

## **Fact Sheet:**

### **Medicaid Early and Periodic Screening, Diagnosis and Treatment: Recent Case Developments<sup>1</sup>**

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## **Fact Sheet: Medicaid Early and Periodic Screening, Diagnosis and Treatment: Recent Case Developments**

Over the last three years, a number of courts have decided questions about EPSDT.<sup>2</sup> The cases discussed below are significant because they decide substantive (as opposed to procedural) questions about how states must implement EPSDT to comply with the Medicaid Act's minimum standards. After listing the cases, this fact sheet discusses the trends emerging from them and then summarizes each case.

### **The EPSDT Cases**

*Frew v. Hawkins*, 124 S.Ct. 899 (2004), *rev'g.*, *Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002), *vacating and remanding*, 109 F. Supp. 2d 579 (E.D. Tex. 2000)

*Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003), *aff'g*, 231 F. Supp. 2d 840 (S.D. Ind. 2002) (hereinafter *Collins*)

*Pediatric Specialty Care v. Ark. Dep't of Human Services & Knickrehm*, 364 F.3d 925 (8th Cir. 2004) (hereinafter *Pediatric Specialty Care II*), *same case* 293 F.3d 472 (8th Cir. 2002) (hereinafter *Pediatric Specialty Care I*)

*Clark v. Richman*, 2004 U.S. Dist. LEXIS 21732 (M.D. Penn. Oct. 7, 2004)

*Memisovski v. Maram*, 2004 U.S. Dist. LEXIS 16772 (N.D. Ill. Aug. 23, 2004)

*S.D. v. Hood*, 2002 U.S. Dist. LEXIS 23535 (E.D. Tex. Dec. 5, 2002) (hereinafter *S.D.*)

*Emily Q. v. Bonta*, 208 F. Supp. 2d 1078 (C.D. Cal. 2001) (hereinafter *Emily Q.*)

*John B. v. Menke*, 176 F. Supp. 2d 786 (M.D. Tenn. 2001) (hereinafter *John B.*)

*Chisholm v. Hood*, 133 F. Supp. 2d 894 (E.D. La. 2001) (hereinafter *Chisholm*)

*Hawkins v. NH Dep't of Health and Human Services*, 2004 DNH 23 (D. NH 2004)

*Lawson v. Dep't of Health & Soc. Services*, 2004 De. Super. LEXIS 60 (Super. Ct. Del. Feb. 25, 2004)

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<sup>2</sup> For discussion of earlier cases, *see, e.g.*, Jane Perkins & Sarah Somers, National Health Law Program, *Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnosis and Treatment Services for Poor Children and Youth* 34-40 (Apr. 2003) (available from NHeLP, [www.healthlaw.org](http://www.healthlaw.org)).

*Jacobus v. Dep't of PATH*, 2004 Vt. 70 (S.Ct. 2004) (hereinafter *Jacobs*)

*Semerzakis v. Wilson-Coker*, 2003 Conn. Super. LEXIS 2378 (Dec. 24, 2003) (hereinafter *Semerzakis*)

*Manglass v. R.I. Dep't of Human Services*, 2003 R.I. Super. LEXIS 122 (Super. Ct. Oct. 6, 2003) (hereinafter *Manglass*)

*Jackson v. Millstone*, 369 Md. 575, 801 A.2d 1034 (Md. Ct. App. 2002) (hereinafter *Jackson*)

*Georgia Dep't of Community Health v. Freels*, 258 Ga. App. 446, 576 S.E. 2d 2 (Ga. Ct. App. 2002) (hereinafter *Freels*)

### **Emerging themes**

The recent EPSDT decisions involved a range of individual and class plaintiffs and various legal forums. Some cases were prosecuted as federally-certified class actions. Others were filed by individual plaintiffs in state courts, and still other cases arrived in state court on appeal from adverse administrative decisions. Regardless of these differences, the cases brought a remarkable level of success to the plaintiffs. When compared with one another, some common themes emerge:

1. State attorneys are filing motions to dismiss EPSDT cases on procedural grounds. The 2001-2004 cases rejected these arguments. Future cases must be closely monitored because, if accepted, these arguments will deny Medicaid beneficiaries their "day in court" regarding the substantive nature of their EPSDT claims.

