

Case No. 08-3931

**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,
Southern District of Ohio
Case No. 2:08-CV-421

BRIEF AMICUS CURIAE ST. VINCENT MERCY CHILDREN'S HOSPITAL, FAMILY HEALTHCARE, INC., THE ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY OHIO, WARRAN KLEINBERG, MD, MEDICAL DIRECTOR ST. VINCENT'S MERCY FAMILY CARE CENTER, THE LEGAL AID SOCIETY OF COLUMBUS CHILD AND YOUTH LAW PROGRAM, ADVOCATES FOR BASIC LEGAL EQUALITY AND LEGAL AID OF WESTERN OHIO, INC., COMMUNITY LEGAL AID SERVICES, LEGAL AID OF GREATER CINCINNATI AND LEGAL AID SOCIETY OF SOUTHWEST OHIO, LLC, OHIO STATE LEGAL SERVICES ASSOCIATION, SOUTHEASTERN OHIO LEGAL SERVICES, THE LEGAL AID SOCIETY OF CLEVELAND, NATIONAL HEALTH LAW PROGRAM, NATIONAL DISABILITY RIGHTS NETWORK, THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, DISABILITY LAW & ADVOCACY CENTER OF TENNESSEE, MICHIGAN PROTECTION & ADVOCACY SERVICE, INC., KENTUCKY PROTECTION AND ADVOCACY IN SUPPORT OF PLAINTIFFS-APPELLEES AND SUPPORTING AFFIRMANCE

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Disclosure of Corporate Affiliations and Financial Interest

Pursuant to Sixth Circuit Rule 26.1, counsel for *amici curiae* hereby state that none of the *amici* are subsidiaries or affiliates of a publicly owned corporation not named in the appeal.

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STATEMENT OF INTEREST¹

As described in more detail in Addendum A, *amici curiae* are national and state-based organizations located within the Sixth Circuit that represent a broad spectrum of Medicaid-participating health care providers and advocacy groups who serve individuals who are covered by Medicaid. The undersigned organizations represent and provide services to families, children, working people, and people with disabilities living in Ohio, the Sixth Circuit, and all over the United States. They provide direct services to low-income families and children with disabilities, including medical treatment and legal advocacy. Further, *amici* educate the public about the issues facing low-income families and about health care issues generally.

A number of the *amici* operate medical-legal collaborations across Ohio, in which lawyers and doctors partner together to overcome obstacles to children's health that each cannot address alone. Attorneys assist children and families with legal issues impacting their health, including Medicaid coverage, while medical professionals treat the patients' medical needs. Overall, the medical-legal collaborations work to improve patient health and development.

Amici have a strong interest in having this Court uphold the District Court's opinion because it prevents the State from violating Medicaid's Early, Periodic

¹ For Statements of Interest specific to each *Amicus*, see Addendum A.

Screening, Diagnostic, and Treatment (EPSDT) requirements. The proposed rule would unlawfully narrow the scope of services covered under EPSDT and illegally deny low-income children access to medically necessary community mental health services. This issue is of critical importance to the work that *amici* perform on behalf of low-income children who rely on EPSDT. Further, *amici* can provide the Court with valuable information in deciding this appeal by offering a broader perspective on the Medicaid program, EPSDT, and the impact the proposed rule changes would have on low-income families.

SUMMARY OF ARGUMENT

Amici Curiae respectfully urge this Court to uphold the District Court's decision to grant a preliminary injunction. The decision will prevent the State from implementing rules that would deny coverage of medically necessary behavioral health care to Medicaid-eligible children, violating Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements.

The EPSDT program was created to provide a broad and comprehensive set of diagnostic, preventative, and treatment services to low-income children, including behavioral and mental health services for children with autism. The proposed state rules restricting Medicaid coverage of Applied Behavioral Analysis (ABA) therapy for children with autism violate EPSDT's guarantee of comprehensive and broad coverage of mental, physical, and behavioral health care services. In particular, under these rules, EPSDT coverage would be limited such that no child born with a disability who needed mental health care services would ever receive coverage for such services. This would irreparably harm Plaintiffs, as well as other low-income children with developmental disabilities. In addition, the public interest would be served by upholding the preliminary injunction so that low-income children can access comprehensive mental and behavioral health care services at the earliest possible opportunity, in order to prevent great public expenditures in the long term.

