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Q&A: Dissecting the EPSDT "request a screen" argument[1]

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Q: Recent lawsuits are seeking to enforce the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement that state Medicaid programs cover treatment services necessary to "correct or ameliorate" children's physical and mental conditions. 42 U.S.C. § 1396d(r)(5). In some of these cases, state Medicaid directors (the defendants) are arguing that, under the Medicaid Act, child health screening services are covered only "where they are requested," 42 U.S.C. § 1396a(a)(43)(B); and treatment, only when "the need … is disclosed by such child health screening services," *id.* at § 1396a(a)(43)(C). According to the Medicaid directors, the children in these cases did not request EPSDT screens and such screens were not, in fact, provided. As a result, they say the statutory treatment requirements were never triggered. Can you explain the basis for this "request a screen" argument and potential responses to it?

Background on EPSDT

EPSDT is a mandatory Medicaid service for children and youth under age 21. Congress clarified and strengthened the EPSDT provisions in 1989, adding, among other things, the explicit "correct or ameliorate" treatment requirement. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

States must effectively inform all Medicaid-eligible persons under age 21 about the availability of EPSDT. *Id*. at § 1396a(a)(43)(A). The Medicaid Act requires states to cover four separate screens: medical, dental, vision, and hearing. The medical screen has five required components: a comprehensive health and developmental history, unclothed physical exam, immunizations, laboratory testing, and health education.

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Screening services must be provided according to "periodicity schedules," pre-set by the state in consultation with child health experts, and at other intervals when needed to determine whether a child needs care. *Id.*at §§ 1396a(a)(43)(B), 1396d(r)(1)-(4).

The Medicaid Act requires states to arrange for corrective treatment. *Id.* at § 1396a(a)(43)(C). It also establishes the scope of covered benefits and medical necessity standard for assessing each child's needs. The scope of benefits includes all mandatory and optional services listed in the Act at 42 U.S.C. § 1396d(a) (listing 29 services categories), whether or not such services are covered for adults. The Act requires coverage of "necessary health care, diagnostic services, treatment, and other measures … to correct or ameliorate defects and physical and mental illnesses and conditions[.]" *Id*. at § 1396d(r)(5). The state Medicaid agency must "make available a variety of individual and group providers qualified and willing to provide EPSDT services," 42 C.F.R. § 441.61, and ensure the timely provision of screening and treatment services, *id.* at § 441.56.

In sum, the EPSDT provisions are designed to ensure "that poor children receive comprehensive health care at an early age ... [and] provide health education, preventive care, and effective follow-up care for conditions identified during check-ups." *Salazar v. District of Columbia,* 954 F. Supp. 278, 303 (D.D.C.1996); *Antrican v. Buell*, 158 F. Supp. 2d 663, 672 (E.D.N.C. 2001) (same).

Over the years, lawsuits have been filed by families and children to challenge states' failures to cover screening and treatment services as required by federal law. *See* Jane Perkins, National Health Law Program, *EPSDT Docket* (Nov. 2013), *at* www.healthlaw.org. (annotated docket of federal and state court cases). Some of these cases focus on a lack of screening and informing, while others concern children who are unable to obtain necessary treatment services. *Id*. In recent years, this latter type of case has become more common. And in response, some state agencies have asked courts to dismiss EPSDT treatment claims using the "request a screen" argument.

Dissecting the "request a screen" argument

States making the "request a screen" argument cite rules of law that require courts, as well as government agencies, to give effect to the unambiguously expressed intent of Congress. See, *e.g.*, *Chevron USA Inc. v. Natural Res. Def. Council*, 467 U.S. 837, 842-43 (1984). The argument isolates two EPSDT provisions: 42 U.S.C. § 1396a(a)(43)(B), which requires Medicaid-participating states to "provid[e] or arrang[e] for the provision of such screening services in all cases where they are requested," and 42 U.S.C. § 1396a(a)(43)(C), which requires states to "arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services." Citing these

subsections, the states argue that the corrective treatment requirement (to cover services necessary to "correct or ameliorate" the child's conditions) is triggered only when the child formally requests an EPSDT screen.

