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UNITED STATES DISTRICT COURT DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

ROSIE D., *et al.*, **Plaintiffs,** **v.** **Charles Baker, *et al.*,** **Defendants.**	**CIVIL ACTION NO. 01-30199-MAP**

DEFENDANTS' (SUBSTITUTED AND CORRECTED) MEMORANDUM IN SUPPORT OF THEIR MOTION REGARDING SUBSTANTIAL COMPLIANCE AND TO TERMINATE MONITORING AND COURT SUPERVISION

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INTRODUCTION

In this litigation, which was filed in 2001, the Plaintiffs alleged, and the Court ultimately found, that Massachusetts, through its Medicaid agency, MassHealth, violated the Medicaid Act in failing to provide a coordinated system to screen, diagnose, and treat Medicaid-eligible children with Serious Emotional Disturbances ("SEDs"). The Plaintiffs offered extensive testimony at the 2005 trial, from the families and caregivers of children with SEDs and from experts in the field, that MassHealth provided only *ad hoc* services for such children and delivered those services primarily in institutional settings with little or no coordination among clinicians who diagnosed and treated class members. In both its determination of liability (entered in 2006) and its judgment and remedial order ("Judgment") (issued in 2007), the Court held that the Plaintiffs, some of the Commonwealth's most vulnerable citizens, deserved better. It determined that, for class members who met medical eligibility criteria, the Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") provisions of the Medicaid Act, 42 U.S.C. §§ 1396a(a)(10)(A), -(a)(43), 1396d(4)(5), -a(4)(B) (2005), required the Commonwealth to provide such children with a wide constellation of remedial services, in the least-restrictive setting possible, as part of a coordinated treatment plan. The Court also found that, under the EPSDT provisions, the Commonwealth had an affirmative duty—at the time of trial, largely unmet—to screen eligible children, when they present for primary-care services, for the presence of SEDs, and to refer those with positive diagnoses for prompt, coordinated treatment. It also held that, in failing to provide coverage for the required EPSDT services, the Commonwealth violated the provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(8), that requires assistance be provided with "reasonable promptness."

The Court's 2007 Judgment set forth the specific steps the Commonwealth was required to take to remedy the identified violations. By the terms of the Judgment, the Court

would continue to monitor and oversee the implementation of the remedy for five years, at which point the "Reporting and Monitoring provisions set forth [in the Judgment] will terminate." Judgment at par. 52.

Notably, the services sought by Plaintiffs were not available even to families with the most comprehensive commercial medical insurance. Indeed, on Count III of the Plaintiffs' complaint, which alleged unequal treatment of Medicaid-eligible families, the Court granted judgment in favor of the Defendants, acknowledging that the services sought by the Plaintiffs under the Medicaid Act were not available to Massachusetts families with private medical insurance, irrespective of who their insurer was, a fact that remains largely true today.

In 2012, at the end of the five-year period of court monitoring prescribed in the Judgment, the Commonwealth made a comprehensive evidentiary submission to this Court demonstrating full compliance with the Judgment. As this memorandum will discuss in detail below, the change in the system and array of behavioral-health services for children, between the time the trial commenced and the time of the Commonwealth's submission (and even more so today), has been nothing short of transformative. All families with EPSDT-eligible children are notified of the availability of services to diagnose and treat SEDs. Primary care providers are required to offer screenings for SEDs at well-child visits and, where appropriate, refer children to behavioral-health clinicians to begin treatment. Children in crisis have access to clinicians trained in stabilizing such situations, 24 hours a day, at the location of their choosing. Children who have a medical need for Intensive Care Coordination, one of the *Rosie D.* remedy services, are assigned a care coordinator, whose job it is to oversee the delivery of the child's Medicaid services, in consultation with family members, medical clinicians, and others who play a role in the child's day-to-day life. The MassHealth system for delivery of in-home and community-based behavioral-health services to children with SED—found to be *ad hoc*

and largely non-existent 12 years ago—has now become the gold standard in Massachusetts, to the point where families with private insurance are supporting efforts to secure coverage of services similar to those provided to Medicaid-eligible youth. The implementation of the *Rosie D.* remedial order has been, and continues to be, a success story.

Nevertheless, the Court has not relinquished active oversight of the remedy, as prescribed in the Judgment. Instead, it has entered a succession of orders extending the Court Monitor's appointment, while directing the parties to negotiate additional activities or measures the Defendants must accomplish to demonstrate improvements to the Commonwealth's robust and dynamic network of services. Even at this late date—more than six years after judicial oversight was to have ended—the Court is entertaining requests by the Plaintiffs to modify the Judgment, adding new requirements not responsive to the violations originally found by the Court, and not contemplated at the time of the Judgment. Rather than expand the reach of the case beyond the parameters of the Judgment, the time has come for the Court to step back, end its active oversight, and permit the Defendants, as the stewards of a fully realized remedy, to manage the system of care that arose from the Judgment, just as they manage all other aspects of the Commonwealth's Medicaid system.

A complex system of care, such as the one constructed pursuant to the Judgment, is a living organism, requiring constant oversight and adjustment to react to challenges and implement improvements. Although they have discharged their obligations under the Judgment, the Defendants do not see a moment, now or in the future, that their work of continued program improvement is "finished." If the Defendants, on their own or with input from others, identify aspects of the service delivery system that might require modification, or are not operating effectively, they understand that they have a responsibility to address such issues. But that responsibility arises from their stewardship of a dynamic system of care; it

cannot and should not be a part of indefinite Court oversight. Maintaining active oversight in this litigation until all operational challenges have been met, no new ones have arisen, and no room for program improvement remains, is waiting for a day that will never come.

As set forth below, the Commonwealth has met all of its obligations under the 2007 Judgment and, in doing so, has fulfilled the important purposes of the remedial order. Therefore, the Defendants are entitled to the relief set out in the terms of the Judgment—for their monitoring and reporting obligations to terminate, and for the Court to end active oversight of the remedy.

BACKGROUND

I. After Trial, the Court Found Violations of the EPSDT and "Reasonable Promptness" Provisions of the Medicaid Act.

Following a non-jury trial conducted over a three-month period in 2005, this Court found that the Commonwealth was violating the Medicaid Act's EPSDT and "reasonable promptness" provisions. *Rosie D. v. Romney*, 410 F. Supp. 18, 23 (D. Mass. 2006). It found that it was violating the ESPDT provision because (a) the Commonwealth was failing to provide comprehensive screening and diagnostic services to all Medicaid-eligible children eligible for EPSDT services necessary to identify those with SEDs and (b) where treatment for a child's SED was medically necessary, the Commonwealth's coordination of intensive care services, including, to the extent possible, in a community-based (as opposed to institutional) setting, was "inadequate" at best and "non-existent" at worst. *Id*. at 23, 52-53. And based on the Commonwealth's failure to "meet the substance of the EPSDT mandate," the Court found that MassHealth "ha[d] not satisfied Congress' command to provide services with 'reasonable promptness.'" *Id*. at 53.

A. In Finding a Violation of the EPSDT Provisions, the Court Identified Five Main Deficiencies in the Commonwealth's Provision of Medical Services to Children with Serious Emotional Disturbances.

The Court identified five main deficiencies in the Commonwealth's provision of medical services to EPSDT-eligible children with SED. Each is discussed below.

