Q&A
Recent EPSDT Cases[1]

Jane Perkins & Amanda Avery

Q: We are considering an action to improve our state's compliance with the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions. Are there recent case developments?

A: Yes. After summarizing the provisions, we will discuss recent opinions that could affect how you choose to address problems in your state.

Discussion

EPSDT Overview

EPSDT is a mandatory Medicaid service for children and youth under age 21. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). Forming the foundation of EPSDT, four separate screens are required: vision (including eyeglasses), hearing (including hearing aids), dental, and medical. The medical screen has five components: a comprehensive health and developmental history, unclothed physical examination, immunizations, laboratory testing (*e.g.*, 2 lead tests by age 3), and health education and anticipatory guidance. Screens must be provided according to periodicity schedules set by the state Medicaid agency in consultation

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with child health experts and at other times as needed to determine whether a child has a condition that needs care. *Id.* at § 1396d(r)(1)-(4).

States must effectively inform all Medicaid-eligible persons in the state who are under age 21 of the availability of EPSDT. *Id.* at § 1369a(a)(43)(A). This includes appointment scheduling and transportation assistance. *See* 42 C.F.R. § 441.56.

States must "arrang[e] for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment" that a child needs. 42 U.S.C. § 1396a(a)(43)(C). The Medicaid Act prescribes a comprehensive scope of treatment benefits and establishes the standard for determining each child's treatment needs:

> The scope of benefits: All mandatory and optional services that the state can cover under Medicaid, whether or not such services are covered for adults. *See* 42 U.S.C. § 1396d(a) (listing services).
>
> The medical necessity standard: All "necessary health care, diagnostic services, treatment, and other measures … to correct or ameliorate defects and physical and mental illnesses and conditions…."

Id. § 1396d(r)(5). In sum, if a health care provider determines that a service is necessary, it should be covered to the extent needed. As stated by the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS), "[t]he goal of EPSDT is to assure that individual children get the health care they need when they need it—the right care to the right child at the right time in the right setting." CMS, *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* 1 (2014), **https://bit.ly/3HfZaYz**.[2]

Recent Court Opinions

Over the years, families and children have gone to court to enforce the EPSDT requirements. Below, we summarize four recent cases.

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[2] For in-depth discussion, *see* Jane Perkins & Sarah Somers, *Medicaid's Gold Standard Coverage for Children and Youth: Past, Present, and Future,* 30 ANNALS OF HEALTH L. & LIFE SCI. 153 (2021).

M.H. v. Berry, No. 1:15-CV-1427, 2021 WL 1192938 (N.D. Ga. Mar. 29, 2021)

In *M.H. v. Berry*, a class of Medicaid-enrolled children sued the Georgia Department of Community Health (DCH) alleging inadequate coverage of in-home skilled nursing services. DCH provides these services through the Georgia Pediatric Program (GAPP), which contracts with a third party, Alliant Health Solutions, to determine the number of hours of skilled nursing care for GAPP participants. 2021 WL 1192938, at *2.

M.H. has involved multiple challenges to GAPP.[3] This recent dispute focused on whether Alliant's policies for making coverage decisions violated federal Medicaid EPSDT provisions. As a preliminary matter, the court rejected DCH's argument that Alliant was a necessary party under Federal Rule of Civil Procedure 16, finding: As the "single state agency," DCH "has the ultimate responsibility to the Plaintiffs" and "an obligation to ensure that it contracts with parties that will adequately carry out DCH's obligations under the Medicaid Act." *Id.* at *7.