There are a number of problems with this argument. It relies on only selected subsections of § 1396a(a)(43), ignoring the provision's overall construction and the congressional intent behind EPSDT. The argument is also inconsistent with long-standing federal agency instructions, and it does not acknowledge the case law. Each of these aspects is discussed below.

The intent of EPSDT and § 1396a(a)(43)

When introducing the EPSDT amendments in 1967, President Johnson said the objective "is to discover, as early as possible, the ills that handicap our children. There must be continuing follow-up treatment so that handicaps do not go untreated … We must enlarge our efforts ... 13 Cong. Rec. 2883, 2885 (Feb. 8, 1967) (Statement of President Lyndon B. Johnson). The idea was to make comprehensive preventive and treatment services available to all children on Medicaid. *See* Centers for Medicare & Medicaid Services (CMS), *State Medicaid Manual* § 5010.

Congress has established how EPSDT is to work in 42 U.S.C. § 1396a(a)(43)(A)-(D),[2] and in these sections, requires Medicaid-participating states to provide for informing, screening, treating and reporting.

As the first step in providing for comprehensive preventive and treatment services, state Medicaid agencies are to "inform all persons in the state who are under age 21 and who have been determined to be eligible for medical assistance" of the availability of EPSDT screening and treatment services. *Id.* at § 1396a(a)(43)(A); *see also* 42 C.F.R. § 441.56 (requiring "effective informing" using a combination of non-technical written and oral methods to provide information about the benefits of preventive care; the EPSDT services that are covered, as well as where and how to obtain them; and that transportation and appointment scheduling assistance are available). The informing obligation is not a one-time event but, rather, is ongoing. *See* CMS, *State Medicaid Manual* § 5310.D ("[N]otifying recipients of the time they are due to receive a screening service is an integral part of … [the state Medicaid agency's] … responsibility ... As individual recipients approach age levels when an EPSDT screening is due, notify them that it is appropriate to receive services.").

Next, the Medicaid Act requires the state agency to "provid[e] or arrang[e] for the provision of such screening services in all cases where they are requested[.]" 42 U.S.C. § 1396a(a)(43)(B); *see also* 1967 U.S. Code Cong. & Admin. News 2834, 3032 (stating

[2] For a description of the "what" of EPSDT, see 42 U.S.C. § 1396d(r).

original Congressional intent that states engage in "vigorous efforts" to screen).[3] In addition to pre-set periodic screens, the Medicaid Act requires states to cover screening services "at such other intervals," as needed. 42 U.S.C. § 1396d(r).

Section 1396a(a)(43)(C) requires the state to "arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services." *Id.* at § 1396a(a)(43)(C). Finally, federal law requires states to report regularly on their EPSDT performance. *Id.* at § 1396a(a)(43)(D).

As the states point out, the subsections of (a)(43) do refer to "such" screening services. The intent behind EPSDT, however, is that these subsections will build upon each other, with all of the building blocks accounted for. And in the question presented to frame this Q&A, the attorney has pointed out that his clients did not know about EPSDT. Arguably, the state has forgotten the intent behind EPSDT and apparently ignored the requirement of (a)(43)(A) to effectively inform families, choosing instead to passively wait for families to discover the existence of EPSDT screening and/or use the magic words for requesting such a screen.

Long-standing federal interpretation

Significantly, regardless of the extent to which a state is effectively informing families and children of EPSDT, the federal Medicaid agency has repeatedly instructed states to make EPSDT easy for children to obtain. To this end, the federal agency has taken the position that states cannot condition EPSDT services on families and children requesting certain, state-recognized screens or require them to use magic words for a request to be considered a screen under 42 U.S.C. §§ 1396a(a)(43)(B) and (43)(C).

