

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

ROSIE D. ET AL.,)
 Plaintiffs,)
)
 v.) CIVIL ACTION NO. 01-30199-MAP
)
MITT ROMNEY ET AL.,)
 Defendants.)

MEMORANDUM OF DECISION

January 26, 2006

PONSOR, D.J.

I. INTRODUCTION

On July 30, 1965, the citizens of this country, through the enactment of the Medicaid Act, Pub. L. 89-97, 79 Stat. 343, committed themselves to providing certain basic medical services to millions of low-income Americans. On December 19, 1989, Congress restated and deepened its commitment to eligible children by amending the Medicaid statute to promise that persons under twenty-one years of age would receive all reasonably necessary medical care regardless of ability to pay. From today's perspective, the scope of this commitment seems breathtaking: no Medicaid-eligible child in this country, whatever his or her economic circumstances, will go without treatment deemed medically necessary by his

or her clinician.

The 1989 amendment made the provision of particular services a mandatory part of each state's Medicaid program. With special relevance to this case, the amended statute called for "early and periodic screening, diagnostic, and treatment services" (so-called "EPSDT" services) for all eligible children.

This lawsuit challenges whether the Commonwealth of Massachusetts, a conceded Medicaid participant, has kept the promise made by Congress to America's children.

Specifically, it charges that Defendants have failed to provide medically necessary EPSDT services to persons who might be described as the neediest of the needy: children suffering from serious emotional disturbances ("SED") such as autism, bi-polar disorder, or post-traumatic stress disorder. Plaintiffs contend that as a result of Defendants' violation of the Medicaid statute, thousands of disabled low-income children continue to suffer needlessly.

On October 31, 2001, Plaintiffs filed their complaint, alleging violations of four specific provisions of the Medicaid Act: the EPSDT provisions, 42 U.S.C. §§ 1396a(a)(10)(A), - (a)(43), 1396d(r)(5), - (a)(4)(B) (2005)

(Count I); the "reasonable promptness" provision, § 1396a (a) (8) (2005) (Count II); the methods of administration or "equal access" provision, § 1396a(a) (30) (A) (2005) (Count III); and the managed care provision, § 1396u-2(b) (5) (Count IV).

The suit named various state officials and agencies as defendants¹ (referred to variously as "Defendants" or "the Commonwealth"): Mitt Romney, the Governor of Massachusetts; Eric Kriss, the Secretary of the Executive Office of Administration and Finance; Ronald Preston, the Secretary of the Executive Office of Health and Human Services (EOHHS); Robert H. Weber, Guardian ad Litem; EOHHS; and the Massachusetts Division of Medical Assistance.

On December 19, 2001, Defendants filed a motion to dismiss, contending, among other things, that the Eleventh Amendment granted them immunity from suit. Two days later, on December 21, 2001, Plaintiffs moved for certification of a class.

On March 29, 2002, the court denied the motion to

¹ Between the time Plaintiffs filed this lawsuit in 2001 and the date the suit went to trial in April 2005, a new administration took over the governor's office. Thus, some parties were terminated and others added. The names specified in this memorandum were the defendants at the time of trial.

dismiss and certified a class of all current and future Medicaid-eligible children in Massachusetts under twenty-one years of age, who were (or might become) eligible to receive, but were not receiving, what Plaintiffs described as "intensive home-based services."

Defendants pursued an interlocutory appeal of the court's denial of their motion to dismiss. On November 7, 2002, the Court of Appeals for the First Circuit affirmed this court's ruling, holding that "Eleventh Amendment immunity does not protect state officials from federal court suits for prospective injunctive relief under the Medicaid Act." Rosie D. ex rel. John D. v. Swift, 310 F.3d 230, 238 (1st Cir. 2002).

On March 25, 2005, the court allowed the parties' joint motion to dismiss Count IV, without prejudice. Non-jury trial with regard to liability on the three remaining counts took place from April 25, 2005, to June 9, 2005. On August 9, 2005, following submission of extensive proposed findings of facts and conclusions of law by the parties, the court heard closing arguments and took the matter under advisement.

For the reasons set forth below, the court finds that

Plaintiffs have proved, by far more than a fair preponderance of the evidence, that Defendants have failed to comply with the EPSDT and "reasonable promptness" provisions of the Medicaid Act. Plaintiffs are therefore entitled to judgment with regard to liability on Counts I and II of their complaint; the court will consider prospective injunctive relief pursuant to the schedule set forth at the end of this memorandum. As for Count III, the claim under the equal access provisions of the Act, the court finds that Plaintiffs have not carried their burden of proof.

Plaintiffs are entitled to judgment on Counts I and II based on two types of violations of the Medicaid Act: (1) inadequate or non-existent medical assessments and coordination of needed services for children with serious emotional disturbances, and (2) inadequate or non-existent in-home behavioral support services for the same group.

