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IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF HAWAII

HAWAI'I DISABILITY RIGHTS  
CENTER, in a representative capacity  
on behalf of its constituents,

Plaintiff,

vs.

KEITH T. HAYASHI, in his official  
capacity as Superintendent of the State  
of Hawai'i, Department of Education;  
and RYAN YAMANE, in his official  
capacity as Director of the State of  
Hawai'i, Department of Human  
Services,

Defendants.

Case No. CV18-00465 LEK-WRP

**PLAINTIFF HAWAI'I DISABILITY  
RIGHTS CENTER'S  
MEMORANDUM IN OPPOSITION  
TO DEFENDANT RYAN YAMANE'S,  
in his official capacity, MOTION FOR  
PARTIAL JUDGMENT ON THE  
PLEADINGS, FILED, NOVEMBER  
14, 2025 [DKT. 190]**

**HEARING**

Date: January 14, 2026

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Judge: Honorable Leslie E. Kobayashi

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**PLAINTIFF HAWAI‘I DISABILITY RIGHTS CENTER’S  
MEMORANDUM IN OPPOSITION TO DEFENDANT  
RYAN YAMANE’S, in his official capacity, MOTION  
FOR PARTIAL JUDGMENT ON THE PLEADINGS,  
FILED, NOVEMBER 14, 2025 [DKT. 190]**

**I. INTRODUCTION**

Defendant Ryan Yamane, Director of the Department of Human Services (“DHS”), moves for judgment on the pleadings, arguing the Supreme Court’s decision in *Medina v. Planned Parenthood S. Atl.*, 145 S.Ct. 2219 (2025), eliminates the private right to enforce the Medicaid Act’s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions. Defendant concedes, however, that *Medina* did not address the specific provisions at issue and that this District Court has already held that these same provisions create privately enforceable rights under §1983. *J.E. v. Wong*, 125 F.Supp.3d 1099 (D. Haw. 2015) (ECF 190-1 at PageID.2349 & fn. 2).

The Court should deny the Motion and allow Plaintiff to proceed with Count III. *Medina* “simply applie[d] the same test this Court applied in *Gonzaga* and again in *Talevski*....” *Medina*, 145 S. Ct. at 2239 n. 9 (referencing *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002) and *Health and Hospital Corp. of Marion Cnty v. Talevski*, 599 U.S. 166 (2023) (“*Talevski*”). For over two decades, federal courts applying the stringent and demanding *Gonzaga* test have uniformly concluded that the EPSDT provisions are among the few that create privately enforceable rights.

*See, e.g., Watson v. Weeks*, 436 F.3d 1152, 1159-60 and n. 8 (9th Cir. 2006).

Defendant thus asks this Court to be the first in the nation to extinguish these vital protections for children, abandoning decades of precedent and embracing the State's invitation to misapply *Medina*.

## II. BACKGROUND

### A. The Parties

Plaintiff Hawai'i Disability Rights Center ("HDRC" or "Plaintiff") "is a federally authorized and funded protection and advocacy organization representing individuals in Hawaii with developmental disabilities, including children and young adults with autism." *Hawai'i Disability Rights Center v. Kishimoto*, 122 F.4th 353, 358 (9th Cir. 2024) ("*Kishimoto*"). Plaintiff "is Hawai'i's designated protection and advocacy system." *Id.* at 360; 42 U.S.C. §15043. Plaintiff has "authority to 'pursue legal, administrative, and other appropriate remedies...to ensure the protection of, and advocacy for, the rights of' individuals with disabilities who are eligible for state-supported services." *Kishimoto* at 360; citing 42 U.S.C. §15043(a)(2)(A)(i).

"DHS is the Hawaii agency designated to administer Hawaii's Medicaid program, including ensuring compliance with federal requirements." *Kishimoto* at 360-61(citing Haw. Rev. Stat. §346-14 and 42 U.S.C. §1396a(a)(5)).

**B. The Medicaid Act and EPSDT**

“Medicaid is a cooperative federal-state program that directs federal funding to states to assist them in providing medical assistance to low-income individuals.” *Katie A., ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1153–54 (9th Cir. 2007) (citing 42 U.S.C. §1396.) “By taking federal funds for its Medicaid program, the State of Hawaii is required to provide ‘early and periodic screening, diagnostic, and treatment’ services (‘EPSDT services’) to all Medicaid eligible children under the age of twenty-one.” *J.E.*, 125 F.Supp.3d at 1104.

“Following identification of a medical need as a result of screening, DHS has ‘an obligation to see that ... services are provided’ to ameliorate the demonstrated need.” *Kishimoto* at 361 (citing *Katie A.*, 481 F.3d at 1158). “As the Medicaid Act requires, DHS provides medically necessary ABA to Medicaid beneficiaries with autism.” *Id.* (citing 42 U.S.C. §1396d(a)(4)(B), (r)(5)). “The Medicaid Act does not allow DHS to ‘prohibit or restrict[ ] payment ... for medical assistance for covered services furnished to a child with a disability because such services are included in the child’s [IEP].’” *Id.* (citing 42 U.S.C. §1396b(c)).

