UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

G.D., by and through his parent, S.D., *et al.*,

Plaintiffs,

v. **Case No. 2:05–cv–980**

Michael Colbert, Director of the Ohio Department of Job and Family Services, **Judge Michael H. Watson**

Defendant.

OPINION AND ORDER

Plaintiffs in this civil rights action move for summary judgment, ECF No. 213. Defendant[1] moves for judgment on the pleadings or, in the alternative, for summary judgment, ECF No. 222. For the reasons that follow, the Court denies Plaintiffs' motion for summary judgment, denies in part and grants in part Defendant's motion for judgment on the pleadings, and grants Defendant summary judgment on the remaining claims.

I. BACKGROUND

Plaintiffs are Medicaid-eligible children who allegedly have been denied access to Medicaid services such as treatments for autism, cerebral palsy,

[1] Michael Colbert, as the current Director of the Ohio Department of Job and Family Services, is automatically substituted for Barbra Riley pursuant to Federal Rule of Civil Procedure 25(d).

spastic quadriplegia, seizure disorder, developmental delay and idiopathic short stature.

This action was initially filed by Plaintiffs G.D., M.D., and G.B. on October 26, 2005, as a class action complaint seeking injunctive and declaratory relief. In their first complaint, Plaintiffs alleged Defendant, the Director of the Ohio Department of Job and Family Services, failed to properly provide information on how to access Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") services. Specifically, Plaintiffs alleged Defendant failed to ensure Medicaid-eligible children and their medical providers are adequately informed about what services are available through EPSDT and how to apply for those services, Defendant failed to have in place policies that ensured reasonable access to request medically necessary services and corrective treatment, and Defendant failed to arrange for the provision of medically necessary services in a reasonable time frame, as required by 42 U.S.C. § 1396a(a)(8) and (43). Plaintiffs A.S. and D.L. were later granted leave to intervene. The case was reassigned to this Judge in September 2010.

After five years of extensive litigation, the parties reached a partial settlement and entered into a consent decree. The consent decree resolved nearly all of the claims asserted in Plaintiffs' complaint, reserving only a single legal issue for the parties to continue to litigate, specifically: "whether the definition of 'medically necessary services' at Ohio Admin. Code 5101:3-1-01

conflicts with federal laws regarding coverage of EPSDT treatment services and results in the denial, to Medicaid eligible children, of treatment services to which they would be entitled under federal law." Consent Decree ¶ 3, ECF No. 180.

On March 7, 2012, the Court granted in part Defendant's prior motion to dismiss the complaint and granted Plaintiffs leave to amend the complaint to include the issue preserved by the consent decree. Order 7, ECF No. 203.

II. MEDICAID LAW

Defendant Michael Colbert is the director of the Ohio Department of Job and Family Services ("ODJFS") and is responsible for the administration of the Medicaid program in Ohio. "Medicaid is a jointly funded cooperative program between the states and the federal government that provides federal funding to participating states to assist those states in providing medical assistance to low income persons and individuals with disabilities." *A.M.H. v. Hayes*, No. C2–03–778, 2004 U.S. Dist. LEXIS 27387, at *5 (S.D. Ohio Sept. 30, 2004). When Ohio chose to participate in the Medicaid program it submitted a medical assistance plan and agreed to comply with the requirements of the Medicaid Act and regulations promulgated by the Secretary of Health and Human Services. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 501 (1990).

Within the Medicaid Act, medical assistance includes twenty-eight specific services. 42 U.S.C. § 1396d(a). Nine of the twenty-eight are mandatory services which a state Medicaid plan must make available for all Medicaid recipients. 42

U.S.C. § 1396a(a)(10).[2] States have the option of providing the other services.

States are also obligated to provide EPSDT services to Medicaid-eligible children and youth under a certain age, as chosen by the state. 42 U.S.C. § 1396d(a)(l) (state may end EPSDT eligibility at age 18, 19, 20 or 21); 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(a)(4)(B). Ohio operates its EPSDT program as Healthchek and requires EPSDT services to be provided to eligible persons under the age of 20. Ohio Admin. Code § 5101:1-38-05(A). States must arrange for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment "the need for which is disclosed by such child health screening services." 42 U.S.C. § 1396a(a)(43)(c). Section 1369d(r) defines EPSDT as screening, vision, dental, and hearing services, and

> [s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section [(the twenty-eight categories of medical assistance)] 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. § 1369d(r)(5).[3] EPSDT services, therefore, require states to provide all

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[2] The mandatory services for all Medicaid-eligible recipients are (1) inpatient hospital services, (2) outpatient hospital services, (3) laboratory and x-ray services, (4) nursing facility services, (5) services of limited practitioners, (6) home health services, (7) nurse-midwife services, (8) certified pediatric (or family) nurse practitioners, and (9) freestanding birthing center services. 42 U.S.C. § 1396a(a)(10).

[3] In the federal administrative code, EPSDT is defined as "(1) screening and diagnostic services to determine physical or mental defects in beneficiaries under age 21; and (2) Health care treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered." 42 C.F.R. § 440.40(b).

necessary services within the twenty-eight categories of medical assistance. *Parents' League for Effective Autism Services v. Jones-Kelley*, 339 F. App'x 542, 547 (6th Cir. 2009); *A.M.H.*, 2004 U.S. Dist. LEXIS 27387, at *29.

Although EPSDT requires treatments that are "necessary" the Medicaid Act does not define "necessary." Instead, the Medicaid Act and its implementing regulations grant states the authority to set reasonable standards for the terms "necessary" and "medical necessity." *See* 42 U.S.C. § 1369a(a)(17); 42 C.F.R. § 440.230(d); *K.G. ex rel. Garrido v. Dudek*, 864 F. Supp. 2d 1314, 1320 (S.D. Fla. 2012).

