

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

MEMISOVSKI, et al.,)	
)	
Plaintiffs,)	
)	
v.)	Case No. 92 C 1982
)	
BARRY S. MARAM, Director of the)	Judge Joan Humphrey Lefkow
Illinois Department of Public)	Magistrate Judge Martin C. Ashman
Aid and CAROL L. ADAMS,)	
Secretary of the Illinois Department)	
of Human Services,)	
)	
Defendants.)	

**PLAINTIFFS' PROPOSED STATEMENT OF CONTESTED
AND UNCONTESTED ISSUES OF LAW**

Plaintiffs, by their undersigned counsel, hereby submit their Proposed Statement of Contested and Uncontested Issues of Law.

Proposed Contested Issues of Law

1. Whether Defendants (collectively, "the State") have violated and continue to violate the rights of the Plaintiff class (the "Children") under the EPSDT requirements of the Medicaid Act and its implementing regulations, 42 U.S.C. §§ 1396a(a)(10) and (43), 1396d(r), and 42 C.F.R. § 430 et seq., and the State Medicaid Manual, in any or all of the following ways:

- a. The State's EPSDT program, taken as a whole, has failed to deliver EPSDT services to all of the Children.
- b. The State has failed to effectively inform all of the Children of the EPSDT program by:

- i. Failing to use written notices and informational materials that are adequately tailored to families with low literacy or English skills and are not distributed frequently enough;
 - ii. Failing to use adequate oral methods to supplement the written materials;
 - iii. Failing to use person-to-person outreach and case management to a sufficient extent to ensure that all Children are aware of the program and receiving services;
 - iv. Failing to use Medicaid usage data to identify Children who are not using the program according to the periodicity schedule and target them for more effective informational activities, outreach and/or case management;
 - v. Failing to use adequate methods to keep track of physicians enrolled in the Medicaid program who are also currently willing to provide EPSDT services to the Children and inform the Children of the those physicians; and/or
 - vi. Failing to use such methods as are sufficient to induce all of the Children to come forward for EPSDT services.
- c. The State has failed to deliver immunizations as required by the periodicity schedule.
 - d. The State has failed to deliver general health, vision, hearing, and blood lead screens of the type and frequency required in the periodicity schedule.
 - e. The State has failed to deliver treatment for diagnosed medical conditions or injuries.

- f. The State has failed to recruit and retain in the program sufficient medical provider resources to provide EPSDT services to all Children according to the periodicity schedule and to treat diagnosed conditions or injuries.
2. Whether the State has violated and continues to violate the Children's rights under the equal access provision, 42 U.S.C. § 1396a(30)(A) and 42 C.F.R. § 447.204, by failing to provide them with access to health care equal to the access to health care enjoyed by children in Cook County insured by private or other public health insurers.
3. Whether the State has violated and continues to violate the Children's rights under the equal access provision, 42 U.S.C. § 1396a(a)(30)(A) and 42 C.F.R. § 427.204, by setting Medicaid reimbursement rates for pediatric physician services in Cook County that are arbitrary and capricious, in that the rates are significantly below the cost of providing the care and were arrived at without any attempt to ascertain the physicians' cost of providing the services or to anticipate the impact of the rates on access to health care.

Proposed Uncontested Issues of Law

I. PARTIES

1. On October 8, 1992, the Court certified the Plaintiff class of children on Medicaid residing in Cook County, Illinois (the "Children"), defined as:

All children (persons under the age of 18) in Cook County, Illinois, who, on or after July 1, 1990, have been, are or will be eligible for the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act.

2. Defendant Barry S. Maram is the Director of the Illinois Department of Public Aid ("IDPA").
3. Defendant Barry S. Maram is sued in his official capacity.
4. Defendant Barry S. Maram has been automatically substituted for his predecessors as a party to this action by operation of Federal Rule of Civil Procedure 25(d).

5. Defendant Carol S. Adams is Secretary of the Illinois Department of Human Services ("IDHS").

6. Defendant Carol S. Adams is sued in her official capacity.

7. Defendant Carol S. Adams has been automatically substituted for her predecessors as a party to this action by operation of Federal Rule of Civil Procedure 25(d).