Federal District Judge Thomas W. Thrash also found fault with the way Alliant operated the GAPP. The Court agreed with the Plaintiffs that DCH "fails to give sufficient weight to the treating physician's determination of the amount of skilled nursing hours that are needed when determining a child's nursing hours…." *Id.* at *5. Alliant's process was primarily controlled by a reviewing nurse, using Alliant's "scoring sheet" to assess the diagnosis and necessary hours. That sheet does not include consideration of the treating physician's recommendation. *Id.* at *6. But as the court found, "DCH and Alliant are not permitted under the Medicaid Act to … disregard that recommendation and the reasons for it in arriving at a much lower total." *Id.* (citing *Moore v. Reese*, 637 F.3d 1220, 1258-59 (11th Cir. 2011) (explaining that the treating physician is "a key figure" who initially determines the amount of necessary nursing services, and the state cannot act as the "final arbiter" of medical necessity and arbitrarily ignore the reasons given in the treating physician's recommendation of higher hours).

The court also disapproved of DCH's "teach and wean" policy under which caregivers are taught skilled nursing tasks, and the child is then weaned from the skilled nursing hours originally considered necessary. According to the court,

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[3] See, *e.g.*, *M.H. v. Cook*, No. 1:08-cv-2930-TWT, 2013 WL 2252917 (N.D. Ga. May 22, 2013) (*M.H. I*) (challenging DCH's denial of requests for increased nursing hours).

> the determination of whether private nursing services are medically necessary should be based on whether a service is medically necessary to correct or ameliorate a beneficiary's condition, not on whether or not the caregiver is able to provide those skills. The Medicaid Act requires private duty nursing services be provided by licensed nurses. It does not provide for the delegation of activities which require the knowledge and skill of a licensed nurse.

Id. at *7 (citing 42 C.F.R. § 440.80, defining "private duty nursing services" as services provided by "a registered nurse or a licensed practical nurse" and "[u]nder the direction of the beneficiary's physician"). The court agreed with *Alberto N. v. Hawkins*, No. 6:99-cv-459, 2007 WL 8429756, at *13 (E.D. Tex. June 8, 2007), which found that Texas Medicaid's policies requiring caregivers to provide a portion of their child's medically necessary nursing services "deprive these children of their entitlement to all medically-necessary nursing services, in violation of the Medicaid Act, and are, therefore, invalid." *Id.* The Court granted Summary Judgment for the Plaintiffs.

C.R. by and through Reed v. Noggle, No. 1:19-cv-04521-LMM, 2021 WL 4538506 (N.D. Ga. Sept. 13, 2021)

This case arose when C.R.'s request for Medicaid coverage of speech therapy and food therapy services was denied. C.R. is a five-year-old child with complex medical conditions that make it difficult to eat, communicate, and manage oral secretions. For a period of time, DCH approved C.R.'s requests for speech and feeding therapy services. In 2019, however, the request was denied. 2021 WL 4538506, at *2-3.

As was the case in *M.H. v. Berry*, the decision to deny coverage was made by DCH's agent, Alliant Health Solutions. *Id.* at *5-6 (finding Alliant to be a state actor under 42 U.S.C. § 1983). Alliant's utilization reviewer described the criteria she used to review C.R.'s request: (1) citing a Medicaid agency manual, whether the denial of treatment "could adversely affect the eligible member's medical condition"; (2) citing an American Speech Language Hearing Association (ASPHA) publication, whether the "treatment [is] expected to yield improvement within a reasonable amount of time"; and (3) whether the child demonstrated rapid improvement in their skills—a criterion the utilization reviewer created herself. *Id.* at *3.

The Court measured these criteria against the federal coverage requirements, which she summarized as requiring DCH to:

> a. Provide speech and feeding therapy services to C.R. when those services are medically necessary to correct or ameliorate her conditions [citing 42 U.S.C. § 1396d(r)(5)].
> b. Provide those services in a sufficient amount, duration, and scope to reasonably achieve their corrective or ameliorative purpose [citing 42 C.F.R. § 440.230(b) and *Moore*, 637 F.3d at 1238].

Id. at *7.