Provisions of the Medicaid Act have traditionally been enforced in federal courts through another federal statute, 42 U.S.C. § 1983. State attorneys are now arguing that Medicaid beneficiaries cannot enforce the EPSDT provisions through § 1983 because Congress did not intend them to be privately enforced. The question of when a federal statute creates a privately enforceable right has been discussed previously. *E.g.*, Sarah Somers, National Health Law Program, *NAPAS Fact Sheet: An Update on Sovereign Immunity Defenses and Private Rights of Action in Medicaid Cases* (Dec. 31, 2002); *see also* Jane Perkins, *42 U.S.C. § 1983 and Medicaid Act – Docket* (updated regularly) (available from NHeLP, NC office).

Briefly, to be enforceable, the courts have traditionally applied the three-prong *Blessing/Wilder* test, asking whether Congress: (1) intended the provision to benefit the plaintiffs; (2) framed the provision in clear and unambiguous terms sufficient to allow a court to enforce it; and (3) made the provision mandatory upon the state. *See Blessing v. Freestone*, 520 U.S. 329 (1997); *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990). If this test is met, the provision is presumptively enforceable. In 2002, the Supreme Court addressed the first prong of the test in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), finding a provision of the Family Education Rights and Privacy Act unenforceable and holding that the Congressional intent to

benefit the plaintiff must be unambiguously clear. Since *Gonzaga*, state attorneys are aggressively arguing that Medicaid provisions, including EPSDT, are not privately enforceable. While the cases, to date, have upheld the individual's ability to enjoin states from ongoing violations of the federal EPSDT law, this area of the law will continue to be quite controversial.

2001-2003 cases (5): *Pediatric Specialty Care, S.D., Collins* (district court), *John B., Jackson* (state court).<sup>3</sup>

2. The 2001-2003 cases focus on the “T” of EPSDT and have surprisingly positive outcomes, given the current procedural quagmire.

The 2001-2003 cases focused, for the most part, on EPSDT treatment requirements.<sup>4</sup> The Medicaid Act includes a broad treatment requirement for children and youth under age 21, stating that EPSDT services must include:

such other necessary health care, diagnostic services, treatment, and other measures . . . [listed in 42 U.S.C. § 1396d(a)] . . . 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.

42 U.S.C. § 1396d(r)(5).

The 2001-2003 cases find this statute to be clear on its face and read it literally. They ask, first, whether the service at issue comes within the scope of Medicaid benefits listed in § 1396d(a), and if so, whether the service is “necessary to correct or ameliorate” a physical or mental condition that the child plaintiff is experiencing. Applying the statute, a number of the cases refused to allow states to precondition EPSDT services on a child meeting any additional requirements.

2001-2003 cases (7): *Collins, Pediatric Specialty Care, S.D., Chisholm, Semerzakis, Jackson, Freels*.

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<sup>3</sup> There are unpublished cases discussing EPSDT enforcement, and a number of 2001-04 cases discuss private enforcement of the EPSDT laws but do not rule on the substantive issues of the case. For a list of cases see, NheLP's publications concerning Medicaid and Enforcement Under 42 U.S.C. § 1983.

<sup>4</sup> *But see, e.g., Frazar v. Gilbert*, 300 F.3d 530, 546 (5th Cir. 2002) (looking at EPSDT screening statute, 42 U.S.C. § 1396a(a)(43)(B), and agreeing with the state defendants “that a statutory violation of this requirement cannot occur except in cases where eligible persons request screening services”), *rev'd on other grounds sub nom. Frew v. Hawkins*, 124 S.Ct. 899 (2004).

3. The courts affirmed the important role of the EPSDT screening provider in deciding whether a state must cover a requested the service.

To decide whether a coverable service is needed to correct or ameliorate the child's condition, the courts paid attention to the following phrase from the statute: "discovered by the screening services." 42 U.S.C. § 1396d(r)(5). The courts tended to defer to the recommendations of the child's treating physician.

2001-2003 cases (5): Collins, Pediatric Specialty Care, S.D., Emily Q., Manglass.

4. Many of the cases focused on community-based behavioral and mental health services.

Over the years, EPSDT litigation has tended to focus on specific aspects of the federal requirements. Early cases sought to require state Medicaid programs to implement an EPSDT program. Later cases focused on the provision of screening services, such as lead blood level assessments. A final "group" of cases obtained coverage for needed transplant services. For more information, see Jane Perkins & Sarah Somers, *An Advocate's Guide to the Medicaid Program* at 4.4–4.5, notes 46-50 (June 2001). Between 2001 and 2003, the subject matter of EPSDT litigation tended to shift towards community-based mental and behavioral health services.

2001-2003 cases (5): Collins, Pediatric Specialty Care, Emily Q., Chisholm, Manglass

5. Courts refused to allow State Medicaid agencies to avoid responsibility for implementing EPSDT, despite their contracts and agreements with private entities and other state and local agencies.