Plaintiffs only ground for relief at this stage of the litigation concerns whether Ohio applies a definition of "medical necessity" which does not comply with EPSDT's mandate to provide services which "correct or amerliorate any defects and physical and mental illnesses and conditions." Ohio applies the "medical necessity" standard in Ohio Administrative Code § 5101:3-1-01 to all Medicaid determinations, including determinations for EPSDT services. Ohio Admin. Code § 5101:1-38-05(8). Ohio Administrative Code § 5101:3-1-01 reads in full:

> (A) "Medical necessity" is a fundamental concept underlying the medicaid program. Physicians, dentists, and limited practitioners render, authorize or prescribe medical services within the scope of their licensure and based on their professional judgment regarding medical services needed by an individual. Unless a more specific definition regarding medical necessity for a particular category of service is included within division-level 5101:3 of the Administrative Code,

> "medically necessary services" are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must:
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> (1) Meet generally accepted standards of medical practice;
> (2) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
> (3) Be appropriate to the intensity of service and level of setting;
> (4) Provide unique, essential, and appropriate information when used for diagnostic purposes;
> (5) Be the lowest cost alternative that effectively addresses and treats the medical problem; and
> (6) Meet general principles regarding reimbursement for medicaid covered services found in rule 5101:3-1-02 of the Administrative Code.
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> (B) Preventive health care, though not customarily thought of as a "medically necessary" service, is available through the departments' early periodic screening, diagnosis and treatment (EPSDT, also known as healthchek) program or through managed care plans (MCPs) that have contracted with the department.

Ohio Admin. Code § 5101:3-1-01.

III. FACTS

On April 6, 2012, Plaintiffs filed their first amended complaint on behalf of G.D., M.D., A.S., D.G., G.B., and D.L., which purports to be a class action suit.[4] All Plaintiffs reside in various Ohio counties and are Medicaid-eligible. The complaint alleges the following about each Plaintiff.

Plaintiff G.D. is 16 years old and is diagnosed with autistic disorder and

[4] Plaintiffs filed a motion to certify a class on July 31, 2012, ECF No. 228. On Defendant's motion, the Court stayed briefing on the motion to certify a class until the Court rules on the dueling motions for summary judgment. Order, ECF No. 233.

mild to moderate mental retardation, and has a history of self injuries and other aggressive behavior. In 2004, G.D.'s doctors determined an intensive behavioral intervention program designed around the principles of applied behavior analysis was medically necessary to prevent further developmental regression, risk of medical problems, and discomfort from increased self injury and aggression. In addition, the doctors recommended other services including speech therapy. In July 2005, G.D's home health care hours were cut from 40 to 35 hours a week. The complaint does not specify whether G.D. was receiving services directly from ODJFS or through a managed care provider or which entity made the decision to cut the hours or therapy. The complaint alleges G.D's mother requested EPSDT services but that G.D. was denied those services.

Plaintiff M.D. is 13 years old and is diagnosed with Pervasive Developmental Disorder - Not Otherwise Specified and has documented deficits in adaptive behavior and delays in social communication, motor skills, and self help skills. In 2005, M.D.'s doctors determined that he requires in home one-on-one supports through a behavioral intervention program for 25 to 30 hours a week and other services including speech therapy. The complaint alleges M.D. was denied EPSDT services.

Plaintiff A.S. is 20 years old and has multiple disabilities including spastic quadriplegia, cerebral palsy, hydrocephalus, developmental delay, and seizure disorder. A.S. requested a Rifton gait trainer which was prescribed by his doctors

as medially necessary to improve his level of functioning and mobility. Defendant denied the gait trainer as a service not covered under Ohio's state Medicaid plan. A.S. also requested a new shower/commode chair which was medically necessary to support A.S.'s body in the shower because he is unable to control his head and trunk. Defendant denied the shower care on the basis it was not medically necessary, was not covered by Ohio's Medicaid State Plan, and should have been requested through A.S.'s Medicaid waiver. A state hearing officer affirmed the initial denial but the decision was overturned on administrative appeal.

Plaintiff D.G. is 16 years old and suffers from idiopathic short stature. He wears braces on his teeth as a result of an undeveloped jaw. On July 18, 2008, D.G.'s doctor requested prior authorization for growth hormone treatment. CareSource, a Medicaid managed care provider, denied the growth hormone as not medically necessary. That decision was overturned by a state hearing officer, who found that CareSource's internal policy underlying its decision to deny services was inconsistent with the Medicaid rules. The state hearing officer ordered CareSource to issue a new determination. On December 30, 2008, CareSource again denied the growth hormone treatment. D.G.'s mother was able to get treatment directly from the growth hormone manufacturer, Eli Lily, and D.G. began growth hormone therapy in January of 2009. On January 7, 2009, a state hearing officer again overturned CareSource's denial because CareSource

had used an incorrect definition of medical necessity which failed to take into account treatment intended to correct or ameliorate abnormalities or diseases.

Plaintiff G.B. is 11 years old and is diagnosed with Pervasive Developmental Disorder and exhibits challenging behaviors and social and communication deficits. In August 2004, G.B. was evaluated by the North Baltimore Local School District and the Kobacker Child Psychiatry Center and was referred for further evaluation and confirmation of the PPD diagnosis. G.B.'s mother was unable to take G.B. for follow up for several months due to unreliable transportation. G.B.'s mother requested transportation to evaluations and medical appointments from the Wood County Department of Job and Family Services but was advised she was not eligible because she had a car registered in her name. Later, she was told she was not eligible for transportation assistance because she had a job, was already getting enough help, and would need to bring a letter in from a mechanic demonstrating that the car did not run.

Plaintiff D.L. is 20 years old and is diagnosed with Pervasive Developmental Disorder with autism. D.L. has serious communication and social deficits and significant behavioral challenges. The complaint alleges D.L. needs further evaluation to determine the specific treatment necessary, and his parents advised the Medina County Department of Job and Family Services of that need but they were not advised regarding how to access those services.

IV. MOTION FOR JUDGMENT ON THE PLEADINGS

Plaintiffs' Amended Complaint presents three claims. Plaintiffs pleaded the first two under 42 U.S.C. § 1983: (1) by applying the medical necessity standard in Ohio Administrative Code § 5101:3-1-01, Ohio violates the Medicaid Act's requirement that states provide or arrange for EPSDT services, 42 U.S.C. §§ 1396a(a)(10)(A) and 1396a(a)(43), and (2) the use of Ohio's medical necessity code prevents Plaintiffs from receiving services with reasonable promptness as required by 42 U.S.C. § 1369a(a)(8). In Claim Three, Plaintiffs allege Ohio's medical necessity standard conflicts with federal EPSDT requirements and is preempted by the Supremacy Clause.

