

Case No. 08-3931

In the
United States Court of Appeals
for the Sixth Circuit

Parents' League for Effective Autism Services, *et al.*
Plaintiffs-Appellees

v.

Helen Jones-Kelley, *et al.*
Defendants-Appellants

On Appeal from the United States District Court
for the Southern District of Ohio, Case No. 2:08-CV-421

Joint Reply Brief of Defendants-Appellants
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I. INTRODUCTION

Neither Plaintiffs nor *Amici* dispute that Step by Step is primarily providing habilitation services. Neither Plaintiffs nor *Amici* dispute that Medicaid does not cover habilitation services, or that CMS has explicitly denied what it viewed as Ohio's past attempts to cover habilitation services. Neither Plaintiffs nor *Amici* have identified any authority showing that Medicaid covers habilitation services. Nevertheless, Plaintiffs and *Amici* maintain that Medicaid must cover the services furnished by Step by Step.

Plaintiffs rest their case primarily on the broad coverage of federal early periodic screening, diagnosis, and treatment ("EPSDT") statutes. Defendants acknowledge that these statutes cover a wide array of services. But that broad coverage is not without limits. And authorities explicitly addressing the issue show that habilitation services fall outside of those coverage limits. In addition, the Proposed Rules that are ostensibly the subject of this litigation do not prevent Plaintiffs from receiving any Medicaid-covered services.

Amici pursue a different tack, stating that autistic children benefit from services such as those provided by Step by Step. *Amici* have marshaled numerous papers and data in support of their claim. *Amici's* brief presents one side of a public policy debate as to why Medicaid should cover habilitation services when

furnished to autistic children. But it identifies virtually no authority showing that Medicaid does, in fact, cover those services.

The issue before this Court is not whether Medicaid should, as a policy matter, cover habilitation services for autistic children. Congress answered that question, “no,” when it created and amended the Medicaid statutes at issue in this case.

The issue before this Court is whether Medicaid covers habilitation services and whether the Proposed Rules would impermissibly terminate Medicaid reimbursement for those services, if covered. As discussed in Defendants’ opening Brief and below, the plain language of the applicable statutes, case law from this Court and other courts, legislative history, and numerous administrative interpretations by CMS show that Medicaid does not cover habilitation services and that the Proposed Rules do not impermissibly terminate Medicaid reimbursement for any Medicaid-covered services.

II. LAW AND ARGUMENT

A. Standard of Review

Preliminary injunction orders are reviewed on an abuse of discretion standard. *Hamilton’s Bogarts, Inc. v. Michigan*, 501 F.3d 644, 649 (6th Cir. 2007); *Tumblebus, Inc. v. Cranmer*, 399 F.3d 754, 760 (6th Cir. 2005). However, the term “abuse of discretion” in this context means that the district court’s legal

conclusions are reviewed de novo. *Jones v. City of Monroe*, 341 F.3d 474, 476 (6th Cir. 2003). The district court's decision to grant an injunction can be overturned if the district court relied upon clearly erroneous findings of fact, improperly applied the governing law, or used an erroneous legal standard. *Hamilton's Bogarts*, 501 F.3d at 649 (quoting *Nightclubs, Inc. v. City of Paducah*, 202 F.3d 884, 888 (6th Cir. 2000)). A finding is "clearly erroneous" when it is supported by some evidence but the reviewing court, after examining all of the evidence, is left with the definite and firm conviction that a mistake has been committed. *Anderson v. Bessemer City*, 470 U.S. 564, 573 (1985).

B. Medicaid Does Not Cover The Habilitation Services Provided By Step by Step.

Defendants' opening Brief stated that the district court erred by holding that Plaintiffs have a likelihood of showing that Medicaid is required to cover the non-covered habilitation services provided by Step by Step. In that Brief, Defendants reviewed the evidence regarding the services provided by Step by Step, including testimony from Step by Step Executive Director Michelle LaMarche, Step by Step psychologist Beth Ann Rosner, Ph.D., Children's Hospital psychologist James A. Mulick, Ph.D., ODMH employee Terry Jones, and ODMH clinicians. *See* Def. Br. at 11-18; 30-33. That evidence overwhelmingly shows that Step by Step primarily provides habilitation services. *Id.* Defendants then reviewed the applicable cases, statutes, legislative history, and administrative materials. Def. Br. at 27-30, 33-48.

Those authorities show that Medicaid does not cover habilitation services unless they are provided to residents of an ICF/MR or provided pursuant to a federally approved Medicaid waiver. Def. Br. at 33-48. Based on the foregoing, Defendants concluded the district court erred when it held that Plaintiffs have a likelihood of showing that Medicaid must cover the habilitation services provided by Step by Step.

