demonstrate the potential effect that *Gonzaga* could have on a circuit court that has previously allowed equal access suits, the case should not be read broadly as a judicial trend away from allowing private enforcement of the equal access clause. The arguments used in *Hawkins* are not the result of new legislation or case law; rather, they are the same arguments that have traditionally been used in ruling that the equal access clause is not enforceable.¹⁴⁶ Although the test from *Gonzaga* certainly has the potential to cause some courts to reinterpret a prior holding allowing recipients to enforce the equal access clause, the Eighth Circuit's holding in *Pediatric Specialty Care* and numerous district court holdings have concluded that *Gonzaga* does not foreclose the enforceability of the equal access clause in § 1983 suits.¹⁴⁷ Therefore, until other circuit courts overturn prior case law in favor of equal

¹⁴³ *Ball v. Rodgers*, 492 F.3d 1094, 1102 (9th Cir. 2007) (reasoning that the equal access clause does not confer individual rights because the provision only refers to Medicaid recipients in the aggregate (citing *Sanchez v. Johnson*, 416 F.3d 1051, 1060 (9th Cir. 2005))). The plaintiffs in that case were a class of elderly, physically disabled, and developmentally disabled individuals who alleged that Arizona was failing to provide them with adequate home- and community-based healthcare services. *Id.* at 1097.

¹⁴⁴ *OKAAP v. Fogarty*, 472 F.3d 1208, 1215 (10th Cir. 2007) (citing *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006)). The plaintiffs included an organization of pediatricians and thirteen individually named children and their parents who complained that the children had not received timely or appropriate access to medical services. *OKAAP v. Fogarty*, 205 F. Supp. 2d 1265, 1268–69 (N.D. Okla. 2002).

¹⁴⁵ See *Ball*, 492 F.3d at 1102; *OKAAP*, 472 F.3d at 1215.

¹⁴⁶ The court in *Hawkins* relied on the aggregate focus of the equal access clause and the Secretary's review of a state plan as an enforcement procedure. See *supra* notes 138–41 and accompanying text. Both of these arguments have traditionally been used against private enforcement and are discussed *supra* Part II.B.2.

¹⁴⁷ See *supra* Part II.B.1.

access enforcement,¹⁴⁸ the issue will still be contested, requiring Supreme Court clarification.

C. *Summary and Conclusions from Equal Access Case Law*

The wide variety of reasoning for and against allowing Medicaid recipients to have enforceable rights through the equal access clause can roughly be divided into several main categories.¹⁴⁹ The multitude of reasoning and the differing conclusions in these opinions demonstrate the difficulties that lower courts have had in applying the *Gonzaga* test to equal access claims.¹⁵⁰ This lower court confusion, due largely to the lack of Supreme Court precedent concerning the § 1983 enforceability of Medicaid Act provisions,¹⁵¹ requires that the Supreme Court addresses this dilemma.

Healthcare policy dictates that there should be some avenue for Medicaid recipients and providers to challenge the levels of reimbursement that a state sets because states are not adequately changing these levels on their own.¹⁵² This Comment suggests three important legal issues that need to be addressed by the Supreme Court in determining whether Medicaid recipients are the primary beneficiaries of the equal access clause under the *Gonzaga* test.

The initial legal concern that the Court would need to consider is the effect that § 1320a-2 has on the Medicaid Act. Section 1320a-2 states that a Medicaid Act provision “is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan.”¹⁵³ This statute is directly applicable to the equal access clause because it begins with the language, “A State plan . . . must . . .”¹⁵⁴ Additionally, the statute’s language and its legislative history suggest that Congress created this statute as a direct response to the

¹⁴⁸ The First, Second, Third, Fourth, Seventh, and Eleventh Circuits have yet to directly rule on the enforceability of the equal access clause to Medicaid recipients in a post-*Gonzaga* decision.

¹⁴⁹ See *supra* Part II.B.1–2.

¹⁵⁰ See Sasha Samberg-Champion, Note, *How to Read Gonzaga: Laying the Seeds of a Coherent Section 1983 Jurisprudence*, 103 COLUM. L. REV. 1838, 1887 (2003) (urging the Supreme Court to clarify *Gonzaga*’s § 1983 test due to lower court confusion).

¹⁵¹ The Supreme Court has not decided a post-*Gonzaga* case involving the applicability of a § 1983 suit for a Medicaid Act statute.

¹⁵² See *supra* Part I.C; *infra* Part IV.

¹⁵³ 42 U.S.C. § 1320a-2 (2006).

¹⁵⁴ *Id.* § 1396a(a).

Supreme Court's denial of an enforceable § 1983 right in *Suter v. Artist M.*¹⁵⁵ The statute found unenforceable in *Suter* required states to make reasonable efforts to keep children out of foster homes.¹⁵⁶ The intent of Congress in passing § 1320a-2 was to clarify that the Medicaid Act put a generalized duty on states while still conferring individual rights.¹⁵⁷ This legislative intent seems to support one of the central arguments advanced by courts in denying an equal access enforceable right: the statute's focus is only on the general objectives of the state, judicially irrelevant in deciding whether a § 1983 claim is available.¹⁵⁸ A resolution of what role § 1320a-2 plays in § 1983 cases needs to occur because no post-*Gonzaga* Supreme Court cases have been decided where a plaintiff asserted a § 1983 right based on a provision of the Medicaid Act.¹⁵⁹

A second potential problem that the Court could address involves lower courts' reasoning that the language of the equal access clause is ill-suited for a judicial remedy.¹⁶⁰ The reasoning of these courts focuses on the "efficiency" and "economy" language of the statute, while largely ignoring the statute's language calling for a comparison of the access to healthcare between Medicaid recipients and "the general population in the geographic area."¹⁶¹ Because this phrase has been interpreted to include privately insured individuals in the geographic area,¹⁶² a comparison of the medical assistance available to Medicaid recipients and privately insured individuals would seem to provide an objective measuring tool.¹⁶³ An argument can also be made that the prohibition in *Gonzaga* against enforcing statutes that are ill-suited for a judicial remedy is of little practical use because most important constitutional

¹⁵⁵ Section 1320a-2 indicates that it is intended to overrule any grounds for overriding the enforceability of a federal statute found in *Suter v. Artist M.*, 503 U.S. 347, 350–51 (1992). 42 U.S.C. § 1320a-2; see also *Watson v. Weeks*, 436 F.3d 1152, 1158 (9th Cir. 2006) (finding that Congress responded to *Suter* by enacting § 1320a-2).

¹⁵⁶ *Suter*, 503 U.S. at 350–51.

¹⁵⁷ See *Clark v. Richman*, 339 F. Supp. 2d 631, 639 (M.D. Pa. 2004) (providing a similar argument).

¹⁵⁸ See *supra* notes 117–19 and accompanying text.