**C. Autism Spectrum Disorder and Applied Behavioral Analysis**

As the Ninth Circuit summarized in this case:

Autism Spectrum Disorder (“autism”) refers to a range of cognitive and neurobiological disorders. Children with autism often suffer from delays or deficiencies in the development of cognitive functioning, language skills, social interaction, and motor coordination. The

impairments and challenges faced by children with autism thus implicate both social and educational development. That duality lies at the heart of this case.

...

The disputed service is Applied Behavioral Analysis (“ABA”), a form of individualized behavioral therapy focused on reinforcing positive behavior in individuals with autism and other developmental disabilities.

*Kishimoto*, 122 F.4th at 358.

Evidence-based ABA programs typically provide 35–42 hours of intensive ABA treatment each week and take place across all settings of a child’s life, including school. In Hawaii, ABA is widely provided to children under the age of 21, either through private medical insurance or, if the child is eligible for Medicaid, through DHS. *See* Haw. Rev. Stat. § 431:10A-133; 42 U.S.C. § 1396d(a)(4)(B), (r)(5). The parties agree that ABA therapy is one of the few effective, evidence-based treatments available for autism.

*Id.*, 122 F.4th at 359.

**D. Count III – Violation of the Medicaid Act by DHS (Section 1983)**

Count III against DHS seeks declaratory and injunctive relief under the Medicaid Act, via Section 1983, “to compel DHS to ‘provide adequate medically necessary ABA during school hours for Medicaid recipients.’” *Kishimoto* at 370 (ECF 1 (Complaint) at p. 21, Prayer(a)(i)). The Ninth Circuit has already ruled that: “The State of Hawai`i is statutorily required under the Medicaid Act to provide early and periodic screening, diagnostic, and treatment services that have been found to be medically necessary, regardless of their educational relevance.”

*Id.* at 371.

DHS admits that it “has an obligation to make sure that Medicaid-eligible children and their families are aware of EPSDT and have access to required screenings and necessary treatment services.” ECF 18 (Answer) at ¶ 12. Count III alleges that DHS is not providing or ensuring the provision of the requisite medical assistance to EPSDT beneficiaries during the school day. ECF 1 at ¶¶25-31, 100-103. This failure deprives EPSDT recipients of timely and sufficient access to medically necessary ABA, causing continuing irreparable harm. *Id.* ¶¶4, 17, 63, 101-105. In fully delegating to DOE the control of and access to ABA at public schools, knowing that DOE only provides what it determines to be educationally relevant, DHS fails to ensure that qualifying persons under the age of 21 have information about or how to access to their full medically necessary ABA if they attend school. *Id.* ¶¶ 25-31, 42, 47, 61-63, 101-104.

Likewise, because DOE limits school-day ABA to only what DOE may provide, DHS is not providing or paying for all requisite services and not all medically necessary ABA is reaching qualifying individuals at the levels prescribed by their medical providers during school hours. *Id.* ¶¶ 25-31, 42, 101. It is insufficient for DHS to only confirm there is a payment mechanism available for DOE to be reimbursed for EPSDT services; DHS must ensure the services are actually provided. *Id.* ¶¶ 30-31. Further, DHS fails to provide ABA in all recommended settings because DOE limits school day access to only what it

deems is educationally relevant. *Id.* ¶¶ 26-31, 42, 101-104. All of these limitations violate EPSDT beneficiaries' rights to medically necessary ABA services under the Medicaid Act. *Id.* ¶¶ 100-105.

### **E. The EPSDT Provisions at Issue**

Count III asserts a violation of civil rights under 42 U.S.C. §1983 and the Medicaid Act, 42 U.S.C. §1396. ECF 1 at p. 19. Based on the allegations throughout the Complaint, as summarized in Section II. D above, the Medicaid Act provisions at issue include (at least) the following: §§1396a; 1396a(a)(8); 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B); 1396d(a)(13); and 1396d(r)(5). These are discussed in detail in Section IV.A.3., below.

### **III. LEGAL STANDARD**

A Rule 12(c) motion is “functionally identical” to one brought under Rule 12(b)(6). *Ryan v. Salisbury*, 382 F.Supp.3d 1031, 1046-47 (D. Haw. 2019) (citations omitted). “The Court must accept as true the facts as pled by the non-movant, and will construe the pleadings in the light most favorable to the nonmoving party.” *Id.* at 1047. Courts “have discretion to grant a Rule 12(c) motion with leave to amend, or dismiss the action instead of entering judgment.” *Ryan*, 382 F.Supp.3d at 1047 (citations omitted) (granting Rule 12(c) motion with leave to amend).