Neither Plaintiffs nor *Amici* have identified any flaws in this legal argument. They have not pointed to any evidence showing that Step by Step is not providing habilitation services. They do not dispute that Medicaid does not cover habilitation services. They have ignored nearly all of the authorities showing that Medicaid does not cover Step by Step's habilitation services, including the following:

- *A.M.H. v. Hayes*, 2004 U.S. Dist. LEXIS 27387 at *25-26 (S.D. Ohio 2004). *A.M.H.* held that community-based services fall outside the scope of 42 U.S.C. §1396d(a) because they are found only in a Medicaid waiver statute, 42 U.S.C. §1396n(c), and do not appear in 42 U.S.C. §1396d(a). *Id.* The same is true for habilitation services. Like community-based services, habilitation services are found only in 42 U.S.C. §1396n(c) and do not appear in 42 U.S.C. §1396d(a). *See* Def. Br. at 35-36.
- *Ohio Dept. of Mental Retardation & Developmental Disabilities v. United States Dept. of Health & Human Servs.*, 761 F.2d 1187 (6th Cir. 1985) (“*ODMRDD*”). In that case, the Court agreed with the federal government's position that Congress viewed habilitation services as non-medical services available only to residents of ICF/MRs or through federally approved Medicaid waivers. *See ODMRDD*, 761 F.2d at 1192, 1194; Def. Br. at 40-41.
- Legislative history allowing (but not requiring) states to cover habilitation services through federally approved Medicaid waivers. *See* Section 6086 of

the Deficit Reduction Act of 2005 (Pub. L. No. 109-107) (giving states new authority to cover habilitation services through federally approved Medicaid waivers pursuant to 42 U.S.C. §1396n(i)); S. Rep. No. 97-139, *reprinted in*, 2 U.S.C.C.A.N. 396, 747-48, 1010, 1328 (explaining that Section 2176¹ of Omnibus Budget Reconciliation Act of 1981 (Pub. L. No. 97-35) gave states new authority to cover habilitation services through federally approved Medicaid waivers pursuant to 42 U.S.C. §1396n(c)).² That legislative history shows that Medicaid does not cover habilitation services pursuant to 42 U.S.C. §1396d(a). If it did, Congress would not have authorized states to provide habilitation services through Medicaid waivers because states would have already been required to cover those services through 42 U.S.C. §1396d(a). *See also*, *ODMRDD*, 761 F.3d at 1194 (noting that Section 2176 of the Omnibus Budget Reconciliation Act of 1981 was intended to authorize waivers to allow states to cover services not previously covered by Medicaid); Def. Br. at 36, 40-41.

- Legislative history preventing states from covering habilitation services pursuant to 42 U.S.C. §1396d(a)(13) unless those services were: 1) provided pursuant to a provision of a state Medicaid plan approved by HCFA on or before June 30, 1989; or 2) provided in accordance with new federal regulations (such regulations have never been finalized). *See* Section 6411(g) of the Omnibus Budget Reconciliation Act of 1989; Def. Br. at 41-43. This shows that Congress explicitly prohibited states from covering habilitation services pursuant to 42 U.S.C. §1396d(a)(13), subject to the exceptions in OBRA '89 (which Ohio cannot meet).
- Administrative materials spanning over 20 years showing that CMS and its predecessor, HCFA, have consistently stated that habilitation services cannot be provided pursuant to 42 U.S.C. §§1396d(a) or 1396d(a)(13). *See, e.g.*:
 - State Medicaid Manual §5123 (stating that EPSDT services do not include habilitation services). Def. Br. at 43. This document is entitled to *Chevron*³ deference. *See A.M.H. v. Hayes*, 2004 U.S. Dist.

¹ The Senate Report references a “bill” section and not a Public Law section. To Defendants’ best knowledge, the referenced section of the bill corresponds to Section 2176 of the Public Law.

² This legislative history is discussed in *ODMRDD*, 761 F.3d at 1192.

³ *See Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

LEXIS at *28-29 (stating CMS' interpretation of limit of EPSDT coverage described in State Medicaid Manual should be granted *Chevron* deference).