¹⁵⁹ See *supra* note 151.

¹⁶⁰ See *supra* notes 121–24 and accompanying text.

¹⁶¹ See, e.g., *Westside Mothers v. Olszewski*, 454 F.3d 532, 542–43 (6th Cir. 2006) (finding the general objectives of "efficiency, economy, and quality of care" to be ill-suited for a judicial remedy).

¹⁶² See *supra* note 33 and accompanying text.

¹⁶³ A similar argument was accepted by the court in *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908, 930–31 (5th Cir. 2000).

provisions are written in broad, open-textured language, which certainly does not include judicially discoverable and manageable standards.¹⁶⁴

The variety of legal reasoning utilized by courts in attempting to apply the *Gonzaga* test suggests that the three factors articulated in the *Gonzaga* and *Blessing* opinions are inadequate to determine whether Medicaid recipients have an enforceable right under the equal access clause.¹⁶⁵ The two opposing, yet reasonable, views of how the *Gonzaga* test should be applied in this context suggest that an additional consideration is needed for courts to consistently apply the *Gonzaga* test to Medicaid Act statutes. This Comment proposes that in determining whether the equal access clause creates an enforceable right for Medicaid recipients, the Supreme Court should consider the lack of available remedies for Medicaid recipients to enforce their right to adequate access to healthcare providers.

Circuit courts have largely ignored whether Medicaid recipients possess alternative ways of enforcing their right of access to healthcare providers because it is not part of the three-pronged test the Supreme Court created in *Gonzaga* and *Blessing*.¹⁶⁶ However, the Supreme Court indirectly acknowledged the effect of alternative remedies in *Gonzaga* by holding that the presence of an explicit enforcement mechanism weighs against inferring a private right of action through a § 1983 suit.¹⁶⁷ In the Supreme Court's only post-*Gonzaga* § 1983 decision, the Court opined that "the existence of a more restrictive private remedy for statutory violations has been the dividing line between those cases in which we have held that an action would lie under § 1983 and those in which we have held it would not."¹⁶⁸ The Court has also looked to the availability of alternative remedies in deciding whether a private right of action exists in other contexts.¹⁶⁹ These Supreme Court holdings strongly suggest that the availability of alternative remedies is relevant when

¹⁶⁴ See Richard H. Fallon, Jr., *Judicially Manageable Standards and Constitutional Meaning*, 119 HARV. L. REV. 1275 (2005).

¹⁶⁵ Circuit courts' application of the *Gonzaga* test to the equal access clause has been widely criticized by legal commentators. See, e.g., Andrew R. Gardella, Note, *The Equal Access Illusion: A Growing Majority of Federal Courts Erroneously Foreclose Private Enforcement of § 1396a(a)(30) of the Medicaid Act Using 42 U.S.C. § 1983*, 38 U. MEM. L. REV. 697 (2008).

¹⁶⁶ See, e.g., *Westside Mothers*, 454 F.3d at 542–43 (strictly applying the three *Gonzaga* factors without assessing whether Medicaid recipients have additional ways to enforce their rights).

¹⁶⁷ See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 289–90 (2002).

¹⁶⁸ *City of Rancho Palos Verdes v. Abrams*, 544 U.S. 113, 121 (2005).

¹⁶⁹ See, e.g., *Bush v. Lucas*, 462 U.S. 367, 378 (1983) (holding that the Court's first step in determining whether a private action for damages exists to enforce constitutional rights is to ask whether an alternative process for protecting the interest exists).

determining whether a statute is enforceable through a § 1983 action. The next Part demonstrates that Medicaid recipients lack additional ways to ensure that they receive “equal access” to healthcare.

III. ALTERNATIVE WAYS FOR MEDICAID RECIPIENTS TO ENFORCE THEIR RIGHTS WHEN THEY ARE NOT RECEIVING EQUAL ACCESS TO HEALTHCARE

The inability of Medicaid recipients to enforce the equal access clause and the need for the Supreme Court to address the issue would be less urgent if recipients could invoke their rights of access to healthcare through other means. The majority of the equal access cases discussed in Part II involved plaintiffs making multiple statutory claims under the Medicaid Act.¹⁷⁰ This Part demonstrates that while some statutory claims certainly overlap with the equal access clause, these additional legal avenues still leave significant portions of the Medicaid population without a legal remedy to their lack of equal access to healthcare because of a state’s low reimbursement rates.

A. *Reasonable Promptness Clause*

The so-called reasonable promptness clause, 42 U.S.C. § 1396a(a)(8), states that “[a] State plan for medical assistance must . . . provide that all individuals wishing to make application for medical assistance under the plan shall have the opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.”¹⁷¹

A large number of the cases brought under the reasonable promptness clause involve Medicaid recipients being placed on state-generated waiting lists for Medicaid-funded services through a Medicaid waiver program.¹⁷² However, there is some legal precedent to suggest that Medicaid recipients

¹⁷⁰ See, e.g., *Ball v. Rodgers*, 492 F.3d 1094, 1097–98 (9th Cir. 2007) (asserting claims of equal access violations and violations of two of the Medicaid Act’s “free choice” provisions contained in 42 U.S.C. §§ 1396n(c)(2)(C), (d)(2)(C)); *OKAAP v. Fogarty*, 472 F.3d 1208, 1209–10 (10th Cir. 2007) (asserting claims under the equal access clause, reasonable promptness clause, and 42 U.S.C. § 1396a(a)(43)).

¹⁷¹ 42 U.S.C. § 1396a(a)(8) (2006).

¹⁷² See, e.g., *Bryson v. Shumway*, 308 F.3d 79, 83 (1st Cir. 2002) (presenting the common problem of a home- and community-based waiver program attracting more applicants than available spots, and, as a result, preventing individuals on the waiting list from receiving reasonably prompt medical services). Medicaid waiver programs are irrelevant to an equal access analysis because the programs are excluded from many of the Medicaid Act’s requirements, such as the requirement that services be available statewide to all individuals equally. 42 U.S.C. § 1396n(c)(3); see also *Bryson*, 308 F.3d at 82 (finding that a state’s waiver program was “designed to allow states to experiment with methods of care . . . without adhering to the strict mandates of the Medicaid system”).

may also bring suit under the reasonable promptness clause if a state's low reimbursement rates prevent the recipients from receiving prompt care.¹⁷³ The Supreme Court has not decided whether the reasonable promptness clause creates an enforceable right for Medicaid patients through § 1983, but circuit courts applying the tests from *Blessing* and *Gonzaga* have consistently found that an enforceable right exists.¹⁷⁴

While courts have consistently agreed that Medicaid patients have a § 1983 enforceable right under the reasonable promptness clause, there are two substantial obstacles for a Medicaid recipient who attempts to file a lawsuit for lack of reasonably prompt healthcare access caused by a state's low reimbursement rates. The medical assistance referred to in the statute is defined as "payment of part or all of the cost" of "care and services" covered by the statute.¹⁷⁵ The central problem is that circuit courts are split over whether the "assistance" that states are required to provide with reasonable promptness should be interpreted as paying for the service or actually providing the service.¹⁷⁶ This distinction is important because for a reasonable promptness claim to cover a situation where low provider reimbursement rates cause an individual to be denied access to medical services, the plaintiff would likely need to prove that the state was obligated *to provide the medical services* in question within a reasonably prompt time.¹⁷⁷ If an individual brought suit in

¹⁷³ See, e.g., *OKAAP v. Fogarty*, 366 F. Supp. 2d 1050, 1109 (N.D. Okla. 2005) (holding that without financial assistance in the form of provider reimbursement sufficient to attract an adequate number of providers "reasonably prompt assistance is effectively denied"), *rev'd* 472 F.3d 1208 (10th Cir. 2007).