LEGAL BACKGROUND: THE MEDICAID ACT

The plain language of the EPSDT provisions, along with the legislative history of the Medicaid Act, reflects Congress' intent that EPSDT ensure that low-income children and children with disabilities receive comprehensive, effective, and preventative treatment services and that States be prohibited from narrowing the scope of coverage of services for beneficiaries under age 21.

The Medicaid program was established in 1965 by Title XIX of the Social Security Act. *See* 42 U.S.C. § 1396-1396v (2006). Cooperatively funded by the federal and state governments, it provides health and long-term care coverage for individuals who cannot pay for that care. *See, e.g., Schweiker v. Gray Panthers*, 453 U.S. 34 (1981). One of the fundamental goals of Medicaid is to establish a uniform and state-wide medical insurance program that adheres to general federal statutory requirements. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 415 (1997). Congress' "very clear . . . intent [was] that the medical and remedial care and services made available to recipients under Title XIX be of high quality and in no way inferior to that enjoyed by the rest of the population. *Id.* at 416, *citing* U.S DEP'T OF HEALTH, EDUC., AND WELFARE, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION § D-5140.

Medicaid is the primary source of health and mental health care for millions of Americans, particularly children, the elderly, and people with disabilities. The

program insures more people in this country than any other system, public or private, covering more than 55 million—about one in five—Americans. CENTER ON BUDGET AND POLICY PRIORITIES, AN INTRODUCTION TO MEDICAID (2006), <http://www.cbpp.org/10-2-06health.htm>. Medicaid pays for one-third of all births in the United States. *Id.* It also pays for more than 40 percent of all long-term care services in this country. KAISER COMM'N ON MEDICAID AND THE UNINSURED, PROFILES OF MEDICAID'S HIGH PROFILE POPULATIONS 6 (2006), <http://www.kff.org/medicaid/upload/7565.pdf>.

Over 28 million children and youth were enrolled in Medicaid in 2005. KAISER COMM'N ON MEDICAID AND THE UNINSURED, HEALTH COVERAGE FOR LOW-INCOME CHILDREN 2 (2007), <http://www.kff.org/uninsured/upload/2144-05.pdf>. In Ohio, children below two-hundred percent of the federal poverty level are eligible for Medicaid coverage.² *See* OHIO REV. CODE ANN. 5101.51 (2000); Ohio Admin. Code 5101:1-40-08 (2008). Nationwide about half of Medicaid enrollees are children, but they account for only one-fifth of all Medicaid spending. CENTER ON BUDGET AND POLICY PRIORITIES, AN INTRODUCTION TO MEDICAID (2006), <http://www.cbpp.org/10-2-06health.htm>.

States are not required to participate in Medicaid, but all do. Once they do participate, States must comply with specified federal requirements. *See, e.g.,*

² Currently, the federal poverty level is \$21,200 for a family of four in the forty-eight continental United States. *See* 73 Fed. Reg. 3971, 3971 (Jan. 23, 2008).

Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 502 (1990) (holding that “[a]lthough participation in the program is voluntary, participating states must comply with certain requirements imposed by the [Medicaid] Act and regulations. . .”).

For example, states must ensure that services are provided in an amount, duration, and scope sufficient to achieve their purpose. 42 C.F.R. § 440.230(b) (2006). In addition, States must cover certain specified services, including in and outpatient hospital, physician, and clinic care. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a) (2006). Accordingly, once an individual is eligible for Medicaid, he is entitled to a defined set of benefits. 42 U.S.C. § 1396a(a)(10)(A) (2006). And, once a state opts to provide Medicaid services, it has an open-ended entitlement to receive federal matching payments for all spending on covered services.³ 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (2006).

ARGUMENT

The District Court correctly decided to issue a preliminary injunction to prevent Appellants from implementing state rules that would exclude Applied Behavioral Analysis (ABA) therapy for children with autism spectrum disorders (ASD) from the scope of coverage as Medicaid community mental health services.