#### IV. ARGUMENT

##### A. The EPSDT Provisions Meet the *Gonzaga/Talevski* Test Reaffirmed by *Medina*.

In *Gonzaga*, the Supreme Court held that federal funding provisions provide no basis for private enforcement under Section 1983 “unless Congress ‘speak[s] with a clear voice,’ and manifests an ‘unambiguous’ intent to confer individual rights.” 536 U.S. at 280 (citations omitted, *evaluating* the Family Educational Rights and Privacy Act (FERPA)). In the last two years, the Court used the *Gonzaga* test to decide *Talevski* and *Medina*—finding two Medicaid Nursing Home Reform Act (FNHRA) provisions enforceable in *Talevski* and one Medicaid (“any-qualified-provider”) provision unenforceable in *Medina*. Neither case established new law. Rather, each “reaffirmed that *Gonzaga* ‘sets forth [the] established method’” for determining unambiguous conferral. *Medina*, 145 S. Ct. at 2234 (*quoting Talevski*, 599 U.S. at 183). *Medina* also clarified that courts should no longer rely on *Blessing v. Freestone*, 520 U.S. 329, 117 S.Ct. 1353 (1997). *Id.*

**1. The Ninth Circuit in *Watson* Has Already Applied *Gonzaga* in Finding that Section 1396a(a)(10) Creates a Private Right of Action Enforceable by Section 1983.**

The Ninth Circuit has already found that Section 1396a(a)(10)<sup>1</sup> creates a private right of action enforceable by Section 1983, applying *Gonzaga*. See *Watson*, 436 F.3d at 1159-60 (joining five other federal circuit courts that had already so held, including two post-*Gonzaga*: *Sabree ex rel. Sabree v. Richman*, 367 F.3d 180 (3d Cir.2004) and *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir.2004) (“*Hood*”). *Watson* explained that Section 1396a(a)(10) was “unmistakably focused on the specific individuals benefited; it provides for medical assistance to all individuals who meet eligibility requirements.” *Watson*, 436 F.3d at 1160. *Watson* also cited *Hood*, in which “the Fifth Circuit similarly held that section 1396a(a)(10) features ‘precisely the sort of ‘rights-creating’ language identified in *Gonzaga* as critical to demonstrating a congressional intent to establish a new right.’” *Id.* at 1160-61 (citing *Hood*, 391 F.3d at 603).

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<sup>1</sup> “According to section 1396a(a)(10), a state plan for medical assistance must provide ‘for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) ... of section 1396d(a) of this title,’ to ‘all individuals’ meeting specified financial eligibility standards.” *Watson* at 1159 (citing 42 U.S.C. § 1396a(a)(10)).

*J.E.* cited *Watson* to likewise hold that HDRC and its constituents had a private cause of action to enforce their rights to EPSDT services under Section 1396a(a)(10) pursuant to Section 1983. 125 F.Supp.3d at 1105-06 and n.3 (D. Haw. 2015) (summarizing in n.3, “The *Watson* decision illustrates, as discussed below, that whether a private right of action exists under a certain provision of the Medicaid law is highly dependent upon the language and nature of the particular provision at issue.”).<sup>2</sup>

## 2. *Watson* Remains Binding Precedent.

Under *Miller v. Gammie*, 335 F.3d 889 (9th Cir. 2003) (*en banc*), Ninth Circuit precedent remains binding unless “the reasoning or theory of ... prior circuit precedent is clearly irreconcilable with the reasoning or theory of intervening higher authority” such that the court should treat “the prior circuit opinion as having been effectively overruled.” 335 F.3d at 893, 899; *Day v.*

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<sup>2</sup> While *J.E.* discussed the now-abandoned *Blessing* factors, it did so to summarize the holding of *Watson* and to address the inapplicability of certain dicta in Part IV of *Armstrong v. Exceptional Child Center, Inc.*, 135 S.Ct. 1378, 1397 (2015). *J.E.* 125 F.Supp.3d at 1106, n.3, 1107. *J.E.* observed that *Armstrong* had not applied the *Blessing* test in that dicta, and that its notion that Medicaid *providers* could not have a private right of action under Section 1396a(a)(30) (pertaining to reimbursement rates) was distinguishable, summarizing the *Blessing* factors. *Id.* at 1107. As a result, *J.E.* concluded that *Armstrong* did not deprive plaintiffs of a private cause of action to enforce Section 1396a(a)(10) based on *Blessing* and on post-*Gonzaga* Ninth Circuit precedent. *Id.* at 1107-08 citing *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) and *Watson*, 436 F.3d at 1159-60.