Many state Medicaid agencies have contracted with private managed care entities to provide all or a set of covered Medicaid services. And in most states, other state and local agencies, such as mental health departments, are agents of the state Medicaid agency implementing parts of the Medicaid program.

The 2001-2003 cases repeatedly noted that these contracts and agreements do not allow the state Medicaid agency to avoid responsibility for implementing EPSDT. Rather, as the "single state agency" under federal law, the state Medicaid agency remains legally responsible for the implementation of the Medicaid program. See 42 U.S.C. § 1396a(a)(5).

2001-2003 cases (2): Emily Q., John B.<sup>5</sup>

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<sup>5</sup> See also *Rosie D. v. Romney*, 256 F. Supp. 2d 115 (D. Mass. 2003) (granting motion to compel production of documents in EPSDT case, finding that documents held by behavioral health

6. Where the parties consented to resolve the issues, extensive and helpful detail was included, and in *Frew*, the Supreme Court has affirmed the ability of federal courts to enforce the provisions of these agreements.

When the EPSDT plaintiffs were able to negotiate settlements with the state officials, the relief obtained was detailed. Rather than simply ordering the officials to stop violating the EPSDT laws, these consent agreements set forth specific steps the state officials would take to comply with the law. Improved coordination among the state Medicaid agency and its agents was addressed. Innovative solutions were developed.

2001-2003 cases (2): *Emily Q.*, *John B.*,

### The case summaries

***Frazar v. Gilbert*, 300 F.3d 530 (5th Cir. 2002), vacating and remanding, 109 F. Supp. 2d 579 (E.D. Tex. 2000), cert. granted in part sub nom. *Frew v. Hawkins*, 123 S.Ct. 1481 (2002)**

Background: This case began in 1993 when mothers of EPSDT-eligible children filed suit against state Medicaid officials. According to the plaintiffs, the Texas Medicaid program: (1) failed to satisfy federal requirements that eligible children receive health, dental, vision and hearing screens, (2) provided inadequate notice of available services to recipients, (3) failed to meet annual participation goals, (4) lacked proper case management procedures, and (5) did not provide uniform services throughout the state. After intense negotiations, the parties entered into a consent decree which outlined a comprehensive plan for implementing the federal EPSDT statute.

Two years after the consent decree was entered, the plaintiffs filed a motion to enforce the decree in federal district court. The state officials denied the allegations and responded that the state sovereign immunity principles of the Eleventh Amendment precluded the federal court from enforcing the decree. Following an evidentiary hearing, the district court held that certain provisions of the consent decree had been violated and rejected the Eleventh Amendment arguments. The state officials were ordered to develop a compliance plan.

The state officials appealed and the Court of Appeals for the Fifth Circuit reversed the lower court's decision, holding that the Eleventh Amendment barred enforcement of the decree: Unless the violation of the consent decree was also a statutory violation of the Medicaid Act that imposed a clear and binding obligation on the State, the consent decree could not be enforced by

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managed care organizations (MCOs) are in the "possession, custody or control" of the state agency within the meaning of Fed. R. Civ. R. Rule 34, because MCOs are agents of the Medicaid agency and the agency has legal authority to obtain the documents).

the federal court.

The Supreme Court's decision: In a unanimous decision, the Court overturned the Fifth Circuit. It held that federal court enforcement of the consent decree did not violate the Eleventh Amendment.

The children asserted that the consent decree could be enforced without violating the Eleventh Amendment for two reasons: 1) the State of Texas waived its Eleventh Amendment immunity in the course of litigation, and 2) enforcement was permitted. Because the Court found that the consent decree was enforceable under *Ex parte Young*, it did not address the argument regarding waiver.

According to the Court, *Frew* involved the intersection of the Eleventh Amendment and the rules governing consent decrees. While the Eleventh Amendment shielded states from law suits brought by individuals without their consent, suits for prospective injunctive relief against state officials who violate federal law are permitted the *Ex parte Young* exception to Eleventh Amendment sovereign immunity that allowing federal courts to enjoin state actors from engaging in ongoing violations of federal law. *Ex parte Young*, 209 U.S. 123 (1908).

The Court acknowledged that consent decrees must be directed at protecting federal interests. In *Firefighters v. Cleveland*, 478 U.S. 502, 525 (1986), the Court found that a consent decree “must spring from, and serve to resolve, a dispute within a court’s subject matter jurisdiction; must come within the general scope of the case made by the pleadings; and must further the objectives of the law upon which the complaint was based.” Thereafter, injunctive relief was not prohibited by the Eleventh Amendment and could be used to enforce a consent decree entered into by the parties and approved by the district court. “Federal courts are not reduced to approving consent decrees and hoping for compliance. Once entered, a consent decree may be enforced.”