In administering the Medicaid program, CMS and its predecessor agency, the Health Care Financing Administration (HCFA), have repeatedly emphasized that Congress's preventive intent for the EPSDT program requires states to actively seek out and screen children who may need corrective treatment. The CMS *State Medicaid Manual* states that the EPSDT law's fundamental purpose is to "[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly." CMS, *State Medicaid Manual* § 5010.B. The State Medicaid Manual continues, establishing mandatory guidelines for the states, as follows:

Consider a recipient [who is] receiving services to be participating [in EPSDT].

[3] The requirement that states provide or arrange for screening services in all cases where they are requested has been a part of the Medicaid Act since 1972. *See* 1972 U.S. Code Cong. & Admin. News 1548, 1712-13 (Oct. 30, 1972); *see* 42 C.F.R. § 441.56(b)(1)

> This is true whether the recipient has requested services directly from you or elsewhere…. Once you know that a recipient is participating, assure that the recipient receives timely delivery of services for the next encounter under the periodicity schedule.

Id. at § 5310; *see also, e.g.*, HCFA, Guidance Letter to State Medicaid Directors at 10 (Jan. 10, 2001) ("Under federal EPSDT rules, States must provide for periodic screens," the "goal" of which is to "assure that all children receive preventive care so that health problems are diagnosed as early as possible, before the problems become complex and treatment more difficult and costly."); State Medicaid Operations Letter No. 91-44 (HCFA Region II) (June 3, 1991) (noting "the concept historically embodied in the EPSDT program [is] to diagnose and treat health problems early before they worsen and become more costly" and "[t]o view this legislation otherwise[] is contrary to the preventative thrust of the program").

As noted above, the Medicaid Act entitles children to coverage of screening at times other than the pre-set periodic screens. *See* 42 U.S.C. § 1396d(r). These screens are commonly referred to as "interperiodic screens." According to CMS, "We have long considered any encounter with a health care professional acting within the scope of his/her practice [to be] inter-periodic screening." CMS Letter to State Medicaid Directors 01-006 (Jan. 10, 2001);[4] *see*, *e.g.*, State Medicaid Operations Letter No. 91-44 (Region II) (June 3, 1991) (stating same and adding, "It does not matter if the child receives the screening services while Medicaid eligible, nor whether the provider is participating in the Medicaid program at the time those screening services are furnished. Any necessary health care required to treat conditions as a result of a screen must be provided."). On another occasion, the agency similarly stated:

> Interperiodic screens are covered through EPSDT. Treatment is not available to the child based solely on parent's assertion that child is ill. However, a self-initiated physician visit by the parent is an interperiodic screen and further diagnosis and treatment would be available. Any physician encounter is potentially an interperiodic screen. Screens may be performed by a non-Medicaid provider as long as additional diagnosis and treatments are performed by Medicaid provide

HCFA Program Issuance Transmittal Notice Region IV (MCD-78-92) (Oct. 7,1992). Moreover, when discussing the meaning of the "discovered during a screen" requirement, the agency has instructed states that

[4] The guidance documents cited in this Q&A are available from NHeLP-NC.

> there is no requirement for a *prior* screening form to be on file. The legislative history is clear in stating that a child who is in need of treatment services *need not wait* to be scheduled for a screen. There is no need to delay treatment to an individual who has not received a periodic screen. The physician visit during which the need for treatment services was found should be considered an interperiodic screen, meeting the requirements of "conditions discovered by the screening services.

DHHS, Medicaid State Bulletin-193 (Region VII) (Aug. 26, 1991).

Most recently, United States Department of Justice filed a Statement of Interest in a pending Medicaid EPSDT case in Mississippi. The magistrate judge has recommended dismissal of an EPSDT claim because the plaintiffs did not properly allege that they requested a screen. Magistrate Judge's Report and Recommendations, Troup v. Barbour, No. 3:10-cv-153 (S.D. Miss. Aug. 23, 2013) (Docket Entry (D.E.) 55) (also titled J.B. et al., v. Bryant). The DOJ has asked the court to reject this recommendation, stating:

> According to the plain language of the statute, this screening obligation is incumbent upon a state only when it is requested. However, a child's visit to a medical professional to address a behavioral problem is in fact a screening encounter related to that behavioral problem. The family need not use the term "EPSDT screen" when requesting such services. Rather, as both the federal and state agencies administering the Medicaid Act have made clear, any such visit or contact with a qualified medical professional is sufficient to satisfy EPSDT's screening requirement ... These contacts with medical professionals constitute screenings for the purposes of EPSDT.