II. JURISDICTION AND VENUE

8. This Court has jurisdiction over this case under 28 U.S.C. §§ 1331 and 1343(a)(3).

9. Venue in this Court is proper as the Children reside in Cook County, Illinois.

III. THE MEDICAID ACT

10. Congress established the Medicaid program in 1965 by enacting Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (the "Medicaid Act").

11. The Children have a cause of action under 42 U.S.C. § 1983 to enforce rights secured to them under the Medicaid Act, 42 U.S.C. § 1396a(a)(30), 1396a(a)(43), 1396d(r) and related statutory provisions and implementing regulations. See Memorandum Opinion and Order (October 17, 2001) at 11-13.

12. Medicaid beneficiaries may seek declaratory and injunctive relief to compel the state to comply with the Medicaid Act. See, e.g., Bond v. Stanton, 655 F.2d 766, 768 (7th Cir. 1981).

13. The Medicaid program provides federal funds (known as "federal financial participation") to states that choose to provide medical services to low-income individuals in conformance with the Medicaid Act. 42 U.S.C. § 1396 et seq.

14. A state's participation in the Medicaid program is voluntary.

15. Once a state opts to participate in the Medicaid program, it must comply with the Act and with the regulations promulgated by the federal Centers for Medicare and Medicaid Services ("CMS"), a part of the United States Department of Health and Human Services ("HHS"). Harris v. McRae, 448 U.S. 297, 301 (1980); Wilder v. Virginia Hospital Association, 496 U.S. 498, 502 (1990).

16. HHS administers the Medicaid program through CMS, formerly known as the Health Care Financing Administration ("HCFA").

17. To qualify for federal reimbursement, the Act requires each state to submit to the federal government "a comprehensive written statement ... describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in ... Chapter IV [of the Code of Federal Regulations], and other applicable official issuances of the Department." See 42 U.S.C. § 1396a; 42 C.F.R. § 430.10.

18. Since 1967, Illinois has elected to participate in the federal Medicaid program. See 305 ILCS §§ 5/5-1 et seq. (originally adopted at Laws 1967, p. 122, § 5-1, eff. April 11, 1967).

19. IDPA is the "single state agency" responsible for administration of the Medicaid program in Illinois. 42 U.S.C. § 1396a(a)(5).

20. Pursuant to 42 U.S.C. §§ 1302 and 1396, HHS is authorized to make and publish such rules and regulations as necessary for the efficient administration of the Medicaid program.

21. CMS, as the federal agency that administers Medicaid, has expertise in administering the Medicaid Act.

22. CMS has promulgated a State Medicaid Manual that is an authoritative explanation of what the Medicaid statute and regulations require states to do in implementing the Medicaid program. See Indiana Family and Social Services Admin. v. Thompson, 286 F.3d 476, 482 (7th Cir. 2002) (State Medicaid Manual warranted deference); Stanton v. Bond, 504 F.2d 1246, 1249 (7th Cir. 1974) (Manual's provisions describe "what is required").

23. Letters written by the Director of CMS or HCFA, known as "State Medicaid Letters," also provide states with direction and interpretive guidance in the provision of state Medicaid programs. See, e.g., Slekis v. Thomas, 525 U.S. 1098 (1999) (vacating Second Circuit's ruling that state was not obligated to cover medically necessary equipment items under its Medicaid plan, and remanding for further consideration "in light of the interpretive guidance issued by [HCFA] on September 4, 1998."); T.L. v. Colorado Dep't. of Health Care Policy and Fin., 42 P.3d 63, 67 (Colo. Ct. App. 2001) (state regulation held invalid under federal law and objectives of Medicaid Act based, in part, on HCFA interpretive guidance letter).