While finding the consent decree enforceable, the Court agreed with the state officials’ concerns that enforcement of the consent decree could undermine the sovereign interests and accountability of state governments. It stated, however, that a response to these concerns came from Rule 60(b)(5) of the Federal Rules of Civil Procedure, not the Eleventh Amendment. The Court explained that Rule 60(b)(5) permits parties to seek relief if the prospective application of the judgment is no longer equitable. According to the Court, state officials charged with the responsibility of complying with a consent decree as a result of a *Ex parte Young* suit should be allowed “latitude and substantial discretion” in satisfying the Court’s order. Courts should be flexible and agree to alter the decree if a state can establish a reason for modification; where a state cannot provide such a reason, the terms of the decree should be enforced.

Note: The Court specifically refused to decide whether the EPSDT provisions create enforceable federal rights under § 1983.

***Collins v. Hamilton*, 2003 US App. LEXIS 22777 (7th Cir. 2003), *aff'g*, 231 F. Supp. 2d 840 (S.D. Ind. 2002)**

Background: This federal court class action challenged the State of Indiana's refusal to cover long-term psychiatric residential treatment facility services (PRTF) for children under age 21. The State contended that other inpatient psychiatric offerings were sufficient to meet the children's needs. After the district court ruled for the plaintiffs, the state officials appealed to the Seventh Circuit Court of Appeals.

The Court's decision: The Seventh Circuit affirmed the district court. Before reaching the merits of the case, however, the Court flatly rejected a State argument that the plaintiffs could get the services through another state program (if the child became a ward of the state):

We . . . reject Indiana's argument concerning the availability of residential placement through the state's CHINS [Child in Need of Services] program. Indiana's obligations under Medicaid stand independent of any services available through its parallel state programs.

2003 U.S. App. LEXIS at \*12 n.7.

To resolve the substance of the dispute, the Court applied the EPSDT treatment statute, 42 U.S.C. § 1396d(r)(5). It looked at whether PRTFs come within the scope of services listed in § 1396d(a) and found that § 1396d(a)(16) covers "inpatient psychiatric hospital services for individuals under age 21" so long as they covered consistent with another Medicaid Act provision, § 1396d(h). Section 1396d(h) includes inpatient psychiatric hospitals and other inpatient settings specified by the Secretary in regulations. In regulations, the Secretary has specifically included PRTF as an inpatient venue. *See* 42 C.F.R. § 441.151 Thus, the Court concluded, "Under the language of the Act and the provisions in the regulations, we find that PRTFs qualify as 'inpatient psychiatric hospitals,' and therefore placement in a PRTF is included within the ambit of covered EPSDT services." *Id.* at \*9-10.

Next, the Court turned to the question of whether coverage of PRTF was required for the plaintiff children. It held that Indiana is required to fund the cost of placement in a PRTF if it is deemed "medically necessary" for the child by an EPSDT screening: "[A] state's discretion to exclude services deemed 'medically necessary' by an EPSDT provider has been circumscribed by the express mandate of the statute . . . to provide to children under age 21 all necessary services." *Id.* at \*14 n.8 (citations omitted).

***Pediatric Specialty Care v. Ark. Dep't of Human Services & Knickrehm*, 293 F.3d 472 (8<sup>th</sup> Cir. 2002)**

Background: Due to budget shortfall, Arkansas amended its state plan to eliminate Early Intervention Day Treatment (EIDT) services for children under age 21. EIDT is provided by

early childhood specialists and overseen by medical staff. The services “are structured to ameliorate conditions discovered by the EPSDT evaluations and to strengthen the skills children learn in therapy.” 293 F.3d at 476 n. 2. Evidence presented by the providers showed that EIDT can reduce developmental disability. The State argued that EIDT is not a required Medicaid service and, thus, need not be covered through EPSDT. Providers of EIDT services and some children who had been receiving EIDT filed suit in federal court to challenge the elimination of coverage.

The Court’s decision: Applying the EPSDT treatment statute, 42 U.S.C. § 1396d(r)(5), the Court decided, first, that EIDT comes within the list of coverable services in § 1396d(a). Specifically, the Court found that EIDT is a “rehabilitative service . . . for the maximum reduction of disability and for restoration of an individual to the best possible functional level.” *See* § 1396d(a)(13). It continued:

[T]he State Plan need not specifically list every treatment service conceivably available under the EPSDT mandate. The State Plan, however, must pay part or all of the cost of treatments to ameliorate conditions discovered by the screening process when those treatments meet the definitions set forth in § 1396a. *See* § 1396 (r)(5).