- See 72 Fed. Reg. 45201-54203 (Aug. 13, 2007) (stating that states are inappropriately using 42 U.S.C. §1396d(a)(13) as a “catch all” category to get Medicaid reimbursement for non-Medicaid services and that states should transition habilitation programs to appropriate Medicaid coverage authorities such as Medicaid waivers).⁴ Def. Br. at 44-45.
- May 12, 2006, letter from CMS to ODJFS (stating that Ohio can receive Medicaid reimbursement for habilitation only when provided to residents of an ICF/MR or pursuant to a federally approved Medicaid waiver). Def. Br. at 45.
- October 28, 2005, letter from CMS to ODJFS, denying ODJFS' proposal to cover habilitation services pursuant to 42 U.S.C. §1396d(a)(13). This document is also entitled to *Chevron* deference. See *Harris v. Olzewski*, 442 F.3d 456, 470 (6th Cir. 2006), citing, *Georgia Dept. of Medical Assistance v. Shalala*, 8 F.3d 1565, 1572-73 (11th Cir. 1993) (granting *Chevron* deference to CMS' denial of a state Medicaid plan amendment). Def. Br. at 45-46.
- OIG Audit A-07-02-3024 demanding, in part, that the Iowa Medicaid program repay Medicaid reimbursement used for habilitative, social, and educational services. Def. Br. at 46.
- *Pennsylvania Dept. of Pub. Welfare*, DAB No. 777 at *102 (Aug. 20, 1986) (containing statements by HCFA administrator that services now referred to as habilitation services are not covered unless

⁴ The regulations proposed in this document have not been finalized. But CMS' position regarding the non-coverage of habilitation services pursuant to 42 U.S.C. §1396d(a)(13) appears in the preamble to the regulatory text – not in the proposed regulations themselves. As such, it remains valid regardless of whether the regulations have been finalized and it is subject to “respectful consideration” by a reviewing court. See *Wisconsin Dept. of Health and Family Servs. v. Blumer*, 534 U.S. 473, 497 (2002) (giving “respectful consideration” to statements in preamble to regulatory text of proposed regulations).

provided to residents of an ICF/MR or through a federally approved Medicaid waiver); Def. Br. at 47.

C. Plaintiffs Have Not Shown That Medicaid Covers The Habilitation Services Provided By Step By Step.

None of the cases cited by Plaintiffs support their claim that federal EPSDT statutes require Medicaid to cover the habilitation services provided by Step by Step. All of those cases are distinguishable because they fail to address the coverage of habilitation services. Two of those cases, *Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003) and *S.D. v. Hood*, 391 F.3d 581 (5th Cir. 2004), are further distinguishable because they deal with factual and legal issues not present in this case. *Collins* deals with whether federal EPSDT laws require states to cover inpatient psychiatric hospitalization pursuant to 42 U.S.C. §1396d(a)(16). *See Collins*, 349 F.3d at 374. The district court did not address the coverage of licensed psychologist services or the scope of coverage of 42 U.S.C. §1396d(a)(16). *S.D.* deals with whether federal EPSDT laws require states to cover medically prescribed disposable incontinence underwear pursuant to 42 U.S.C. §1396d(a)(7). *See S.D.*, 391 F.3d at 584, 595, 596-97. This case does not involve coverage of incontinence supplies or the scope of coverage of 42 U.S.C. §1396d(a)(7).

Another pair of cases, *John B. v. Menke*, 176 F. Supp.2d 786 (M.D. Tenn., 2001) and *Chisolm v. Hood*, 133 F. Supp.2d 894 (E.D. Louisiana, 2001), are

simply inapplicable to this case. Both of those cases deal with the scope of coverage of federally approved Medicaid waiver programs. *See, e.g., John B.*, 176 F. Supp.2d at 788-789;⁵ *Chisolm*, 133 F. Supp.2d at 895 (noting that certified class is comprised of individuals who are or will be “placed on the Mental Retardation/Developmental Disabilities (“MR/DD”) Waiver waiting list”) (emphasis added). But Plaintiffs in this case have stated that they are not seeking waiver services. Tr. at 194 (“Plaintiffs in this case are not asking for community-based services. They are not asking for waiver services.”). That difference is critical because habilitation services are available through federally approved Medicaid waivers and to residents of ICF/MRs. *See* May 12, 2006, letter from CMS to ODJFS (Rec. at 700). *See also*, 42 U.S.C. §1396d(a)(15) and 42 C.F.R. §§483.430 – 483.440 (coverage of habilitation services in ICF/MRs); 42 U.S.C. §§1396n(c)(1) & (4); 1396n(i)(1); 1396u(a)(2) & (g) (coverage of habilitation services through federally-approved Medicaid waivers). Therefore, *Chisolm* and *John B.* are not persuasive authority in this case, which does not involve Medicaid waivers.

Chisolm is further inapplicable because the issue in that case was whether the State of Louisiana was required to allow licensed psychologists to enroll

⁵ Tennessee operated under a Medicaid waiver from Jan. 1, 1994 through Jan. 1, 1999. *John B.*, 176 F. Supp.2d at 788. The plaintiffs in *John B.* sued in March 1998, when the waiver program was in effect. *Id.* at 789.

directly in Louisiana's Medicaid program. *Chisolm*, 133 F. Supp.2d at 899. That is not an issue in this case. Also, the *Chisolm* plaintiffs were seeking services rendered by licensed psychologists. *Chisolm*, 133 F. Supp.2d at 896 ("The sole issue before the Court is the extent to which federal law requires the State . . . to provide community-based behavioral and psychological services rendered by licensed psychologists, to class members diagnosed with autism.") (footnotes omitted). But with the exception of the psychological evaluations performed by Step by Step psychologists, unlicensed aids provide the day-to-day ABA at Step by Step.