Defendant's motion for judgment on the pleadings pursuant to Federal Rule of Civil Procedure 12(c) asks the Court to hold Plaintiffs to the narrow issue in the consent decree; strike changes to the complaint that were not, in Defendant's opinion, allowed by the Court's leave to file an amended complaint; and hold Plaintiffs' claims are not properly before the Court due to a variety of justiciability concerns.

A. STANDARD OF REVIEW

The standard of review for a motion for judgment on the pleadings under Federal Rule of Civil Procedure 12(c) is the same as that for a motion for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6). *Monroe Retail, Inc. v. RBS Citizens, N.A.*, 589 F.3d 274, 279 (6th Cir. 2009). A claim survives a

motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) if it "contain[s] sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). "The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Id.* A complaint's "[f]actual allegations must be enough to raise a right to relief above the speculative level, on the assumption that all of the complaint's allegations are true." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555–56 (2007) (internal citations omitted).

A court must also "construe the complaint in the light most favorable to the plaintiff." *Inge v. Rock Fin. Corp.*, 281 F.3d 613, 619 (6th Cir. 2002). In doing so, however, a plaintiff must provide "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Twombly*, 550 U.S. at 555; *see also Iqbal*, 556 U.S. at 678 ("Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice."); *Ass'n of Cleveland Fire Fighters v. City of Cleveland, Ohio*, 502 F.3d 545, 548 (6th Cir. 2007). "[A] naked assertion . . . gets the complaint close to stating a claim, but without some further enhancement it stops short of the line between possibility and plausibility . . . ." *Twombly*, 550 U.S. at 557. Thus, "something beyond the mere possibility of relief must be alleged, lest a plaintiff with a largely groundless claim be allowed to take up the time of a number of

other people, with the right to do so representing an *in terrorem* increment of the settlement value." *Id.* at 557–58 (internal citations omitted).

B. DISCUSSION

1. Consent Decree

Defendant first argues the Court must dismiss all of Plaintiffs' allegations dealing with delays in services, including Claim Two in its entirety, because that issue was not preserved in the consent decree. The consent decree signed by all parties on December 30, 2010 states:

> Plaintiffs and their parents release ODJFS and its officials, employees, successors, and assigns (in their personal and official capacities) from any and all current or future claims and expenses of every nature whatsoever . . . arising out of or in connection with the Dispute[5], except that the parties will litigate the issue of whether the definition of "medically necessary services" at Ohio Admin. Code 5101:3-1-01 conflicts with federal laws regarding coverage of EPSDT treatment services and results in the denial, to medicaid eligible children, of treatment services to which they would be entitled under federal law.

Consent Decree ¶ 3, ECF No. 180. Defendant emphasizes that the claim is limited to whether the conflict "results in *denial* . . . of treatment services to which they would be entitled under federal law." *Id.* (emphasis added). Plaintiffs respond that delays are caused by initial denials and, therefore, denials and delays are intertwined, and no other portion of the consent decree specifically

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[5] "'The 'Dispute' means the case of *G.D. v. Riley*, Case No. 05–CV–980, United States District Court for the Southern District of Ohio, Eastern Division." Consent Decree ¶ 1.c, ECF No. 180.

precludes Plaintiffs from moving forward on a theory of delay.

"A consent decree is essentially a settlement agreement subject to continued judicial policing. It is a hybrid in the law, sharing features of both a voluntary settlement agreement that requires no judicial intervention and a final judgment order that throws the prestige of the court behind the compromise of the parties." *Nat'l Ecological Found. v. Alexander*, 496 F.3d 466, 477 (6th Cir. 2007). The Court's task in interpreting the consent decree is to ascertain the intent of the parties at the time of settlement. *NEFT, LLC v. Border State Energy, LLC*, 297 F. App'x 406, 408 (6th Cir. 2008).

Having nothing but the Consent Decree itself to consider in discerning the parties intent, the Court holds the term "results in denial of treatment services" covers the delay of services. A delay is a denial of services for the time period between the first request and the grant of services. If, as Plaintiffs' claim, services were not approved because of an improper application of Ohio's definition of "medical necessity" then Plaintiffs' were illegally denied treatment services during the period of delay.

2. Court's March 7, 2012 Order

Next, Defendants argue the Court must "dismiss" changes to the complaint that were not authorized by the Court's March 7, 2012 Order that granted Plaintiffs leave to amend the complaint. Specifically, Defendant requests that the

Court "dismiss" Plaintiffs' allegations regarding delays of Medicaid services; the third cause of action regarding the Supremacy Clause; revisions to the proposed class, including adding future Medicaid-eligible children and individuals who experienced a delay in the receipt of services; citations and allegations indicating Plaintiffs may seek a preliminary injunction; and a claim that A.S. was improperly denied a shower/commode chair in 2009. Plaintiff responds the changes and additions were to ensure that the Court's decision satisfies the case and controversy requirement, a concern specifically articulated by the Court, and that the additions fit squarely within the one remaining legal issue.

The Court's Order states only that the Court grants Plaintiffs leave to amend the complaint within thirty days of the Order. Order 7, ECF No. 203. This grant was made in response to the Court's finding that the issue preserved in the Consent Decree was not contained in the complaint. All of the changes and additions Plaintiffs made to the complaint were related to the central issue both parties agreed to litigate: whether Ohio's definition of "medical necessity" results in improper denials of EPSDT services. Therefore, the Court denies Defendant's request to remove these changes.

3. Failure to State a Claim

Defendant argues Plaintiffs G.D., M.D., G.B. and D.L. have not alleged a plausible claim of a denial of any particular service due to a conflict between state and federal law, and Ohio's definition is not an incorrect standard. Plaintiffs

respond the amended complaint puts Defendant on notice that Ohio's "medical necessity" definition conflicts with Medicaid requirements, they are not required to state their theory of recovery in the claim, and Plaintiffs G.D., M.D., G.B., and D.L. are all subject to the incorrect standard and therefore could be done harm in the future.[6]

a. Counts One and Two

In order to establish a 42 U.S.C. § 1983 claim, Plaintiffs' complaint must allege that (1) the conduct in controversy was committed by a person acting under color of law, and (2) the conduct deprived the plaintiff of a federal right, either constitutional or statutory. *Westside Mothers v. Olszewski*, 454 F.3d 532, 543–44 (6th Cir. 2006).