With regard to assessment and coordination of services, the testimony of virtually all of Plaintiffs' -- and for that matter Defendants' -- witnesses established that compliance with Medicaid's EPSDT mandate for children with a serious emotional disturbance requires that Defendants

provide, at a minimum, reasonably comprehensive medical assessments and ongoing clinical oversight of the services being provided. The evidence established overwhelmingly that, for this particularly needy group, assessment and coordination is essential to (a) identify promptly a child suffering from a serious emotional disturbance, (b) assess comprehensively the nature of the child's disability, (c) develop an overarching treatment plan for the child, and (d) oversee implementation of this plan (typically by multiple medical providers) as the needs of the child evolve.

The evidence showed, time and again, that the Commonwealth's efforts to comply with these minimum EPSDT assessment and service coordination requirements were woefully inadequate, with detrimental consequences for thousands of vulnerable children. At present, thousands of needy SED children lack comprehensive assessments; treatment occurs haphazardly, with no single person or entity providing oversight and ensuring consistency. Multiple providers offer overlapping and sometimes conflicting services, with little or no knowledgeable, overall coordination.

The second aspect of Defendants' Medicaid violation

concerns the provision of in-home behavioral support services. Plaintiffs offered credible evidence that such services are a medical necessity for many SED children, particularly the roughly 15,000 Medicaid-eligible SED children in the Commonwealth who suffer extreme functional impairment. Except in rare instances, however, Defendants fail to provide these services adequately. The result of this failure is that thousands of Massachusetts children with serious emotional disabilities are forced to endure unnecessary confinement in residential facilities, or to remain in costly institutions far longer than their medical conditions require. The shortage or inadequacy of in-home support services often results in removal of a fragile child from his or her home. While such a removal is a heartbreaking consequence in and of itself, it is equally clear that the unnecessary isolation of a child in an expensive residential facility has well-documented, objective clinical sequelae. These are reflected in exacerbated symptoms including: failure at school, inability to relate positively to others, isolating depression, and assaultive or other anti-social behavior.

The undisputed evidence offered at trial made it clear

that children with serious emotional disabilities are among the most fragile members of our society; their medical needs frequently extend across a spectrum of service providers and state agencies. Prompt, coordinated services that support a child's continuation in the home can allow even the most disabled child a reasonable chance at a happy, fulfilling life. Without such services a child may face a stunted existence, eked out in the shadows and devoid of almost everything that gives meaning to the gift of life.

Defendants' failure to provide adequate assessments, service coordination, and home-based supportive services for Medicaid-eligible children with serious emotional disturbances was glaring from the evidence and at times shocking in its consequences.

II. THE STATUTORY ENVIRONMENT

A. The Medicaid Act and Regulations.

In passing the Medicaid Act, Congress embarked on an ambitious program to provide medical care for the country's poorest people. The Act creates a "cooperative federal-state program" through which states that elect to participate receive federal financial assistance to pay for the medical treatment of specific groups of needy

individuals. See Pharm. Research & Mfrs. of Am. v. Walsh, 538 U.S. 644, 650 (2003); Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 502 (1989). To receive the funds, states are required first to formulate a plan that meets federal requirements. See Frew ex rel. Frew v. Hawkins, 540 U.S. 431, 433 (2004); Ark. Med. Soc'y, Inc. v. Reynolds, 6 F.3d 519, 522 (8th Cir. 1993) (noting that a state's plan must comply with the "fifty-eight subsections outlined in 42 U.S.C. § 1396a").

A state's plan must provide coverage to seven designated classes of needy individuals, termed "categorically needy," for at least seven specific kinds of medical care or services. See §§ 1396a(a)(10)(A)(i), -(a)(17), 1396d(a). See Pharm. Research & Mfrs., 538 U.S. at 651 n.4. A state may, if it chooses, extend this coverage to other designated populations, termed "medically needy."

§ 1396a(a)(10)(C). Additionally, the state may choose to expand the care and services available under its plan beyond the seven mandated categories. See §§ 1396a(10)(A), 1396d(a) (defining "medical assistance" by enumerating twenty-eight types of care and services). For example, a state must provide coverage of inpatient hospital and

physicians' services, but retains the option of covering private duty nursing or physical therapy services. See §§ 1396a(a)(10)(A), 1396d(a).

Congress does not require states to participate in the Medicaid Act. However, once a state opts in, it must abide by Medicaid's laws and regulations in order to obtain federal funds. See Bowen v. Massachusetts, 487 U.S. 879, 883 (1988); Bryson v. Shumway, 308 F.3d 79, 81 (1st Cir. 2002); see also 42 U.S.C. § 1396a. Although the Medicaid statute and its regulations impose many obligations, states do retain substantial discretion in implementing their plans and in choosing "the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in the best interests of the recipients." Alexander v. Choate, 469 U.S. 287, 303 (1985), quoted in Pharm. Research & Mfrs., 538 U.S. at 665; see also 42 C.F.R. § 440.230(d) (2005) (allowing states to "place appropriate limits on service based on such criteria as medical necessity or on utilization control procedures"); S.D. ex rel. Dickson v. Hood, 391 F.3d 581, 591 (5th Cir. 2004); Ark. Med. Soc'y, 6 F.3d at 531 (holding, in a case involving the equal access provision, that a state "may take

. . . budget factors into consideration when setting its reimbursement methodology," but "may not ignore the Medicaid Act's requirements in order to suit budgetary needs"); J.K. ex rel. R.K. v. Dillenberg, 836 F. Supp. 694, 697 (D. Ariz. 1993).