¹⁷⁴ See, e.g., *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180, 190–92 (3d Cir. 2004) (holding that the plain meaning of § 1396a(a)(8) clearly demonstrates Congress's intent to confer a right to individuals and that legislative history provides further support for this interpretation); *Doe ex rel. Doe Sr. v. Chiles*, 136 F.3d 709, 718–19 (11th Cir. 1998) (holding that § 1396a(a)(8) meets the *Blessing* test and that Medicaid recipients are the intended beneficiaries of the reasonable promptness clause); see also Brian J. Dunne, *Enforcement of the Medicaid Act Under 42 U.S.C. § 1983 After Gonzaga University v. Doe: The "Dispassionate Lens" Examined*, 74 U. CHI. L. REV. 991, 1007 (2007) (noting that there is "reasonably well-settled post-*Gonzaga* law in a majority of circuits upholding recipient enforcement of the [reasonable promptness clause]").

¹⁷⁵ 42 U.S.C. § 1396d(a).

¹⁷⁶ See Kenneth R. Wiggins, *Medicaid and the Enforceable Right to Receive Medical Assistance: The Need for a Definition of "Medical Assistance,"* 47 WM. & MARY L. REV. 1487 (2006) (discussing the circuit split and arguing that, for waiver programs, medical assistance should be interpreted as providing financial services). For an example of a circuit court interpreting medical assistance to mean actual services, see *Chiles*, 136 F.3d at 716–17 (examining whether the provision of Medicaid services are reasonably prompt). For an example of a circuit court concluding that the term "assistance" refers only to financial assistance, see *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003) (denying plaintiff's claim that facilities were too far away because the statutory reference to assistance appears to mean only financial assistance).

¹⁷⁷ Cf. *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006) (finding that individuals were denied equal access to services, but due to the state's payment for those services, the individuals could not bring suit because the reasonable promptness clause only refers to financial assistance).

a circuit that interpreted the term “medical assistance” in the reasonable promptness clause to mean only financial assistance, that individual would likely be prevented from asserting a reasonable promptness claim for lack of access to medical services.¹⁷⁸ As one recent circuit court wrote, allowing a reasonable promptness claim based on the difficulties Medicaid patients face in receiving reasonably prompt care due to low reimbursement rates “would broaden § 1396a(a)(8) far beyond its intended scope.”¹⁷⁹

A second potential problem with Medicaid recipients’ use of the reasonable promptness clause is that courts have not determined an exact time limit for what constitutes “reasonable promptness.” Some courts have taken the approach that the time limit for when a medical service must be furnished should be within one year from the time an individual is eligible,¹⁸⁰ while other courts have found that a month-and-a-half wait is a violation of the reasonable promptness clause.¹⁸¹ Even using the most liberal one-and-a-half-month standard, an individual arguing that low provider reimbursement rates are impeding access to healthcare would have to demonstrate that the reimbursement rates resulted in more than just a temporary lack of access. Therefore, a suit under the reasonable promptness clause could allow Medicaid recipients to incur significantly more injury than would a suit under the equal access clause if the privately insured receive medical services in a matter of days.¹⁸²

¹⁷⁸ See *OKAAP v. Fogarty*, 472 F.3d 1208, 1209 (10th Cir. 2007) (holding that low reimbursement rates causing fewer healthcare providers to treat Medicaid recipients did not mean that the defendants had failed to be reasonably prompt in paying for services actually rendered by available providers).

¹⁷⁹ *Id.* at 1214–15. In response to the Tenth Circuit’s holding that the reasonable promptness clause only applies to the requirement that medical service providers be promptly paid, the plaintiffs filed a petition of certiorari to the U.S. Supreme Court; however, the Supreme Court chose not to clarify this issue and denied certiorari. *OKAAP*, 472 F.3d 1208, *petition for cert. filed*, 2007 WL 1379703 (May 7, 2007) (No. 06-1482), *cert. denied*, 128 S. Ct. 68 (2007).

¹⁸⁰ See, e.g., *Bryson v. Shumway*, 308 F.3d 79, 89 (1st Cir. 2002) (finding that waiver services should be implemented within one year from the time an individual is found to be eligible); see also *Lewis v. N.M. Dep’t of Health*, 275 F. Supp. 2d 1319, 1345 (D.N.M. 2003) (holding that the reasonable promptness clause is violated when a defendant admits that individuals who have been allocated to the state’s community-based waiver program would not receive services until the following year).

¹⁸¹ See *Health Care for All v. Romney*, 2005 WL 1660677, at *10–*11 (D. Mass. July 14, 2005) (finding that setting reimbursement rates so low that some Medicaid recipients could not be seen by private dentists for a month-and-a-half violates the reasonable promptness clause).

¹⁸² For an equal access claim, the relevant inquiry is whether Medicaid recipients are receiving services to the same extent as the general population covered by private insurance. See *supra* notes 33–34 and accompanying text. Therefore, if privately insured individuals have prompt access to service, an equal access claim could presumably be brought for short-term lack of access to a particular type of provider.

B. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid Statute

A state plan for medical assistance, according to 42 U.S.C. § 1396a(a)(10), must make available to all qualified individuals the care and services listed in § 1396d(a)(4).¹⁸³ The relevant portion of the statute provides that “medical assistance” includes “early and periodic screening, diagnostic, and treatment [EPSDT] services . . . for individuals who are eligible under the plan and are under the age of 21.”¹⁸⁴ A state Medicaid plan must inform all eligible people under twenty-one of the availability of EPSDT, provide or arrange for the provision of screening services, arrange for corrective treatment, and report certain information concerning the number of children receiving the services.¹⁸⁵ Specifically, the Medicaid Act provides that EPSDT services include “[s]uch other necessary health care, diagnostic services, treatment, and other measures . . . 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.”¹⁸⁶

The Supreme Court has held that a consent decree stemming from a lawsuit filed on behalf of children eligible for EPSDT can be enforced against state officials.¹⁸⁷ However, the Court has not specifically addressed whether the EPSDT statutes are enforceable through § 1983.¹⁸⁸ Circuit courts have consistently held that the statutes encompassing EPSDT create an enforceable right for individuals who qualify for EPSDT.¹⁸⁹

The majority of EPSDT claims are brought on the theory that either the state has inadequately informed Medicaid recipients of EPSDT services or that a state has refused to provide a service that it is required to under the EPSDT statute.¹⁹⁰ An example of the latter theory is evident in *Collins v. Hamilton*.¹⁹¹

¹⁸³ 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(4) (2006).

