UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al., Plaintiffs, v. DEVAL L. PATRICK, et al., Defendants	C.A. No. 01-30199-MAP

DEFENDANT'S OPPOSITION TO PLAINTIFFS' MOTION FOR ORDER TO ENSURE TIMELY ACCESS TO SERVICES

The Massachusetts Executive Office of Health and Human Services ("EOHHS"), defendant in the above-captioned matter, hereby opposes the motion of the plaintiffs, styled as a Motion to Ensure Timely Access to Remedial Services. As set forth more fully below, EOHHS opposes the plaintiffs' motion on several, related bases: because, as a factual matter, the plaintiffs overstate the magnitude of the problem in ensuring prompt access to services, particularly for services in their state-up phase; because, as a legal matter, delays in the delivery of services cause by lack of sufficient capacity at available private providers cannot serve as the basis for relief against a state Medicaid agency, unless the delays are the result of some action or omission committed by the state; and because, as a practical matter, the order sought by the plaintiffs in their motion, if entered, would be unenforceably vague.

Background

At a status conference in May, 2010, plaintiffs' counsel voiced a concern, based on anecdotes they had heard from the advocate community, that waiting lists were accruing with respect to Intensive Care Coordination (ICC) and other remedy services, thereby raising the specter of children with SEDs experiencing onerous delays in accessing such services. At the Court's invitation, the plaintiffs on June 1, 2010, submitted a proposed form of order to address the issue. See Docket # 490. That proposed order, in addition to directing defendants to collect various data and to file periodic reports regarding same, also purported to direct the defendants to "make their best efforts to eliminate waiting lists," as they were "required" to do under the Medicaid Act. See Docket # 490 at ¶¶ 2, 3.

In their June 18, 2010 response to the proposed order, the defendants objected to its entry on various grounds, including that a "best efforts" requirement would offer them no guidance as to what steps they must undertake to comply with it and, accordingly, would be impossible, as a practical matter, to monitor or enforce. The defendants also noted that no showing had been made that they were out of compliance with the Judgment, thus necessitating any further action of this Court. See Docket # 495. Noting that the defendants were in the process of collecting a first round of systemic data regarding access issues, the Court has held the proposed motion in abeyance since its submission.

Those data have now been collected, collated, and distributed to the Monitor and the parties. Its principal findings are discussed in the accompanying affidavit of Emily Sherwood (the "Sherwood Affidavit"), and in the attachments thereto. At the invitation of the Court, the plaintiffs have renewed their request for entry of the proposed form of

order they had previously submitted. See Docket # 507 (filed te, October 22, 2010). For the reasons discussed below, the defendants continue to oppose the entry of the proposed order, on the ground that it is factually unnecessary, legally unwarranted, and practically unhelpful.

ARGUMENT

I. Contrary to the Plaintiffs' Suggestions, the Recently Collected Data Describe a Service Structure that – Except for Certain Outliers – Is Relatively Free of Access Issues.

As the Sherwood Affidavit sets forth in detail, the results of EOHHS's recent data collection regarding access to ICC and other services in September, 2010 – the first comprehensive data collection effort to focus on timeliness issues – were largely salutary. System-wide, more than 7,500 Massachusetts children and families have utilized the ICC service since its inception in 2009, almost half of whom were utilizing the service as of the end of September. Sherwood Affidavit at ¶ 4.

The recent data collection effort also used September, 2010, as a snapshot within which to measure quantitatively access to ICC. Data showed that, of the 348 youths who began receiving ICC services in September, almost half (158, or 45 %) had their first appointment made available to them within three days of the family's initial request for services. Within 30 days of the initial request, 274 (or 79%) had a first appointment made available. Sherwood Affidavit at ¶ 5. Data also demonstrated that, over time, the average elapsed time between a request for services and the availability of a first appointment is going down, as providers gain more experience in administering the service: the mean time elapsed in July was 21.5 days; in August, 16.7 days, and in September, 16.3 days. Sherwood Affidavit at ¶ 7.

The data also revealed, however, that access problems – while present in a distinct minority of cases – do exist. Of the 20 percent of first-time ICC recipients who waited more than 30 days for their first appointment, more than half had a first appointment made available to them in 60 days or fewer. Sherwood Affidavit at ¶ 8. Nonetheless, there remained a small percentage of youths (21 out of the 348 who became eligible in September, or roughly 6 percent) who waited for than two months for their first appointment. Id. Well over half of these cases occurred at one of four "outlier" Community Service Agencies ("CSAs") – three in Central Massachusetts, one in Western Massachusetts. Sherwood Affidavit at ¶ 9. A total of thirteen CSAs had no waiting lists at all, and twelve had waiting lists of between one and ten youths. Id.