Q. And who would be with the kids on a day-to-day basis or hour-to-hour basis? What type of therapist would be with the person?

A. We called them behavior technicians. . . .

* * *

Q. Are they licensed by any entity?

A. No.

LaMarche Depo. at 13, 14 (Rec. at 731, 732).

Therefore, *Chisolm* does not show that Medicaid must cover the services of Step by Step's unlicensed aids.⁶ Finally, in *Chisolm*, the State of Louisiana conceded

⁶ *Chisolm* stated that psychologist services are also covered pursuant to 42 U.S.C. §1396d(a)(13). See *Chisolm*, 133 F. Supp.2d at 898. But it provided no analysis for that conclusion. *Id.*

that federal Medicaid laws require it to provide the services sought by the plaintiffs in that case. *Chisolm*, 133 F. Supp.2d at 897. It defended on the ground that it was actually providing those services. *Id.* That is different from the situation here where: 1) Defendants can show that Plaintiffs are seeking non-Medicaid covered habilitation services; and 2) CMS has denied ODJFS' attempts to provide habilitation services outside of an ICF/MR or without a federally approved Medicaid waiver (*see* Rec. at 366) and deferred payment for services furnished by Step by Step. *See* Rec. at 384. CMS took these actions against ODJFS under the old versions of the Proposed Rules – rules which Plaintiffs claim entitle them to habilitation services.

John B. is further inapplicable because the State of Tennessee agreed to a consent decree almost immediately after the case was filed. *John B.*, 176 F. Supp.2d at 789. Much of the opinion in *John B.* deals with the State's obligations under that consent decree. *See, e.g., John B.*, 176 F. Supp.2d at 790 (caption heading, "A. The State's Efforts to Implement the March 1998 Consent Decree."), 794 n. 5 (referencing p. 44 of "consent decree"). The portions of the opinion that do not deal with the State's obligations under the consent decree deal with issues not relevant to this case. Such issues include whether Tennessee provided physician services pursuant to 42 U.S.C. §1396d(e) and Tennessee's difficulties with private managed care companies. *Id.* at 800-806. Regarding Tennessee's

failure to provide treatment in accordance with federal EPSDT laws, *John B.* stated that Tennessee provided financial incentives to managed care organizations that resulted in managed care organizations denying or suspending care that Tennessee was required to provide pursuant to federal EPSDT requirements. *Id.* at 805. Such financial incentives and managed care relationships are not at issue in this case.

Other cases cited by Plaintiffs are inapplicable because those cases hold that federal EPSDT statutes require coverage of all medically necessary services within the scope of 42 U.S.C. §1396d(a). They do not address one of the main issues in this case, which is whether the habilitation services provided by Step by Step fall within the scope of 42 U.S.C. §1396d(a). For example, *Rosie D. v. Romney*, 410 F. Supp.2d 18 (Dist. Mass 2006) states:

Thus, Congress:

imposed a mandatory duty upon participating states to provide EPSDT-eligible children with *all the health care, services, treatments and other measures described in § 1396d(a) of the Act*, when necessary to correct or ameliorate health problems discovered by screening, *regardless of whether the applicable state plan covers such services.*

Rosie D., 410 F. Supp.2d at 25. *Moore v. Meadows*, 563 F. Supp.2d 1354 (N.D. Georgia 2008) states:

The federal circuit courts that have analyzed the 1989 EPSDT amendment agree that . . . participating states must provide all services within the scope of §1396d(a) which are necessary to correct or ameliorate defects, illnesses, and conditions discovered in children discovered by the screening services.

Moore v. Meadows, 563 F. Supp.2d at 1357.

Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Servs., 293 F.3d 472 (8th Cir. 2002) states:

The State [Medicaid] 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 [sic].⁷

Pediatric Specialty Care, Inc., 293 F.3d at 481.

Plaintiffs' claim that the habilitation services furnished by Step by Step may be covered as "preventive" services also fails. *See* Pl. Br. at 24-25. "Preventive services" must, among other things, be "provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law." *See* 42 C.F.R. §440.130(c). As stated above, the day-to-day services furnished by Step by Step are furnished by non-licensed aids. Therefore, they cannot be covered as "preventive" services.