1. Notification. As of September 2004,[1] there were 14,000 to 15,000 Medicaid-eligible children in Massachusetts with SED and extreme functional impairment. *Rosie D.*, 410 F. Supp. 2d at 33 (FF 7). MassHealth was providing these children little, if any, notification of "their EPSDT rights." EPSDT services (*i.e.*, early, periodic screening, diagnosis, and treatment) were not specifically mentioned in the MassHealth Enrollment Guide, in plan booklets, or in periodic notices that MassHealth sent to members. *Id*. at 34 (FF 13-15).

2. Comprehensive Assessment. The Commonwealth was failing to ensure that "SED children … receive[d] … periodic [behavioral health] assessments at any particular time or in any consistent form," "with thousands of SED children in Massachusetts get[ting] no comprehensive assessments at all." *Id*. at 34 (FF 19). When a child did receive an assessment, it was often "ad hoc," lacking the "depth and comprehensiveness" necessary to serve as a foundation of the child's long-term behavioral health treatment. *Id*. And even then, there was no one designated to ensure that these initial assessments (however faulty) were passed on to the agencies or treatment providers who would ultimately be responsible for providing the treatment. *Id*. Observing this process, the Court found:

> Even acknowledging the many genuinely committed people within the Commonwealth's system of care, it is hard not to suspect an element of cynicism in this deficiency. The simplest way to escape the challenge of serving an SED child is to avoid conducting the sort of in-depth, comprehensive

[1] Although the Court's findings of fact with respect to liability were set forth in a Memorandum of Decision dated January 26, 2006, they were drawn from "information current as of September 30, 2004." *Rosie D.*, 410 F.Supp.2d at 30 n.4.

> assessment that will reveal the real extent of that child's medical needs. Whether conscious or unconscious, this is the strategy being employed by the current system as regards many of the SED children in the Commonwealth at this time.

Id. (FF 21).

3. Crisis Services. The Court found that, for most children suffering from SED with extreme dysfunction, "acute episodes were inevitable." *Id*. at 35 (FF 22). For this reason, crisis services, which included foreseeing the crises and pre-planning the proper clinical response, were a "necessary" part of a child's treatment plan. *Id*. at 35 (FF 22). The Commonwealth's crisis services, however, were "difficult[]" to access, often being delivered only in a hospital's emergency department or in some other institutional setting. Accordingly, the Court found that the Commonwealth was failing to provide "crisis" services "to the overwhelming majority of SED children in the Commonwealth." *Id*. at 35 (FF 22).

Even when crisis services were provided, most were "short-term counselling," designed to help the children and family through the "immediate emergency situation." *Id*. at 35-36 (FF 23, 26). After "quell[ing] the immediate crisis," the service often terminated. *Id*. at 36 (FF 26). Moreover, it was "almost never coordinated" into any broader aspect of the child's treatment plan. *Id*. at 36 (FF 27).

Other crisis services were provided in a community-based, 24-hour setting (*i.e.*, a group home). *Id*. at 35-36 (FF 25). But although those "hospital-level services" "sometimes helped to reintegrate a child with his or her family," more "frequently" they merely "act[ed] as a transition from home to a long-term residential placement." *Id*. at 35-36 (FF 25).

4. In-Home Support Services. The Court found that the Commonwealth's in-home support programs—services intended to "head off crises and forestall clinically unnecessary placements outside the home"—existed "largely on paper and to a limited degree only." *Id*. at

36 (FF 28-29). The in-home support services fell "far short of what [wa]s required [under] the Medicaid statute," in part because the programs (a) were designed as short-term interventions during acute periods (as opposed to providing services to children with chronic conditions throughout "their entire childhood and adolescence"), (b) were not properly coordinated with the children's other treatment, and (c) were "so restricted [in availability] that they reach[ed] only a minute fraction of the children who might benefit from them." *Id*. at 36-37 (FF 28-37).

5. Service Coordination. The Court found that "[i]t is impossible to overstate the importance of active, informed case management … for children with SED." *Id*. at 39 (FF 43). As the Court explained, a coordinator should meet regularly with the children and family, assist them in identifying the appropriate programs from the "maze" of available mental health services, coordinate necessary diagnosis efforts, oversee the formulation of a plan to address the child's needs, and take primary responsibility to ensure that the plan is carried out and modified as the child's needs evolve. *Id*. at 38-39 (FF 38, 43).

But excepting "a very few children" in "specific geographic areas," the Court found that "a child with SED in the Commonwealth does not receive adequate case management services." *Id*. at 38 (FF 38). "[D]eficiencies that plague[d] this critical service" included durational time limits, with services ending as soon as the child "moved beyond a pressing crisis," lack of personal interaction between the child, family, and service provider, and, for the children with the most intensive needs, access limited to just "a small fraction of the children in the plaintiff class." *Id*. at 38-39 (FF 38-43).

B. After Making Liability Findings, the Court Ordered the Parties to Submit Proposed Plans to Remedy the Violations, and Ultimately Adopted MassHealth's Proposed Plan, With Some Minor Modifications.

In the conclusion of its January 26, 2006, Memorandum of Decision, the Court held that, given the EPSDT and "reasonable promptness" violations it had found, it was required,

"unless voluntary remedial action is taken, to issue permanent injunctive relief to prevent continued, irreparable harm to the plaintiff class members." *Rosie D.*, 410 F. Supp. 2d at 54. It further directed the parties to submit a proposed plan to remedy the adjudicated violations, either jointly "or, if they are unable to agree, then separately." *Id.*

When negotiations between the parties did not result in a joint proposal for a remedial order, the parties each submitted their own version. *See* Docket No. 338 (Att. 3-5) & 339 (Att. 1). "Recognizing that the provision of adequate services for this extremely needy population of children presents a complex and daunting challenge and that no plan … can guarantee an ideal level of service," the Court, on February 22, 2007, entered a Memorandum and Order Regarding Remedy in which it adopted the Defendants' proposed remedial order, with certain modifications. *See* Docket No. 354. Therein, the Court explained that it "[wa]s convinced that the Defendants' plan has been offered in good faith and presents a 'real prospect' for curing the Medicaid violations found by the court 'at the earliest practicable date.'" *Id*. at 2 (quoting from *Green v. Cty. Sch. Bd. of New Kent Cty., Va.*, 391 U.S. 430, 439 (1968)). The plan "[wa]s detailed," "directly address[ed] each of the areas of deficit identified by the Court in its January 26, 2006 memorandum," and "if implemented and successful, … represent[s] a new day for this population of underserved, disabled children." *Id*. at 4. Simply put, it held the "potential to be an enormous step forward." *Id*. at 4.

"Apart from [the defendants' plan's] potential efficacy," the Court identified two other "special advantages" in adopting the Commonwealth's proposal. The first was that the Supreme Court "ha[d] emphatically underlined the obligation of the court to defer to the judgment of authorities in fashioning remedial orders and to avoid extensive intrusiveness." *Id.* at 3 (citing *Lewis v. Casey*, 518 U.S. 343, 362 (1996)). Thus, out of "respect for the sovereignty of the Commonwealth and the competence of its officials," the Court said it was required to let

the Defendants structure their response to the Court's findings. *Id*. The second, a practical matter, was that the Commonwealth, as the plan's proponent, was in the best position to commit to strategies that it deemed feasible. *Id.* at 3-4.