*Id.* at 480. Having found EIDT within the scope of Medicaid benefits, the Court described the test for deciding whether children need the service:

[A] Medicaid eligible individual has a federal right to early intervention day treatment when a physician recommends such treatment. . . . Therefore, . . . , if the CHMS [Child Health Management Services] physician prescribes early intervention day treatment as a service that would lead to the maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level, the Arkansas State Plan must reimburse the treatment.

*Id.* at 480-81.

The Court closed with a reminder to the state officials that it intended children and their families actually to know about Medicaid coverage of EIDT.

Finally, we remind state that it has a duty under 42 U.S.C. § 1396a(a)(43) to inform Medicaid recipients about the EPSDT services that are available to them and that it must arrange for the corrective treatment prescribed by physicians. The state may not shirk its responsibilities to Medicaid recipients by burying information about available services in a complex bureaucratic scheme.

*Id.* at 481.

***S.D. v. Hood*, 2002 US Dist. LEXIS 23535 (E.D. Tex. Dec. 5, 2002)**

Background: This Louisiana federal court case seeks coverage of incontinence underwear prescribed for a teenage Medicaid beneficiary who is totally incontinent as a result of spina bifida. The State denied coverage, saying that incontinence underwear is not medical in nature or within the scope of the Medicaid program. The diapers were specifically excluded from coverage in the State's Medicaid policy manuals.

The Court's decision: The Court held that the exclusion of incontinence supplies under EPSDT is improper because they are "unquestionably within the scope of services fundable under § 1396d(a)." 2002 U.S. Dist. LEXIS 23535, \*28. Specifically, the Court found that the supplies could be covered through a number of the services listed in § 1396d(a), for example, as home health, durable medical equipment, or preventive services. *Id.* at \*11-12. The Court also noted that the federal Medicaid agency has approved state plans for at least eight states which include incontinence supplies, thus surmising that the service must be coverable under § 1396d(a). *Id.* at \*28.

The Court then looked at whether the incontinence supplies were needed by the teenaged plaintiff. It found substantial evidence of need given by the child's treating physician and rejected the state physician's "after-the-fact determination" that incontinence underwear is not medically necessary. *Id.* at \*31. The Court also discounted the qualifications of the state's physician finding that the doctor's experience was "singularly focused on adult and pediatric cardiology" and that the doctor made no "overtures about having studied the medical records of SD, having examined SD, or even having had the occasion to treat patients like SD with any regularity." *Id.*

Fifth Circuit review: The state officials appealed the case to the Fifth Circuit Court of Appeals. Oral argument was heard in September 2003. In briefing and at oral argument, the state officials, represented by Covington & Burling, argued that the EPSDT provisions are not privately enforceable (citing *Gonzaga*) and that coverage is not required because the EPSDT laws

do not specifically state that incontinence supplies are a required EPSDT service (citing *Alexander v. Sandoval*, 532 U.S. 275 (2001)).

***Emily Q. v. Bonta*, 208 F. Supp. 2d 1078 (C.D. Cal. 2001)**

Background: In this federal court class action case, children with intensive mental health needs allege that state Medicaid officials have failed to cover the full range of mental health services under EPSDT. The published opinion, cited above, concerns one service in particular, Therapeutic Behavioral Service (TBS), short term 1:1 assistance to a needy child in home or community-based settings to allow institutionalization to be avoided or ended. After the complaint was filed, the state Medicaid defendant stipulated to the allegations of the First Amended Complaint, to entry of judgment against her on all claims, and to entry of a permanent injunction. However, disputes arose over the extent of relief that the Defendant would provide. The plaintiffs filed a motion for a permanent injunction with the district court.

The Court's decision: The Court granted in part and denied in part the permanent injunction. The ruling resolves a number of disputes regarding the nature of the state Medicaid agency's EPSDT informing, screening and treatment obligations and the role of the state Medicaid agency vis-a-vis mental health departments and managed care organizations.

Regarding the State's argument that its obligations had been shifted to mental health departments and MCOs, the Court held:

. . . [The Department of Health Services] DHS is the 'single state agency responsible for the administration of the Medicaid program' in California. Therefore, DHS decides how to operate Medicaid, and DMH [Department of Mental Health] and the MHPs [Mental Health Plans] must comply with any decision of DHS, i.e., DMH and the MHPs are subject to the 'control' of DHS in the administration of Medicaid.