As the Sherwood Affidavit makes clear, the reasons for the problems at the four underperforming CSAs varied: one experienced unforeseen staffing turnover, while another was systematically overreporting its waiting lists due to a failure to remove families that had declined (or not responded to) offers of services from its lists. Sherwood Affidavit at ¶ 12.

Irrespective of the root cause of these problems, EOHHS, in concert with its contracted MCEs, has worked expeditiously to correct them. The MCEs, through their Technical Assistance (or "TA") teams, have developed Waitlist Guidelines, setting forth the steps that a provider must take when its capacity to provide ICC services is insufficient to meet current demand. Sherwood Affidavit at ¶ 14. (A copy of the Waitlist Guidelines is attached as an exhibit to the Sherwood Affidavit.) The Guidelines make clear that, where a CSA lacks capacity to provide ICC services to a family that has requested them, the provider must, at a minimum: investigate referral to another CSA

with the capacity to offer ICC promptly; review what relevant services, if any, are available while the family waits for ICC services to become available; and stay in regular telephonic contact with the family to appraise members on the waiting list of how much longer the wait is likely to be. Sherwood Affidavit at ¶ 14. Under contracts with the MCEs, providers experiencing capacity issues also must submit corrective action plans, which both investigate the cause of any current access issue and propose concrete steps to be taken to address the issue. Sherwood Affidavit at ¶ 12. The submission of a corrective action plan, in turn, triggers closer scrutiny by both the MCE and EOHHS, until the problem is satisfactorily resolved.

The plaintiffs, in the affidavits accompanying their motion, provide anecdotal evidence regarding various unnamed youths who described waiting an inordinate period before the commencement of ICC services. As described in the Sherwood Affidavit, the plaintiffs, citing client-confidentiality concerns, would positively identify to the defendants only one of the children whose case was described in the affidavits; the details of another case were sufficiently unique that MCE staff was able to identify another subject child to a reasonable degree of certainty. Sherwood Affidavit at ¶ 27.

Thus, to the limited extent they were able, the defendants reviewed the facts of the referenced cases. In each case, the MCE had already compelled the CSA in question to review all aspects of the case, to determine to what extent the Waitlist Guidelines were followed, and to provide assurances that the subject child was currently receiving the service in question. (In both cases, they were.) Sherwood Affidavit at ¶¶ 28, 29. The CSA was also compelled promptly to submit a detailed corrective action plan, setting

forth the affirmative steps it was taking to insure that a similar incident would not occur, going forward. Id.

This procedure is entirely consistent with the federal regulations governing the timely delivery of Medicaid services by contracted MCEs. Under 42 C.F.R. § 438.206(b)(1), a state is obligated to ensure that an MCE maintains and monitors a network of "appropriate" providers that is "sufficient to provide adequate access" to required services.[1] Further, 42 C.F.R. § 438.206(c)(1) sets forth the affirmative steps that an MCE must follow in order to assure that its providers offer such adequate access to services to eligible Medicaid members. These requirements, among other things, include closely monitoring its providers' staffing and hours of operation; holding providers accountable for complying with applicable state and federal timeliness standards for the services it provides; and working with providers to take corrective action where compliance shows signs of lagging. 42 C.F.R. § 438.206(c)(1)(i)-(vi). These are precisely the steps that the defendants and their MCEs have been taking, both as a general matter and, specifically, in the identified cases where providers have not offered access to ICC in accordance with the standards set by MassHealth.

In short, and contrary to plaintiffs' assertions, the timeliness record for ICC and other services, while by no means perfect, is a strong one, particularly for a service of such recent creation. Where compliance with contractual time standards has fallen short,

[1] [1] Under these regulations, it is up to the state to determine what access is "adequate." In this case, Massachusetts, through its MCE contracts, has set very rigorous access standards for ICC providers. These contractual standards are well in excess of the minimum federal requirement of "adequate" access. Plaintiffs claim in error that the Commonwealth's Program Standards (which contain access standards) "were submitted to CMS as a part of its review of the State Plan Amendments for these services, and are subject to federal audit." This is not the case. CMS never requested any of the Commonwealth's Program Standards and the approved amendments to the State Plan describing the Remedy Services make no reference to them. See Affidavit of Sharon Boyle (the "Boyle Affidavit") at ¶ 2.

EOHHS is largely aware of the underlying reasons and, in all cases, has taken, and continues to take, the appropriate steps to ameliorate it. No order of the Court is necessary to compel the defendants' continued and aggressive intervention.

