National Health Law Program

March 23, 2005

To: Health Advocates
From: Jane Perkins

Re: EPSDT Q&A: The *Pediatric Specialty Care* EPSDT case[1]

Question: My client is the parent of a four-year-old girl who is at risk for developmental delay. The child has been receiving speech and physical therapy and early intervention day treatment six hours per day. Medicaid has covered these services. However, the client recently received a letter from the state Medicaid agency stating that the day treatment program is being reduced to two hours per day. I think the state's policy is based on overall budget concerns, rather than any change in the child's condition or the medical literature. What can I do?

Answer: As discussed in our November 2004 Q&A (regarding *S.D. v. Hood*), the Medicaid Act requires the state Medicaid agency to assure that children who are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services receive the care and treatment necessary to correct or ameliorate their health conditions. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (2005). The across-the-board reduction in day treatment announced by the State does not comply with this mandate. An ongoing case from Arkansas, *Pediatric Specialty Care v. Knickrehm*, is quite similar to your situation. A series of rulings in the case reinforce the role of EPSDT in assuring necessary care and treatment and illustrate how important it is for you to investigate why the State is implementing a service reduction. The case is discussed below.

Discussion

Background

Pediatric Specialty Care concerns repeated attempts by the Arkansas Department of Human Services (ADHS) to reduce Medicaid coverage of Child Health Management Services (CHMS). CHMS is the health care delivery model that has been used by the

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Department to provide early intervention diagnostic and therapy services to children between the ages of six months and six years. These children have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services beyond that required by children generally. Children are eligible for CHMS if they have a medical diagnosis, such as AIDS, cystic fibrosis, or Down Syndrome; a developmental diagnosis, such as autism or cerebral palsy; blindness, deafness or impairments of vision or hearing; developmental delay; or mental retardation.

CHMS are comprehensive in nature. Following referral from a physician, CHMS clinics use a multi-disciplinary approach to perform diagnostic and evaluative assessments of the child. A CHMS physician then prepares an individual treatment plan and prescribes needed care, which is provided at CHMS clinics across the State. Treatments include nutrition services, behavior therapies, speech and language pathology services, psychological services, and early intervention day treatment. Early intervention day treatment is a type of day care program which reinforces the skills learned in therapy and is operated by early childhood specialists and overseen by a medical staff.

In November 2001, ADHS issued a press release announcing that it would significantly alter CHMS by ending Medicaid coverage of therapeutic services and early intervention day treatment and remove the listing of those treatments from the state Medicaid plan. The diagnostic and evaluation component of CHMS would remain intact. In response to the announcement, Pediatric Specialty Care, a CHMS clinic, along with other clinics and the parents of three recipients, filed *Pediatric Specialty Care, Inc. et al., v. Arkansas Dep't of Human Serv.*, No. 4:01CV00830WRW (E.D. Ark.). The complaint, filed pursuant to 42 U.S.C. § 1983, alleges that the ADHS is violating the Plaintiffs' federal right to EPSDT services and their procedural and substantive due process rights.

Pediatric Specialty Care I: Federal Statutory Rights

The Defendants responded to the complaint by arguing that they were complying with the law and that the Plaintiffs lacked standing to bring the suit. Following a full hearing, the federal district court found that the proposed CHMS changes would cause children to lose early intervention day treatment services altogether, because the only way children could receive the services under the state Medicaid plan was to be enrolled in the CHMS program. Moreover, while the children could obtain therapy services from other providers, therapy services not provided in conjunction with CHMS day treatment services would fail to maximize their treatment. According to the court, the cutbacks violated the EPSDT statute's requirement that states cover services listed in 42 U.S.C. § 1396d which are needed to "correct or ameliorate" a child's health condition. The court found the day treatment and therapy services met the definition of rehabilitation services within section 1396d(a)(13) because they were needed for "maximum reduction of disability and for restoration [of a developmentally delayed child] to the best possible functional level." *Pediatric Specialty Care v. Arkansas Dep't of Human Serv.*, No. 4:01CV00830WRW, slip op. at 10 (E.D. Ark. Dec. 10, 2001).

The district court also held that categorically needy children who require medical assistance covered under section 1396d(a)(13) and for whom a physician recommends

early intervention day treatment have a federally enforceable right to the treatment. It permanently enjoined the CHMS cutbacks and ordered the ADHS to continue to list the CHMS services in its state Medicaid plan. ADHS appealed to the Eighth Circuit Court of Appeals.