³ The federal government reimburses states for a substantial portion of their Medicaid costs, ranging from 50 percent to 83 percent, depending on the average per capita income of the state. 42 U.S.C. §§ 1396b(a), 1396d(b) (2006). Ohio’s matching percentage rate for 2009 is 62.14 percent. 72 Fed. Reg. 67306 (Nov. 28, 2007).

See OHIO ADMIN. CODE 5101:3-27-02, 5122-29-17 (effective July 1, 2008). Plaintiffs, like other children with disabilities, are entitled to services pursuant to Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment requirements, which provide for comprehensive health care services for eligible children. *See* 42 U.S.C. § 1396d(r) (2006). EPSDT provides a separate and broader level of coverage for children than adults, covering all “health care, diagnostic services, treatment, and other measures” to “correct or ameliorate defects and physical and mental illnesses and conditions . . . whether or not such services are covered under the State plan.” 42 U.S.C. § 1396d(r)(5) (2006). Under EPSDT, a state plan must provide coverage for all services that fall into the categories listed under 42 U.S.C. § 1396d(a), including:

other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

42 U.S.C. § 1396d(a)(13) (2006).⁴

⁴ In this brief, *amici* focus on coverage of rehabilitative services that fall under the definition set forth in § 1396d(a)(13). It is important to note, however, that the ABA services at issue here could arguably fit within the definition of preventive services, as discussed by the District Court and Plaintiff-Appellees. *See Parents League*, 565 F. Supp. 2d at 913; Plaintiffs-Appellees’ Response Brief at 24, *Parents League* (No. 08-3931).

Despite the clear scope of this Medicaid provision, The State's proposed rules have limited coverage to only "rehabilitative" mental health care services. OHIO ADMIN. CODE 5101:3-27-02(A) (effective July 1, 2008). The rules narrowly define "rehabilitative" services as those that "provide for the maximum reduction of *mental illness* and are intended to restore an individual to the best possible functional level." *Id.* (emphasis added). The State has therefore excluded coverage for children who need treatment for other mental and behavioral conditions and disabilities. *Id.*; *see also* OHIO ADMIN. CODE 5122-29-17 (effective July 1, 2008). Further, the State interprets 42 U.S.C. § 1396d(a)(13) to provide for coverage only of services that are "restoring" skills that a child previously had and lost. *See Parents League for Effective Autism Services, et al. v. Jones-Kelly, et al.*, 565 F. Supp. 2d 905, 916 (2008).

The State's narrow definition of rehabilitative services is contrary to Congress' intent that preventative and broad coverage be provided to low-income children under EPSDT. *Id.* Accordingly, the proposed changes unlawfully narrow the scope of services covered under EPSDT and illegally deny low-income children access to comprehensive mental health care services.

I. Congress intended for EPSDT to ensure comprehensive and preventative health care to children.

Medicaid services for children and youth are governed by the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program requirements. 42

U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (2006). By creating EPSDT, Congress and the President recognized that low-income children and youth have significantly more illnesses and disabilities than higher-income children and that children's health and developmental needs differ from those of adults. President Johnson summed up the goal of the EPSDT program when introducing the legislation as a 1967 amendment to the Medicaid Act, stating:

The problem is to discover, as early as possible, the ills that handicap our children. There must be continuing follow up and treatment so that handicaps do not go neglected. We must enlarge our efforts to give proper eye care to a needy child. We must provide help to straighten a poor youngster's crippled limb before he becomes permanently disabled. We must stop tuberculosis in the first stages, before it causes serious harm.⁵

113 CONG. REC. 2883 (1967).⁶

⁵ This statement clearly conveys the goals of the Medicaid program despite the dated terminology, such as use of the word "handicap" instead of "disability."