II. The Court Entered a Detailed Judgment Setting Forth Specific Steps the Defendants Must Take to Remedy the Violations Identified in Its Post-Trial Findings.

On July 16, 2007, the Court entered the Defendants' proposed remedial order, with minor modifications and provisos, as the final Judgment in this case. *See* Docket No. 368. The Judgment separates neatly into six discrete sections: four specifying program improvements that the defendants were required to implement to remedy the violations identified in the January 26, 2006, Memorandum, *see id*., par. 2-33, one establishing a detailed implementation and monitoring process, *see id*., par. 34-49, and one addressing modification, dispute resolution, and related matters. *Id*., par. 50-52.

1. Notification. The Judgment required defendants to make specific improvements to their methods for notifying Medicaid-eligible individuals enrolled in MassHealth, providers, public and private child-serving agencies, and other interested parties about the availability of behavioral health services and behavioral health screenings in primary care settings. Judgment, par. 2. It directed the Defendants to inform all EPSDT-eligible MassHealth members and their families about the availability of EPSDT services and the "enhanced availability" of screening services and intensive care coordination upon enrollment. *Id*., par. 3. It also instructed the Defendants to publicize the program improvements required by the Judgment and to educate customer service representatives about the program updates. *Id*., par. 4.

The Judgment also dictated that the defendants undertake a series of education initiatives. *See* Judgment, par. 5-7. For members, this meant updating and distributing EPSDT notices to make specific reference to the availability of behavioral health screening and

services, updating member education materials (including the member handbook) with discussions of the improvements and explanation of how to access the new services, amending applicable regulations, and participating in public outreach with advocacy groups. *Id*., par. 5. For providers, this included updating the applicable regulations and associated provider manual, distributing a special communication describing the improvements, updating existing provider-education materials to reflect the improvements and expanding their distribution points, amending managed care contracts to include notification and education requirements, and coordinating those efforts with EOHHS' website. *Id*., par. 6. Finally, for the public, the Judgment directed the Defendants to inform appropriate officials in the Commonwealth, create new informational materials describing the improvements, implement training programs for staff at state agencies explaining how to access the services implemented as a result of the Judgment (the "remedy services"), and distribute outreach materials to entities and locations that were likely to come in contact with children with SED or their families. *Id*., par. 7.

2. Screening and Referrals. The Judgment also required the Defendants to improve behavioral health screening and referrals. Judgment, par. 8-10 (screening) & 11-12 (referrals). As to screening, it instructed the Defendants to amend applicable regulations to require that all primary care providers offer periodic and inter-periodic screens. *Id*. par. 9. It also directed the Defendants to ensure that all primary care providers who perform periodic and medically necessary inter-periodic behavioral health screenings do so from "a menu of standardized behavioral health screening tools" and, relatedly, to use quality improvement initiatives to educate providers about the most effective tools and when to make referrals to behavioral health clinicians. *Id*. par. 8-10.

Regarding referrals, the Judgment provided that MassHealth continue its practice of not requiring a primary care visit or EPSDT screening as a prerequisite for behavioral health

services. *Id*. par. 11. Rather, a child could self-refer or be referred by eligible family members, another doctor or health center, or by another state agency or public school. *Id*. The Judgment also called for the Defendants to work with other state agencies that serve children, to ensure that staff at those agencies knew about the remedy services and knew how and when to connect children with SED to EPSDT screenings, assessments, and medically necessary services. *Id*. par. 12.

3. Assessment, Diagnosis, and Treatment Planning. The Judgment required the Defendants to take specific actions to improve behavioral health assessments, diagnosis, and treatment planning. Judgment, par. 13-16 (assessment and diagnosis) & 19-30 (treatment planning). For assessment and diagnosis, the Judgment ordered that the Defendants ensure that EPSDT services include a clinical assessment process, leading to a clinical diagnosis, when a child presents for behavioral health treatment. *Id*. par. 14-16. The Judgment also required that providers use a standardized clinical information collection tool known as the Child and Adolescent Needs and Strengths ("CANS") to help identify and assess a child's behavioral health needs. *Id*. par. 15, 16(b). Moreover, the Judgment provided "that the assessment process lead[] to a clinical diagnosis and the commencement of treatment planning." *Id*. par. 16(c).

The Judgment also required that the Defendants provide intensive care coordination (with a detailed written plan, care manager, and care planning team) to any eligible child that meets medical necessity criteria for the service and requests it. Judgment, par. 19. The Judgment detailed the responsibilities of the care manager in coordinating and monitoring a child's services, *id*. par. 20-21, and specified the minimum qualifications for the position,

including that the manager be trained in the "wraparound" process[2] for providing care within a "System of Care."[3] *Id*. par. 22. Similarly, the Judgment instructed members of the care planning team to perform a comprehensive assessment, including conducting a CANS standardized instruction, to develop an individualized plan of care that most effectively meets the child's needs and guides the treatment process. *Id*. par. 23-24, 26. The Judgment mandated that each plan describe the child's strengths, needs, and services needed (including frequency and intensity), set forth the treatment goals and objectives (including timetables for achieving them), contain include a crisis plan, and identify providers. *Id*. par. 28. Moreover, the plan needed to be reviewed periodically by the care manager (monthly) and planning team (quarterly), and updated, as necessary, to reflect the child's changing needs. *Id*. par. 24, 26, 29. Finally, where children were receiving services from multiple EOHHS agencies, EOHHS needed to ensure that a representative from each agency would be a part of the child's care planning team. *Id*. par. 30.

4. Services. The Judgment directed the Defendants, subject to the availability of federal financial participation, to cover multiple services for eligible members with SED if the services are medically necessary. Judgment, par. 31. These included:

- Assessments, including the CANS assessment, as described above. *See, supra,* pp. 11-12.
- The intensive care coordination and treatment planning process, also described

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[2] The Court defined the "wraparound process" as a "planning process involving child and family that results in a unique set of community services and natural supports individualized for that child to achieve a positive set of outcomes." Judgment, par. 22.

[3] The Court defined "System of Care" as a "cross-system coordinated network of services and support organized to address the complex and changing needs of the child" and consistent with the "principles and values of the Child-Adolescent Services System Program." Judgment, par. 22.

(footnote continued)

above. *See, supra,* pp. 11-12.

- Two categories of crisis management: (1) mobile crisis intervention[4] on a 24-7 basis and (2) crisis stabilization[5] to monitor and treat the child (and support the parent or caretaker) for up to 7 days. *Id*. par. 32(a)-(b). The Judgment set forth the specifics of each. *Id*.

- Three types of home and community-based services: (1) in-home behavioral services (including behavior management therapy and behavior management monitoring), (2) in-home therapy services (including a therapeutic clinical intervention and ongoing training and therapeutic support), and (3) mentor services (including independent living skills mentors and child/family support mentors). *Id*. par. 33. The Judgment set forth specifics for each service. *See id.*, par. 33(a)-(c).