The Circuit Court upheld the district court in most respects. 293 F.3d 472 (8th Cir. 2002) (*Pediatric Specialty Care I*). First, it held that the EPSDT statutes created federal rights that the Plaintiffs could enforce pursuant to section 1983. *Id.* at 477-79. In a ruling issued ten days after *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002),[2] the Eighth Circuit, without mentioning *Gonzaga*, applied the three-prong enforcement test and determined that: (1) the plaintiffs are the intended beneficiaries of the EPSDT statutes, 42 U.S.C. §§ 1396a(a)(10)(A) and 1396a(a)(43), as defined by §§ 1396d(a)(4)(B) and 1396d(r); (2) the statute is written with sufficient clarity to be judicially enforceable; and (3) the statute creates a binding obligation on ADHS to create a state plan that includes the provision of EPSDT services as they are defined in section 1396d(r).[3] *Id.* The Court added that "even without individual standing, the provider plaintiffs . . . have standing to assert the rights of their CHMS patients." *Id.* at 478 (citing *Singleton v. Wulff*, 428 U.S. 106 (1976)).

Next, the Court upheld the district court's substantive findings, noting that "early intervention day treatment services provide numerous benefits to children, including increased IQ levels, reduction in developmental disabilities, and a decreased chance of being placed in special education classes." *Id.* at 479. The Court also agreed that the Medicaid Act requires the ADHS to reimburse early intervention day treatment services when a physician prescribes them as medically necessary for the maximum reduction of a disability. *Id.* (citing §§ 1396d(r) and 1396d(a)(13)). Because CHMS clinics were the only providers of early intervention day treatment, the Court ordered ADHS to reimburse those clinics. *Id.* at 480-81. However, the Court reversed the district court to the extent that it had required CHMS early intervention day treatment services to be specifically listed as a service in the state Medicaid plan. *Id.* at 480.

Finally, the Court reminded the state that it had a duty under section 1396a(a)(43) to inform Medicaid recipients about EPSDT services 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. The case was remanded to the district court

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[2] *Gonzaga* addressed the issue of individual enforcement of statutory rights through section 1983, focusing on the first prong of the enforcement test. The National Health Law Program has discussed private enforcement of Medicaid Act provisions in previous mailings. *See, e.g.*, Enforcing "Reasonable Standards" in State Medicaid Programs (July 2003); Gonzaga University v. Doe (July 2002).

[3] Two later cases have cited this holding with favor: Memisovski v. Maram, 2004 U.S. Dist. LEXIS 16772, *34, *37 (N.D. Ill. Aug. 23, 2004) (citing 293 F.3d at 479, and holding EPSDT statutes create federal rights); S.D. v. Hood, 2002 U.S. Dist. LEXIS 23535, *22 n.34 (E.D. La. Dec. 5, 2002) (same).

for entry of a modified injunction and consideration of the Plaintiffs' constitutional due process claims.

Pediatric Specialty Care II: Constitutional Due Process Rights

After remand and further proceedings, the district court ruled for the Plaintiffs on their due process claims and ordered the Department to continue CHMS without any change. *Pediatric Specialty Care v. Arkansas Dep't of Human Serv.*, No. 4:01CV00830WRW, slip op. at 12 (E.D. Ark. Nov. 27, 2002). According to the court, by seeking to terminate elements of the program, ADHS made a decision affecting the "methods and procedures" of payment, thus invoking 42 U.S.C. § 1396a(a)(30)(A). Section 1396a(a)(30)(A) requires Medicaid payments for services to be consistent with principles of efficiency, economy, quality of care and equal access. The court enjoined ADHS from terminating services within CHMS until it complied with Plaintiffs' procedural due process rights by completing a comprehensive study of the impact of the proposed changes to assure that the section (30)(A) principles would not be jeopardized. The district court also held for the Plaintiffs on their substantive due process claim, finding that ADHS' consistent attempts to ignore the needs of children and curtail CHMS "shocked the conscience." *Id.* at 15. Again, ADHS appealed to the Eighth Circuit Court of Appeals.

The Circuit Court agreed that the Plaintiffs' procedural due process rights had been violated. 364 F.3d 925, 930-31 (8th Cir. 2004) (*Pediatric Specialty Care II*). The panel of judges easily held that the plaintiffs have a property interest in equal access to quality services as required by section 1396a(a)(30)(A). *Id.* (citing *Ark. Med. Soc'y v. Reynolds,* 6 F.3d 519, 528 (8th Cir. 1993), finding (30)(A) creates federally enforceable rights and requiring impact study prior to reductions in Medicaid payments). In ruling for the Plaintiffs, the Court rejected ADHS' argument that section (30)(A) did not apply because the rate of provider payments would remain the same, noting that section (30)(A) "concerns not only the rate, but also the method and process of payment for services." *Id.* at 930.