Next, the court needed to decide what it means to "correct or ameliorate" a condition and, for this, looked to CMS, *EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*. *Id.* (citing *Christensen v. Harris Cnty.*, 529 U.S. 576, 587 (2000) (explaining that agencies' interpretative guidelines "are 'entitled to respect' ... to the extent that those interpretations have the 'power to persuade.'") (citation omitted). As noted by the Court, the CMS Guide explains that

> services "are covered when they prevent a condition from worsening or prevent development of additional health problems" … Because an ameliorative treatment need only keep a patient's condition in stasis, Ms. Walker's "rapid improvement" standard and the AS[P]HA "expected to yield improvement" standard are incompatible with the … mandate to cover ameliorative EPSDT services.

Id. The Court permanently enjoined DCH from reviewing C.R.'s requests for prior authorization of additional units of speech and feeding therapy using a standard other than the "correct or ameliorate" standard. *Id.* at *13.[4]

[4] Judge May also concluded that DCH's notices of denial violated Due Process and Medicaid's notice and hearing requirements. One notice executed the denial by simply providing a three-letter code, which the court pointed out does not give the average person any indication of the reason for the denial. *Id.* at *9. And while noting that the State's subsequent notices could have cured the deficiency, the court found they merely informed C.R. that the documentation she submitted was insufficient without saying "*why* the documentation submitted did not justify C.R.'s requested quantity of therapy or *why* the services C.R. requested were not medically necessary [and] that is an explanation without 'reasons.'" *Id*. (quoting *Goldberg v. Kelly*, 397 U.S. 254, 267 (1970)).

Hennessy-Waller v. Snyder, 529 F. Supp. 3d 1031 (D. Ariz. 2021) (on appeal)

Plaintiffs, two transgender adolescents enrolled in Arizona's Medicaid program, were diagnosed with gender dysphoria. Their health care providers recommended male chest reconstruction surgery to treat their conditions. However, Arizona would not cover the treatment due to a state regulation excluding coverage of "gender reassignment surgery."[5] The plaintiffs filed suit challenging the policy on Equal Protection and statutory grounds, citing section 1557 of the Affordable Care Act and also the EPSDT coverage requirements. Federal District Judge Scott H. Rash denied plaintiffs' motion for a preliminary injunction.

The court's opinion is problematic on a number of levels. For example, the court disregarded medical standards of care, developed by the World Professional Association for Transgender Health (WPATH) and endorsed by the American Academy of Pediatrics and AMA, and the testimony of plaintiffs' experts, who included a surgeon and a child and adolescent psychiatrist. The court concluded instead that the plaintiffs had not "clearly shown the surgery is medically necessary for them or that it is safe and effective for correcting their gender dysphoria." 529 F. Supp. 3d at 1042.

The case has been appealed to the Ninth Circuit (No. 21-15668). It was argued and submitted on November 19, 2021. NHeLP is co-counsel in this case and will provide updates as they occur.

A.A. by and through P.A. v. Phillips, 339 F.R.D. 232 (M.D. La. 2021) (on appeal)

In this case, the court considered a motion for class certification from plaintiffs challenging the Louisiana Department of Health's (LDH) failure to provide "intensive home and community-based services" (IHCBS) to children with mental illnesses and behavioral disorders.[6] Plaintiffs moved for class certification pursuant to Rules 23(a) and (b)(2) of the Federal Rules of Civil Procedure, with the ultimate goal of obtaining declaratory and injunctive relief requiring LDH

[5] Eleven states exclude certain gender-affirming treatments from Medicaid coverage: Arizona, Arkansas, Georgia, Hawaii, Missouri, Nebraska, Ohio, Tennessee, Texas, Wyoming, and West Virginia. *See* Healthcare Laws and Policies: Medicaid Coverage for Transition-Related Care (Dec. 2021), https://www.lgbtmap.org/img/maps/citations-medicaid.pdf.

[6] The court accepted plaintiffs' definition of IHCBS as "intensive care coordination, crisis services, and intensive behavioral services and supports that are necessary to correct or ameliorate [Plaintiffs'] mental illnesses or conditions." 339 F.R.D. at 236.

to provide IHCBS to plaintiffs and the class. Although defendant objected to the motion on numerous grounds, they did not object to the findings in a 2018 report from the Louisiana Legislative Auditor outlining the critical shortage of mental health interventions available to children across the State.