Although "a complaint need not pin plaintiff's claim for relief to a precise legal theory," *Skinner v. Switzer*, 131 S.Ct. 1289, 1296, a plaintiff must plead facts which make the claim plausible, *Iqbal*, 556 U.S. at 678. Because Plaintiffs' § 1983 claims are centered around the conflict between the Ohio definition of "medical necessity" and the Medicaid Act, Plaintiffs must allege facts that Plaintiffs G.D., M.D., G.B. and D.L. were denied their federal rights due to the conflict described in the claims for relief.

Plaintiffs G.D., M.D., G.B. and D.L. do not state a claim upon which relief

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[6] To the extent G.D., M.D., G.B. and D.L. assert claims for the future, such claims are not ripe. *See infra* Section II.A.7.

can be granted under § 1983. The allegations pertaining to G.D. and M.D. only state the services prescribed by their doctors, relief was requested, and they were denied EPSDT services. Am. Compl. ¶¶ 52–59, 63–66, ECF No. 206. There is nothing in these facts to infer G.D. or M.D. was denied services, and therefore deprived of a federal right, because of a conflict between Ohio's definition of "medical necessity" and the Medicaid Act. The explanation of G.B.'s denial of services gives specific reasons G.B. was denied transportation, none of which are related to Ohio's definition of "medical necessity." *Id.* ¶¶ 69, 71. Although those reasons might also have been illegal, they do not support the § 1983 claims in the amended complaint. The section pertaining to D.L. simply states D.L.'s parents advised Medina County Department of Job and Family Services of the need for further diagnostic evaluation and they were not told how to access those services. *Id.* ¶¶ 79, 80. There is nothing to suggest D.L. even requested services and that he was denied them. Accordingly, the Court grants Defendant's motion for judgment on the pleadings as to the § 1983 claims of Plaintiffs G.D., M.D., G.B. and D.L.

b. Count Three

Defendant does not specifically address what Plaintiffs must plead to state a claim under the Supremacy Clause of the United States Constitution, but instead argues generally that Plaintiffs have failed to state any claim because there was no harm done to them by a conflict in Ohio and Medicaid law. There is,

however, no indication in case law that a plaintiff must allege a specific harm in a Supremacy Clause claim. *See, e.g., Chase Bank USA, N.A. v. City of Cleveland*, 695 F.3d 548, 554 (6th Cir. 2012)[7]; *Jackie S. v. Connelly*, 442 F. Supp. 2d 503, 528 (S.D. Ohio 2006). Because Defendant raises no other argument at this stage, the Court declines to grant Defendant judgment on the pleadings as to Plaintiffs' Supremacy Clause claim for failure to state a claim.[8]

4. Statute of Limitations

Defendant argues A.S.'s "claim" that in May 2009, ODJFS improperly denied his request for a shower/commode chair should be dismissed because it was not included in A.S.'s March 2009 intervenor complaint and is therefore barred by the two-year statute of limitations for § 1983 claims in Ohio or constitutes a supplemental complaint which the Court did not grant leave to file. Plaintiffs respond the shower/commode

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[7] The panel in *Chase Bank USA* notes that the United States Supreme Court left the scope of a right of action under the Supremacy Clause undefined in *Douglas v. Independent Living Center of Southern California, Inc.*, –U.S.—, 132 S.Ct. 1204, 1207–08 (2012). 695 F.3d at 554 n.4. Although *Douglas* dealt specifically with the Medicaid Act, neither side raises the issue considered in *Douglas*—whether Medicaid providers and recipients may maintain a cause of action under the Supremacy Clause to enforce a federal Medicaid law—in the instant case. In addition, neither party raises whether there is a private right of action under the provisions of the Medicaid Act implicated in this action. The Sixth Circuit has previously held Sections 1369a(a)(10)(A),1369a(a)(8), and 1369a(a)(43) create a private right of action under § 1983. *Westside Mothers v. Haveman*, 289 F.3d 852, 863 (6th Cir. 2002).

[8] The Court does, however, hold that because Plaintiffs do not allege an injury in fact due to the alleged conflict in regards to G.D., M.D., G.B. and D.L., these plaintiffs do not have standing to pursue the Supremacy Clause claim. *See infra* section II.B.5.

allegation is not a separate claim and therefore cannot be dismissed pursuant to the statute of limitations; even if it was a claim, it relates back to A.S.'s initial intervenor complaint; and there is an exception to the statute of limitations in a class action.

The Court views the addition of the shower/commode allegation as within the Court's grant of leave to amend the complaint to reflect the issue the parties agreed to litigate. It is not on its own a claim, it only supports the claims Plaintiffs make. Therefore, the addition of such allegations need not comply with the statute of limitations or relate back to any earlier complaint.

5. Standing

Defendant argues D.G. does not have standing to proceed because his requests for growth hormones were granted prior to his intervention in this case and any concern over future denials is speculative. Plaintiffs reply D.G. was injured by the delay in his receipt of growth hormones and faces an increased risk of future harm.

Plaintiffs have the burden of demonstrating they have standing. *Rosen v. Tennessee Comm'n of Fin. and Admin.*, 288 F.3d 918, 927 (6th Cir. 2002). A plaintiff must show: (1) he has suffered an "injury in fact" that is (a) concrete and particularized, and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged act of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision. *Friends of*

the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc., 528 U.S. 167, 180–81 (2000).[9]

Standing is determined as of the date the complaint is filed. *Ailor v. City of Maynardsville*, 368 F.3d 587, 596 (6th Cir. 2004). When past wrongs have been remedied by the time a complaint is filed, there is no injury-in-fact that is actual or imminent. *Id.*

Plaintiffs allege D.G.'s doctor first requested prior authorization for growth hormone treatment for D.G. through his Medicaid Managed Care Provider, CareSource, on July 28, 2008. Compl. ¶ 99. On July 30, 2008, CareSource denied the request on the basis that it was not medically necessary for short stature under CareSources' medical policy. *Id.* ¶ 100. In September 2008, D.G. appealed the denial. At the state administrative hearing, held in November 2008, CareSource argued that D.G. did not meet the CareSource guideline for approval of growth hormone therapy. D.G.'s counsel argued that CareSources's policy did not meet medical necessity rules. *Id.* ¶ 101. The hearing officer sustained the appeal, finding CareSource's internal policy underlying its decision to deny services was inconsistent with Medicaid rules and ordered CareSource to review Ohio Medicaid and federal EPSDT rules and issue a new determination. *Id.* ¶ 102.