D. Federal EPSDT Laws Require Medicaid To Cover Only Those Services Listed At 42 U.S.C. §1396d(a).

Plaintiffs claim that services need not be specifically listed in 42 U.S.C. §1396d(a) in order to be covered pursuant to federal EPSDT statutes. *See* Pl. Br. at

⁷ Defendants respectfully submit that this must be a typographical error that should read "§1396d(a)." 42 U.S.C. §1396a contains a myriad of administrative requirements regarding state Medicaid plans but does not define categories of health care items and services. 42 U.S.C. §1396d(a) contains only definitions of health care items and services (and other terms).

20. But that claim is contrary to the plain language of the definition of EPSDT services and numerous circuit court cases.

EPSDT services are screening, vision, dental, and hearing services, as well as “such other necessary health care, diagnostic services, treatment, and other measures described in section 1905 (a) [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)(1) – (5) (emphasis added). Cases cited by Plaintiffs rely on that statutory definition when stating that EPSDT services include those services listed at 42 U.S.C. §1396d(a). *See, e.g., S.D.*, 391 F.3d at 590 (“Accordingly, every Circuit which has examined the scope of the EPSDT program has recognized that states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a).”); *Pediatric Specialty Care, Inc.*, 293 F.3d at 480 (“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.”)⁸, *citing*, 42 U.S.C. §1396d(r)(5); *Collins*, 349 F.3d at 374 (same).

⁸ *See supra*, footnote 8.

Plaintiffs and *Amici* raise an irrelevant issue when they claim that EPSDT services include services that are not covered under the state Medicaid plan. *See* Pl. Br. at 20-21, *Amici* Br. at 10. Regardless of whether a service is on a state Medicaid plan, EPSDT services are clearly limited to those services listed at 42 U.S.C. §1396d(a). *See* 42 U.S.C. §1396d(r)(5).

E. The Proposed Rules Do Not Impermissibly Narrow Medicaid Coverage.

The Proposed Rules do not impermissibly narrow Medicaid coverage for the habilitation services provided by Step by Step because those services are not covered by Medicaid. Thus, there is no scope of coverage to narrow. But even if Medicaid did cover such services (and it does not), the Proposed Rules would not narrow the scope of that coverage.

Ohio Admin. Code 5122-29-17 does not narrow Medicaid coverage because it determines only whether a given service is classified as CPST – and therefore payable at a rate of \$85.32/hr. Def. Br. at 48-49. It does not determine Medicaid coverage. *Id.* Plaintiffs have not responded to this reasoning.⁹

The limited scope of Ohio Admin. Code 5122-29-17 also defeats Plaintiffs' main challenges to that rule. Plaintiffs claim that Ohio Admin. Code 5122-29-17

⁹ Plaintiffs claim that the old version of Ohio Admin. Code 5122-29-17 allowed Step by Step to receive Medicaid reimbursement for the services it was providing. *See* Pl. Br. at 11. But Plaintiffs ignore the fact that CMS deferred payment under that old rule.

“defines CPST services in a more restrictive manner than is permissible under EPSDT.” Pl. Br. at 25. But federal EPSDT statutes do not contain any standards for defining CPST. *See* 42 U.S.C. §1396d(r). Federal EPSDT statutes and Ohio Admin. Code 5122-29-17 simply concern different subjects.

Ohio Admin. Code 5101:3-27-02 does not impermissibly narrow Medicaid coverage because it does not conflict with federal law. *See* Def. Br. at 52-56. Because it does not conflict with federal law, it is not preempted by federal law. *Id.* Plaintiffs have not responded to this assertion, or any of the evidence cited in pages 52-56 of Defendants’ Brief (regarding conflict preemption).

F. The Proposed Rules Will Not Irreparably Harm Plaintiffs Because They Can Still Get All Medicaid-Covered Services.

Defendants’ opening brief explained that the Proposed Rules will not irreparably harm Plaintiffs because those rules will not prevent Plaintiffs from getting all the Medicaid-covered services to which they are legally entitled. *See* Def. Br. at 49-52. Plaintiffs have responded by stating that they will suffer irreparable harm if they are unable to obtain the services they seek. *See* Pl. Br. at 28-29. But that response misses the point because it does not explain how Plaintiffs have a legal right to those services and how the Proposed Rules will deprive them of that legal right.

In fact, the Proposed Rules will not deprive Plaintiffs of any legal right. If Defendants are correct and federal Medicaid statutes prohibit the Ohio Medicaid

program from covering the habilitation services provided by Step by Step, then the Proposed Rules would not injure Plaintiffs regardless of their effect. Plaintiffs have no right to continued Medicaid payment for non-Medicaid covered services. But even if the Ohio Medicaid program were required to cover the habilitation services provided by Step by Step (and it is not), Plaintiffs can still get those services by requesting state hearings or prior authorization. *See* Def. Br. at 49-52.