*Apoliona*, 496 F.3d 1027, 1031 (9th Cir.2007) (reversing this District Court’s dismissal of §1983 claim based on *Gonzaga* because it was not irreconcilable with prior Ninth Circuit cases). The *Miller* standard is a high bar.<sup>3</sup> See *Gatlin v. Contra Costa County*, 2025 WL 2459354 (N.D. Cal. August 26, 2025) (applying *Miller* in rejecting State’s argument that Ninth Circuit authority applying both *Blessing* and *Gonzaga* was no longer viable after *Medina*, and reaffirming right of foster children to enforce the provisions of the federal Adoption Assistance and Child Welfare Act).

*Medina* does not address EPSDT. However, the Ninth Circuit has already applied *Gonzaga* to find a private cause of action under the Medicaid Act for several EPSDT provisions at issue here. *Watson*, 436 F.3d at 1159-62 (§1396a(a)(10)); *Ball v. Rodgers*, 492 F.3d 1094, 1108-09 (9th Cir. 2007) (finding other Medicaid provisions satisfy the *Gonzaga* “rights-creating” standard).

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<sup>3</sup> *Lair v. Bulluck*, 697 F.3d 1200, 1207 (9th Cir. 2012), summarizes the *Miller* standard:

Although we should consider the intervening authority's reasoning and analysis, as long as we can apply our prior circuit precedent without ‘running afoul’ of the intervening authority, we must do so. *United States v. Orm Hieng*, 679 F.3d 1131, 1140 (9th Cir.2012). It is not enough for there to be ‘some tension’ between the intervening higher authority and prior circuit precedent, *id.* at 1140–41, or for the intervening higher authority to ‘cast doubt’ on the prior circuit precedent, *United States v. Delgado–Ramos*, 635 F.3d 1237, 1239 (9th Cir.2011). The intervening higher precedent must be “clearly inconsistent” with the prior circuit precedent. *Orm Hieng*, 679 F.3d at 1141. This is a ‘high standard.’ *Delgado–Ramos*, 635 F.3d at 1239.

The fact that *Watson* and *Ball* cite both *Gonzaga* and *Blessing* do not make them “clearly irreconcilable” with *Medina*, because each applied *Gonzaga*’s hyper-focus on the specific language of the statute to determine whether it was unambiguously rights-creating. *Watson* scrutinized the specific wording of section 1396a(a)(10) in which “Congress used ‘all individuals’ as a focal term and established entitlements to specific benefits for individuals” to find that it featured precisely the sort of unambiguously conferred right required by *Gonzaga*. 463 F.3d at 1161. *Ball* similarly applied *Gonzaga* to find, “[b]ased on the plain and precise language used in the statute that Congress intended for the free choice provisions to confer upon the plaintiffs here – Medicaid recipients who qualify for HCBS [home-and community-based services] – private rights that can be enforced via § 1983.” 492 F.3d at 1107 (citing *Gonzaga* (internal citations omitted) and noting that the provisions twice use “individuals” and are thus phrased in terms of persons benefitted with explicitly identified rights to be informed of and choose care alternatives).

Since *Watson* is still good law, *J.E.*’s reliance on it is still well-founded and *J.E.* remains persuasive authority. *J.E.* also aligns with more recent district court decisions, including that of *Isaac A. v. Carlson*, 775 F.Supp.3d 1296 (N.D. Ga. March 25, 2025), which relied entirely on *Gonzaga* and *Talevski* to conclude that “[a]s to the two relevant rights-creating EPSDT provisions — § 1396a(a)(10)(A)

and § 1396a(a)(8) — every court of appeals that has addressed this issue has determined that these provisions create enforceable rights.” 775 F.Supp.3d at 1336 (compiling cases).

**3. *Medina*’s “Contents” Placement Observation Does Not Foreclose Private Enforcement of the EPSDT Provisions at Issue.**

The Motion’s reliance on *Medina*’s observation that the “any-qualified-provider” provision appears in §1396a(a)’s “Contents” list is misplaced for at least three independent reasons: (1) Congress has expressly directed courts not to treat “Contents” placement as disabling private enforcement; (2) the Supreme Court itself cautioned in *Medina* that placement alone does not carry the day; and (3) the EPSDT provisions, unlike the “any-qualified-provider” provision (§1396a(a)(23)(A)) evaluated by *Medina*, contain the kind of mandatory, individual-centric commands and cross-referenced entitlements that courts have long recognized as enforceable by beneficiaries.

First, in the “*Suter* fix,” Congress established that provisions are not unenforceable under §1983 because they are included: “in a section of this chapter requiring a State plan **or specifying the required contents of a State plan.**” 42 U.S.C. §1320a-2 (emphasis added) (*citing Suter v. Artist M.*, 112 S.Ct. 1360 (1992); *Watson*, 436 F.3d at 1160-61 (endorsing *Hood*, 391 F.3d at 603,

confirming the *Suter* fix establishes that section 1396a(a)(10) is not unenforceable merely because it requires action under a state plan).