Defendant's primarily objected to certification on the ground of vagueness, arguing that it was impossible to determine: (1) the nature of plaintiffs' claims, and (2) the scope of the proposed class. *Id.* at 242-44, 248. Citing to the findings in the 2018 report, Federal District Judge Brian A. Jackson found that defendants were "acutely aware" of the scope of mental health interventions covered by the term IHCBS. *Id.* at 242. The court also found that the proposed class was ascertainable and sufficiently numerous based on the data in the report. *Id.* at 242-43, 244. The court, however, agreed with defendant that including all children "eligible for" IHCBS could potentially open the class to children who had not yet undergone individualized screening and diagnosis. *Id.* at 244. Accordingly, the court modified the class definition to restrict membership to Medicaid-eligible children whose physicians had *already recommended* IHCBS to treat their mental health conditions or behavioral disorders. *Id.*

Defendant also argued that certification was improper because this case presented numerous patient-specific questions that were not resolvable on a class-wide basis. The court rejected this argument, emphasizing that plaintiffs' core allegation concerned LDH's blanket policy of *not* providing medically necessary IHCBS. *Id.* at 244, 248. The court reasoned that "LDH's alleged policy of *not* providing IHCBS harms all class members essentially the same way" even if the recommended form of IHCBS varied among class members. *Id.* at 247. For this reason, the court ruled that there was a common question as to whether LDH failed to provide IHCBS that could only be remedied by class-wide relief:

> Should [p]laintiffs prevail, LDH will necessarily be required to modify its policies to properly implement the Medicaid Act's EPSDT mandate. Such policies would be generally applicable—not based on 'a patient-specific inquiry' (because all such individualized determinations required in this case have already been made)—and would benefit all class members.

Id. at 248-49.[7] Finding the requirements of Rules 23(a) and (b)(2) were satisfied, the court granted plaintiffs' motion for class certification.

The Fifth Circuit has granted defendant permission to appeal the class certification order (No. 21-90023). NHeLP is co-counsel in this case and will provide updates as they occur.

Conclusion and Recommendations

Courts are being called upon to apply the EPSDT "correct or ameliorate" standard. When briefing this standard, advocates should quote the Medicaid Act and cite helpful case law. The National Health Law Program maintains an annotated EPSDT docket, which is available upon request.

Advocates should also include helpful citations from CMS's *EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014), **https://bit.ly/3HfZaYz.** "While it does not establish new EPSDT policy, this guide serves the important purpose of compiling into a single document various EPSDT policy guidances that CMS has issued over the years." *Id.* at 2.

As recent cases illustrate, courts are deferring to the CMS Guide. *See M.H.,* 2021 WL 1192938, at *4-5 (quoting CMS Guide to find, "The EPSDT benefit is more robust than the Medicaid…. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting."); *C.R.*, 2021 WL 4538506, at *7 (deferring to CMS Guide's explanation of "correct or ameliorate"); *A.A.*, 2021 WL 2102829, at *2 (citing CMS Guide to find that "*all* services and interventions recommended by a physician or other licensed practitioner of the healing arts to correct or ameliorate a diagnosed condition . . . necessarily *includes* recommended IHCBS").

[7] For another recent case involving IHCBS, *see J.D. v. Dep't of Child. & Fam.*, No. A-3411-17T4, 2020 WL 4811558 (N.J. Sup. Ct. App. Div. 2020) (per curiam) (acknowledging plaintiff's challenge to policies that resulted in a "hard cap" on the amount of IHCBS was first raised on appeal, but deeming the issues of "significant public interest" to warrant review and, upon consideration of them, remanding for development of the record and consideration of whether the policies violated EPSDT and Americans with Disabilities Act provisions).