24. Although states may contract with private and public health care providers to deliver the panoply of services guaranteed under the Medicaid program, states retain ultimate responsibility to ensure compliance with the Medicaid Act. See Carr v. Wilson-Coker, 203 F.R.D. 66, 75 (D. Conn. 2001) (describing state's duties under Medicaid Act as "non-delegable"); Salazar v. District of Columbia, No. CA-93-452, 1997 WL 306876, *11 (D.D.C. Jan 17, 1997) ("Defendants may enter into contracts with providers delegating the requirements of this paragraph but, if they do so, Defendants shall monitor these activities and enforce these contractual provisions in order to assure that they are fully carried out."); J.K. By and Through R.K. v. Dillenberg, 836 F. Supp. 694, 699-700 (D. Ariz. 1993) ("It is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity.").

IV. EPSDT

A. General Provisions

25. One of the requirements of the Medicaid Act is that state programs provide for children on Medicaid to receive "early and periodic screening, diagnostic, and treatment services," commonly known by the acronym EPSDT. See 42 U.S.C. §§ 1396a(a)(10), 1396d(a)(4)(B).

26. Detailed definitions of the services encompassed within EPSDT are set forth at 42 U.S.C. § 1396d(r) and 42 C.F.R. § 441.56.

27. States must "make available a variety of individual and group providers qualified and willing to provide EPSDT services." 42 C.F.R. § 441.61(b).

28. IDPA's Handbook for Providers of Healthy Kids Services describes the EPSDT services Illinois requires medical providers to provide to Children.

29. States must "make appropriate use" of all other agencies and programs dealing with public health, mental health, education and related programs "to ensure an effective child health program." 42 C.F.R. § 441.61(c).

30. States must provide Medicaid recipients with transportation services and help with scheduling medical appointments. See 42 C.F.R. § 441.62 (requiring the provision of transportation and scheduling services); State Medicaid Manual § 5150.

B. Informing

31. The Medicaid Act requires that the states provide information to recipients that effectively promotes the use of EPSDT services. 42 U.S.C. § 1396a(a)(43).

32. Medicaid regulations require states to "[p]rovide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program." 42 C.F.R. § 441.56(a)(1).

33. States must use "clear, non-technical language" to inform people of "the benefits of preventive health care," the availability of EPSDT services and where and how to obtain them. 42 C.F.R. § 441.56(a)(2).

34. States must "effectively inform" those who are blind or deaf or who cannot read or understand the English language. 42 C.F.R. § 441.56(a)(3).

35. States must provide assurance to CMS that "processes are in place to effectively inform individuals" regarding EPSDT. 42 C.F.R. § 441.56(a)(4).

36. The State Medicaid Manual instructs the states to "use methods of communication that recipients can clearly and easily understand to ensure that they have the information they need to utilize services to which they are entitled." State Medicaid Manual § 5121(A).

37. Oral informational methods are expressly required by the Medicaid Act, including such methods as face-to-face communications from eligibility workers, health aides, and providers, public service announcements, community awareness campaigns and audio and visual methods. State Medicaid Manual § 5121(A); 42 U.S.C § 1396a(a)(43)(A).

C. Periodicity Schedule

38. EPSDT services are required to be performed at intervals that meet reasonable standards of medical and dental practice, as set forth in a "periodicity schedule" of required examinations, tests and services. 42 C.F.R. § 441.58.

39. EPSDT services may be required to be provided more frequently than the standard periodicity schedule if medically necessary for any individual child. 42 U.S.C. § 1396d(r)(1)(A)(ii).

40. Illinois has adopted a periodicity schedule based on the recommendations of the American Academy of Pediatrics, which incorporates a nationally recognized schedule for immunizations. See 89 Ill. Admin. Code § 140.488.

41. Under the State of Illinois' periodicity schedule, children between the ages of 10 days and 11 months should receive six well-child screening examinations at 2 weeks, 1 month, 2 months, 4 months, 6 months and 9 months.

42. Under the State of Illinois' periodicity schedule, children between the ages of 11 months and 23 months should receive three well-child screening examinations, at 12 months, 15 months, and 18 months.