¹⁸⁴ *Id.* § 1396d(a)(4)(B).

¹⁸⁵ *Id.* §§ 1396a(a)(43)(A)–(D).

¹⁸⁶ *Id.* § 1396d(r)(5).

¹⁸⁷ *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 431 (2004).

¹⁸⁸ *See Dunne, supra* note 174, at 1007 (noting that it is “reasonably well-settled post-*Gonzaga* law in a majority of circuits” that the statute is enforceable).

¹⁸⁹ *See, e.g., S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602–06 (5th Cir. 2004); *Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003); *Westside Mothers v. Haveman*, 289 F.3d 852, 862–63 (6th Cir. 2002).

¹⁹⁰ *See, e.g., Dickson*, 391 F.3d at 585 (involving the state’s refusal to provide prescribed disposable incontinence underwear as part of EPDST treatment); *Collins*, 349 F.3d at 372 (involving the state’s failure to provide long-term residential treatment in psychiatric facilities).

¹⁹¹ *Collins*, 349 F.3d at 372.

In *Collins*, the plaintiffs brought a suit alleging violation of the EPSDT statutes based on the state's "failure to provide long-term residential treatment in psychiatric residential treatment facilities" for children under twenty-one.¹⁹² The court held that the state must provide Medicaid-eligible children under twenty-one with the mental health treatment found to be necessary by EPSDT screenings.¹⁹³

At least one case suggests that an EPSDT claim may be brought when a state does pay for a required EPSDT service but not at a rate where patients actually have access to the service.¹⁹⁴ In *Memisovski ex rel. Memisovski v. Maram*, Medicaid recipients brought suit based on the theory that the state had not established a Medicaid program designed to provide EPSDT services to all Medicaid-enrolled children on a timely basis.¹⁹⁵ The district court held that the state was violating the EPSDT provisions of the Medicaid Act by failing to establish a system designed to deliver the full amount of recommended healthcare to all covered children because only small percentages of children were receiving a number of the required screenings.¹⁹⁶ The court reasoned that the "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."¹⁹⁷

There are several problems with Medicaid recipients using the EPSDT statute to enforce their right to access healthcare services. First, the statute only applies to individuals who are under twenty-one.¹⁹⁸ Therefore, a significant number of Medicaid recipients are categorically excluded from enforcing this right.¹⁹⁹ Second, the EPSDT statute only applies if the low reimbursement rates effectively deny Medicaid recipients access to certain medical services that the statute requires.²⁰⁰ Finally, the notion that Medicaid

¹⁹² *Id.*

¹⁹³ *Id.* at 375–76 (reasoning that residential treatment, even if long term, can still fit within the statutory definition of active treatment that improves or ameliorates a condition).

¹⁹⁴ *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332 (N.D. Ill. Aug. 23, 2004).

¹⁹⁵ *Id.* at *1. The plaintiffs were also successful in bringing an equal access claim. *Id.* at *8.

¹⁹⁶ *Id.* at *32 (noting that only between 20% and 40% of eligible recipients were receiving the screenings).

¹⁹⁷ *Id.* at *50. However, much of the court's analysis focused on the lack of information the state was providing to recipients related to EPSDT services, as opposed to actual reimbursement rates. *Id.* at *49.

¹⁹⁸ 42 U.S.C. § 1396d(a)(4)(B) (2006).

¹⁹⁹ *FURROW ET AL.*, *supra* note 22, at 772–76. In addition to children, Medicaid also covers pregnant women, disabled adults, and dually eligible Medicaid and Medicare recipients. *Id.* at 774–75.

²⁰⁰ 42 U.S.C. § 1396d(r) (listing the services that the EPSDT statute covers).

recipients can bring an EPSDT suit when a state pays for a required service, but at an insufficient rate to ensure access, has not gained widespread judicial approval.²⁰¹

C. Writs of Mandate

1. Federal Writs of Mandate

The federal mandamus statute gives the district courts original jurisdiction over “any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.”²⁰² To be entitled to a writ of mandamus, a petitioner must demonstrate “(1) a clear right . . . to the relief sought; (2) a plainly defined and peremptory duty on the part of the respondent to do the act in question; and (3) that there is no other adequate remedy available.”²⁰³ The availability of a Medicaid recipient or provider to bring suit against the Secretary for low reimbursement rates would presumably be limited because the equal access clause only requires the state, and not the Secretary, to comply with its requirements.²⁰⁴ Because the Secretary owes no duty to Medicaid recipients under the equal access clause,²⁰⁵ a federal writ of mandamus seeking the Secretary to force states to raise reimbursement rates would likely fail.

A Medicaid recipient could argue that by agreeing to participate in the federal Medicaid program, state officials in charge of the program agreed to follow federal law. This argument has never been successfully made in a federal court, and there appear to be two potential difficulties with this reasoning. First, the general judicial rule is that mandamus is only employed under exceptional circumstances, in clear cases of illegality.²⁰⁶ The difficulty

²⁰¹ See *Memisovski*, 2004 WL 1878332. One of the few cases suggesting this type of use for the EPSDT statute, *Memisovski* focuses mainly on the lack of information about the availability of EPSDT services as opposed to the effect of reimbursement levels. *Id.* at *40–*49.

²⁰² 28 U.S.C. § 1361 (2006).

²⁰³ *Yip v. Fed. Bureau of Prisons*, 363 F. Supp. 2d 548, 551 (E.D.N.Y. 2005) (alteration in original) (quoting *Anderson v. Bowen*, 881 F.2d 1, 5 (2d Cir. 1989)) (quotation marks omitted) (brackets omitted).

²⁰⁴ No published judicial opinions asserting a claim on this basis were found during the research for this Comment.

²⁰⁵ The language of the equal access clause declares that “[a] State plan for medical assistance must . . . provide”; and does not mention any role to be assumed by the Secretary. 42 U.S.C. § 1396a(a)(3)(A); see *supra* note 31 and accompanying text.