Plaintiffs have responded with general objections to these administrative remedies and also with specific objections to state hearings and the prior authorization process. Regarding their general objections, Plaintiffs claim that Defendants are trying to “have it both ways” by stating that habilitation services are not covered by Medicaid and also claiming habilitation services are available through other means. This argument is easily dispensed with, as Defendants’ opening brief states that “to the extent that any services that Step by Step is providing to the Plaintiffs are covered by Medicaid, Plaintiffs can obtain those services by requesting administrative hearings or asking Step by Step to request ‘prior authorization’ of those services.” Def. Br. at 4-5. Plaintiffs also raise the general objection that they need not exhaust administrative remedies before suing pursuant to 42 U.S.C. §1983. Pl. Br. at 29, n.10. Even if true, that has no bearing on whether Plaintiffs have another way of getting Medicaid-covered services so that they would not be harmed by the Proposed Rules.

Plaintiffs claim that state hearings are inadequate because they would have to be denied services (and therefore suffer an injury) before getting a hearing. Pl. Br. at 30. But state hearing rules explicitly state that an individual can request a state hearing when ODJFS “has proposed or acted to reduce, suspend, terminate, or withhold benefits . . .” *See* Ohio Admin. Code 5101:5-3-02(A)(3).¹⁰ Therefore, Plaintiffs need not wait until benefits are reduced before requesting a state hearing. They can request a hearing based on a proposal to reduce benefits.

Plaintiffs claim that prior authorization is inadequate because only Medicaid providers, such as Step by Step, can request prior authorization. That response fails because legislative history of the 1989 amendments to federal EPSDT statutes explicitly permit state Medicaid programs to impose a prior authorization requirement on EPSDT treatment services (but not screening services). *See* H. Rep. No. 101-247 at 400, *reprinted in*, 3 U.S.C.C.A.N. 1906 at 2126 (“While states may, at their option, impose prior authorization requirements on treatment services, the Committee intends that, consistent with the preventive thrust of the EPSDT benefit, both the regular periodic screening services and the interperiodic screening services be provided without prior authorization.”) (emphasis added). Plaintiffs’

¹⁰ An exception states that ODJFS need not offer state hearings when a change in law “requires automatic adjustment of benefits.” *See* Ohio Admin. Code 5101:6-3-01(D). That exception is inapplicable to this case because there has been no change in law, as habilitation services have never been covered outside Medicaid waivers or ICF/MRs at any time relevant to this case. Nevertheless, Plaintiffs are entitled to hearings if they wish to challenge this position.

response also fails because Medicaid providers have the sole authority to take a host of actions that affect their ability to receive Medicaid reimbursement. For example, Medicaid providers must document the provision of services, code the services correctly, and timely submit the bills to ODJFS. Further, as a practical matter, it is difficult to imagine that Step by Step would refuse to request prior authorization on a Plaintiff's behalf. Its interests are aligned with the Plaintiffs in terms of providing services and receiving Medicaid reimbursement.

Plaintiffs next claim that prior authorization is inadequate because ODJFS would subject their request to an "overly restrictive definition of rehabilitative services." Pl. Br. at 30. This is not true. Prior authorization is available for any Medicaid-covered service – not just rehabilitative services. *See* Def. Br. at 50, quoting Erika Robbins ("Q. Are you aware of any Medicaid-covered service that cannot be obtained through a prior authorization? A. No."). Thus, a service need not be "rehabilitative" in order to be covered by prior authorization. Services need only be rehabilitative if they are covered pursuant to 42 U.S.C. §1396d(a)(13). If Plaintiffs believe that ODJFS is applying an overly-restrictive definition of "rehabilitative services" Plaintiffs could challenge that definition by requesting an administrative appeal and judicial review. *See* Ohio Admin. Code 5101:6-3-01(A)(6); 5101:6-8-01; 5101:6-9-01; R.C. 119.12 and 5101.35.

In short, if Step by Step is providing Medicaid-covered services, Plaintiffs can get those services through state hearings and/or prior authorization requests. Plaintiffs have not shown how those they would be unable to obtain Medicaid-covered services through those means.

G. Plaintiffs' Response Brief Raises Irrelevant Legal Issues.

Plaintiffs raise three irrelevant issues in their response brief. The first is the claim that federal EPSDT statutes require Medicaid to cover services listed at 42 U.S.C. §1396d(a) if a licensed practitioner finds the service to be medically necessary to correct or ameliorate a condition. *See* Pl. Br. at 16-19. The second is the claim that 42 U.S.C. §1396d(a)(13) does not require services to be rehabilitative because the district court concluded that services are covered if they “improve,” rather than “restore” and individual’s condition. *See* Pl. Br. at 22. The third is that Ohio’s definition of “medical necessity” “supports the trial court’s conclusion and does not require services to be restorative.” Pl. Br. at 23. Each of these issues is addressed below.