However, the Circuit Court reversed the district court's holding that the Plaintiffs' substantive due process rights had been violated The Court recognized that ADHS was seeking to restructure the CHMS program in part because of a budget shortfall. It also acknowledged the ongoing injunction and testimony from ADHS officials unequivocally stating that the program would continue paying for CHMS-like services. Thus, it found that the evidence of wrongdoing did not "shock the conscience." However, the Court cautioned that, following the impact study, new issues could come to light as to whether cutting CHMS would be a substantive due process violation. *Id.* at 932.[4] The Circuit Court again remanded the case for further proceedings.

[4] The Circuit Court also reversed a district court order that extended the injunction to the Centers for Medicare & Medicaid Services (CMS) and requiring CMS to continue federal payments to Arkansas for CHMS. The lower court's reliance on Fed. R. Civ. P. 65(d) was ruled improper because CMS was not an "active participant" in the decision to terminate the treatment services. 364 F.3d at 933.

Pediatric Specialty Care III: Revealing the Details of a Cutback

On February 7, 2005, federal district court Judge William R. Wilson issued yet another *Pediatric Specialty Care* decision, ruling on a motion for summary judgment filed by the ADHS state officials. The motion argued that the case should be dismissed because the Plaintiffs lacked standing to bring the action and because ADHS was properly covering CHMS through a new prior authorization and medical necessity process. The Plaintiffs responded that the prior authorization process was implemented for the sole purpose of meeting budget concerns, without considering efficiency, economy, quality of care, or equal access, and that the defendants were continuing to violate their procedural and substantive due process rights. The Plaintiffs also amended their complaint to add an allegation and introduce evidence of misrepresentation and fraud in the peer review process used by the ADHS to authorize eligibility for EPSDT services. This time, Plaintiffs sought injunctive relief *and* money damages against state officials in their individual capacities. *Pediatric Specialty Care v. Arkansas Dep't of Human Serv.*, No. 4:01CV00830WRW, slip op. at 3 (E.D. Ark. Feb. 7, 2005).

The district court denied the Defendants' motion in an extensive 40-page decision that touches on a number of issues: standing, medical necessity, government misconduct, and state officials' individual liability for wrongdoing.

Standing. Citing earlier circuit court decisions including *Pediatric Specialty Care I*, the district court easily reaffirms that the EPSDT statutes give providers and recipients a federal right to enforce coverage of early intervention day treatment when a physician recommends such treatment. *Id.*, slip op. at 8. The court also rejects ADHS' argument that the Plaintiffs lacked standing because they had not exhausted their administrative remedies, stating: "The fact that Plaintiffs can challenge denials through a state administrative process is irrelevant to their right to seek redress under § 1983—especially when the denial of benefits is as sweeping as has allegedly occurred in this case." *Id.*, slip op. at 10.

Medical necessity. The district court reviews the law on medical necessity (including cases from the Eighth Circuit Court of Appeals, which has the most extensively reasoned analysis of medical necessity of any circuit court of appeals). The court finds that the State has the right to place limits on treatment based on medical necessity but "the boundaries of state discretion are limited by the rules and regulations of the Medicaid Act," *Id.*, slip op. at 10-15. The court discusses eight important limits on the medical necessity standards:

- There is a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment. *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980); *Smith v. Rasmussen*, 249 F.3d 755 , 759 (8th Cir. 2001).

- Medical necessity standards adopted by the state must be "reasonable" and "consistent with the objectives of the Act." *Beal v. Doe*, 432 U.S. 438, 443 (1977).

- Services must be covered sufficient in amount, duration and scope to reasonably achieve their purpose. 42 C.F.R. § 440.230(b). Reduction of day treatment services from six hours to 3.5 hours raises the inference that section 440.230(b) has been violated. *Pediatric Specialty Care III,* slip op. at 16.

- Serious statutory questions are presented by a state plan that categorically excludes necessary medical treatment from its *coverage*, as distinct from a plan that allows case-specific determinations that deny coverage. *Beal,* 432 U.S. at 444.

- Once a state designates the services it will provide, the state may make eligibility decisions only on the basis of individual need. The only time a state can make sweeping exclusions of a medical procedure is when the procedure is "never, or generally never, of sufficient medial necessity." *Hodgson v. Board of County Comm'r, Co. of Hennepin*, 614 F.2d 601, 608 (1980).

- Determinations based on type of condition, illness, or diagnoses are never reasonable. *Id.* at 608; 42 C.F.R. § 440.230(c). Thus, ADHS guidelines that refuse prior authorization to a child with a single impairment, requiring only one type of therapy "may well" violate section 440.230(c). *Pediatric Specialty Care III,* slip op. at 17.