²⁰⁶ See, e.g., *Ass’n of Am. Med. Colls. v. Califano*, 569 F.2d 101, 110–11 n.80 (D.C. Cir. 1977); see also *Craig v. Colburn*, 414 F. Supp. 185, 193 (D. Kan. 1976) (“Mandamus is an extraordinary remedy which should be utilized only in the clearest and most compelling of cases.”).

that lower courts have had in creating a definite standard for when states violate the equal access clause may create a problem in overcoming the high burden of proving a clear case of illegality.²⁰⁷ Second, for a federal writ of mandate to apply, the duty owed by the actor must not be discretionary.²⁰⁸ State officials are allowed to determine the reimbursement rates paid to healthcare providers as part of their state's plan,²⁰⁹ suggesting that a federal writ of mandate is unavailable because the rates are left to the officials' discretion.

2. *State Writs of Mandate*

When a state Medicaid plan makes a specific requirement concerning reimbursement rates, that requirement may be enforceable through a state writ of mandate.²¹⁰ In *California Ass'n for Health Services at Home v. State Department of Health Services*, home healthcare providers and recipients sought a writ of mandate to force California to raise or review Medicaid reimbursement rates paid to providers.²¹¹ The plaintiffs alleged a violation of federal Medicaid law and of the California State Plan, which required annual reviews of the reimbursement rates paid to home health service agencies.²¹² The court ruled that California had a duty to perform an annual review of provider reimbursement rates and issued a writ forcing the state to review those rates.²¹³ However, the court also ruled that it was not a function of the writ to set the reimbursement rates.²¹⁴

This opinion suggests that while recipients cannot challenge violations of Medicaid Act requirements, such as the equal access clause, through a state writ of mandate, this remedy may be appropriate when a violation of the state

²⁰⁷ See *supra* Part II.B for various opinions on what constitutes a violation of the equal access clause.

²⁰⁸ *Nixon v. Hampton*, 400 F. Supp. 881, 885 (E.D. Pa. 1975) (stating that mandamus is available only where plaintiff alleges that an officer of government owes him a "legal duty which is a specific, plain ministerial act 'devoid of the exercise of judgment or discretion'" (citation omitted)).

²⁰⁹ 42 C.F.R. § 430.0 (2006).

²¹⁰ *Cal. Ass'n for Health Servs. at Home v. State Dep't of Health Servs.*, 148 Cal. App. 4th 696, 700 (Cal. Ct. App. 2007) (allowing a writ of mandate to require state to review reimbursement rates).

²¹¹ *Id.*

²¹² *Id.* at 702. The California statute that formerly required annual reviews of reimbursement rates for home health agency services is CAL. CODE REGS. tit. 22, § 51523 (2006). *Cal. Ass'n for Health Servs.*, 148 Cal. App. 4th at 701 n.1. Despite this requirement for annual reviews, no reviews of applicable reimbursement rates had occurred for five years. *Id.* at 702.

²¹³ *Id.* at 707–08, 710 (holding that the state plan prescribes a ministerial duty to perform an annual review of reimbursement rates).

²¹⁴ *Id.* (holding that it is not a function of the writ of mandamus in this setting to compel the setting of rates, regardless of the rates' inadequacy).

plan has occurred.²¹⁵ However, this means of enforcing rights is ineffective because most state plans only require that the reimbursement rates be reviewed periodically, but do not set any requirements for actually changing the rates.²¹⁶ Additionally, states can easily avoid any potential suits by removing requirements for specific review or rate-setting from their state plans.²¹⁷

D. Preemption

Another possible way for Medicaid recipients to ensure that a state's Medicaid reimbursement rates are not set too low is to challenge a state statute under the Supremacy Clause as being preempted by the equal access clause.²¹⁸ State laws are invalid under the Supremacy Clause if they "interfere with, or are contrary to the laws of Congress, made in pursuance of the Constitution."²¹⁹ Lawsuits utilizing this approach have potential for Medicaid recipients because the right of private parties to seek injunctive relief under the Supremacy Clause does not depend upon whether the allegedly preemptive statute confers a federal right. Rather, a plaintiff only has to satisfy the traditional Article III standing requirements of injury in fact, a causal connection between the injury and the conduct complained of, and a likelihood that the injury will be redressed by a favorable decision.²²⁰

In *Independent Living Center of Southern California, Inc. v. Shewry*, the Ninth Circuit Court of Appeals recently held that Medicaid beneficiaries participating in the state's Medicaid program have standing to bring suit under

²¹⁵ *Id.* at 705. The court reasoned that this suit differed from a § 1983 suit alleging violation of the Medicaid Act's requirements for a state plan. *Id.* The court found that a violation of the terms of the state plan, which is a state law, gives the plaintiffs standing. *Id.*

²¹⁶ For example, a California statute only required that the reimbursement rates be reviewed, not necessarily changed, annually. *Id.* at 707–08. New Hampshire also requires periodic review of reimbursement rates but does not require changing those rates. N.H. REV. STAT. ANN. § 126-A:18-b (2007) (requiring the state department of health and human services to review Medicaid reimbursement rates every two years).

²¹⁷ This is in fact what the California legislature did after a lawsuit was filed—it repealed the annual review requirement. *Cal. Ass'n for Health Servs.*, 148 Cal. App. 4th at 703. However, the plaintiffs were still able to obtain retrospective relief for the years when the state did not perform the reviews. *Id.* at 709. The writ of mandate compelled the department to conduct an annual review of the reimbursement rates from 2001–2005. *Id.*

²¹⁸ The Supremacy Clause provides, "This Constitution, and the laws of the United States which shall be made in pursuance thereof . . . shall be the supreme law of the land; and the judges in every state shall be bound thereby . . ." U.S. CONST. art. VI, cl. 2.

²¹⁹ *Wis. Pub. Intervenor v. Mortier*, 501 U.S. 597, 604 (1991) (quoting *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 211 (1824)).

²²⁰ *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).

the Supremacy Clause.²²¹ The plaintiffs in *Shewry* challenged a California bill that would reduce the payments to healthcare providers under California's Medicaid program by ten percent as violating the equal access clause.²²² The court held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right' in the sense that term has been recently used in suits brought under § 1983, but need only satisfy traditional standing requirements."²²³ This decision is important because the Ninth Circuit has held that the equal access clause does not confer an enforceable right to Medicaid recipients for purposes of a §1983 suit.²²⁴ The court found that the plaintiff recipients had met the Article III standing requirement because the provider payment cuts would reduce the recipients' access to healthcare providers, and such an injury "to those individuals most directly affected by the administration of [a state welfare] program" is sufficient to allow the Medicaid recipients to seek injunctive relief.²²⁵

Although the decision in *Shewry* appears promising for Medicaid recipients denied access to healthcare, there are potential problems with using the Supremacy Clause as a vehicle to strike down state laws that set state reimbursement rates at low levels. The central problem concerns whether a Medicaid recipient who attempts to strike down a state statute as being preempted by the equal access clause is likely to succeed on the merits. Although the court in *Shewry* found that the plaintiff recipients had standing, it expressed no opinion on the merits of the actual preemption claim.²²⁶ The Supreme Court has indicated that preemption of a state law by a federal statute "is not favored 'in the absence of persuasive reasons—either that the nature of the regulated subject matter permits no other conclusion, or that the Congress has unmistakably so ordained.'"²²⁷ The Supreme Court has further held that this presumption is especially powerful "[w]here coordinate state and federal efforts exist within a complementary administrative framework, and in the

²²¹ 543 F.3d 1050 (9th Cir. 2008).