⁶ The introduction of the EPSDT legislation was likely motivated in part by a government study on the high rate of rejection of young men drafted into the military. In 1962, nearly 50 percent of draftees were found to be unfit for military service for health reasons. The study revealed that a substantial number of men otherwise eligible for military service suffered from mental, physical and developmental conditions that were largely preventable and treatable, particularly if detected early. ROSENBAUM ET AL., NATIONAL SECURITY AND U.S. CHILD HEALTH POLICY: THE ORIGINS AND CONTINUING ROLE OF MEDICAID AND EPSDT 6 (Apr. 2005) (citing PRESIDENTIAL TASK FORCE ON MANPOWER CONSERVATION, ONE THIRD OF A NATION: A REPORT ON YOUNG MEN FOUND UNQUALIFIED FOR SERVICE, (1964)). Significantly, most of these young men came from poor families. Among other recommendations, the Task Force recommended improvement in screening, diagnosis and treatment of preventable conditions at the earliest time possible. *Id.* at 10. Shortly after this study was submitted, the 1967 EPSDT legislation, which included these improvements, was introduced and added to the Medicaid Act. *Id.* at 10–11.

Thus, from the time of EPSDT's origin, it was envisioned as a complete treatment program to seek out children's health care needs and address them. It was aimed at the significant, but preventable, health problems and disabilities affecting many American citizens. In the original legislative history, Congress emphasized that the States would be required to make "vigorous efforts to screen and treat children." S. Rep. No. 90-744 (1967), *as reprinted in* 1967 U.S.C.C.A.N. 2843, 3032. Funds expended through EPSDT were intended to reduce the discrepancies in the number of children served from state to state and to help states with the "early identification of children in need of correction" of disabilities. *Id.*

EPSDT evolved over several decades and, by the late 1980's, it was similar in form to the current system. Congress made the most significant expansion to EPSDT through the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). OBRA 89 established, for the first time, the current definition: screening services that are provided at intervals meeting reasonable standards of medical practice, as well as "[s]uch other necessary health care, diagnostic services, treatment, and other measures . . . 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) (2006) (emphasis added). During the passage of OBRA 89, Congress recognized that "[t]he EPSDT benefit is, in effect, the Nation's largest preventive health program for children."

H.R. Rep. No. 101-247, at 398 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2124. Emphasis was placed on eliminating delay in the provision of care. When Senator Bentsen introduced the EPSDT provisions in 1989, he stated “This bill . . . requires prompt treatment once a condition has been diagnosed.” *Id.* at 399.

The amendments were enacted in response to the ongoing failure of states to provide for aggressive preventative and ameliorative services for the children living in poverty, who experience a high level of “preventable physical, dental, and mental health care conditions.” H.R. Rep. 110-600 (2008) (considering and explaining the public policy behind EPSDT when considering later Medicaid amendments). The statutory language expressly stated the goal, means, and standard for EPSDT and imposed a duty on states to effectuate the program regardless of whether such services were generally covered under the state plan. *See* 42 U.S.C. § 1396d(r)(5) (2006).

The express language of EPSDT and the legislative history show that Congress intended to make these services more accessible and effective for low-income children with developmental disabilities. *See S.D. v. Hood*, 391 F.3d 581, 592 (5th Cir. 2004) (explaining that the legislative history demonstrates that Congress intended to make health care and treatment more accessible and effective “by imposing an obligatory, not discretionary, duty on states to effectuate this aspect of the EPSDT program ‘whether or not such services are covered under the

State plan.’’). Congress intended for the strengthened EPSDT provisions to provide children with access to preventative health care in order to identify children with disabilities early and provide them with services. *See, e.g.*, H.R. Rep. No. 101-247, at 4211–4214 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2121–2127; S. Rep. No. 90-744, at II-G (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 2869–2871. The State’s narrow scope of coverage of mental health services is at odds with EPSDT’s broad mandate.

II. Low-income children will suffer irreparable harm if they are denied access to meaningful health care treatment by the State’s overly restrictive administrative rules.

If the State’s proposed rules go into effect, low-income children who rely on Medicaid coverage for medically necessary mental and behavioral health care services would suffer irreparable harm.