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[9] A plaintiff must also demonstrate the prudential standing principles. *McGone v. Bell*, 681 F.3d 718, 728 (6th Cir. 2012). Accordingly, the plaintiff must (1) generally assert only his or her own rights, not claims of third parties; (2) not allege grievances more suitable for legislative or executive resolution; and (3) raise a claim within the zone of interest protected by the statute or constitutional provision in question. *Id.* at 729. Those requirements are not at issue in this case.

On December 30, 2008, CareSource again denied the growth hormone treatment because CareSource only offered growth hormone therapy for patients diagnosed with Growth Hormone Deficiency. *Id.* ¶ 103. D.G.'s mother was able to get treatment directly from the manufacturer, Eli Lily, in January 2009. *Id.* ¶ 104.

On January 7, 2009, D.G.'s mother appealed CareSource's second denial. At the hearing held March 30, 2009, CareSource again argued growth hormone treatment was not medically necessary for idiopathic short stature. On April 8, 2009, the Hearing Officer found that CareSource had used an incorrect definition of medical necessity that failed to take into account treatment intended to "correct or ameliorate" abnormalities or disease, that CareSource's definition could not be used to deny Medicaid covered services and ordered CareSource to approve D.G.'s prior authorization requested. *Id.* ¶ 104–05. CareSource authorized D.G.'s treatment for one year and has since re-approved coverage for 2011 and 2012.

Plaintiffs allege they all have suffered and continue to suffer irreparable harm due to the Defendant's policy, practice, and procedure of applying the incorrect standard of medical necessity that causes the denial of, or delay in, the provision of medically necessary treatment that are required to correct or ameliorate the Plaintiff's defects, illnesses and conditions. *Id.* ¶ 113.

The complaint states D.G.'s mother is concerned that he will be denied coverage for future growth hormones because D.G.'s endocrinologist recently moved to a new practice and D.G. must find a new endocrinologist. Compl. ¶ 110, ECF No. 206.

Neither CareSource's growth hormone policy nor Ohio's definition of "medical necessity" has changed. *Id.* ¶ 109. D.G.'s mother worries coverage might be interrupted if CareSource uses the change of providers as an opportunity to revisit its prior authorization or if the new provider is part of a different managed care plan.

D.G. filed his motion to intervene on July 15, 2009, ECF No. 119, which was granted on November 2, 2009, ECF No. 39. The intervenor complaint was filed that same day. ECF No. 140.

D.G. has not alleged facts which support his standing to sue. While it is plausible that he has suffered an "injury in fact" that is concrete, particularized, and actual due to the year long delay in growth hormones, the injury is not fairly traceable to the challenged act of the defendant, namely the conflict between Ohio's definition of "medical necessity" and the Medicaid Act. Rather, Plaintiffs allege the delay was due to CareSource's continued failure to apply the correct standard to determine eligibility and that Defendant disagreed with this denial twice. Although Defendant should have a responsibility to ensure its Managed Care Providers use the correct standard, that is not the basis of Plaintiffs claim. Nor can it be because that was not the issue preserved in the Consent Decree. Accordingly, D.G. does not have standing to bring his claim and the Court dismisses his claims.[10]

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[10] Even if D.G. had alleged facts to support standing the Court would have been compelled to grant judgment for Defendant as there is no evidence of a connection between Ohio's definition of "medical necessity" and the delay in approving D.G.'s growth hormones. The letters of denial and the state hearing decisions make clear that

Although Defendant does not explicity argue that Plaintiffs G.D., M.D., G.B., D.L. and D.G. do not have standing as to their Supremacy Clause claim, standing is jurisdictional and the Court has a duty to raise the issue *sua sponte*. *LPP Mort., Ltd. v. Brinley*, 547 F.3d 643, 647 (6th Cir. 2008). Plaintiffs G.D., M.D., G.B., D.L. and D.G. do not have standing to assert the Supremacy Clause claim because there is no indication in the complaint that any injury done to them was "fairly traceable to the challenged act of the defendant"—Ohio's use of its definition of "medical necessity." Accordingly, the Court dismisses Plaintiffs G.D., M.D., G.B., D.L. and D.G.'s Supremacy Clause claim for lack of standing.

6. Mootness

Defendant argues A.S.'s claims are moot because Defendant already authorized payment for his gait trainer in 2006 and for his shower/commode chair in 2009.[11]

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the reason for the inappropriate denials was CareSource's own policy. *See* July 30, 2008 CareSource Letter, Def. Mot. Summ. J. Ex. 53, ECF No. 222-53; November 2008 State Hearing Decision, Def. Mot. Summ. J. Ex. 54, ECF No. 222-54; CareSource's State Hearing Summary, Def. Mot. Summ. Jud. Ex. 56, ECF No. 222-56; April 2009 State Hearing Decision, Def. Mot. Summ. J. Ex. 4, ECF No. 222-4. Indeed, State Hearing Officer Pollard expressly states it was CareSource's mistaken reliance on CareSource's own policy to the exclusion of the Healthchek definition of "medical necessity" that caused the denials. April 2009 State Hearing Decision, Def. Mot. Summ. J. Ex. 4, ECF No. 222-4. Although Pollard's analysis does not control this Court, the Court has no evidence before it that Pollard was incorrect. Accordingly, even if this Court had standing, D.G. was not deprived of any federal right due to a conflict between Ohio's definition of "medical necessity" and federal EPSDT standards and there is no genuine dispute of material fact regarding D.G.'s § 1983 claims.

[11] In a heading in his brief, Defendant states that in addition to lacking standing, D.G.'s claims are moot or unripe. The text of the section which follows addresses only D.G.'s

Plaintiffs respond that A.S.'s claims meet two exceptions to the mootness doctrine: capable of repetition, yet evading review, and voluntary cessation.[12]

"Mootness addresses whether the plaintiff continues to have an interest in the outcome of the litigation. 'A case is moot when the issues presented are no longer "live" or the parties lack a legally cognizable interest in the outcome.'" *Ailor*, 368 F.3d at 596 (quoting *Powell v. McCormack*, 395 U.S. 486, 496 (1969)).