Second, *Medina* acknowledges this limit on any “placement” inference. After noting that section 1396a(a) lists many plan contents “directed to the Secretary,” the Court cautioned: “None of this may suffice to prove that the any-qualified-provider provision is unenforceable under § 1983. See § 1320a–2.” *Medina*, 145 S. Ct. at 2237. *Medina* contrasted section 1396a(a)(23)(A) with statutes that “employed explicit and unmistakable ‘rights-creating language.’” *Id.* at 2233–34, 2236. Thus, *Medina* did not erect a categorical bar against section 1983 enforcement of provisions housed in section 1396a(a). The question remains textual: does the provision “clear[ly] and unambiguous[ly]” use “rights-creating terms” with “an unmistakable focus” on “individuals”? *Id.* at 2229. *Talevski* itself enforced provisions incorporated by section 1396a(a)(28). 599 U.S. at 180–88 and n.10 (“we hereafter follow the parties and the Court of Appeals in referring only to the pertinent Medicaid provisions, as codified in the U.S. Code (§§1396a(a)(28), 1396(r)”).

Third, the EPSDT provisions differ in critical, text-and-structure ways from the “any-qualified-provider” clause that *Medina* held unenforceable. *See Medina*, 145 S. Ct. at 2233–39. The EPSDT scheme is a paired set of mandatory, individualized entitlements in section 1396a(a) and substantive definitions outside

section 1396a that together alert grantees that accepting federal funds comes with a duty to answer private suits, aligning EPSDT with the enforceable FNHRA provisions in *Talevski* rather than the discretionary “any-qualified-provider” clause in *Medina*. The relevant provisions clearly and unambiguously use rights-creating terms with an unmistakable focus on individuals and removal of State discretion:

- Section 1396a(a)(10)(A) requires that “A State plan for medical assistance **must --... (10) provide** – (A) for making **medical assistance** available ... to **all individuals**” in enumerated categories, including children under 21 and with EPSDT expressly included as “medical assistance” in §1396d(a)(4)(B) (emphasis added).
- Section 1396a(a)(8) requires that “A state plan for medical assistance **must-- ... (8) provide** that **all individuals** wishing to make application for **medical assistance** under the plan shall have the opportunity to do so, and that such **assistance shall be furnished** with reasonable promptness to **all eligible individuals.**” 42 U.S.C. §1396a(a)(8) (emphasis added).
- Section 1396a(a)(43) provides that “A State plan for medical assistance **must --... (43) provide for** – (A) “informing **all persons** in the State who are under the age of 21 and who have been determined to be eligible for **medical assistance** ... of the availability of [EPSDT] services as described in section 1396(d)(r) . . . ;” (B) “providing or arranging for the provision of such

screening services in **all cases where they are requested,**” and (C) “**arranging 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)(A)-(D) (emphasis added).

- Section 1396d(r) describes EPSDT services in detail, stating in four places what they “**shall at a minimum include,**” and in 1396d(r)(5) defines EPSDT to include “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) ... to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, **whether or not such services are covered under the State plan.**” 42 U.S.C. §1396d(r)(5).<sup>4</sup>
- Section 1396d(a)(13) requires the State provide preventative services such as “**other diagnostic, screening, and rehabilitative services,** including ... (C) **any medical or remedial services (provided in a facility, a home, or other setting) recommended** by a physician or other licensed practitioner of the

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<sup>4</sup> As the Fifth Circuit explained, “[t]he natural reading of § 1396d(r)(5)’s phrases is that all of the health care, services, treatments and other measures described by § 1396d(a) must be provided by state Medicaid agencies when necessary to correct or ameliorate unhealthful conditions discovered by screening, regardless of whether they are covered by the state plan.” *Hood*, 391 F.3d 581, 602 (5th Cir. 2004).

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) (emphasis added).

These provisions identify the beneficiaries (“all individuals,” “all eligible individuals,” “all persons”), the services (“medical assistance,” EPSDT, “other diagnostic, screening, and rehabilitative services”), the trigger (“when ... requested” and when “necessary ... to correct or ameliorate” conditions), the setting (“in a facility, a home, or other setting”), the level (“maximum reduction” of disability and “restoration of an individual to the best possible functional level”) and the timing (“reasonable promptness”). They are framed in mandatory terms (“must provide,” “shall be furnished,” “shall at a minimum include,” “whether or not such services are covered under the State plan”). And they are cabined by detailed statutory definitions, making them sufficiently specific as to be judicially enforceable.

Unlike §1396a(a)(23)(A), EPSDT does not pair an asserted individual guarantee with carve-outs that leave its scope to state control. *Medina* identified as fatal that the “any-qualified-provider” clause “proceeds to carve out various exceptions,” such that “Congress would grant rights in one breath while letting States control their scope in the next.” *Medina*, 145 S. Ct. at 2235. EPSDT contains

no such carve-outs. To the contrary, Congress removed state discretion by requiring that EPSDT treatment be provided when “necessary ... to correct or ameliorate” a child’s condition and by specifying that the obligation attaches “whether or not such services are covered under the State plan.” 42 U.S.C. §1396d(r)(5). *See also Hood*, 391 F.3d at 602–03 (holding EPSDT requires coverage of necessary treatment “whether or not” otherwise listed and is enforceable under § 1983). States may administer, but they do not possess a veto over the entitlement’s scope. That is the *Talevski* “yardstick.”