- EPSDT requires medical necessity to be determined by whether the child needs the treatment to ameliorate his disability. Any reduction in services that is applied to *all* children without consideration of an individual child's diagnosed medical condition and prescribed treatment and the accumulated knowledge of the medical community would run afoul of the Medicaid Act. *Pediatric Specialty Care I*; *S.D. v. Hood*, 391 F.3d 581, 592 (5th Cir. 2004). Judge Wilson added, "There is nothing in the Medicaid Act which limits EPSDT services to only children with a need for two or more intervention therapies … [A]cross-the-board denial of CHMS day treatment services to children with a single impairment raises a reasonable inference that children are being denied their right to EPSDT." *Pediatric Specialty Care III,* slip op. at 17.

- Coverage schemes based solely on budget concerns are invalid. *Reynolds*, 6 F.3d at 522, 531. Regarding rates, the district court stated:

> The *conclusive* factor in rate determination *must not be* the amount of money appropriated by a given state's legislature; rather the state Medicaid agency must make an objective, principled decision regarding what is reasonable and adequate to meet the needs of medical beneficiaries. *Pediatric Specialty Care III*, slip op. at 15.

Government misconduct. The Plaintiffs investigated the prior authorization process being used by ADHS to review requests for CHMS and learned that AHDS had contracted these reviews to a peer review organization, the Arkansas Foundation for Medical Care (AFMC). The Plaintiffs obtained testimony from employees within AFMC

that implicated "the ADH[S] and the AFMC in widespread abuses that demonstrate a disregard for the medical needs of eligible children as well as … the Medicaid Act, the Orders of this [District] Court, and the Circuit Court." *Pediatric Specialty Care III*, slip op. at 19. An AFMC nurse reviewer and the only board certified pediatrician working with AFMC testified:

- AFMC nurse reviewers altered files by overriding the opinions of physicians and reducing the amount and scope of CHMS;
- In frequent memos, AFMC singled out services and told review nurses never to approve them;
- AFMC developed a system of "canned denials" referred to as "one minute charts," thus creating a set of rote rationales that could be used to routinely deny authorization. Nurse reviewers could use canned denials at their discretion;
- AFMC supervisors and legal counsel were informed of these activities; legal counsel advised nurses "not to bring up" the use of canned denials in their depositions;
- AFMC intentionally made the application and authorization process as difficult as possible to discourage CHMS clinics from seeking services;
- During state administrative hearings, AFMC and ADHS refused to identify and compel the testimony of physicians and others responsible for making service determinations;
- Cost savings was the primary incentive for decisions made by AFMC and was the basis for ADHS renewal of the AFMC utilization review contract;
- Monthly cost reports and the ability of AFMC continuously to reduce cost by reducing services was the sole basis for AFMC's contract with the State;
- Testimony created the inference that the ADHS Medicaid Director was not only aware of the practices, but also gave incentives and rewarded the practices by maintaining the contract with AFMC.

According to the court, this evidence showed that AFMC and ADHS failed to give proper deference to the treating physician, failed to ensure medical reviews were performed by qualified personnel, failed to insure that reviews were based on reasonable medical standards, denied services based on diagnosis alone, and limited the amount and duration of services based only on budget concerns. *Pediatric Specialty Care III*, slip op. at 19-24. The court denied summary judgment for the Defendants and inferred, instead, that the Defendants are violating federal Medicaid and procedural and substantive due process requirements. The court also ruled that, during administrative hearings, Medicaid

recipients can compel the testimony of each member of the review organization responsible for adverse decisions. *Id.*, slip op. at 28.

Individual liability. As noted above, the Plaintiffs took the unusual step of including in the amended complaint a section 1983 damages claim against the Defendants in their individual capacities. Specifically, the Plaintiffs alleged that the requirements for equal access and EPSDT services have been clearly established in the federal statute and by the courts, and the Defendants should have known that their actions adversely affecting these rights would have legal consequences. *Id.*, slip op. at 34-35. Reviewing the evidence, the court decided that the Secretary of ADHS did not have a close enough connection to the activities to expose him to individual liability; however, the Medicaid directors were "deeply involved" in the alleged misconduct and thus subject to individual liability. *Id.*, slip op. at 41.

Conclusion

In light of the February 2005 ruling, the case faces a trial at the district court level. Meanwhile, the district and circuit court rulings in the case should inform advocacy on a range of EPSDT and Medicaid issues, including recipient standing, Medicaid cutbacks, and potential government misconduct and individual liability. However, given its track record, advocates should not be surprised if yet another circuit court appeal is filed in the *Pediatric Specialty Care* case.