Plaintiffs challenge Defendants' compliance with three Medicaid Act provisions: EPSDT, reasonable promptness, and equal access. Each has its own particular requirements.

1. EPSDT.

As broad as the overall Medicaid umbrella is generally, the initiatives aimed at children are far more expansive. When Congress amended the Medicaid statute in 1989, it made the provision of "early and periodic screening, diagnostic, and treatment services" ("EPSDT" services) to Medicaid-eligible children mandatory for participating states. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, 103 Stat. 2261-2265, 2268, 2269 (codified as amended at 42 U.S.C. § 1396d(r) (2005)); 42 U.S.C. § 1396d(a) (4) (B), - (r). In defining EPSDT services, Congress required states to include four types of specific services: screening, vision, dental, and hearing services. In addition to these services, the statute mandated the

provision of

[s]uch 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.

42 U.S.C. § 1396d(r) (5) (emphasis added).

Subsection (a), which defines the term "medical assistance," enumerates seven categories of care and services that must be covered under a state's plan. In addition, twenty-one other categories may, at the option of the state, be included under the state's Medicaid plan. See § 1396d(a). Therefore all twenty-eight types of medical care and services contained within the definition of "medical assistance" are mandated EPSDT services. Thus, Congress

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

S.D., 391 F.3d at 589-90 (emphasis added); see also Rosie D., 310 F.3d at 232 (stating that the 1989 amendments "required states to provide Medicaid coverage for any service

'identified as medically necessary through the EPSDT program'" (quoting 135 Cong. Rec. S6899, 6900 (daily ed. June 19, 1989) (statement of Sen. Chafee)).

In other words, while a state may chose which medical services beyond the mandated seven it may offer to eligible adults, states are bound, when it is medically necessary, to make available to Medicaid-eligible children all of the twenty-eight types of care and services included as part of the definition of medical assistance in the Act. See S.D., 391 F.3d at 590 ("[E]very Circuit which has examined the scope of the EPSDT program has recognized that states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under 1396d(a)."); Collins v. Hamilton, 349 F.3d 371, 376 n.8 (7th Cir. 2003) ("[O]ther circuits [have] also found that in the context of individuals under the age of twenty-one subject to EPSDT services, a state's discretion to exclude services deemed 'medically necessary' by an EPSDT provider has been circumscribed by the express mandate of the statute.")

Because the only limit placed on the provision of EPSDT services is the requirement that they be "medically

necessary," the scope of the EPSDT program is broad. See, e.g., S.D., 391 F.3d at 594-95 (finding disposable incontinence underwear qualifies under "home health care services", § 1396d(a)(7), as a form of medical assistance for which the state must cover the costs); Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs., 293 F.3d 472, 480 (8th Cir. 2002) (holding that Medicaid-eligible children have "a federal right to early intervention day treatment when a physician recommends such treatment"); Pittman ex rel. Pope v. Sec'y, Fla. Dep't of Health & Rehab. Servs., 998 F.2d 887, 892 (11th Cir. 1993) (holding that the discretion Medicaid gives states to elect not to cover organ transplants for adults does not extend to cases involving qualified Medicaid recipients under age twenty-one); Chisholm v. Hood, 133 F. Supp. 2d 894 (E.D. La. 2001) (holding that the state must provide services rendered by a licensed psychologist because services by psychiatrists or other practitioners cannot substitute).

The breadth of EPSDT requirements is underscored by the statute's definition of "medical services." Section 1396d(a)(13) defines as covered medical services any "diagnostic, screening, preventative, and rehabilitative

services, including any medical or remedial services . . . 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). Thus, if a licensed clinician finds a particular service to be medically necessary to help a child improve his or her functional level, this service must be paid for by a state's Medicaid plan pursuant to the EPSDT mandate. See §§ 1396d(a)(13), 1396d(r)(5); Pediatric Specialty Care, 293 F.3d 472.

Courts construing EPSDT requirements have ruled that so long as a competent medical provider finds specific care to be "medically necessary" to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it. See, e.g., Collins, 349 F.3d at 375 (holding that if a competent medical service provider determines that a specific type of care or service is medically necessary, state may not substitute a different service that it deems equivalent); see also Rosie D., 310 F.3d at 232; John B. ex rel. L.A. v. Menke, 176 F. Supp. 2d 786, 800 (M.D. Tenn. 2001) (noting that a state "is bound by federal law to provide 'medically