²²² *Id.* at 1053.

²²³ *Id.* at 1058. In the opinion, the court notes, "The Supreme Court has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under § 1983 be met . . ." *Id.* at 1055.

²²⁴ *Sanchez v. Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005).

²²⁵ *Shewry*, 543 F.3d at 1065 (alteration in original) (quoting *Rosado v. Wyman*, 397 U.S. 397, 420 (1970)) (internal quotation marks omitted).

²²⁶ *Id.* at 1066.

²²⁷ *Commonwealth Edison Co. v. Montana*, 453 U.S. 609, 634 (1981) (quoting *Chi. & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981)).

pursuit of common purposes.”²²⁸ Because the Medicaid Act is a cooperative federalism program in which states are given discretion in developing their Medicaid plans, a plaintiff faces a high burden in proving that a state statute or regulation is preempted by the equal access clause. Thus, even though a plaintiff has standing to challenge a state law under the Supremacy Clause, a Medicaid recipient will still have substantial difficulty proving that a state law regulating Medicaid reimbursements is actually preempted.

Further, because *Shewry* is the first court of appeals decision to require only traditional standing for parties challenging a state statute as preempted by the equal access clause, it is unclear whether other circuit courts will follow this decision. Due to the recent nature of Supremacy Clause challenges to state laws setting reimbursement rates, further case law is necessary to determine whether Supremacy Clause challenges are truly a viable alternative to § 1983 suits.

E. Lawsuits Brought by Healthcare Providers

Because the Medicaid reimbursement levels set by a state directly affect how much money a healthcare provider will receive for treating a Medicaid patient, allowing providers to bring suit against the state would seem to ensure that low reimbursement rates would not prevent a Medicaid recipient from having access to healthcare.²²⁹ In other words, if a healthcare provider believes that a state’s Medicaid reimbursement rates were too low for treatment to occur without economic detriment to the provider, the provider could potentially bring suit.

There are two central problems with the assumption that provider lawsuits will protect the healthcare access of Medicaid recipients. First, the majority of federal courts have held that healthcare providers cannot bring a § 1983 suit under any provision of the Medicaid Act.²³⁰ Most courts hold that there is no

²²⁸ N.Y. State Dep’t of Soc. Servs. v. Dublino, 413 U.S. 405, 421 (1973).

²²⁹ See, e.g., *Sanchez*, 416 F.3d at 1054 (providers who received Medicaid reimbursement from the state of California sued due to low reimbursement rates); *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 700 (5th Cir. 2007) (a doctor, a hospital, and a health maintenance organization brought suit to challenge low reimbursement rates).

²³⁰ See *Sanchez*, 416 F.3d at 1062 (holding that providers cannot sue under equal access clause); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 58–59 (1st Cir. 2004) (holding that providers cannot sue under the equal access clause); *OKAAP v. Fogarty*, 366 F. Supp. 2d 1050, 1102–11 (N.D. Okla. 2005) (holding that providers cannot sue under equal access, reasonable promptness, or EPSDT provisions); *In re NYAHS Litig.*, 318 F. Supp. 2d 30, 38–40 (N.D.N.Y. 2004) (deciding that providers cannot sue under § 1396a(a)(13)(A)’s rate-setting “process” or equal access clause, or under § 1396r’s nursing care “quality of

rights-creating language in the equal access clause that targets healthcare providers as beneficiaries.²³¹ Additionally, legislative history suggests that Congress intended to exclude providers from bringing private suits under the equal access clause.²³² As one circuit court suggested, the only options for providers dissatisfied with Medicaid reimbursement rates are to convince the Secretary to act or to move to another area with better reimbursement rates.²³³ The latter is extremely difficult for providers to accomplish, and the former option leaves Medicaid recipients with no means of treatment.

The second problem with providers protecting the rights of Medicaid recipients is that healthcare providers may not be willing to bring such suits. Even if healthcare providers are able to bring suit, as in the Eighth Circuit, they would have little incentive to do so because of the undesirable circumstances surrounding treatment of Medicaid recipients.²³⁴ Many providers prefer to not treat Medicaid patients.²³⁵ Providers may also decide that moving to another area where Medicaid reimbursement rates are higher is easier than incurring the expenses of prolonged litigation.²³⁶ Most providers can also afford to avoid Medicaid patients because such patients make up only a small portion of the provider's overall income.²³⁷ Therefore, the expense of litigation and the minimal financial gain generated by a change in reimbursement rates would likely discourage many healthcare providers from filing a suit under the equal access clause.

life" provision). The one notable exception of a circuit court holding that providers can bring suit occurred in *Pediatric Specialty Care v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1015–16 (8th Cir. 2006) (holding that providers do have enforceable rights under the equal access clause).

²³¹ *Long Term Care Pharmacy*, 362 F.3d at 57 (finding that the equal access clause suggests no intent to make healthcare providers an intended beneficiary); see also *Evergreen Presbyterian Ministries v. Hood*, 235 F.3d 908, 928–29 (5th Cir. 2000) (reasoning that “while recipients have an individual entitlement to equal access to medical care, any benefit to health care providers is indirect at best,” and finding that providers are not intended beneficiaries).

²³² See *supra* note 88 and accompanying text; see also *Long Term Care Pharmacy*, 362 F.3d at 58 (finding that Congress repealed an earlier amendment giving providers more opportunity to bring suit in order to increase the flexibility of the states).

²³³ *Long Term Care Pharmacy*, 362 F.3d at 59 (suggesting that the only option for healthcare providers is to “vote with their feet”).

²³⁴ See *supra* notes 47–48 and accompanying text. Some undesirable aspects of treating Medicaid patients include lower reimbursement rates, higher likelihood of missed appointments, and difficulties in billing practices. See *supra* note 48 and accompanying text.

²³⁵ See *supra* notes 42–45 and accompanying text.

²³⁶ See *Equal Access for El Paso v. Hawkins*, 509 F.3d 697, 701 (5th Cir. 2007) (recognizing plaintiff's contention that the combination of inadequate reimbursement rates with a high Medicaid population creates a financial incentive for physicians to relocate and practice in other communities).

²³⁷ *Watson*, *supra* note 47.