Courts have long recognized that this language mirrors “rights-creating” formulations. *See Gonzaga*, 536 U.S. at 283–86; *Hood*, 391 F.3d at 603. Likewise, the Ninth Circuit endorsed the reasoning of the Third Circuit that it is “difficult, if not impossible, as a linguistic matter, to distinguish the import of the relevant [Medicaid Act] language—‘A State plan must provide’—from the ‘No person shall’ language of Titles VI and IX,” concluding that the “individual focus” of §1396a(a)(10) is “unmistakable.” *Watson*, 436 F.3d at 1160–61 (*citing Sabree*, 367 F.3d at 190).

*Medina*’s structural concerns do not apply to EPSDT, which courts have consistently recognized as one of the few Medicaid provisions meeting *Gonzaga*’s demanding standard. District and circuit courts have repeatedly emphasized EPSDT’s “unmistakable focus on the persons benefitted,” its “mandatory” text,

and its “detailed, objective, and manageable standards.”<sup>5</sup> *See, e.g., Salazar v. District of Columbia*, 729 F. Supp. 2d 257, 264 (D.D.C. 2010) (recognizing enforceability of EPSDT provisions and rejecting State’s argument that *Gonzaga* represented an intervening change in law); *Watson*, 436 F.3d at 1160–61 (describing §1396a(a)(10)’s individual focus).

*Medina* does not displace this analysis; it reaffirms *Gonzaga* and *Talevski* while expressly preserving §1320a-2’s instruction. *Medina* underscores that what matters is what Congress enacted, and for Spending Clause statutes, “what the States are clearly told.” *Medina*, 145 S. Ct. at 2236-37. Here, Congress clearly told States they “must provide” EPSDT “to all individuals” under 21 and that “necessary” services must be provided “whether or not” covered elsewhere in the plan. 42 U.S.C. §§1396a(a)(10)(A), 1396d(r)(5). Those are individualized, beneficiary-facing commands that meet *Gonzaga*’s requirement of an “unmistakable focus on the benefited class” and an “individual entitlement.” *Gonzaga*, 536 U.S. at 283–87. And critically, *Medina* itself acknowledged that its

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<sup>5</sup> Likewise, the detailed definitions in Section 1396d, which are incorporated by reference in Section 1396a, avoid ambiguity in communicating these rights and provides unambiguous notice to the State of its obligations and the rights of Medicaid-eligible recipients of EPSDT services. This is consistent with the Supreme Court’s admonition that unambiguous notice is required because Spending Clause statutes are “much in the nature of a contract.” *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).

placement observations were insufficient to prove unenforceability in light of §1320a–2. *Medina*, 145 S. Ct. at 2236.

*Medina*'s treatment of §1396a(a)(23)(A) does not remotely foreclose private enforcement of EPSDT. Congress “knows how to give a grantee clear and unambiguous notice,” and it did so here. *Medina*, 145 S.Ct. at 2235. The EPSDT provisions combine mandatory, individual-centric directives in §1396a(a)(8), §1396a(a)(10)(A), and §1396a(a)(43) with a separate, substantive entitlement in §1396d(r)(5) that strips state discretion and requires coverage “whether or not” listed in a plan. The Motion’s structural argument—that §1396a(a)’s “Contents” heading and administrative orientation are dispositive—cannot be squared with Congress’s *Suter*-fix, *Medina*'s own caution, *Talevski*'s yardstick, or the EPSDT text Congress actually enacted. *See* 42 U.S.C. §1320a-2; *Medina*, 145 S. Ct. at 2236–39; *Talevski*, 599 U.S. at 182–83.

**4. *Medina* Did Not Require the Use of the Word “Right” in the Operative Text.**

Defendants also argue that there is no “direct authoritative language in the EPSDT provisions within Section 1396a that indicate Medicaid recipients have a clear, unambiguous *right* to enforce the benefits available under the statute.” ECF 190-1 PageID.2355. To the extent DHS is arguing that the word “right” must be included in the provision to make it privately enforceable, it overreads *Medina* and misunderstands the governing test. The Supreme Court has never required

talismanic use of the word “right” in the operative text as a prerequisite to §1983 enforcement. Rather, the question under *Gonzaga* and *Talevski*, as reaffirmed in *Medina*, is whether the statute “clear[ly] and unambiguous[ly]” uses “rights-creating terms” with “an unmistakable focus” on the individuals protected. *Medina*, 145 S. Ct. at 2229 (quoting *Gonzaga*, 536 U.S. at 284, 290).