A dispute is "capable of repetition" while "evading review" if (1) the challenged action is too short in its duration to be fully litigated prior to its cessation or expiration and (2) there is a reasonable expectation that the same complaining party will be subjected to the same action again. *Turner v. Rogers*, 131 S.Ct. 2507, 2515 (2011). "The party asserting that this exception applies bears the burden of establishing both prongs." *Lawrence v. Blackwell*, 430 F.3d 368, 371 (6th Cir. 2005).

A.S. was approved for payment for the gait trainer in November 2006.[13] Neither

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standing. Accordingly, the Court does not address Defendant's undeveloped argument that D.G.'s claims are moot or unripe.

[12] Although Defendant includes the argument that A.S.'s claims are moot as part of its motion under Federal Rule of Civil Procedure 12(c), Defendant cites to evidence in the record to demonstrate that the claims are moot. Accordingly, the Court construes this as a factual attack on this Court's jurisdiction under Federal Rule of Civil Procedure 12(b)(1). Plaintiffs do not object to Defendant's use of evidence and, therefore, the Court considers evidence in section A.6 of this motion for judgment on the pleadings portion of this Opinion.

[13] Defendant cites to Exhibit 13 of its Motion for Summary judgment to demonstrate that ODJFS approved payment for a gait trainer for A.S. in 2006. From Defendant's motion, the Court knows that this document is supposed to be pages from the deposition of A.S.'s mother. There is, however, no indication on the document itself of what it

of the parties point the Court to the date on which A.S. first requested this equipment. Accordingly, the Court cannot find the time was too short to allow for review.

However, the complaint alleges that in February and March 2009, A.S.'s mother requested a new shower/commode chair and this request was denied in May 2009 but was granted after appeal in December 2009. This ten month period is too short to allow for effective review. *See Turner*, 131 S.Ct. at 2515 (12 months too short to allow for review). *See also Case v. Jones-Kelly*, No. 2:08–cv–1171, 2010 WL 99086, at *4 (S.D. Ohio Jan. 5, 2010) (based on either 90 day requirement or 258 day average waiting period, duration of time is sufficiently short).

There is also a reasonable expectation that A.S. will experience similar types of delays and denials in the future. A mere theoretical possibility that a plaintiff might encounter the same circumstances again does not amount to a reasonable expectation. *Murphy v. Hunt*, 455 U.S. 478, 482 (1982). However, a reasonable expectation can be shown by a plaintiff's history. *See, e.g., Honig v.*

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purports to be or that is authenticated in any way. On what is labeled page 61, the person answering questions states that she got notification that A.S. had been approved for a gait trainer in November 2006, a few months after an organization named Ali Baba provided the gait trainer. Def. Mot. Summ. J. Ex. 14, ECF No. 222-15. Because Plaintiffs seem to agree A.S. was eventually approved for payment for his gait trainer, the Court assumes it to be true, rather than taking as evidence this purported deposition.

In addition, the Defendant's Exhibit 14 does not demonstrate that Defendant approved payment for the shower/commode chair, just that it reversed the denial and instructed A.S. to request the service through his Medicaid waiver case manager. Def. Mot. Summ. J. Ex. 14, ECF No. 222-16. However, the fact that payment was approved is included in Plaintiffs' amended complaint.

Doe, 484 U.S. 305, 320 (1988); *Lumpkin*, 808 F. Supp. 2d at 1012–13. A.S. has been diagnosed with several chronic conditions including Cerebral Palsy and partial epilepsy with impairment of consciousness. Mot. Summ. J. Ex. 7 PAGEID # 4758, ECF No. 213-7. Due to these conditions, he has severe motor and functional impairments which require assistance in bathing, using the toilet, and dressing. *Id.* His physical therapist recommended equipment for bath and toilet use. *Id.* Because A.S.'s conditions are chronic and several months remain in A.S.'s eligibility for Medicaid, A.S. will likely need to request such equipment in the future.[14] As Ohio's definition of "medical necessity" remains the same, there is a reasonable expectation that A.S. will face the challenged policy again. Accordingly, the Court finds A.S.'s claim is capable of repetition and yet evading review and, therefore, not moot.

7. Ripeness

Defendant also argues A.S.'s claims regarding future denials are not ripe. Plaintiffs respond that the claim that A.S. will request and be denied medical equipment in the future is ripe because he has a chronic condition, and Ohio continues to use an incorrect standard of "medical necessity."

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[14] The amended complaint states A.S. was born January 1, 1993. Am. Compl. ¶ 16, ECF No. 206. Accordingly, A.S. will turn 21 on January 1, 2014 and will no longer be eligible for Healthcheck services. Ohio. Admin. Code § 5101:1-38-05(A).

To determine ripeness, a court should consider: "(1) whether the court would benefit from a 'concrete factual context'; (2) whether the agency may modify its legal position or refine its policies rendering a judicial decision premature; and (3) hardship to the plaintiffs in waiting for enforcement." *Wright v. O'Day*, ---F.3d----, 2013 WL 465534, at *4 (6th Cir. 2013).

Taking these factors into consideration, A.S.'s claims for future harm are not ripe. The Court could benefit from a concrete factual context in relation to any future denial A.S. may experience. Unlike his concrete claim concerning the shower/commode chair, the Court lacks the benefit of allegations or evidence regarding the reason for any future denials. Although it is unlikely that after six years of litigating this case, Ohio will change the definition of "medical necessity" any time soon, Plaintiffs have not demonstrated they will undergo any hardship if relief is denied at this stage. Plaintiffs argue they will suffer significant hardship because they have waited for six years for relief in this case and they have invested significant time and energy in this case. However, these concerns will be addressed by the Court's consideration of the merits of A.S.'s claim for past harm. Therefore, the Court holds A.S.'s claim for future harm is not ripe and dismisses that claim.

This analysis also applies to the "future claims" of the other Plaintiffs. The

Court does not have before it enough information to understand what future denials there may be and how the conflict between Ohio and federal law might contribute to those possible conflicts. Although the Court found A.S.'s claims capable of repetition and therefore not moot, these possibilities of repetition would not aid the Court in resolving the future conflicts and therefore do not affect its holding that the "future claims" are not ripe.