Medicaid is the primary health care option for Ohio’s growing population of low-income children. In Ohio, almost 40 percent of children live in families with incomes below 200 percent of the federal poverty guidelines (which is the current income eligibility level for children’s Medicaid). *See* U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY: ANNUAL SOCIAL AND ECONOMIC SUPPLEMENT (2007), http://pubdb3.census.gov/macro/032008/pov/new46_185200_11.htm. Many low-income working families lack the resources to pay for private treatment for their children. *See generally* H.R. Rep. 100-391(I), 4102 (1987). When a low-

income working family cannot afford treatment for their child, frequently the child's only option is Medicaid. Consequently, the State's overly restrictive coverage rules will harm many low-income children who need behavioral and mental health care treatment.⁷

Early diagnosis and treatment is critical for correcting and ameliorating health care issues that may "otherwise leave a child permanently disabled." H.R. Rep. 100-391(I), 4102 (1987). For example, children with autism spectrum disorder (ASD) can achieve normal levels of learning and can live and work independently as adults when provided with intensive early services. *See* Mulick Decl. at ¶ 11, Doc. #3-2; Rec. at. 44. While later services can still significantly increase the functioning of a child with autism, children experience better outcomes when services are provided early. If the window for early services is lost, services are not as effective and children experience worse long-term

⁷ Despite the State's claim that other resources, such as the autism scholarship, could be used to provide services, there simply are no other realistic options for low-income children. OHIO REV. CODE 3310.41; Jt. Brief of Defs. at 29. A recent Ohio study examined the autism scholarship program, and explained that the autism scholarship program is not a viable option for low-income families for numerous reasons, including: 1) low-income parents' inability to pay educational expenses exceeding the voucher amount; 2) services, especially at the pre-school level, are home-based, requiring a low-income, working parent to stay home during the day; 3) service providers are geographically concentrated in wealthier metropolitan areas, leaving poorer, rural Ohioans unable to access the voucher; and 4) generally, research indicates that poverty is a barrier to parental involvement in education. POLICY MATTERS OHIO, ANALYZING AUTISM VOUCHERS IN OHIO (2008), http://www.policymattersohio.org/pdf/AnalyzingAutismVouchers2008_0319.pdf.

outcomes. Consequently, low-income children will suffer irreparable harm if the State's overly restrictive rules are enacted and low-income children are denied coverage for mental health care services.

The State's overly restrictive rules violate EPSDT's requirements. The rules would restrict Medicaid coverage of community mental health services to only individuals with "mental *illness*," thus excluding coverage for children who need treatment for other physical and mental disabilities, including not only autism but other developmental disabilities as well. *See* OHIO ADMIN. CODE 5122-29-17 (effective July 1, 2008) (emphasis added). The State's rules also explicitly limit coverage to services that would "*restore* the individual's functioning to the highest level possible." *Id.* (emphasis added); *See also* OHIO ADMIN. CODE 5101:3-27-02(A) (effective July 1, 2008). Such a narrow construction is contrary to the mandate of EPSDT because, as the District Court held, the logical conclusion of this restrictive interpretation would be that no child born with a disability could ever receive community mental health services through Ohio Medicaid. *Parents League*, 565 F. Supp. 2d at 916. This ignores the reality that some functions may not have been possible or age-appropriate for a child to achieve at an earlier time. Such a narrow construction is contrary to the mandate of EPSDT.

III. Ensuring that low-income children receive comprehensive, early, and effective health care services is in the public interest.

The State's attempt to deny low-income children early, cost-effective treatment is contrary to the public interest. Denying necessary behavioral health care services when children are young can necessitate greater public expenditures in the long term. A principal goal of EPSDT is to "assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly." *S.D. v. Hood*, 391 F.3d 581, 586 (5th Cir. 2004). Congress has repeatedly recognized that children living in poverty experience a high level of preventable physical, dental, and mental health conditions. *See, e.g.*, H.R. Rep. 110-600 (2008). For low-income children, those medical conditions can be "exacerbated by external traumas arising from poverty, family chaos or violence, drug abuse, separation from loved ones, and institutionalization." *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 32 (D. Mass. 2006).