Justice Jackson’s *Medina* dissent made the same point expressly: “The fact that the provision does not specifically use the word ‘right’ is not dispositive. We have never required Congress to use specific verbiage to establish individual rights. And forcing Congress to use the specific word ‘right’ would make little sense in this context anyway in light of § 1983’s more capacious phrase ‘rights, privileges, or immunities.’” 145 S. Ct. at 2255-56 (JACKSON, J., dissenting). While that statement is from the dissent, it is fully consistent with the majority’s governing test and with *Gonzaga*’s emphasis on textual focus and rights-creating terms rather than magic words. *See Gonzaga*, 536 U.S. at 284 and n.3, 287. (identifying “No person shall” formulation as paradigmatic rights-creating language).

*Talevski—Medina*’s “yardstick” for §1983 enforceability (145 S. Ct. at 2234) found two FNHRA provisions privately enforceable because they used clear, individual-focused, rights-creating language. The Court emphasized that the first obliged facilities to “protect and promote ... [t]he right to be free from ... any

physical or chemical restraints.” *Talevski*, 599 U.S. at 184 (quoting 42 U.S.C. §1396r(c)(1)(A)(ii)). It then upheld a second provision “in a subparagraph titled ‘[t]ransfer and discharge rights’” that stated nursing homes “must not transfer or discharge [a] resident” absent specified notice and conditions. *Id.* at 184–85 (quoting §1396r(c)(2)(A)-(B)). *Id.* at 184-85. In other words, *Talevski* enforced one provision that expressly used the word “right,” and another whose operative command did not itself use the word “right” but was unmistakably individual-focused and set within “[r]equirements *relating to residents’ rights.*” *Id.* at 184 (internal quotation marks omitted). *Medina* summarized *Talevski* the same way. 145 S. Ct. at 2234. *Talevski* thus confirms that the absence of the word “right” in the operative sentence is not a bar when the provision otherwise unambiguously confers an individually enforceable entitlement.

**B. The Ninth Circuit’s Decision in This Case Reinforces EPSDT’s Mandatory Nature and the Impropriety of DHS’s Policy.**

In reversing summary judgment on exhaustion for the non-IDEA claims, the Ninth Circuit squarely recognized DHS’s duty under EPSDT to provide medically necessary ABA “regardless of [its] educational relevance,” and it identified DHS’s obligation—once a need is identified—to “see that ... services are provided” to ameliorate the need. *Kishimoto*, 122 F.4th at 371–73 (citing *Katie A.*, 481 F.3d at 1162 (citing 42 U.S.C. § 1396a(a)(43)) and 361. That analysis is consistent with EPSDT’s individual-rights structure and contradicts DHS’s theory that EPSDT

lacks rights-creating force. This underscores why the §1983 claim should not be dismissed at the pleadings stage.

**C. Defendant’s Contrary Authorities Either Address Different Statutes or Cut the Other Way.**

Defendant’s cases (*Curtis, Timken, Washington v. Daviess Cnty. Hosp., Emrich, N.G.*) involve non-Medicaid or non-EPSTD provisions and hold only that those texts lack rights-creating language. *See Curtis v. Inslee*, 154 F.4th 678, 687–88 (9th Cir. 2025) (challenge to COVID-19 policies; non-Medicaid statutes) ; *Timken v. S. Denver Cardiology Assocs., P.C.*, 155 F.4th 1227, 1234 (10th Cir. 2025) (same); *Washington v. Daviess Cnty. Hosp.*, No. 1:24-cv-01914-MPB-MJD, 2025 WL 2944258, at \*3 (S.D. Ind. Oct. 14, 2025) (evaluating Federal Nursing Home Reform Act provisions); *Emrich Aerial Spraying LLC v. City of Pawhuska*, No. 25-cv-00115-SH, 2025 WL 2987889, at \*11 (N.D. Okla. Oct. 23, 2025) (“grant assurances” promulgated by the Secretary of Transportation and given by state and local governments receiving federal funding for airport improvements do not support private causes of action under Section 1983). *N.G. by & through V.G. v. Ohio Dep’t of Developmental Disabilities*, No. 2:24-CV-2027, 2025 WL 28880203 (S.D. Ohio Oct. 9, 2025) found that 1396a(23)(A), the same provision at issue in *Medina*, did create a private claim.

*Nansemond Indian Nation v. Virginia*, simply held that § 1396a(a)(8), which references “individuals,” did not confer a Section 1983 right to the provider-

plaintiffs (an Indian tribe and health clinic). No. 2:25-cv-195, 2025 WL 2320358, at \*20 (E.D. Va. Aug. 8, 2025). *Nansemond*'s dicta that “even if 42 U.S.C. § 1396a(a)(8) were phrased in terms of providers, it would not confer an enforceable right because it used the word “shall,” which “expresses a mandate, it does not create a right” is not persuasive, as discussed above, and is contrary to Ninth Circuit precedent. *Cf Ball*, 492 F.3d at 1108-1109 (recognizing that 1396a(a)(8) satisfies the ‘rights-creating’ standard set forth in *Gonzaga*).