8. Res Judicata

Defendant's last procedural argument is that some of A.S.'s claims are barred by res judicata.[15] Defendant argues that because A.S. had a hearing on his gait trainer and shower/commode chair, he cannot raise claims that they could have raised in his earlier administrative hearings. Plaintiffs respond that A.S. has not previously litigated the issue that is before the Court, the administrative hearings were limited to application of the regulations, and Defendant waived the defense of claim preclusion by agreeing to litigate this issue in the consent decree.

"[W]hen a state agency 'acting in a judicial capacity resolves disputed issues of fact properly before it which the parties have had an adequate

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[15] Defendant also argues that A.S. would not benefit from injunctive relief because he was already approved for his gait trainer and shower/commode chair. However, as the Court has held this an issue capable of repetition and yet evading review, A.S. might still benefit from injunctive relief.

opportunity to litigate' . . . federal courts must give the agency's fact finding the same preclusive effect to which it would be entitled in the State's courts" in regards to 42 U.S.C. § 1983 claims. *University of Tennessee v. Elliot*, 478 U.S. 788, 799 (1986) (internal citation omitted); *see also Taylor v. Commissioner*, 1999 U.S. App. LEXIS 23182, at *5 (6th Cir. 1999) (holding social security litigant could not challenge prior finding of "not disabled" which she did not appeal).

"Under Ohio law, 'res judicata, whether claim preclusion or issue preclusion, applies to administrative proceedings that are of a judicial nature and where the parties have had an ample opportunity to litigate the issues involved in the proceeding.'" *Davet v. City of Cleveland*, 456 F.3d 549, 552 (2006) (quoting *Grava v. Parkman Twp.*, 73 Ohio St. 3d 379, 381(1995)).

Plaintiff A.S. did not have the opportunity to litigate whether Ohio's definition of "medical necessity" conflicts with the EPSDT requirements of the Medicaid Act in the administrative hearing. ODJFS could not have considered such a conflict because the hearing officer is confined to consider whether the agency's action or inaction was in accordance with applicable regulations. Ohio Admin. Code § 5101:6-6-02(C)(6). *See* 18B Charles Wright and Arthur Miller, Federal Practice & Procedure § 4475 (2d ed. 2012) (it is "common to find that an agency decision does not support claim preclusion as to statutory or common-law

claims that lie outside the agency's jurisdiction"). Accordingly, res judicata does not bar A.S.'s claims.

C. CONCLUSION

The Court grants in part and denies in part Defendant's motion for judgment on the pleadings. The Court grants Defendant judgment on the pleadings as the § 1983 claims of Plaintiffs G.D., M.D., G.B. and D.L. The Court dismisses Plaintiffs G.D., M.D., G.B. and D.L.'s Supremacy Clause claim, Plaintiff G.D.'s claims, and all Plaintiffs' future claims. The Court denies Defendant's motion for judgment on the pleadings as to Plaintiff A.S.'s remaining claims.

V. MOTION FOR SUMMARY JUDGMENT

Defendant argues that there is no conflict between Ohio's definition of "medical necessity" and the Medicaid Act's requirements regarding EPSDT, and even if there was a conflict, no harm was done to Plaintiffs A.S. due to that conflict. Plaintiff argues a conflict exists which delayed services being provided to A.S.[16]

A. STANDARD OF REVIEW

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[16] Plaintiffs also argues there will be harm to all Plaintiffs in the future due to the conflict between Ohio's definition of "medical necessity" and federal EPSDT standards. The Court has already declined to consider Plaintiffs claims of future harm as they are not ripe. *See supra* Section IV.B.7.

The standard governing summary judgment is set forth in Federal Rule of Civil Procedure 56(a), which provides: "The court shall grant summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a).

The Court must grant summary judgment if the opposing party fails to make a showing sufficient to establish the existence of an element essential to that party's case and on which that party will bear the burden of proof at trial. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). *See also Van Gorder v. Grand Trunk Western R.R., Inc.*, 509 F.3d 265 (6th Cir. 2007).

When reviewing a summary judgment motion, the Court must draw all reasonable inferences in favor of the nonmoving party, who must set forth specific facts showing there is a genuine dispute of material fact for trial, and the Court must refrain from making credibility determinations or weighing the evidence. *Matsushita Elec. Indus. Co.*, 475 U.S. 574, 587 (1986); *Pittman v. Cuyahoga Cnty. Dept. of Children and Family Serv.*, 640 F.3d 716, 723 (6th Cir. 2011). The Court disregards all evidence favorable to the moving party that the jury would not be required to believe. *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 150–51 (2000). Summary judgment will not lie if the dispute about a material fact is genuine, "that is, if the evidence is such that a reasonable

jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986); *Barrett v. Whirlpool Corp.*, 556 F.3d 502, 511 (6th Cir. 2009).

Thus, the central issue is "'whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law.'" *Pittman*, 640 F.3d at 723 (quoting *Anderson*, 477 U.S. at 251–52).

C. DISCUSSION

To prevail on a claim brought under 42 U.S.C. § 1983, the plaintiffs must prove that the defendants acted 'under color of law' and that the defendants' conduct deprived them of a right, privilege or immunity secured by the Constitution or the law of the United States. *Markva v. Haveman*, 317 F.3d 547, 552 (6th Cir. 2003).

Defendant argues A.S. was not harmed by any conflict between Ohio's definition of "medical necessity" and federal EPSDT standards because A.S. was initially denied his gait trainer and shower/commode chair for reasons other than Ohio's definition of "medical necessity." Specifically, Defendant argues ODJFS denied approval of a gait trainer because it was "non-covered" equipment and denied approval of the shower/commode chair because he had a bath lift that

performed the same function. Plaintiffs respond that the denial and State Hearing Decision expressly stated the shower/commode chair was not medically necessary and, therefore, it is the conflict between Ohio's definition of"medical necessity" and federal EPSDT requirements which caused the delay in receiving payment for A.S.'s chair. Plaintiffs do not address A.S.'s request for a gait trainer in response to Defendants argument there is no evidence A.S. was deprived a right.