The first claim is irrelevant because it begs the question of whether the habilitation services provided by Step by Step fall within the scope of 42 U.S.C. §1396d(a). As discussed above, Defendants have provided numerous authorities showing that habilitation services do not fall within the scope of 42 U.S.C. §1396d(a). Plaintiffs have not responded to these authorities. Therefore,

Plaintiffs' arguments about EPSDT covering everything in 42 U.S.C. §1396d(a) is irrelevant. Even if true, it does not determine the scope of 42 U.S.C. §1396d(a) or whether Medicaid covers the habilitation services provided by Step by Step.

The second claim is irrelevant because habilitation services are not included in any portion of 42 U.S.C. §1396d(a) – including 42 U.S.C. §1396d(a)(13). *See supra*, Section II(B) & (C); Def. Br. at 37-48. Even if it were relevant, Defendants respectfully disagree that 42 U.S.C. §1396d(a)(13) does not require services to be rehabilitative. The plain language of the statute requires that services under 42 U.S.C. §1396d(a)(13) provide for “the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.” 42 U.S.C. §1396d(a)(13) (emphasis added). A cardinal principle of statutory construction is to preserve the entire statute and accord each clause and word due effect. *United States Dept. of Labor v. Goudy*, 777 F.2d 1122, 1127 (6th Cir. 1985). Plaintiffs' reading of 42 U.S.C. §1396d(a)(13) reads the “restoration” requirement right out of the law.

In response, Plaintiffs claim that *Rosie D.*, 410 F. Supp.2d 18, and the district court's reasoning show that services do not need to be rehabilitative in order to be covered under 42 U.S.C. §1396d(a)(13). Plaintiffs claim that *Rosie D.* found that 42 U.S.C. §1396d(a)(13) covers non-rehabilitative services because it “used the word ‘improve’ and not ‘restore’ in concluding that services were

covered. Pl. Br. at 22. But the court in *Rosie D.* referred to “improvement” of a condition when paraphrasing 42 U.S.C. §1396d(a) – immediately after it cited the requirement that services under 42 U.S.C. §1396d(a)(13) restore an individual to the best possible functional level. *See Rosie D.*, 410 F. Supp.2d at 26. Later on, when explicitly discussing the scope of 42 U.S.C. §1396d(a)(13), the court stated that “[t]he in-home support offered by MBHP falls far short of what is required, pursuant to the terms of the Medicaid statute, ‘for the maximum reduction of physical or mental disability and restoration of the individual to the best possible functional level.’ 42 U.S.C. § 1396d(a)(13).” (emphasis added). *Rosie D.*, 410 F. Supp.2d at 46. Therefore, *Rosie D.* does not support Plaintiffs attempt to read the restorative requirement out of the statute.

Plaintiffs and *Amici* also rely on the district court’s reasoning that 42 U.S.C. §1396d(a)(13) must cover non-rehabilitative services because if it did not cover such services, “no child born with a disability who needed mental health care services would ever receive coverage for such services.” *Amici Br.* at 3. *See also*, *Pl. Br.* at 23. This argument is misleading at best. Medicaid covers the services of licensed psychologists and psychiatrists without requiring them to be “rehabilitative.” *See* 42 U.S.C. §1396d(a)(6); Ohio Admin. Code 5101:3-8-05. Medicaid also covers inpatient and outpatient hospital services, physician services, home health care services, private duty nursing services, clinic services,

prescription drugs, and inpatient psychiatric hospital services – all without requiring them to be “rehabilitative.” *See* 42 U.S.C. §1396d(a)(1), (2), (5), (7), (8), (9), (12), (17). *See also*, Ohio Admin. Code 5101:3-4-29 (“Services for the diagnosis and treatment of mental and emotional disorders are covered as physician services when the services are performed by a licensed social worker, professional counselor, or professional clinical counselor who is employed by or under contract with the physician or clinic as long as the services provided are within the licensed social worker’s professional counselor’s, or professional clinical counselor’s scope of practice as defined in [R.C. Chpt. 4757] and [meet certain requirements regarding supervision.]”); Ohio Admin. Code 5101:3-8-01(C)(5) and (D) (describing Medicaid coverage of services of licensed psychologists and stating that eligible providers of psychology services include fee for service ambulatory health care clinics, rural health clinics, outpatient health facilities, federally-qualified health centers, and hospitals). All of these services are available to children born with disabilities who need mental health services, regardless of whether they are “rehabilitative.”

The third claim, regarding Ohio’s definition of medical necessity, is irrelevant because Ohio’s “medical necessity” definition is a general definition that applies to all Medicaid-covered services. *See* Ohio Admin. Code 5101:3-1-01(A).