5. Implementation, Data Collection, and Monitoring. By its terms, the Judgment was to be implemented in four discrete stages or "projects," each of which carried a concrete timeline for its completion. Judgment, par. 34-39. Additionally, to "improve the quality of [MassHealth's] behavioral health services for children, and to reassure the Court of success," the Judgment included several paragraphs regarding "Data Collection." *Id.*, par. 40-46. Collectively, those paragraphs required the Defendants to track "basic" and "potential" data via existing and contemplated data collection systems, respectively, to monitor, measure, and evaluate the behavioral health care for children with SED. *Id*. To improve the "basic" tracking measures, the Judgment directed EOHHS to continue with the replacement of the Medicaid Management Information System ("MMIS"), and instructed EOHHS to review the possibility of tracking "potential" data relating to EPSDT behavioral health screening, clinical

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[4] The Court described mobile crisis intervention as a "mobile, on-site, face-to-face therapeutic response to a child experiencing a mental health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation in community settings … and reducing the immediate risk of danger to the child and others." Judgment, par. 32(a).

[5] The Court defined crisis stabilization as services "designed to prevent or ameliorate a crisis that may otherwise result in a child being hospitalized or placed outside the home as a result of the acuity of the child's mental health condition." Judgment, par. 32(b).

assessments, intensive care coordination services and home-based assessments, intensive home-based services treatment, child and system outcome measures, and member satisfaction measures. *Id*.

The Judgment also created specific roles for the Court Monitor, *id.* par. 48, and the Commonwealth's compliance coordinator. *Id.* par. 47.

6. Modification and Jurisdiction. The Judgment provided that its terms "are subject to modification as follows: (a) for good cause upon application to the Court by either party; or (b) by agreement of the parties." Judgment, par. 50. The Judgment was "subject to the Court's exercise of ongoing jurisdiction to insure implementation." *Id*. par. 52. Finally, the Judgment stated that the "Reporting and Monitoring provisions … will terminate five years after the date of entry of this Judgment [*i.e.*, July 16, 2012]." *Id*. par. 52.

III. The Defendants Worked Diligently to Implement the Judgment, and, in May 2012, Reported that They Were in Compliance in All Respects.

From 2007 through 2012, MassHealth worked diligently to implement the Judgment. The Commonwealth completed each of the four enumerated "projects" on or before the date contemplated by the Judgment, except where the deadline was expressly extended by the Court. *See* Docket No. 575, pp. 30-37 (Project 1); p. 52 (Project 2); pp. 62-78 (Project 3); pp. 78-88 (Project 4). As discussed in greater detail below, they also implemented each of the Judgment's other requirements. Accordingly, on May 16, 2012, in advance of the last status conference before the date set out in the Judgment for termination of the reporting and court monitoring requirements (June 25, 2012), the Defendants filed an exhaustive status report (112 pages, plus 71 exhibits) that apprised the Court, the Court Monitor, and the Plaintiffs of all actions the Defendants had undertaken to implement the Judgment during the preceding five

years.[6] *See* Docket No. 575.

Much like the Defendants' present filing, the 2012 status report discussed, with respect to each of the Judgment's 52 paragraphs, what affirmative obligations the paragraph imposed upon the Commonwealth and what steps the Commonwealth had taken to fulfill them. *See* Docket No. 575. Most significantly, the 2012 report detailed the holistic transformation of the system of care for Medicaid-eligible children with SEDs between the time of trial (2005) and the date of the status report; how the diffuse and *ad hoc* services of 2004 had been replaced by a robust and interconnected network of remedy services, *see id*. at pp. 2-10, 30-78; how families, clinicians, state agencies and other stakeholders had been made aware of the new service delivery model, *see id*. at pp. 10, 15-29; how positively the members themselves described the new environment created by the Judgment, *see id*. at pp. 11-14; how MassHealth continued to work to educate its managed care entities ("MCEs") and providers and to improve the overall quality of the services, *see id*. at pp. 44-51; and what steps MassHealth was taking to "lock in" the gains made during the implementation period. And based on its submission, the Commonwealth reported that it had "fully implemented all remedy services required by the July 16, 2007 judgment, and [is] in substantial compliance with all tasks set forth in that judgment." *See id.* at 111. In response, the Plaintiffs challenged the Defendants' assertion of substantial compliance, but made no motion asking the Court to find the Defendants out of compliance, nor did they make any evidentiary showing to support their assertion. *See* Docket No. 578.

IV. Six Years of "Disengagement" Fail to Result in an End to Active Monitoring.

At the status conference on June 25, 2012, the Court stated its disinclination to make

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[6] That filing is incorporated as if fully set forth herein.

any findings regarding the Defendants' compliance with the Judgment. *See* Transcript of June 25, 2012 Status Conference at 7-10. Because the Defendants' filing discussed some activities that remained ongoing, or that would continue into the future, the Court was not comfortable in allowing either the Court Monitor's tenure or its own active scrutiny of the remedial plan to "terminate," as set forth in the Judgment. Rather, the Court requested that the Defendants develop a "road map" for bringing an end to the Court's oversight. *Id*. at 8. Accordingly, the Court ordered the parties to make filings addressing what the final phase of this litigation should look like, and what remained to be done as a precondition to disengagement. *See id*. at 32-33.[7]

At the Court's behest, the parties generated a joint disengagement document, which laid out four broad areas where the Defendants *voluntarily* agreed to take additional steps, above and beyond those specified in the Judgment, to address certain concerns raised by the Plaintiffs.[8] *See* Docket No. 621, Ex. 1. In responding to the Court's directive, and participating in the disengagement process, the Defendants continued expressly to reserve their position that they had been in substantial compliance with the Judgment since at least 2012 and did not agree that the achievement of such tasks constituted any measure of their compliance with the Judgment. *See, e.g.,* Defendants' Supplemental Proposal Regarding Disengagement Criteria, Docket No. 584, dated September 27, 2012, at 2 ("In May of this year, the defendants . . .

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[7] Noting its need for the Court Monitor's continued assistance in reviewing the parties' filings, the Court also extended the Court Monitor's appointment through December 31, 2012. *See* Transcript of June 25, 2012, Status Conference at 24. This proved to be the first of ten such orders extending the term of the Court Monitor's appointment. *See, e.g.,* Docket Nos. 666, 690. Her tenure is presently scheduled to run through and including December 31, 2018.

[8] They included: access to remedy services; proper utilization of remedy services; effectiveness of remedy services; and uniformity of practice. Docket No. 621, Ex. 1.

assert[ed] that they have substantially complied with each of the remedial tasks set out for them in the Judgment. That assertion still stands.").

The Defendants performed each of these voluntary tasks on the understanding that the achievement of these tasks would lead to the end of active monitoring. Rather than terminating active monitoring, however, the Court, at the November 8, 2016 status conference, further directed the parties to reach agreement (if possible), or to file separate versions (if necessary), of a list of numerical targets for year-over-year improvement of various aspects of the remedy network in 2017 and 2018 (again, outside the parameters of the original requirements of the Judgment) which, if attained over the ensuing two years, were to result in an end to active monitoring. *See* Transcript of Nov. 8, 2016, Status Conference at 25-26.

The Defendants once again participated in the requested disengagement discussions, despite maintaining that they had been in substantial compliance with the Judgment since 2012 and that any such metrics were not a measure of the Defendants' compliance with the Judgment. After protracted negotiations, although the parties reached agreement as to most of these numerical targets, each submitted its own proposal to the Court on December 13, 2016.[9] Docket Nos. 762-763.