208 F. Supp. 2d at 1093.

From here, the Court required DHS, individually and through its agents, to undertake a number of specified outreach activities designed to inform beneficiaries and behavioral health providers, periodically, about EPSDT and TBS. *Id.* at 1096-98. The Court also issued a detailed injunction regarding screening and treatment for TBS services. Among other things, it required DHS to assure that assessment and treatment of children occur and enjoined DHS to consult with state licensing boards and MHPs to adopt certification standards for the mental health professionals who would be providing TBS. *Id.* at 1111-12. Finally, the Court ordered compensatory TBS for class members who had been denied services. *Id.* at 1108-11.

While the Court granted most of the injunctive relief requested by the plaintiffs, it refused to allow direct requests for TBS services. Looking at the words of the EPSDT statute, the Court found that it covers treatment "the need for which is disclosed by a child health screen." 42 U.S.C. § 1396d(r)(5). Therefore, according to the Court, direct requests from the

child's family or care takers were not required. The Court took the position that TBS would properly be covered if the State provides adequate notices to beneficiaries that TBS is a covered Medicaid service, thus enabling beneficiaries to seek screening and discuss all service options, including TBS, with the screening provider. The request for TBS would then come from the child health screener. *Id.* at 1100.

***John B. v Menke*, 176 F Supp. 2d 786 (M.D. Tenn 2001)**

Background: This federal class action complaint, filed in 1998, alleged a failure by the state Medicaid agency to implement EPSDT in its statewide managed care system, called TennCare. The parties quickly filed an agreed upon consent decree. However, the state failed to implement a number of provisions in the decree, so the plaintiffs filed a motion for contempt.

The Court's decision: After reviewing of the State's efforts, the Court found that the informing and EPSDT service requirements of federal law were being violated. It did not, however, hold the State in contempt. Rather, the Court appointed a "special master" with expertise in the matters at issue and charged this person with the responsibility of working with the parties to improve compliance with the federal EPSDT laws. The Court's decision on the contempt motion is notable for its discussion of the role of managed care. Looking at the situation in Tennessee, the Court stated:

[M]anaged care creates incentives for cutting costs and denial of care. However, commentators have rightly observed that managed care, at least in theory, would appear to be an ideal model for the delivery of EPSDT services because it promotes preventive and primary care. However, in practice, the first of these incentives appears to outweigh the latter. In practice, MCOs and BHOs [behavioral health organizations] do not appear to take a long-term approach to the provision of EPSDT services in order to prevent future expenditures. . . . Creative government is only effective when that creativity spurs positive change.

176 F. Supp. 2d at 801, 803. The Court then commented on the failure of the State Medicaid officials to implement EPSDT in managed care settings.

EPSDT cannot be simply relinquished to the MCOs, as the State remains ultimately bound by the EPSDT regulations. . . . EPSDT does not trickle down; it requires hard work and mandatory language. . . . Clearly, the failure of State contractors to follow the federal requirements does not relieve the State Defendants of their responsibilities. *Id.* at 801 (quoting *J.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993) ("It is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibility by contracting away its obligations to a private entity.")).

A person can only be deemed "informed" when she has enough information to determine that she has been informed in the first place. *Id.* at 802.

The Defendants should be commended for attempting to use performance indicators to reward and penalize its contractors. However, EPSDT is a federal requirement. The State may not simply throw monetary incentives at a contractor, as a trainer throws fish to a sea lion, in order to meet its screening mandates. Meeting EPSDT screening requirements is a duty, not something that merits a reward. *Id.* at 803.

Finally, the Court noted the difference between the legal standards that apply to alleged violations of a consent decree and those that apply to alleged violations of federal law: “[W]hereas Defendants may theoretically escape contempt by a showing of substantial compliance with the Consent Decree, federal law requires strict compliance. Hence, the Court finds that Defendants’ failure to comply with the EPSDT mandate does constitute a violation of federal law.” *Id.* at 806-07.

***Chisholm v. Hood*, 133 F. Supp. 2d 894 (E.D. La. 2001)**

Background: The class action case was filed in 1997. While the parties were able to settle most of the case, one issue could not be resolved. This issue concerned the State’s obligation under EPSDT law to provide psychological and behavioral services rendered by psychologists to class members diagnosed with autism. The Medicaid agency argued that these services were adequately covered through other health care providers.