On December 12, 2005, Defendant notified A.S. it was denying his request for a gait trainer because it was "non-covered" equipment. State Hearing Decision 1, ECF No. 222-47. On March 20, 2006, State Hearing Officer Wilson issued an opinion upholding Defendant's denial of payment for a gait trainer. *Id.* at 3. State Hearing Officer Wilson noted the Bureau of Medical Operations Representative "explained that the E8000 gait trainer is a non-covered service and that is why it is denied; not because it is not medically necessary." *Id.* at 2. The representative also testified "there are other types of walkers that are Medicaid covered and suggested getting with the provider and finding out what is covered to determine what would be appropriate" for A.S. *Id.* State Hearing Officer Wilson's final holding stated Ohio Administrative Code §§ 5101:3-10-02 and 5101:3-1-60 "do not show the gait trainer as a covered medical supplier

service and the Hearing Officer concludes that the requested gait trainer is a non-covered Medicaid service/supply." *Id.* at 3.[17]

There is no evidence in the record to suggest A.S. was denied a federally protected right due to a conflict between Ohio Administrative Code § 5101:3-1-01 and federal EPSDT requirements in relation to his gait trainer. Ohio Administrative Code § 5101:3-10-02 speaks specifically to the scope of coverage for durable medical equipment and references appendixes which lists those services within the medicaid program. Ohio Administrative Code § 5101:3-1-01 Appendix DD lists code E8000 as a gait trainer and indicates that as of September 1, 2005, the gait trainer was not covered. The hearing officer specifically stated it was these provisions of the Ohio Administrative Code that supported denial of A.S.'s gait trainer. Any conflict between these provisions and federal EPSDT requirements is beyond the scope of the Plaintiffs claims in this action as preserved by the consent decree.

On March 15, 2009 and May 31, 2009, ODJFS notified A.S. that his requests for a shower/commode chair were denied. A.S.'s State Hearing Decision, Def. Mot. Summ. J. Ex. 46 PAGEID # 6143, ECF No. 222-46. The reasons for denial were that: (1) the particular chair requested is not a covered

[17] A.S. allegedly received approval for his gait trainer in November 2006, there is, however, no credible evidence on which to base this finding. *See supra* n.12.

item, (2) medical necessity was not established, and (3) a bath lift was previously authorized. *Id.* State Hearing Officer Shane restated all relevant law including Ohio's definition of medical necessity under Ohio Administrative Code §§ 5101:3-1-01 and the services covered under EPSDT pursuant to 42 U.S.C. § 1396(r)(5). *Id.* at PAGEID # 6144–46. A.S.'s administrative appeal was denied as untimely. Administrative Appeal Decision, ECF No. 222-48.

State Hearing Officer Shane ultimately concluded

> because the Appellant was recently approved for a bath lift . . . the shower/commode chair is not medically necessary for the Appellant nor the most cost-effective item . . . . The shower/commode chair will not ameliorate defects or illness nor is its approval required under the EPSDT (Healthchek) program because a request is made by a medical professional for a particular item.

Id. at PAGEID # 6148.[18]

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[18] State Hearing Officer Shane also specifically addressed the EPSDT standard earlier in the decision but without a clear outcome. She stated:

> The Appellant's attorney argues that this shower/commode chair is medically necessary and is a covered service under the federal and state EPSDT regulations. EPSDT in Ohio is known as Healthchek. The attorney argues the Appellant is eligible for Healthchek services because he is under twenty-one years of age. Appellant is 16 years old and does qualify for services under Healthchek. However, this argument is not well taken that because Appellant is eligible for services under Healthchek that services requested must be covered under the provision "Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section 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.

On November 27, 2009, an Administrative Appeals panel reversed the denial.[19] Administrative Appeal Decision, Def. Mot. Summ. J. Ex. 16 PAGEID # 5105, ECF No. 222-16. After reviewing Ohio's definition of "medical necessity" and the federal EPSDT standard, the panel stated they did not agree that "a Medicaid recipient is essentially limited to one means of personal bathing. Thus given the configuration bathrooms in your home, the shower/commode chair is conceptually medically necessary to accomplish the overall Ohio Home Care goal . . . ." *Id.* at PAGEID # 5105.

There is not enough information in the record to determine what standard ODJFS used when first denying A.S. the shower/commode chair. Although the State Hearing Decision lists lack of medical necessity as one reason for denial, there is no evidence about what standard the decision maker applied. A.S.'s State Hearing Decision, Def. Mot. Summ. J. Ex. 46 PAGEID # 6143, ECF No. 222-46. The State Hearing Decision specifically applied the EPSDT standard and still found a shower/commode chair was not required. *Id.* at PAGEID # 6148.

A.S.'s State Hearing Decision, Def. Mot. Summ. J. Ex. 46 PAGEID # 6147, ECF No. 222-46.

[19] Although the panel reversed the denial it did not order payment. Instead the panel directed A.S. to consult with his Ohio Home Care waiver case manager to determine what type of service plan amendment was needed in order to allow A.S. to access his roll-in shower/commode.

There is nothing in the Administrative Appeal, which reversed the denial, that indicates it was an application of the federal standard rather than Ohio's definition of "medical necessity" that swayed the panel. Accordingly, Plaintiff has failed to prove or even raise a genuine dispute of material fact that A.S. was deprived of a federal right due to a conflict between Ohio's administrative code and federal EPSDT requirements. The Court grants Defendant summary judgment on A.S.'s § 1983 claims.

3. Supremacy Clause Claims

As with Plaintiffs G.D., M.D., G.B., D.L. and G.D., A.S. does not have standing to assert a Supremacy Clause claim. After the Court's analysis on summary judgment, it is clear that any injury done to D.G. or A.S. was not "fairly traceable to the challenged act of the defendant"—Ohio's continued use of its definition of "medical necessity." Accordingly, the Court grants Defendant summary judgment on A.S.'s Supremacy Clause claim.

C. CONCLUSION

The Court grants Defendant and denies Plaintiffs summary judgment on A.S.'s claims.

VI. DISPOSITION

The Court **GRANTS IN PART** and **DENIES IN PART** Defendant's motion for judgment on the pleadings, ECF NO. 222. The Court **DENIES** Plaintiffs' motion for summary judgment, ECF No. 213, and **GRANTS** Defendant's motion for summary judgment, ECF No. 222. The Courts finds **MOOT** Plaintiffs' motion to certify a class, ECF No. 228.

IT IS SO ORDERED.

MICHAEL H. WATSON, JUDGE
UNITED STATES DISTRICT COURT