V. The Present Dispute.

Beginning in early 2017, the Plaintiffs sought to amend the Judgment to add obligations upon the Defendants that did not appear in the Court's 2007 Judgment. On February 16, 2017,

[9] Importantly, the disengagement measures filed with the Court in late 2016 and early 2017 were not tied to any specific provision or mandate of the Judgment. As will be discussed in greater detail in response to Plaintiffs' anticipated filing regarding disengagement, the Defendants' performance on or achievement of these measures is not a measure of their substantial compliance with the Judgment and may not be used by the Court in making such determination.

the Plaintiffs filed a motion asking the Court to take the numerical targets for year-over-year system improvements and enter them as orders of the Court. Docket No. 776. On the following day, they filed a second motion, this one seeking to modify the Judgment by incorporating certain of the Defendants' voluntary actions (pertaining to outpatient therapists' delivery of care coordination), actions not required under the terms of the Judgment, as compulsory decrees of the Court. Docket No. 777.

The Defendants objected to the motions because (1) they fell outside the scope of the Judgment; (2) they did not relate to any federal-law violation found by the Court in its Memorandum of Decision as to liability; and (3) they sought to make voluntarily-undertaken quality-improvement measures subject to judicial enforcement. After hearing oral argument in April, 2017, the Court denied both motions, without prejudice, on September 27, 2017. Docket No. 815.

On May 11, 2018, the Plaintiffs filed another motion, this time requesting, among other things, that the Court order a mandatory numerical target to increase the percentage of children receiving an initial appointment for intensive care coordination and in-home therapy within 14 days and require the Defendants to increase the reimbursement rates for certain remedy-service providers. *See* Docket No. 835. The Defendants objected to this motion too, because under controlling case law, the Court lacked the authority to modify or supplement the Judgment unless, among other proof, (a) the Plaintiffs had demonstrated, and the Court found, that the Defendants had violated the Judgment, and the proposed modification was necessary to cure an ongoing violation; or (b) the Plaintiffs demonstrated under Rule 60(b)(6) an unanticipated change, either in law or in fact, rendering enforcement of the Judgment as written inequitable. *See* Docket No. 839, p. 4 (citing, *inter alia, Ricci v. Patrick*, 544 F.3d 8, 22 (1st Cir. 2008)). At the hearing on June 13, 2018, the Court declined to rule on the Plaintiffs' May 11, 2018,

motion. Instead, while the Plaintiffs' latest motion remained under advisement, this Court ordered the Defendants to file a Motion Regarding Substantial Compliance and directed the Plaintiffs to file a Motion to Incorporate the Disengagement Criteria as an Order of the Court. *See* Docket No. 844, pp. 3-4. The order specified that the Defendants' supporting memorandum "lay[] out in detail [how] they have substantially complied with the court's remedial order of July 16, 2007." *Id*. at 3. That explanation follows.

VI. The Defendants' Evidence of Substantial Compliance With the 2007 Remedial Order.

As stated fully to the Court in 2012, the Defendants are in substantial compliance with the Judgment. Since 2010, the number of youth receiving remedy services has almost doubled and providers have been paid over $1.3 billion to provide remedy services to over 125,000 individual MassHealth members, many of whom receive more than one remedy service. Defendants' Statement of Material Facts ("SMF") ¶ 69. Moreover, 82% of the youth who received remedy services in state fiscal year 2017 never required admission to a 24-hour level-of-care facility at any time during the year. SMF ¶ 71.

A detailed overview of the Defendants' evidence of substantial compliance for each section of the Judgment is set forth below. Additional detail is provided in the Defendants' accompanying Statement of Material Facts, which the Defendants hereby incorporate by reference.

A. The Defendants' Compliance with the Judgment's Notification Remedies.

Sections I.A (¶¶ 2-7) and I.E.1 (¶¶ 36-37) of the Judgment required the Defendants to improve their methods for notifying Medicaid-eligible individuals enrolled in MassHealth, MassHealth providers, public and private child-serving agencies, and other interested parties about the availability of the remedial behavioral health services and screenings in primary care

settings.

MassHealth has, since 2007, notified all EPSDT-eligible members about SED screenings and the panoply of remedy services, both when the member child first enrolls in MassHealth, and then again, annually, on the child's birthday. SMF ¶ 9. Since 2007, MassHealth has also published member handbooks, in both paper and digital forms, with information about remedy services, and requires MCEs to provide this information to member families. SMF ¶ 10.

To comply with the other notification requirements, the Defendants train all customer service representatives who interface with members about EPSDT and remedy services. SMF ¶ 11. Since 2007, the Defendants have met regularly with advocacy and stakeholder groups, including the Parent/Professional Advocacy League ("PPAL") and the Association for Behavioral Health ("ABH") as a means of informational outreach. SMF ¶ 12. The Defendants create and distribute provider education materials, to apprise providers regularly of their obligations under the Judgment, including, for example, their obligation to perform CANS assessments on all children referred for behavioral health treatment. SMF ¶ 14. In 2007, the Defendants created, and have since regularly updated, the Children's Behavioral Health Initiative ("CBHI") website, which serves as a central repository for information about remedy services and which is accessible to members, providers and other stakeholders. SMF ¶¶ 15-16. Additionally, the Defendants have authored written protocols instructing staff of other Commonwealth child-serving agencies (*e.g.*, DYS, DMH, DCF, etc.) on how to refer their Medicaid-eligible clients for diagnosis and treatment. SMF ¶ 18.

Finally, to ensure that these notice-focused remedies remain in place in the future, effective December 31, 2007, the Defendants updated the MassHealth regulations governing medical protocols and periodicity schedules for EPSDT services and behavioral health

screenings, as well as Appendix W of the MassHealth provider manual. SMF ¶ 13; *see also* 130 C.M.R. §§ 450.140-150; 130 C.M.R. § 450.140(B) (noting objective of EPSDT program "to create an awareness of the services available under the EPSDT program, and where and how to obtain those services"). These regulations remain in effect today. *See also* 130 C.M.R. §§ 450.140-150.

B. The Defendants' Compliance with the Judgment's Screening and Referral Remedies.

So as to make screening for SEDs as close to universal as possible, and to streamline the path from behavioral health screening to referral for treatment (and in the process comply with Sections I.A.2 (¶¶ 8-10), I.A.3 (¶¶ 11-12), I.B (¶ 16), and I.E.1 (¶ 36) of the Judgment), the Defendants, in 2007, amended their regulations to require all primary care providers ("PCPs") to offer behavioral health screenings using a standardized screening tool from among a list of approved tools. SMF ¶ 19; *see also* 130 C.M.R. §§ 450.140-150. MassHealth's contracts with its Managed Care Organizations ("MCOs") and new Accountable Care Partnership Plans ("ACPPs") also require PCPs to offer such screenings when providing services to members enrolled in one of these health plans. SMF ¶ 20.

The Defendants annually review the approved tools to be used, and the frequency with which screenings must be conducted, with outside experts, including the Massachusetts Chapter of the American Academy of Pediatrics. SMF ¶ 22.

Between 2009 and 2011, the Defendants developed and distributed written protocols for providers and other state agencies, setting forth both screening and referral requirements. SMF ¶ 24. Additionally, MassHealth uses the CBHI website as a forum to offer providers and users constant access to training and resource materials related to behavioral health screening. SMF

¶ 21.[10]

According to a study conducted in 2013 by the Center for Health Policy Research at the University of Massachusetts Medical School ("UMMS"), the implementation of these changes "has fundamentally transformed the relationship between primary care services and behavioral health services within the Commonwealth." SMF ¶ 25. Indeed, the study, commonly known as a Clinical Topic Review, shows that changes "in regulation and payment have resulted in the implementation of widespread behavioral health screening in primary care practices in Massachusetts that care for children and adolescents on Medicaid." *Id*.