The Court’s decision. The Court ruled for the child plaintiffs. It noted that psychologists are licensed health practitioners who provide both preventive and rehabilitative services to persons with autism. The Court then turned to the treatment provisions of the EPSDT statute, § 1396d(r)(5). Applying the statute, the Court looked at whether the behavioral and psychological services at issue come within the listing of coverable services at § 1396d(a). Looking over the benefits, the Court found these services fall within at least two of the described services: remedial care recognized under state law, § 1396d(a)(6), and preventive and rehabilitative services recommended by a health care provider for the “maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level,” § 1396d(a)(13). Therefore, the Court reasoned, the services “must be provided when needed to correct or ameliorate conditions, as required by 42 U.S.C. § 1396d(r)(5).” *Id.* at 898.

Next, the Court addressed the State’s arguments that needed services were available through the current mental health system:

Psychiatrists. Plaintiffs’ expert testimony established that psychiatrists do not substitute for psychologists because they generally are not trained in and do not provide the types of intensive behavioral treatments that have been shown to be effective in treating autism.

Mental health clinics and rehabilitation programs. The State’s criteria conditioned access on a diagnosis of mental illness and did not include autism as mental illness. Also, these programs were not required to have psychologists on staff.

Rural health clinics and federally qualified health centers. These sites provide mostly acute and preventive services and are not primarily engaged in providing mental health services. Psychologists are not commonly on staff.

School services. Services in schools are focused on the educational needs of the child and do not address other needs such as behavioral services. Individual plans are sued during school hours and do not meet a child's needs at home or elsewhere in the community.

Physician's offices. Psychologists generally have independent practices. Unlike speech or occupational therapists, they do not provide services through other providers.

*Id.* at 899-901. After considering all of the State's current offerings, the Court said they were "more theoretical than actual." *Id.* at 901. It found the EPSDT treatment statute, § 1396d(r)(5), was being violated and ordered the parties to develop a remedial plan.

***Semerzakis v. Wilson-Coker, 2003 Conn. Super. LEXIS 2348 (Super. Ct. Dec. 24, 2003)***

Background: The Connecticut Medicaid agency denied the child's request for orthodontic services. State regulations provided that the need for orthodontia would be determined based on the "Salzmann Assessment" for determining handicapping malocclusions. The Department deemed orthodontic treatment to be medically necessary for persons who achieved a certain score on the Assessment. The plaintiff, whose score did not qualify, was required to show that, if left untreated, the problems would cause "irreversible damage to the teeth and underlying structures." The state argued this regulation was a permissible utilization control authorized by 42 C.F.R. § 440.230(d) (allowing the state to place "appropriate limits on services based on criteria such as medical necessity"). The plaintiff argued that the limitation violated the EPSDT treatment requirements established at 42 U.S.C. § 1396d(r)(5).

The Court's decision: The hearing decision "conspicuously ignored" the provisions of § 1396d(r)(5). 2003 Conn. Super. LEXIS 3478 \*10. It applied a one-step analysis, dealing only with Connecticut's rules and failed to take the second-step of the analysis mandated by § 1396d(r)(5), "which requires that a determination be made of whether orthodontic services are 'necessary,' even though not provided for in Connecticut's plan." *Id.* at \*9. The case was remanded to a new hearing officer.

***Manglass v. R.I. Dep't of Human Services, 2003 R.I. Super. LEXIS 122 (Super. Ct. Oct. 6, 2003)***

Background: This case involved a child with Williams Syndrome, a condition which causes global developmental delays and behavior problems. After evaluating the child, her treating physician and hospital team recommended that she receive home-based therapeutic services. LaPlante Center, which was going to provide the services, submitted a request to the state Medicaid agency seeking coverage of 40 hours per week. The State, following the

recommendation of its physician reviewer, approved only 15 hours per week. An administrative hearing affirmed the State's decision. The final administrative decision was then appealed to state court.

The Court's decision: The Court agreed that the claimant had not established the need for 40 hours per week of home-based therapeutic services; however, it also found that the State's reduction to 15 hours per week was not adequately supported. The case was remanded to the agency to determine the correct number of home-based therapeutic service hours for the child.

The Court had to balance the contending allegations of the child's providers and the state agency's utilization review physician. The Court refused to discount the testimony of the agency's physician just because he had not treated the child. "The EPSDT regulations do not require the agency to evaluate the child. . . . [T]he agency's reliance on reports from professionals for the basis of its decision was not clearly erroneous." 2003 R.I. Super. LEXIS 122, \*14.