United States Department of Justice Statement of interest at 2, J.B. et al., v. Bryant, No. 3:10-cv-153 (S.D. Miss. Sept. 6, 2013) (D.E. 57).

In sum, the "request a screen" requirement is at odds with the federal agency's guidance to states that "[a] screening under EPSDT need not be a formal event separate from a child's normal assessment and treatment interactions with his or her medical professional." *Id.* at 3.

The case law

As discussed above, a federal magistrate judge in Mississippi has recommended that plaintiffs' EPSDT claim be dismissed because they did not formally request an EPSDT screen. Although the plaintiffs are arguing that the infrastructure to provide screening does not exist within Mississippi, the magistrate finds the "statute contains no exception to Subsection (43)(B)'s requirement" to request a screen. Magistrate Judge's

Report and Recommendations, *supra*, at 10. The plaintiffs and DOJ are challenging this recommendation, but the district judge has not yet issued an opinion. If accepted, this reasoning would be at odds with not only EPSDT's structure and enforcement history but also the reasoning of other courts.

In *Stanton v. Bond*, 504 F.2d 1246 (7th Cir. 1974), for example, the Indiana Medicaid agency cited the "request a screen" language as a precondition to EPSDT coverage. The Seventh Circuit rejected this "somewhat casual approach to EPSDT" noting that it "hardly conforms to the aggressive search for early detection of child health problems envisaged by Congress." *Id.* at 1250. The Court also stated:

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

Id. at 1251; *see Frew v. Gilbert*, 109 F. Supp. 2d 579, 609 (E.D. Tex. 2000) ("Whatever might be discerned about the goals of the founders of EPSDT, one may fairly assume that they did not intend to create a means by which states that fail to inform poor and unhealthy children about the program might turn around and use this ["request" language] as a defense to their failure to provide services."); *see also Rosie D. v. Romney,* 410 F. Supp. 2d 18, 34 (D. Mass. 2006) (finding Massachusetts' approach to screening was "deficient" because "no feature of the Commonwealth's Medicaid system assures that SED [seriously emotionally disabled] children will necessarily receive these pediatric assessments . . . [, so] thousands of SED children in Massachusetts get no comprehensive assessments at all").

Conclusions and recommendations

Here are some steps you can take:

1. If supported by the facts, include allegations in the complaint that the children have not been adequately informed of EPSDT.

2. Make sure that the complaint includes allegations that the children have requested services from a health care provider who has, in turn, determined the nature and extent of their health care needs (i.e. has performed screening services).

3. Note the particular considerations associated with clients who are in state custody. Even if the state's argument were valid, the state itself would be responsible for requesting the EPSDT screening services for these children. Moreover, to obtain services in an institutional setting, each of these children would have to have been

identified (i.e. screened) by a mental health professional as having a mental health condition.

4. Review the state Medicaid website and written beneficiary materials. While developing a response to North Carolina's motion to dismiss an EPSDT claim based on the "request a screen" argument (*Antrican v. Buell*, *supra*.), the National Health Law Program carefully reviewed the Medicaid website, application, and informational materials. We found that the application for children and families to apply for Medicaid was, on its face, worded to automatically request EPSDT services. The Medicaid informational brochure and materials included EPSDT benefits in the listing of covered Medicaid benefits and also described the responsibilities of the Medicaid beneficiary. Nowhere did it inform the beneficiary of a separate responsibility to submit a request to an appropriate government agency or official. Rather, from the face of these documents, once the individual has completed the application, she has requested EPSDT services. Therefore, we argued that, even assuming the validity of the request of screen requirement, the clients had indeed requested a screen. The court denied the motion to dismiss as part of an overall settlement.

5. Contact the National Health Law Program for assistance if children in your state are met with a "request a screen" requirement.