Post-*Medina* decisions (e.g., *Gatlin*; *Williams*) also confirm *Medina* did not alter the *Gonzaga* test. See *Gatlin*, 2025 WL 2459354, at \*2; *Williams v. Cheltenham Sch. Dist.*, No. 25-3395, 2025 WL 2712217, at \*3–4 (E.D. Pa. Sept. 23, 2025). Dicta in *Indiana Prot. & Advoc. Servs. Comm’n v. Indiana Fam. & Soc. Servs. Admin.*, suggesting *Medina* “may well have undermined” §1983 enforcement of certain Medicaid provisions is neither binding nor persuasive, especially in light of its caveat that “some provisions of section 1396a(a) may yet satisfy it.” 149 F.4th 917, 926-27 (7th Cir. 2025).

Every federal circuit court to consider the provisions at issue here post-*Gonzaga* has concluded that Medicaid beneficiaries have the right to enforce them. See *Waskul v. Washtenaw Co. Comty. Mental Health*, 979 F.3d 426 (6th Cir. 2020) (concerning §1396a(a)(8) and (10)); *Bontrager v. Ind. Fam. & Soc. Servs. Admin.*, 697 F.3d 604, 607 (7th Cir. 2012) (concerning §1396a(a)(10)); *John B. v. Goetz*,

626 F.3d 356, 361 (6th Cir. 2010) (concerning §1396a(a)(43)); *Watson*, 436 F.3d 1152, 1159 (9th Cir. 2006) (concerning §1396a(a)(10)(A)), *S.D. v. Hood*, 391 F.3d 585 (5th Cir. 2004) (concerning §§1396a(a)(10)(A), 1396d(a), (r)); *Sabree v. Richman*, 367 F.3d 180, 190 (3d Cir. 2004) (concerning §§1396a(a)(8,10), 1396d(a)(15)). Also since *Gonzaga*, all of the more than two dozen federal district courts (including this one) to have decided the question have likewise found enforceability.<sup>6</sup> *Medina*'s reaffirmation of the *Gonzaga* test does not undermine the long-standing and consistent track record of federal court enforcement of the EPSDT provisions.

**D. Dismissal on the Pleadings is Unwarranted.**

Even if the Court were uncertain how *Gonzaga/Talevski* and *Medina* ultimately resolve the EPSDT question, the claim is amply plausible given the statutory text, the Ninth Circuit's description of DHS's obligations, and the weight of authority recognizing EPSDT enforcement. Judgment without leave to amend

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<sup>6</sup> See, e.g., *Isaac A*, 775 F.Supp.3d at 1335-36 (N.D. Ga. 2025) (evaluating §1396a(a)(8,10) and concluding given "this mandatory and individual-centric language, there can be no doubt that Congress intended to create a federal right for the identified class, i.e., low-income children under 21."); *M.G. v. Scrace*, No. 1:22-cv-000325, 2023 WL 3686751 (D.N.M. May 26, 2023) (§1396a(a)(10)(A) and §1396a(a)(43)); *S.R. v. Pa. Dep't of Hum. Servs.*, 309 F.Supp.3d 250, 260-62 (M.D. Pa. 2018) (referencing § 1396a(a)(43)); *Cruz v. Zucker*, 116 F.Supp.3d 334, 346 (S.D.N.Y. 2015) ("regarding §§1396a(a)(10)(A), 1396d(a)); *O.B. v. Norwood*, 170 F.Supp.3d 1186 (N.D. Ill. 2016) (§§1396a(a)(8), (10)(A), 1396d(a)(4)(B), and 1396a(a)(43)(C)); *A.H.R. v. Wash. State Health Care Auth.*, 469 F.Supp.3d 1018, 1042 (W.D. Wash. 2016) (§§1396d(a) and 1396d(a)(8)).

would be particularly harsh; at least one amendment should be allowed to address any perceived deficiencies created by *Medina*. *See Ryan*, 382 F.Supp.3d at 1061 (granting with leave to file amended complaint within 30 days).

**E. Policy Considerations Confirm Denial is the Correct Result.**

Extinguishing private enforcement of the EPSDT provisions of the Medicaid Act would undermine access to medically necessary care for some of the State’s most vulnerable children. Erasing those rights now would depart from controlling precedent and be an affront to the civil rights of Hawaii’s citizens—especially low-income children with disabilities who depend on EPSDT for timely, necessary treatment. The better course, consistent with precedent and the governing Supreme Court framework, is to allow these claims to proceed.

**V. CONCLUSION**

The motion should be denied. If the Court is inclined to grant the motion, Plaintiff requests leave to amend.

DATED: Honolulu, Hawai‘i, December 2, 2025.

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