Notably, the agency physician's recommendation was not contrary that of the child's treating professionals. All agreed that she needed home-based therapeutic services. However, neither her pediatrician nor the hospital team indicated the number of hours needed. LaPlante Center did indicate a need for 40 hours per week, but the Court refused to defer to this recommendation because the Center was "a service provider and does not have experience with diagnosis of Williams Syndrome children." *Id.* at \*14 n.2. Yet, finding "no reliable, probative and substantial evidence in the record to support the agency physician's recommendation" of 15 hours, the case was remanded to the agency. *Id.* at \*16.

***Jackson v. Millstone*, 369 Md. 575, 801 A.2d 1034 (Ct. App. 2002)**

Background: Johns Hopkins Hospital requested prior authorization from the state Medicaid agency of liver transplant surgeries for two children. The authorization was denied, based on the State's prior authorization regulation. The regulation required documentation to show that the treatment was both *necessary* (i.e., directly related to preventive, curative treatment) and *appropriate* (i.e., effective, taking into consideration the particular circumstances of the individual and cost of alternatives). Prior authorization of the transplants was denied as not appropriate for either child. Johns Hopkins Hospital, nevertheless, performed the transplant surgeries and then appealed the decision to state court on behalf of itself and the families of the children.

The Court's decision: As a preliminary matter, the Court addressed a number of arguments by the State that the plaintiffs lacked standing to sue. First, the State argued that the case was moot because the surgeries already had occurred and one of the children had died. The Court held that the case was not moot with respect to the live plaintiff because it concerned a department regulation that could affect the child in the future.

Next, the State claimed that it had sovereign immunity to suit. The Court rejected this

argument on a number of grounds, finding that it could decide a number of the plaintiffs' claims, including one based on the state declaratory relief statute, which allows for declaratory judgments from the court as to the correct application of a law and gives plaintiffs standing to enjoin state officials from enforcing a state law claimed to be repugnant to federal law. *Id.* at 590-93.

Finally, the court turned to the merits. It focused on the EPSDT statute, specifically the requirement that EPSDT include "necessary health care, diagnostic services, treatment, and other measures. . . ." 42 U.S.C. § 1396d(r)(5). The Court found no mention of an appropriateness requirement in the statute. It refused to allow the State to add the requirement through the state prior authorization regulation:

The federal program makes no mention of utilizing an "appropriateness" analysis in determining whether a medicaid-eligible child should receive medically necessary treatments provided through EPSDT services. . . . Therefore, because the [state] provision imposes additional criteria upon qualified recipients, which illegally denies services to those who would normally receive medically necessary treatment, we agree with the plaintiffs that . . . [the state prior authorization regulation] . . . is partially invalid under federal law.

*Id.* at 600.

Note: Following this decision, the State of Maryland amended its rules to omit the "appropriateness" requirement for EPSDT services.<sup>6</sup>

***Georgia Dep't of Community Health v. Freels*, 258 Ga. App. 446, 576 S.E. 2d 2 (Ct. App. 2002)**

Background: This case involved EPSDT coverage of hyperbaric oxygen therapy (HBOT) for a child with cerebral palsy. Used for many years to treat individuals suffering from diving accidents and other problems, HBOT has only recently been used to treat children with cerebral palsy. The Freels family paid for their son to receive a limited number of HBOT treatments, and the treating providers improvements in his speech and motor activity. A request was submitted to the Medicaid program to cover HBOT, but the service was denied. The State decided that the claimant had failed to show that HBOT was an acceptable standard of medical practice or that it was medically necessary for Freels.

The Court's decision: The Court looked at the EPSDT statute's "necessary health care" requirement. 42 U.S.C. § 1396d(r)(5). It held that the "federal statute does not require that a treatment also be 'an acceptable standard of medical practice' to be eligible for reimbursement."

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<sup>6</sup> Conversation with Laurie Norris, J.D., Center for Public Justice, Baltimore, MD (December 8, 2003).

258 Ga. App. at 450. Thus, the Court found that the State had applied the wrong standard of proof:

Instead of requiring proof that HBOT is the accepted standard medical practice, or that it meets the definition of medical necessity reserved for adult Medicaid recipients, the [Department] should have focused its inquiry on whether HBOT was necessary to correct or ameliorate [Freels'] physical condition.

*Id.* (quoting superior court decision).

### **Conclusion**

In the coming months, state and federal courts will continue to decide cases involving the EPSDT program. Barring a novel ruling from the Supreme Court that Medicaid Act or EPSDT cannot be privately enforced, the trends identified in this fact sheet will certainly continue to develop. The National Health Law Program will post information in electronic and hard copy formats to inform advocates of developments in EPSDT law.