II. Failure of Private Providers to Eliminate Waiting Lists, Without More, Does Not Violate the Reasonable Promptness or EPSDT Provisions of the Medicaid Act.

The only relief that the plaintiffs seek, at least at this stage, is a seemingly-innocuous order directing the defendants to "make their best efforts to eliminate waiting lists" for ICC and other remedy services. As set forth in Section I, supra, defendants' overarching objection to such an order is that it is superfluous: The defendants are already expending their best efforts in furtherance of removing barriers to access for Medicaid members with SEDs, and those efforts have, on the whole, yielded a program with a good record for prompt delivery of services, particularly given that the remedy services have all been created recently, and from whole cloth. As the Sherwood Affidavit demonstrates, the removal of barriers to access is not something that the Court needs to address – it is a programmatic imperative.

That being said, the plaintiffs also suggest that such an order – if indeed it could be shown to be necessary – could be grounded in the affirmative requirements of the "reasonable promptness" or EPSDT provisions of the Medicaid Act (and in the provisions of the Judgment that implement the Act's requirements. Extant caselaw on the subject, however, undermines rather than supports this contention.[2]

The Medicaid Act, at 42 U.S.C. § 1396a(a)(8), requires that all states participating in the Medicaid program submit a state plan that, among other things, ensures that

[2] Likewise, the Judgment in this case does not – indeed, could not – create any affirmative obligation relating to timely access beyond that which is contemplated by the Medicaid Act.

"medical assistance under the plan" shall be "furnished with reasonable promptness to all eligible individuals." This provision is made operational with respect to EPSDT services by 42 C.F.R. § 441.56(e), which requires state Medicaid agencies, among other things, to "set standards for the timely provision of EPSDT services, which meet reasonable standards for medical and dental practice" and to "employ processes to ensure timely initiation of treatment."

Courts construing this language, however, have cast considerable doubt as to the scope of a state Medicaid agency's obligation under the "reasonable promptness" provision. In the leading case under Section (a)(8), Bruggeman ex. rel. Bruggeman v. Blagojevich, 324 F.3d 906, 910 (7th Cir. 2003), a Seventh Circuit opinion authored by Judge Posner, plaintiffs sought a declaration that the Illinois Medicaid agency violated Section (a)(8) when it failed to provide prompt access to intermediate care facilities for the developmentally disabled ("ICF/DD") to patients in the northern portion of the state, insofar as ICF/DD vacancies were disproportionately clustered in southern Illinois. The Seventh Circuit upheld the dismissal of the claim on the ground that the Medicaid agency, as the payor of claims for medical assistance, could not be held liable for delays in the actual provision of services, but only for undue delays caused by the state's own eligibility determinations or payment rules. As the Court concluded:

> Medicaid is a payment scheme, not a scheme for state-provided medical assistance, as through state-owned hospitals. The regulations that implement the provision indicate that what is required is a prompt determination of eligibility and prompt provision of funds to eligible individuals to enable them to obtain the covered services that they need, see 42 C.F.R. § 435.911(a), 930(a)-(b); a requirement ot prompt treatment would amount to a direct regulation of medical services.

Id. at 610 (emphasis in original).[3]

In the main, courts reviewing reasonable-promptness claims have adhered to this distinction – i.e., that state Medicaid agencies can be found liable when their own time standards (or absence of same) causes undue delay in the delivery of covered services, but not when medical providers themselves are the root cause of the delay. In Clark v. Richman, 339 F.Supp. 2d 631 (M.D. Pa. 2004), for example, the court, following Bruggeman, denied plaintiffs' claims that Pennsylvania had violated Section (a)(8) by failing to ensure that Medicaid-eligible children had prompt access to dental services. The Clark court agreed with the Bruggeman court that, "as a matter of law," "the reasonable promptness provision does not afford plaintiffs the relief they seek because the provision requires the Commonwealth to provide timely medical assistance, i.e., financial assistance, and does not require the provision of actual services." Id. at 643.