43. Under the State of Illinois' periodicity schedule, children between the age of 10 days and 11 months should receive three Haemophilus B (HIB) immunizations, at 2 months, at 4 months, and at 6 months (a fourth is due between 12 and 18 months).

44. Under the State of Illinois' periodicity schedule, children should receive two polio (IPV) immunizations between the ages of 10 days and 5.5 months.

45. Under the State of Illinois' periodicity schedule, children should receive three Diphtheria and Tetanus (DtaP) immunizations between the ages of 10 days and 11 months.

46. Under the State of Illinois' periodicity schedule, children should receive their first Measles, Mumps and Rubella (MMR) immunization between 12 and 18 months of age.

D. Corrective Treatment

47. States must provide all care, treatment, services or other measures that are medically necessary to address any conditions that are discovered through EPSDT screening and diagnostic services. 42 U.S.C. § 1396d(r)(2)-(5).

48. A state Medicaid program must ensure that children get corrective treatment if necessary for conditions disclosed in EPSDT screens. 42 U.S.C. § 1396a(a)(43)(C).

49. States must provide any and all diagnostic and treatment services allowed under the federal Medicaid scheme to address the needs indicated by EPSDT screens, regardless of whether the state has opted to provide those services to adult Medicaid recipients. 42 C.F.R. § 441.56(c)

E. Program Monitoring and Follow-up

50. States are required "to effectively inform" individuals of EPSDT on an annual basis for any children that "have not utilized EPSDT services." 42 C.F.R. § 441.56(a)(4).

51. The states have an obligation to monitor the level of healthcare actually provided to help them improve their performance. See Salazar, 1997 WL 306876, *10-11 (District required to establish a tracking system to assure that all Medicaid-eligible children receive all age-appropriate EPSDT services).

52. If states do not know how the program is performing with respect to informing recipients of EPSDT services, the failure to monitor the program is itself a violation of the EPSDT requirements. Bond, 655 F.2d at 770-771 (state violated EPSDT statute by failing to monitor whether complete screening services are being performed on EPSDT-eligible children); Salazar v. District of Columbia, 954 F. Supp. 278, 329 (D.D.C. 1996) (agency's failure to respond to parental requests for EPSDT services for their children, failure to conduct site visits to monitor providers serving EPSDT-eligible children, and lack of data collection requirements or organized system for receiving feedback from providers and for enforcing those requirements evidenced district's failure to monitor whether EPSDT-eligible children receive complete screening services).

53. The Medicaid Act requires the Secretary of HHS to "develop and set annual participation goals for each State for participation of individuals who are covered under

the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services." 42 U.S.C. § 1396d(r)(5).

54. In 1990 the Secretary of HHS established a schedule of goals in the State Medicaid Manual, directing the states to show by 1995 a "participant ratio" (measuring how many eligible children received at least one EPSDT service in that year) and a "screening ratio" (measuring the number of eligible children who receive all required services under the state's periodicity schedule) of at least 80%. See State Medicaid Manual § 5360(B), (C).

V. EQUAL ACCESS

55. Under the Medicaid Act, states are required to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to ... assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). This requirement is commonly referred to as the "equal access" provision of the Medicaid Act. See 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.204.

56. Portions of the equal access requirement originated in regulations promulgated by CMS. See 42 C.F.R. § 447.204 ("The [state] agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.").

57. In 1989, Congress endorsed CMS' interpretation by importing it into the Medicaid Act itself. See Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a).

58. The stated Congressional impetus for amending the equal access requirement within the Medicaid Act was that states were improperly limiting provider reimbursement rates as "one method of controlling program costs." See Report of the House Budget Committee on H.R. 3299 (Sept. 20, 1989) *reprinted in* Medicare & Medicaid Guide (CCH), Extra Edition No. 596 (Oct. 5, 1990) at 390 (hereinafter "H.R. 3299 Report").

59. Congress expressly determined with regard to provider reimbursement under Medicaid that "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program." See H.R. 3299 Report.

60. In enacting the equal access provision, Congress required states to compare the access of Medicaid beneficiaries "to the access of other individuals in the same geographic area with private or public coverage." H.R. Rep. No. 1010-247, 101st Cong., 1st Sess. 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116.