F. *Withholding of Funds by the Secretary*

A final alternative for Medicaid recipients denied treatment because of low provider reimbursement rates is to rely on the Secretary to take action against the state.²³⁸ The Secretary has the authority to revoke federal funding for a state's Medicaid program if the state does not comply with the equal access clause.²³⁹ Because states receive a significant portion of their Medicaid budget from federal funds,²⁴⁰ the Secretary's withholding of funds might play a vital role in forcing states to set adequate reimbursement rates.

There are two significant problems with relying on the Secretary to enforce the equal access clause by withholding federal funds. First, federal agency action following state noncompliance is rare,²⁴¹ and the Secretary rarely, if ever, withholds federal funds as a penalty for noncompliance.²⁴² This general inaction is particularly common in the Medicaid context because of the large number of Medicaid recipients who would lose medical coverage as a result of a decision to withhold funds.²⁴³ Further evidence of the Secretary's decision not to withhold funds is apparent in the considerable number of equal access clause suits brought by unsatisfied Medicaid recipients.²⁴⁴

A second problem with this approach is that Medicaid recipients are unlikely to want a remedy that further deprives funds from a program that they rely on for their well-being. Justice White wrote that "a funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act."²⁴⁵ The financially perilous situation that most Medicaid recipients

²³⁸ See *Long Term Care Pharmacy*, 362 F.3d at 58–59 (stating that providers must rely on the Secretary to enforce a state's compliance with the equal access clause).

²³⁹ See 42 U.S.C. § 1396c (2006); see also *Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 940 (9th Cir. 2005) (holding that the Secretary has the power to determine whether a state's Medicaid program violates the equal access clause).

²⁴⁰ In 2007, states were given federal funds in the amount of between 50% and 75% of the money they spent on their Medicaid Programs. Federal Financial Participation in State Assistance Expenditures, 70 Fed. Reg. 71,856, 71,857 (Nov. 30, 2005). The amount of matching federal funds a state receives depends on the state's average per capita income. 42 U.S.C. § 1396d(b).

²⁴¹ See *Samberg-Champion*, *supra* note 150, at 1859 (noting that this statement is backed by empirical data and providing the example of how the Department of Education did not once in thirty years withhold funding for a violation of the statute at issue in *Gonzaga*).

²⁴² See *id.* at 1839 (referring to the withholding of federal Medicaid funding as "the blunt and seldom-used club").

²⁴³ States often have massive budget overruns and become locked into federal financial participation. See Dunne, *supra* note 174, at 994–95.

²⁴⁴ See cases discussed *supra* Part II.B.

²⁴⁵ *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 52 (1981) (White, J., dissenting).

are in prevents them from seeking private healthcare coverage while a state tries to correct its program.²⁴⁶ Ultimately, the Secretary's withholding of funds would likely harm not only the state Medicaid program but also the Medicaid recipients who rely on the state for services, the healthcare providers who rely on the reimbursements for income, and the state taxpayers who would have to shoulder their state's substantial financial burden.

G. Summary of Alternative Legal Avenues for Recipients Who Are Not Receiving Equal Access to Healthcare

The equal access clause is the only legal remedy that fully addresses the problem of states that set provider rates so low that few healthcare providers are willing to provide services to Medicaid recipients. Each additional course of action for Medicaid recipients faced with this dilemma either is unavailable to a large portion of the Medicaid population,²⁴⁷ would have little chance of judicial success,²⁴⁸ would only force review of rates and not changes to those rates,²⁴⁹ or would be adverse to the recipients' best interests.²⁵⁰ Therefore, the only way to ensure that all Medicaid recipients have access to healthcare is by allowing them to enforce the equal access clause through a § 1983 suit.

IV. IMPLICATIONS OF ALLOWING MEDICAID RECIPIENTS TO BRING A SUIT UNDER THE EQUAL ACCESS CLAUSE

The direct result of allowing Medicaid recipients to bring a § 1983 suit to force states to comply with the equal access clause would be higher reimbursement rates for healthcare providers who treat Medicaid patients. Because healthcare providers presently consider low reimbursement rates a significant deterrent to providing services to Medicaid recipients,²⁵¹ increased

²⁴⁶ Medicaid recipients generally have to be at or near the federal poverty level. *See supra* note 22 and accompanying text.

²⁴⁷ This is the case with EPSDT suits, which are only available to recipients under twenty-one and for certain services. *See supra* notes 198–99 and accompanying text.

²⁴⁸ This is the case for suits brought under the reasonable promptness clause, federal writ of mandamus theory, and suits by healthcare providers. *See supra* Part III.A, C.1, D.

²⁴⁹ This is the case for suits brought under a state writ of mandate theory. *See supra* note 216 and accompanying text.

²⁵⁰ This is the case when a recipient petitions the Secretary to withhold funding from a state due to the state's noncompliance with the equal access clause. *See supra* notes 241–42 and accompanying text.

²⁵¹ *See* CUNNINGHAM & MAY, *supra* note 42, at 1–3 (noting that low reimbursement rates is one of several factors that deter healthcare providers from treating Medicaid patients); *see also* Stephen Berman et al., *Impact of a Decline in Colorado Medicaid Managed Care Enrollment on Access and Quality of Preventive Primary*

reimbursement rates would presumably augment the number of healthcare providers who treat Medicaid recipients. Having more Medicaid providers would increase access to healthcare for Medicaid recipients, and would at least partially alleviate the extended periods that Medicaid patients often wait before finding and being treated by a healthcare provider.²⁵²

The most concerning negative implication that could arise from allowing Medicaid recipients to have enforceable rights under the equal access clause is that states would not have the resources to pay the higher reimbursement costs. This scenario is realistic because state Medicaid directors are already concerned about shortfalls in Medicaid funding,²⁵³ and paying higher reimbursement rates to healthcare providers would require additional state resources. Possible short-term solutions are for states to rely on reserve funds; find new sources of revenue, such as sin taxes or tobacco settlement funds; or for the federal government to take an increased proportion of fiscal responsibility for the Medicaid program.²⁵⁴ However, the only long-term solution is for states to raise taxes to generate additional income for the Medicaid program.²⁵⁵

Despite the financial burden that increased reimbursement rates would place on states, a compelling argument exists that the long-term result of increased access to medical services, particularly preventative services, will actually lower the amount of money spent on indigent healthcare.²⁵⁶ For example, low-income children who have their first preventative dental visit by age one are less likely to require subsequent restorative and emergency room visits, resulting in average dental-related costs almost 40% lower over a five-year period than low-income children who do not have access to a dentist until after age one.²⁵⁷ Providing increased access to primary care physicians can

Care Services, 116 PEDIATRICS 1474, 1476 (2005) (noting a Colorado survey finding that more than half of pediatricians would be willing to accept more Medicaid patients if Medicaid rates were increased to 100% of Medicare rates).

²⁵² See Cunningham & Nichols, *supra* note 56, at 694–95.