Like the instant case, however, Clark arose under the EPSDT provision of the Medicaid Act. Under 42 U.S.C. § 1396a(a)(43), state Medicaid agencies have additional responsibilities, including "providing or arranging for the provision of . . . screening services in all cases where they are requested" (subsection B), and "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" (subsection C). Reading these sections together with Section (a)(8), the Clark court acknowledged that "the Commonwealth's obligations with respect to EPSDT

[3] The Bruggeman court was construing, among other things, the definition of "medical assistance" contained in the Medicaid Act's definitional section at 42 U.S.C. § 1396d(a). The 2010 Patient Protection and Affordable Care Act, at § 2304, modified the definition of "medical assistance" by adding the disjunctive phrase "or the care and services themselves, or both." This change is immaterial to the instant analysis, however; as described below, the new language merely recognizes a reality acknowledged by the Bruggeman court and many others: that where a claim was brought under the EPSDT sections of the Medicaid Act, the state's obligations already transcended payment and related, in certain specified ways, to the delivery of services themselves.

services require more proactive steps, such as actual provision of services, than other statutory provisions previously discussed in this opinion." Id. at 646-647.

Accordingly, the court did not grant summary judgment in favor of the state on the plaintiffs' count brought under Section (a)(43). Notably, however, nor did it grant judgment in favor of the plaintiffs. Instead, the court held that determination of the (a)(43) claim turned on a factual determination as to whether the state had set timeliness standards, both for authorization and for provision of services after eligibility had been determined. Id. at 647. Thus, here, too, the court observed the distinction between failures by the state (such as the alleged failure to set timeliness standards), for which it could be found liable under the Medicaid Act, and failures of third parties (e.g., delays caused by the providers themselves), for which the state could not be held culpable.

The scant reasonable-promptness jurisprudence in the First Circuit, too, appears to honor this distinction between state action and delays caused by other sources. In Bryson v. Shumway, 308 F..3d 79 (1st Cir. 2002), the First Circuit reviewed a claim that New Hampshire had violated Section (a)(8) by failing to provide prompt access to Medicaid members who qualified for a waiver service that provided community-based services to individuals with acquired brain disorders. Id. at 81-82. The First Circuit held that Section (a)(8) did create a private right of action under Section 1983. Id. at 88-89; but also see, Bruggeman, 324 F.3d at 910 (criticizing Bryson court for having "missed" distinction between claims for prompt payment and claims for prompt delivery of actual services under Section (a)(8)). But the First Circuit went on to remand the case to the District Court for factual development on the question of whether vacant slots existed under the waiver program, and whether New Hampshire was exercising due diligence in

filling such slots once they came available. Id. at 89. The court expressly conditioned New Hampshire's liability under the reasonable-promptness provision on whether the waiting list for services was caused by the state's own dilatoriness in filling vacant slots (which would be actionable), or by the absence of open slots (not actionable).

Similarly, in Boulet v. Cellucci, 107 F.Supp.2d 61 (D.Mass. 2000), Judge Woodlock expressly rejected the distinction later adopted by the Seventh Circuit in Bruggeman, holding that the reasonable-promptness requirement in Section (a)(8) "must apply to the services themselves, rather than only to eligibility requirements, as the defendants argue." Id. at 79. Even the Boulet court, however, conditioned relief upon factual development concerning whether the plaintiffs' wait (of multiple years' duration) for residential habilitative services was occasioned by the Commonwealth's failures (because available facilities were going unused) or by a genuine shortage of available facilities in the community. Id. at 80 ("I find that all the requested services are subject to § 1389a(a)(8)'s requirement and that defendants have failed to meet that requirement if facilities where their delivery can take place are available") (emphasis added).

Even the case where a court awarded relief that most closely approximates the result plaintiffs ultimately seek here – Kirk T. v. Houston, 2000 WL 830731 (E.D.Pa.) – the relief serves as a sanction upon the state for failing to take acts within its immediate control. The factual predicate in Kirk T. was, in many ways, the obverse of the situation here. In Kirk T., the state had promulgated time standards governing when its managed care organizations (MCOs) were to commence therapeutic intervention after the MCO had made a decision to authorize payment for services the MCO determined were medically necessary (a process typically referred to as "prior authorization"). Id. at * 4.

It had not, however, established time standards for the MCO to make such prior authorization decisions, a process the state's contracted MCOs were routinely taking many months to complete. Id.

Assuming that the reasonable-promptness dictate of Section (a)(8) applied, the court observed that it had no objective standard by which to measure the state's timely provision of services. The court further found that 42 C.F.R. § 441.56(e), the regulation governing implementation of EPSDT services, put the burden on states to "employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the request for screening services." Id. at *4. . Because Pennsylvania had developed no timeliness standards regarding action on provider requests for prior authorization, the court held the state accountable for the absence of an objective standard by which to measure "reasonable promptness," and therefore, *on a temporary basis*, adopted the seven-day period (between eligibility determination and initial clinical intervention) set forth in the state's contract with its MCOs as the standard for measuring timeliness. Id. at *4-5. The Court freely acknowledged that the seven-day period was an aspirational figure taken out of context from the MCO contracts, but indicated that it had adopted the figure as a prod to the state to fill its own vacuum:

> The Court is sympathetic to Defendant's position that Plaintiffs are "asking for too much" and that her policies are designed to sufficiently screen individuals before prescribing . . . services. Howver, the fact that screening policies are necessary does not suspend the need for the timely initiation of services. This Court might ultimately decide that Plaintiffs' thirty day (30) comprehensive time line is unrealistic. However, at this juncture there seems to be no dispute that many children . . . are not receiving reasonably prompt . . . services as defined by [Pennsylvania's] own guidelines. Until the state develops some method of measuring timeliness, it will be impossible to tell whether the state is in compliance with the Medicaid statute.

Id. at *7. Thus, even the court that applied the most sweeping construction to the reasonable-promptness provision used it only to issue interim relief, and only as a spur to compel the state to take a step – the setting of timeliness standards for prior authorization – that was well within its control, and that it had thus far failed to take.

In short, courts have been reluctant to grant any relief under Section (a)(8), standing alone, unless the relief relates to the timeliness of payment, rather than treatment, particularly where the delay is a result of the lack of available, willing providers with capacity. (See, e.g., Boulet, 107 F.Supp.2d at 70, *supra*). When, as here, plaintiffs have invoked Section (a)(8) in concert with an EPSDT claim under Section (a)(23), courts have generally agreed that a state's obligation encompasses more than just timely payment, but have only granted declaratory or injunctive relief where they find that a state has failed to do something under its direct control or responsibility, such as setting timeliness standards for authorizing payment for services (e.g., Kirk T.) or promptly filling vacant slots in an available service with members whose eligibility is clear (e.g., Bryson, Boulet).

Here, however, plaintiffs suggest that the Court could use those sections to do even more – e.g., to order the defendants to eliminate waiting lists for services accrued due to temporary lack of capacity at one or more provider. There is no allegation that prior authorization delays are a contributing factor to waiting lists. There is no allegation that waiting lists exist where providers actually have vacancies that have gone unfilled, due to some administrative obstacle interposed by the defendants.

Rather, the core allegation is that waiting lists exist, for a small number of service providers, primarily because those providers have experienced difficulty in attracting or

retaining clinicians adequately trained to deliver a constellation of services that has only recently come on-line. The Sherwood Affidavit describes in detail the steps that EOHHS is taking to address this issue. To the extent that plaintiffs suggest that the reasonable-promptness provision of the Medicaid Act can be used to backstop an order compelling the defendants somehow to "solve" this thorny problem overnight, their reliance is misplaced.

III. The Proposed Form of Order, if Entered, Would Be So Vague as to Be Unenforceable.

The plaintiffs could well note, and fairly so, that this is not the nature of the order they are seeking at this point in time. The relief they do seek, however, presents its own problems.

What the plaintiffs have asked the Court to do is to enter the proposed form of order that they filed on June 1, 2010. That order, if entered, would direct the defendants to "make their best efforts to eliminate waiting lists" for ICC and other remedy services. In addition to its other flaws discussed above, such an order would have one insuperable problem: Neither the Court that issued it, nor the defendants who would be subject to it, would have any objective means of determining whether it has been complied with.

It is axiomatic that, to be enforceable, an injunction must be sufficiently specific to permit the party subject to it to know what actions are required or proscribed. This requirement is incorporated into Fed. R. Civ. P. 65(d), which states that every injunctive order must, among other things, "(B) state its terms specifically; and (C) describe in reasonable detail – and not by reference to the complaint or other document – the act or acts restrained or required." Fed. R. Civ. P. 65(d)(1)(B)-(C). Pursuant to this rule, courts

regularly deny requests for injunctions that leave ambiguity as to steps necessary to remain in compliance, such as requests merely to enjoin a party from failing to comply with a statute or regulation. See, e.g., Burton v. City of Belle Glade, 178 F.3d 1175, 1201 (11th Cir. 1999).

The requested injunction here illustrates the problem. It would neither "require" nor "restrain" any specific act, per the dictate of Rule 65(d). The proposed standard – "make their best efforts" – while seemingly benign, would require subjective judgment by both the parties and the Court to determine whether the defendants have complied with it. Accordingly, it does not satisfy the requisites of an enforceable injunctive order.

CONCLUSION

For the reasons discussed above, the plaintiffs' motion should be denied.

Respectfully submitted,

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Date: November 12, 2010

I hereby certify that a true copy of this document was served electronically upon counsel of record through the Court's electronic filing system on today's date.

/s/ Daniel J. Hammond

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