61. The uninsured are not to be considered as part of the "general population" for purposes of the equal access provision. See, e.g., Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519, 527 (8th Cir. 1993) ("[T]o construe the language 'general population' to include the uninsured members of the population would be directly contrary to the intent of the Medicaid statute.... To suggest that Congress appropriated vast sums of money and enacted a huge bureaucratic structure to ensure that recipients of the federal Medicaid program have equivalent access to medical services as their uninsured neighbors (i.e. close to none) is ridiculous.").

62. Under the equal access provision, if the provider reimbursement rates paid by a state under Medicaid are insufficient to generate access to care for Medicaid beneficiaries equal to the access to care enjoyed by their neighbors who are insured under private insurance or other public programs, the state must raise its rates until equal access is achieved. See, e.g.,

Methodist Hospitals, Inc. v. Sullivan, 91 F.3d 1026, 1029 (7th Cir. 1996) ("Under [the equal access provision] ... states may behave like other buyers of goods and services in the marketplace: they may say what they are willing to pay and see whether this brings forth an adequate supply. If not, the state may (and under § 1396a(a)(30), must) raise the price until the market clears.") (emphasis added).

63. States are required to monitor the level of access to care for Medicaid recipients being achieved under its rate structure, and to adjust the rates as necessary to assure equal access. See American Society of Consultant Pharmacies v. Garner, 180 F. Supp. 2d 953, 973 (N.D. Ill. 2001) ("Methodist Hospitals makes plain that the IDPA has a duty to monitor the supply that results from the new rates, and must raise the price if experience shows that the supply is not adequate under Section 30(A).").

64. In cases where there is a challenge by recipients to the adequacy of a state's monitoring of access to care, there are several factors a court may consider to evaluate whether a state has complied with the "equal access" provision, including: (a) the level of reimbursement to participating physicians in the context of the market and the cost of providing services; (b) the level of physician participation in the Medicaid program and whether providers are opting out of or restricting their Medicaid caseloads; (c) whether there is a stream of reports that recipients are having difficulty obtaining care; (d) whether the rate at which Medicaid recipients utilize the program is lower than the rate at which the generally insured population uses those programs; and (e) whether defendants have admitted that reimbursement rates are inadequate. See, e.g., Clark v. Kizer, 758 F. Supp. 572, 575-78 (E.D. Cal. 1990), *aff'd in relevant part sub nom.*, Clark v. Coye, 967 F.2d 585 (1992); Methodist Hospitals, 91 F.3d 1029-1030 (mandating studies to determine impact of rates on access and recommending physician participation and consumers or recipient complaints as two factors for such studies).

65. Administrative actions by government agencies may not be "arbitrary and capricious" in nature. See, e.g., Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 40-41 (1983).

66. While no particular rate-setting method or rate is mandated by the equal access provision, the state's actions with respect to rate-setting cannot be arbitrary and capricious. See, e.g., Rite-Aid of Pennsylvania, Inc. v. Houston, 171 F.3d 842, 853 (3d Cir. 1999).

67. With respect to Medicaid reimbursement rate-setting, some of the factors used to determine whether a rate is arbitrary and capricious include: (i) whether, "by considering [a] study and other sources of information, [the state] made a reasonable effort to anticipate the effects of its action"; and (ii) whether the rate the state arrived at "would allow [providers] to maintain provision of care and earn a profit." Rite-Aid of Pennsylvania, Inc. v. Houston, 171 F.3d 842, 854-55 (3d Cir. 1999).

68. Where a state's methodology for adopting Medicaid reimbursement rates is found to be arbitrary and capricious, the state may be held to have violated the equal access provision. See, e.g., Arkansas Medical Society, Inc. v. Reynolds, 819 F. Supp. 816, 823 (E.D. Ark. 1993), aff'd, 6 F.3d 519 (8th Cir. 1993).

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Respectfully submitted,

MEMISOVSKI, et al.

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