²⁵³ See *supra* notes 51–53 and accompanying text.

²⁵⁴ See HOSPITAL TREND WATCH, *supra* note 52, at 5.

²⁵⁵ Moncrieff, *supra* note 90, at 704.

²⁵⁶ See, e.g., STEPHANIE LAWRENCE, ROCKEFELLER CTR. AT DARTMOUTH COLL., MEDICAID REPORT: NEW HAMPSHIRE AND VERMONT: PREVENTIVE CARE AND OBESITY 5 (2006), <http://policyresearch.dartmouth.edu/assets/pdf/obesity.pdf> (arguing that increased access to preventative obesity healthcare services for Medicaid recipients will result in additional expenses for the government, but in the long-run will save up to 8.6% of Medicaid costs for New Hampshire and Vermont).

²⁵⁷ Matthew F. Savage et al., *Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs*, 114 PEDIATRICS 418, 422 (2004).

also significantly reduce the amount of money that the Medicaid program spends on costly hospital emergency room visits.²⁵⁸ Medicaid spent an estimated \$8 billion for 22 million hospital emergency room visits in 2003.²⁵⁹ Studies have shown that regular access to healthcare significantly reduces the inappropriate use of emergency rooms as treatment for primary care symptoms.²⁶⁰

A second possible negative implication of increasing Medicaid reimbursement rates is that privately insured patients will have less access to healthcare because more healthcare providers will be treating Medicaid recipients. This argument has little merit due to the additional deterrents that cause healthcare providers to choose to not treat Medicaid patients.²⁶¹ Healthcare providers will likely still prefer privately insured individuals because of the higher payment rates and fewer difficulties that accompany treating them. Additionally, if fewer Medicaid recipients are visiting hospital emergency rooms due to increased access to primary healthcare providers,²⁶² privately insured and Medicare patients will experience more timely access to emergency room care.

CONCLUSION

The Supreme Court must address the issue of whether Medicaid recipients can enforce the equal access clause through a § 1983 suit. The variety of arguments used by the lower courts indicate a struggle to apply the *Gonzaga* test for § 1983 rights in the context of the Medicaid statute. The Court has denied at least four petitions for certiorari in Medicaid Act cases that offered opportunities to clarify the application of the *Gonzaga* test in this area.²⁶³ The

²⁵⁸ Partnership for Medicaid, Reducing Inappropriate Emergency Room Use Among Medicaid Recipients by Linking Them to a Regular Source of Care, <http://www.clinicians.org/advocacy/ER%20Reduction%20Proposal%20-%20FINAL%208.25.05.pdf> (last visited Oct. 8, 2008) (finding that almost 20% of all emergency room visits are made by Medicaid beneficiaries, who account for less than 15% of all U.S. residents).

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ See *supra* note 48 and accompanying text.

²⁶² See *supra* note 258 and accompanying text.

²⁶³ See, e.g., *OKAAP v. Fogarty*, 472 F.3d 1208, 1209–10 (10th Cir. 2007) (holding after *Gonzaga* that providers do not have enforceable rights under § 1396a(a)(30)(A)), *cert. denied*, 128 S. Ct. 68 (2007); *Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002), *cert. granted in part*, *Frew ex rel. Frew v. Hawkins*, 538 U.S. 905 (2003) (granting certiorari for two of the questions but denying request to review § 1983's applicability to the Medicaid Act), *rev'd*, 540 U.S. 431 (2004); *Antrican v. Odom*, 290 F.3d 178 (4th Cir. 2002) (holding that a state official could not claim immunity under *Ex Parte Young* in an action brought under § 1983), *cert. denied*,

rising cost of healthcare and increased efforts by states to reduce Medicaid costs ensure that low reimbursement rates to healthcare providers will continue to have an adverse effect on Medicaid recipients. With the distinct possibility that even more individuals could be covered under the Medicaid program following healthcare reform in the upcoming year,²⁶⁴ it is imperative that the Court promptly decide this issue.

Despite recent case law to the contrary, the Court should allow Medicaid recipients to bring § 1983 suits under the equal access clause. It is unnecessary for the Court to rely on Congress to change the statute because the subjectivity of the *Gonzaga* test allows for courts to interpret the equal access clause in a way that would allow Medicaid recipients to enforce it.²⁶⁵ Even if Congress were to attempt to clarify the statute, it would be difficult for Congress to satisfy the *Gonzaga* test due to its subjective and complex application. Legislative history already suggests that Congress did, in fact, intend Medicaid recipients to be able to seek recourse for violations of the equal access clause through the courts.²⁶⁶

The Court has noted the relevance of alternative remedies, and the inquiry is particularly relevant for statutes, such as the Medicaid Act, that lack the structure for typical rights-creating language. The lack of alternative legal avenues for Medicaid recipients denied adequate access to healthcare due to low provider reimbursement rates strongly suggests that the Court should rule in favor of an enforceable § 1983 right.

Through the Medicaid program, Congress has chosen to extend healthcare coverage to our nation's poorest citizens. For this program to work, Medicaid recipients must not only receive funding for their medical treatment, but must

537 U.S. 973 (2002); *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir. 2002) (ruling on whether an enforceable right was created by § 1983), *cert. denied*, 537 U.S. 1045 (2002).

²⁶⁴ President Barack Obama supports expanding Medicaid to cover more individuals. See Press Release, The White House, American Reinvestment and Recovery Plan—By the Numbers (Jan. 24, 2009), http://www.whitehouse.gov/assets/Documents/Recovery_Plan_Metrics_Report_508.pdf.

²⁶⁵ In fact, Justice Alito, while serving as a Circuit Judge on the Third Circuit Court of Appeals, wrote that “Medicaid recipients [suing under the equal access clause] plainly satisfy the intended-to-benefit requirement [of a §1983 suit] and are thus potential private plaintiffs.” *Pa. Pharmacists Ass’n v. Houstoun*, 283 F.3d 531, 543–44 (3rd Cir. 2002) (en banc).

²⁶⁶ See H.R. REP. NO. 97-158, at 301 (1981) (noting in passing amendments to the equal access clause that “in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action.”); see also *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1123 (E.D. Cal. 2003) (reasoning that this legislative history demonstrates that Congress intended recipients to be the beneficiaries of the equal access clause); *Memisovski ex rel. Memisovski v. Maram*, No. 92-C-1982, 2004 WL 1878332 (D. Ill. Aug. 23, 2004) (same).

also have access to the physicians, dentists, and hospitals that provide these treatments. The only way to effectuate the purpose of the Medicaid Act and fully ensure that Medicaid recipients have access to an adequate number of healthcare providers is for the Supreme Court to allow Medicaid recipients to enforce the equal access clause through a § 1983 suit, thus ensuring that the equal access clause is not merely “illusory.”

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