It lacks a requirement that services be “rehabilitative” because not all Medicaid-covered services must be rehabilitative.

H. The District Court Did Not Accord Proper Deference To Administrative Materials Showing That Medicaid Does Not Cover Habilitation Services.

Defendants’ opening brief discussed numerous administrative documents showing that CMS has consistently stated that Medicaid does not cover habilitation services unless those services are provided to residents of an ICF/MR or provided in accordance with a federally approved Medicaid waiver. *See* Def. Br. at 43-47. Such documents included a statement from CMS’ State Medicaid Manual. *See* Def. Br. at 43, citing, State Medicaid Manual §5123(F) (Rec. 835). That manual provides instructions and information for implementing provisions of federal Medicaid law. *See* Def. Br. at 43, *citing*, State Medicaid Manual, Forward §(B)(1).

Plaintiffs have not challenged the substance of any of those administrative materials. Plaintiffs claim that the district court adequately considered the administrative materials, but properly held that none of those materials were subject to *Chevron* deference.¹¹ *See* Pl. Br. at 33. There are several problems with that claim. First, courts have stated that some of the administrative materials cited by Defendants are subject to *Chevron* deference. This Court cited with approval an Eleventh Circuit decision granting *Chevron* deference to CMS’ disapproval of a

¹¹ *See Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

state Medicaid plan. *See Harris v. Olzewski*, 442 F.3d 456, 470 (6th Cir. 2006), *citing, Georgia Dept. of Medical Assistance*, 8 F.3d at 1572-73.¹² That is relevant to this case because CMS denied an Ohio state Medicaid plan amendment on the ground that it covered habilitation services outside of an ICF/MR or a federally approved Medicaid waiver. *See Rec.* at 858; *Def. Br.* at 45-46. Also, *A.M.H.* specifically stated that the State Medicaid Manual (also cited by Defendants) is subject to *Chevron* deference. *See A.M.H.*, 2004 U.S. Dist. LEXIS at *28-29 (“Indeed, even if the Court found that the statute was ambiguous as to whether or not [42 U.S.C.] §1396d(r)(5) mandates community based services, the Court must defer to the interpretation given to the statute by CMS in accordance with *Chevron*.”). Second, even if these materials were not subject to *Chevron* deference, the State Medicaid Manual is entitled to “a significant measure of deference” in light of CMS’ significant expertise, the technical complexity of the Medicaid program, and CMS’ exceptionally broad authority. *Morenz v. Wilson-Coker*, 415 F.3d 230, 235 (2nd Cir. 2005). Other administrative materials are subject to “respectful consideration,” at least. *See, e.g., Wisconsin Dept. of Health and Family Servs.*, 534 U.S. at 497 (giving “respectful consideration” to agency statements in preamble to regulatory text of proposed regulations); *Lankford v.*

¹² *See also, Pharmaceutical Research & Manufacturers of America v. Thompson*, 360 U.S. App. D.C. 375, 379-80 (D.C. Cir. 2004) (granting *Chevron* deference to CMS interpretations of Medicaid law).

Sherman, 451 F.3d 496, 512 (8th Cir. 2006) (giving “considerable deference” to letters from CMS to state Medicaid directors). This is particularly true given the nature of the Medicaid program. *Stephenson v. Petrowicz*, 87 F.3d 350, 356 (9th Cir. 1996) (“Medicare and Medicaid are enormously complicated programs. The system is a web; a tug at one strand pulls on every other.”). If the district court had given appropriate deference to the administrative materials cited by Defendants, it could not have determined that Plaintiffs could show that Medicaid covers the habilitation services provided by Step by Step.

Plaintiffs also claim that administrative materials show that CMS is uncertain about whether Medicaid covers the services furnished by Step by Step. See Pl. Br. at 33, n.15. But Plaintiffs have identified no evidence showing that Medicaid covers the habilitation services that Step by Step is providing. Plaintiffs’ citation to Erika Robbins’ testimony does not show that Medicaid covers habilitation services. See Tr. at 132-134. It shows that some aspects of ABA therapy may be covered by Medicaid. But it does not show that Medicaid covers the habilitation-services component of ABA. Plaintiffs’ citation to Mr. D’Allesandro’s opening remarks (which are not evidence) also fail to show that Medicaid covers habilitation services. They show only that CMS has not yet determined which of the services provided by Step by Step are covered by Medicaid. See Pl. Br. at 33, n. 16, *citing*, Tr. at 15-17.

III. CONCLUSION

Defendants respectfully request that the Court reverse the district court's order enjoining the Proposed Rules.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 26, 2009, a copy of the foregoing Joint Reply Brief of Defendants-Appellants was filed electronically. Notice of this filing will be sent to all parties by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

/s/ Ara Mekhjian
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