As the District Court correctly recognized, though the cost of providing necessary treatment services to children with autism "appears daunting, the potential that such care will have to be continued throughout adulthood poses a potentially larger economic burden." *Parents' League*, 565 F. Supp. 2d at 918 (citing studies showing savings of \$1,000,000 per child over the child's lifetime by receiving necessary early intervention). Providing health care services at the earliest opportunity helps children grow into healthy, independently functioning

adults who can work and care for themselves, and are not reliant on public assistance. *See* Mulick Decl. at ¶ 11, Doc. #3-2; Rec. at. 44. Research related to ASD treatment shows that “47% of children who receive Applied Behavior Analysis treatment will become ‘indistinguishable among their peers’ and mainstream back into the regular school environment.” LaMarche Decl. at ¶ A, Doc. #3-3; Rec. at. 79; *see also* Rosner Decl. at ¶ 3, Doc. #45-6; Rec. at 1124–1125. If children are denied early treatment, they will be highly unlikely to succeed in school and their chances of independence and economic self-sufficiency will be severely damaged. The State itself recognizes this reality, as reflected in the rules the State is attempting to change. *See* OHIO ADMIN. CODE 5122-29-17(B)(9) (effective July 1, 2008) (stating that covered services included “mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking or maintaining education and employment.”).

Moreover, studies have shown that parents of children with ASD, even more than parents of children with other developmental disabilities, face incredibly high levels of stress. Laura A. Schieve et al., *The Relationship Between Autism and Parenting Stress*, 119 PEDIATRICS S114, S114 (2007) (finding that a study using the Aggravation Parenting Scale concluded that parents of children with autism were more likely to score in the high aggravation range (55%) than parents of

children with developmental disabilities other than autism (44%), parents of children with non-developmental disabilities (12%), and parents of children without special health care needs (11%).) The additional stressors that low-income parents face and the behavioral challenges associated with autism may increase the likelihood of abuse or neglect. *See generally* Paula Kienberger Jaudes & Lucy Mackey-Bilaver, *Do Chronic Conditions Increase Young Children's Risk of Being Maltreated?* 32 CHILD ABUSE & NEGLECT 671 (2008). Under these circumstances, parents are frequently forced to turn to the child welfare system when they are not able to obtain needed mental health care services via Medicaid. *See generally* UNITED STATES GENERAL ACCOUNTING OFFICE, FEDERAL AGENCIES COULD PLAY A STRONGER ROLE IN HELPING STATES REDUCE THE NUMBER OF CHILDREN PLACED SOLELY TO OBTAIN MENTAL HEALTH SERVICES (2003), <http://www.gao.gov/new.items/d03397.pdf> [hereinafter GAO REPORT].

Also, failure to obtain early treatment may result in a child being institutionalized or even incarcerated. For example, Plaintiff X.C.'s mother testified that X.C.'s behaviors might force her to place him in an institutional facility if the intensive services received are discontinued or reduced pursuant to the State's rules. Tr. at 92-93. In addition to being terrible environments for children, institutions and detention centers are extremely expensive. The costs of a residential treatment facility, for example, can be over \$250,000 per year for a

single child. GAO REPORT at 2 & 11. Accordingly, providing early intervention services to address health care problems before they become more complex and costly is in the public interest.

CONCLUSION

The State's rules would violate Medicaid's EPSDT requirements by denying coverage of necessary mental health services to Plaintiffs. These rules will harm the Plaintiffs, as well as other low-income children with developmental disabilities who will be denied access to mental health care services. Accordingly, *amici curiae* respectfully urge that this court uphold the District Court's decision to issue a preliminary injunction preventing these rules from going into effect.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation provided in Rule 32(a)(7)(C)(i) of the Federal Rules of Appellate Procedure. This brief contains 4,516 words of Times New Roman (14 point) proportional type and was prepared using Microsoft Word.

/s/ Vanessa K. Coterel
Vanessa K. Coterel

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing brief for Amici Curiae the Child and Youth Law Program of The Legal Aid Society of Columbus was served upon all counsel of record by means of the Court's electronic filing service on this 22nd day of January, 2009.

/s/ Vanessa K. Coterel
Vanessa K. Coterel