C. The Defendants' Compliance with the Judgment's Assessment and Treatment Planning Remedies.

The Defendants have taken a number of steps to ensure that behavioral health services now incorporate clinical assessment practices for eligible children and that those assessment practices lead to treatment planning, as required in Sections I.B. (¶¶ 13-16) and I.E.1 (¶ 37) of the Judgment. The Defendants amended all relevant regulations in 2008 to ensure that clinical assessments begin at the point of a child's intake for behavioral health services; that such clinical assessments are performed by licensed clinicians or other appropriately trained professionals; that providers complete a CANS assessment as part of their clinical assessment practice; and that these clinical assessment practices lead to clinical diagnoses and the commencement of treatment planning.[11] SMF ¶¶ 26-30. Moreover, since 2008, MassHealth's

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[10] MassHealth continues not to require a primary care visit or behavioral health screening in order for a member to access behavioral health services. SMF ¶ 23. Rather, a member may self-refer to behavioral health services, or may be referred by other state agencies, public schools, community health centers, hospitals, community mental health providers, PCPs, or other behavioral health providers. *Id*.

[11] Further, medically necessary services are available while clinical assessment and treatment planning practices are ongoing. SMF ¶ 26.

contracts with its Managed Care Entities have required clinical assessments for children with SED who are enrolled in those plans. SMF ¶ 28.

Since 2008, the Defendants have also prepared and implemented numerous training platforms to certify clinicians to perform CANS assessments and have certified over 28,000 practitioners to perform these assessments. SMF ¶ 32. Most recently, the Defendants worked with the University of Massachusetts Medical School to create a comprehensive online training program which will come on-line in the winter of 2019. SMF ¶ 27.

D. The Defendants' Compliance with the Judgment's Covered Service Remedies.

The Defendants' compliance with each section of the Judgment's Covered Service Remedies (Sections I.C. (¶¶ 19-30), I.D. (¶¶ 31-35), I.E.1 (¶ 38), and I.E. (¶ 49)) is set forth by remedy service below.

1. The Defendants' Compliance with the Judgment's Covered Service Remedies' Foundational Requirements.

By amending its Medicaid State Plan, the Commonwealth attained CMS approval (a necessary pre-condition, as contemplated by the Judgment) for all the new services, except Crisis Stabilization.[12] SMF ¶ 33. The Defendants amended their contracts with MCEs to require each MCE to create and manage a system of providers of each remedy service, and to pay network providers at least the MassHealth regulatory rates for remedy services.[13] SMF ¶ 35. To ensure uniformity of the remedy services provided, they developed Performance Specifications (effective since 2009), exacting descriptions of each remedy service, and

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[12] Report, Section VII.C.iv., pp. 70-71; Judgment, Section I.D.1 (¶ 32).

[13] In 2017, MassHealth sought and obtained approval from CMS to continue imposing this minimum rate floor on the MCEs under the new federal managed care directed payment regulations. SMF ¶ 35; *see also* 42 C.F.R. 438.6.

required that all providers of remedy services must be licensed clinicians or supervised by licensed clinicians. SMF ¶¶ 34, 36. In collaboration with stakeholders, they also established Medical Necessity Criteria, to create an objective standard to determine member eligibility for each remedy service. SMF ¶ 37.

2. The Defendants' Compliance with the Judgment's Mandates Regarding the Delivery of Required Remedy Services.

Through its MCEs, the Commonwealth built a statewide service delivery network of Community Service Agencies ("CSAs") to provide ICC and Family Support and Training ("FS&T"), as required in the Judgment in Sections I.D.1 (¶ 35) and Section I.E.1 (¶ 38). SMF ¶ 38. There are currently 32 CSAs operating in Massachusetts, all of which have been actively providing ICC services since July 30, 2009.[14] SMF ¶ 40.

Apart from the CSAs, each MCE also manages a network of providers to deliver the other remedy services specified by the Judgment. SMF ¶ 42. At the Defendants' direction, MCEs continue to expand their networks to meet demand for these services. *Id*. As a result, between 2009 and 2018, the number of providers contracting with MCEs to provide In-Home Behavioral Services ("IHBS"), In-Home Therapy ("IHT"), and Therapeutic Mentoring ("TM") has more than doubled. *Id*.

The Defendants regularly evaluate the geographic availability of providers of remedy services. SMF ¶ 43. An analysis assessing the geographic availability of IHT, IHBS and TM service providers is completed bi-annually and shows that the majority of all cities and towns in Massachusetts have at least one service provider within a 20-mile radius of their center. *Id*.

[14] There are currently 29 regional CSAs, whose service areas align with the 29 DCF Service Areas. SMF ¶ 40. There are three additional CSAs operated by provider organizations whose missions are limited to particular populations, for example, the Deaf and Hard of Hearing. *Id*.

Additionally, in 2018, the Defendants conducted specific time-and-distance analyses for IHBS, TM, and IHT services to be delivered by newly procured managed care plans, which confirmed that over 99% of all covered youth had access to at least two IHBS, TM, and IHT providers within 30 miles or 30 minutes of their homes. SMF ¶ 44.

The specifics of the Defendants' compliance with the Judgment's three Covered Service Remedies—intensive care coordination, crisis management, and home and community-based services—is summarized below and set forth in additional detail in the Defendants' Statement of Material Facts. *See* SMF ¶¶ 46-71.

a. Intensive Care Coordination.

The Defendants provide ICC to all eligible children who meet medical necessity criteria, and who choose to utilize the service.[15] SMF ¶ 46. Since 2010, ICC providers have been paid over $200 million for the more than 50,000 units of ICC services they have delivered to MassHealth members. SMF ¶ 47. During this time, the Defendants have raised payment rates for ICC approximately 29% (for Master's level clinicians) and 25% (for Bachelor's level clinicians). SMF ¶ 35. Additionally, since 2010, 78 percent of youth seeking ICC have begun treatment within 14 days of being referred to the service, with 84 percent starting treatment within 21 days, and 88 percent within 28 days. SMF ¶ 47. During this period, the average wait time from referral to ICC until the commencement of services has been 11 days, with more than half of new referrals beginning treatment within three days. *Id.*

The Defendants require that all ICC services include the assembly of a Care Planning

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[15] In state fiscal year 2017 (i.*e.*, July 1, 2016 – June 30, 2017), 8,116 youth received ICC through MassHealth. SMF ¶ 46.

(footnote continued)

Team and the assignment of a care manager,[16] who is either a licensed mental health professional or works under the direct supervision of one. SMF ¶¶ 48-49. The Care Planning Team[17] is responsible for developing a treatment plan tailored to the needs of each individual child, identifying and arranging all medically necessary clinical services, and periodically reviewing and modifying the treatment plan. SMF, ¶¶ 50-53.

b. Crisis Management.

The Commonwealth complies with the crisis management requirements in Section I.D.1 (¶ 32) of the Judgment by contracting with MBHP, which in turn manages a network of 21 statewide Emergency Service Providers (ESPs) who deliver Mobile Crisis Intervention (MCI) services throughout the Commonwealth. SMF ¶ 55. MassHealth's other MCEs are required to contract with this network of ESPs for the provision of MCI to youth enrolled in those health plans. Since July 2010, ESPs have been paid over $101 million for MCI services provided to members, and the Defendants have raised payment rates for this service approximately 10%. SMF ¶¶ 35, 56. In state fiscal year 2017, 14,846 members received MCI through MassHealth. SMF ¶ 56. Sixty percent of these youth did not require an admission to a 24-hour level of care facility at any time during the year. SMF ¶ 58.

MCI providers must be on-call and available seven days a week, 24 hours a day. SMF

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16 The care manager is responsible for coordinating and integrating the multiple services in accordance with the member's needs and with links to interested stakeholders and services. SMF ¶¶ 48-49.

17 The Care Planning Team is comprised of a variety of interested stakeholders, including relevant state agency staff, school personnel, and natural supports. SMF ¶ 50. With the custodian's consent, the Care Planning Team can include representatives of other child-involved EOHHS agencies. SMF ¶ 51. Representatives to the Care Planning Team coordinate agency-specific planning and treatment. *Id*.

¶¶ 57, 60. The service, which is delivered wherever the member is located, consists of a face-to-face therapeutic response to a child experiencing a mental health crisis, and is designed to stabilize the situation and mitigate imminent physical and psychological danger. SMF ¶ 57. The Defendants require that all individuals providing this service be licensed clinicians trained in MCI, or that they be working under the supervision of a licensed clinician. SMF ¶ 59.

c. Home and Community-Based Services.

The Defendants have implemented the Home and Community Based services remedy requirements by developing four services—IHT,[18] IHBS,[19] TM[20] and FS&T[21]—pursuant to the specifications set out in Section I.D.2 (¶¶ 33-34) of the Judgment, and deliver each in a home- or community-based setting. SMF ¶¶ 62, 64. The IHBS, TM, and FS&T services are delivered in accordance with the member's treatment plan and provided in conjunction with ICC, IHT, or traditional outpatient therapy. SMF ¶ 64. Each of these services is likewise delivered by, or under the supervision of, a licensed clinician. SMF ¶¶ 65-68.

Between July 2016 and June 2017, 5,226 youth received FS&T; 2,505 youth received

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[18] IHT services include a therapeutic clinical intervention and ongoing training and therapeutic support to meet specific emotional or relational issues. SMF ¶ 62.

[19] IHBS consists of in-home behavioral therapy ("IHBT") and in-home behavioral monitoring ("IHBM"). SMF ¶ 62. IHBT is provided by a qualified and trained clinician who coordinates interventions to address specific behavioral objectives and incorporates those interventions into the treatment plan. SMF ¶ 61. IHBM is provided by a qualified and trained paraprofessional who implements and monitors the specific behavioral objectives and interventions developed by the IHBS clinician. *Id*.

[20] TM services provide a structured one-on-one relationship to address socialization needs. SMF ¶ 67. They must include the development of independent living goals to be included in the Treatment Plan. *Id*.

[21] FS&T services provide a structured, one-on-one relationship with the caregiver(s) to address issues directly related to the child's emotional and social needs. SMF ¶ 68.

IHBS; 13,835 youth received TM; and 15,976 youth received IHT. SMF ¶ 63. Since 2010, IHBS providers have been paid approximately $83 million to deliver IHBS services; IHT providers have been paid $593 million to deliver IHT services; TM providers have been paid $275 million to deliver TM services; and FS&T providers have been paid $109 million to deliver FS&T for MassHealth members. *Id*. During this time, the Defendants have raised payment rates for FS&T approximately 23%, and raised rates for IHBS, IHT, and TM approximately 10%. SMF ¶ 35.

E. The Defendants' Compliance with the Judgment's Information Technology Development and Data Collection Remedies.

The Defendants' compliance with the Judgment's commands in Sections I.E.1 (¶ 39) and I.E.2 (¶¶ 40-46)[22] regarding Informational Technology and data collection are set forth in detail in the Defendants' Statement of Material Facts. See SMF ¶¶ 72-86. As an example of compliance activities, the Defendants:

- developed a web-based CANS application giving service providers instant access to assessment tools and training materials (SMF ¶ 72);
- developed and implemented, in 2013, the Massachusetts Practice Review ("MPR") tool as a means to conduct annual detailed reviews of a sample of individual members' cases, as a means of analyzing quality of care and overall outcomes (SMF ¶ 77)[23]; and

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[22] As previously reported to the Court, several of the contemplated technology requirements in the Judgment were found to be unnecessary to Defendants' implementation of the Judgment and are therefore not further discussed here. SMF ¶ 74.

[23] The MPR reviews often include specific comments from the reviewers regarding the strengths and weaknesses of the clinical practice. For example, in 2017, an MPR reviewer of ICC practice noted the "extraordinarily good service planning, service delivery, cultural responsiveness, and overall clinical understanding" of the provider and the comprehensive care team formation which included the child's numerous service providers, prescriber, school representatives (including assistant principal, school psychologist, special education coordinator and others), and two pastors. SMF ¶ 77.

(footnote continued)

- compiled extensive data on the numbers of screenings and referrals,[24] the results of clinical assessments, and monthly snapshots of all variables pertaining to the ICC network (SMF ¶¶ 79-81).

A complete overview of the Defendants' section-by-section compliance is set forth in the Defendants' Statement of Material Facts and incorporated herein in its entirety.

ARGUMENT

The Court should terminate monitoring and reporting requirements and bring its active scrutiny of the 11-year-old Judgment in this case to a close, for three reasons. First, because the Commonwealth is in substantial compliance with the Judgment, the Court should give effect to the unequivocal language in the Judgment that the monitoring and reporting obligations "will terminate" five years from the date of entry of the Judgment. Second, controlling case law makes clear that where, as here, a governmental defendant has substantially complied with its duties under a court order, a district court may not perpetuate its active involvement in the case without intruding upon the rightful role of state officials charged with administering the state's institutions. Finally, there has never been a finding of contempt—or even a request by the Plaintiffs that such a finding be made—during the 11 years the Judgment has been in place, even as case law makes clear that such a request was the proper vehicle for the Plaintiffs to have disputed the Defendants' compliance with the Judgment.

I. The Judgment Expressly Provided that Monitoring and Reporting Requirements Would "Terminate" in 2012, and the Court Should Now, Based on the Substantial Compliance Showing, Give Effect to that Mandate.

The Judgment's final paragraph provides that, while the Court would retain "ongoing jurisdiction to ensure implementation," "[t]he Reporting and Monitoring provisions set forth

[24] Between January 1, 2012 and December 30, 2017, providers completed 2,315,665 behavioral health screens, and 8.12% of those screens indicated referral or follow-up was required. SMF ¶ 79.

[above] *will terminate* five years after the date of entry of this Judgment." Judgment ¶ 52 (emphasis added). The Court should now give effect to that mandate.

As an initial matter, the Commonwealth's implementation of the Judgment has been robust, enthusiastic, and complete, resulting in a comprehensive system of care in 2018 that bears no resemblance to that surveyed by the Court in 2004. Indeed, 12 years after the Court's finding of the legal deficiencies of the Commonwealth's system of behavioral health care for children with SED, that system has been supplanted by a new array of diagnosis and treatment services, all implemented in accordance with the terms of the court's order. Where MassHealth-eligible families previously were not adequately told about the availability of EPSDT services, *see Rosie D.*, 410 F.Supp.2d at 33 (FF 7), eligible members now receive clear and specific notices, both upon their enrollment in MassHealth and then annually thereafter. SMF ¶ 7. Where clinical assessments for children suspected of having SEDs were once so rare as to invite the Court's cynicism, *see Rosie D.*, 410 F. Supp. 2d at 34 (FF 21) ("The simplest way to escape the challenge of serving an SED child is to avoid conducting the sort of assessment . . . that will reveal the real extent of that child's medical needs,"), the Commonwealth now requires all primary-care providers to perform regular screenings using a tool from an array of approved and regularly updated screening tools, SMF ¶ 17, and, when appropriate, to refer those with positive diagnoses to a behavioral-health clinician, who will commence treatment by performing a clinical assessment. SMF ¶ 24. Further, where many children experiencing a mental-health crisis were previously treated in an institutional setting, for lack of any practicable alternatives, *see Rosie D.*, 410 F. Supp. 2d at 35 (FF 22), the Commonwealth's MCI service now provides rapid response, at the location of one's choosing, at all hours of the day or night. SMF ¶ 56.

The most critical vacuum the Court identified in 2004—the absence of any meaningful

coordination of care, integrating a child's various clinicians into a single unit with a clear objective, *see Rosie D.*, 410 F. Supp. 2d at 38-39 (FF 38-43)—has been filled by the ICC service, which provides each child who needs and wants it with a dedicated care coordinator, an individualized treatment plan, a Care Planning Team (comprised of family, school personnel and other stakeholders), and ready access to other medically necessary services, all delivered in a home- or community-based setting. SMF ¶¶ 46-54. While a variety of factors can impact the time it takes for a child to begin receiving ICC services, since 2010, 78 percent of new referrals have begun treatment within 14 days, and the average wait time to obtain ICC is 11 days, with more than half of members beginning treatment within three days. SMF ¶ 47.

These changes are the direct result of the Commonwealth's compliance in full with the court order. As set forth above and in greater detail in the accompanying Statement of Material Facts, the Commonwealth has completed every task set out for it in the 2007 Judgment. *See*, *supra*, pp. 19-29; SMF ¶¶ 1-86. The Commonwealth has:

- Satisfied Sections I.A. and I.E.1 by taking steps to inform not only the universe of EPSDT-eligible families, but also behavioral-health providers, child-serving agencies, and other interested parties about how children could receive screenings and what services were available for children diagnosed as having SEDs. *See*, *supra*, pp. 19-21 & SMF ¶¶ 9-18.

- Complied with Sections I.A.2, I.A.3, I.B, and I.E.1 by ensuring that all EPSDT-eligible children are offered screenings for the presence of SEDs, using standard and reliable screening tools. *See*, *supra,* pp. 21-22 & SMF ¶¶ 19-25.

- Met the requirements in Sections I.B and I.E.1 by ensuring that children found to have an SED receive a prompt assessment and treatment plan upon commencing behavioral health treatment. *See*, *supra*, pp. 22-23 & SMF ¶¶ 26-32.

- Executed the requirements in Sections I.C, I.D and I.E.1 by completing the administrative steps necessary to create the required remedy service, to build a network to deliver the services, and to coordinate with federal authorities to receive the necessary federal approvals to implement the new services. *See*, *supra,* pp. 23-28 & SMF ¶¶ 33-45.

- Completed the requirements of Section I.C, I.D.1 and I.D.2 by implementing remedy services in three broad areas: Intensive Care Coordination, Crisis Management and Community-Based clinical services. *See, supra*, pp. 25-26 & SMF ¶¶ 46-54 (Intensive Care Coordination); *supra* pp. 26-27 & SMF ¶¶ 55-61 (Crisis Management); and *supra* pp. 27-28 & SMF ¶¶ 62-68 (Community-Based clinical services).

- Fulfilled the information technology development and data collection requirements in Sections I.E.1 and I.E.2 of the Judgment with robust and comprehensive data collection efforts. *See, supra,* pp. 28-29 & SMF ¶¶ 72-86.

A key indication of the success of the Defendants' implementation can be seen in the avoidance of hospitalizations and the other 24-hour level of care admissions by youth who receive remedy services. In State Fiscal Year 2017, for example, 82% of youth who received remedy services had no behavioral health-related hospitalization or other 24-hour level of care admission during the year. And even among those youth who received MCI—youth who might otherwise have been immediately admitted to a 24-hour facility to deal with a crisis—60% of these youth also showed no behavioral health-related hospital or other 24-hour level of care utilization during the year. Indeed, the Association of Behavioral Healthcare recently lauded the Commonwealth's system as being "incredibly successfully in keeping children and adolescents in their homes, schools, and communities." *See* Affidavit of Marylou Sudders, Massachusetts Secretary of Health and Human Services ("Sudders Affidavit"), ¶15 and Ex. 2.

In fact, the success of the remedy—and the remedy services—has become so evident that advocates and families with *private* insurance are now supporting efforts to require private insurers to cover a set of services largely identical to those covered by MassHealth as a result of the successful implementation of the Judgment. *Id.* ¶¶ 13-15.

Nor is there is any reason to suspect that the gains achieved by the Commonwealth in implementing the Judgment will be ephemeral, or will evaporate in the absence of Court oversight. Since 2012, when the Commonwealth first asserted it had come into compliance

with the Judgment, the Defendants have continued to make broad and sustained efforts to improve the quality of their network.

Moreover, the Commonwealth has demonstrated commitments to the continued viability of the remedy outside of the confines of the Court's oversight as well. For example, the Commonwealth obtained federal authority to invest over $7 million in infrastructure and capacity building for CSAs over five years. *Id.* ¶ 10. These funds will be used by CSAs to achieve specific, measurable gains in areas such as enhancing integration between the CSA and primary care, increased training of CSA staff in the wraparound model and reflective supervision and improving or implementing electronic health records. *Id.* The Commonwealth is also making additional resources available to the clinicians who serve as providers of remedy services – such as opportunities to apply for student loan repayments and providing standardized training in high-fidelity wraparound and behavioral health integration. *Id.* ¶ 11. These investments will help ensure that the CSAs and other remedy providers are equipped to continue delivering high quality services to MassHealth members for years to come.

In light of the Defendants' compliance (which continues to this day) and the changes it has fostered, the only appropriate course for the Court at this juncture is to terminate active monitoring and reporting requirements and to discontinue active judicial oversight of the Judgment. For all these reasons, there is simply no need for the Court to continue to oversee these efforts. Accordingly, it should give effect to paragraph 52 of the Judgment and terminate the Commonwealth's monitoring and reporting requirements.

II. Where State Government Defendants Have Substantially Complied With a Judicial Order in an Institutional Reform Case, There is No Basis for Ongoing Court Oversight.

Even if the Court had not prescribed an end date to active judicial oversight, it could not justify continuing oversight indefinitely, where, as set forth above, the Defendants have

demonstrated their compliance with each command of the Judgment. As the Supreme Court first articulated in *Milliken v. Bradley*, 433 U.S. 267, 282 (1977), and then explained more clearly in *Horne v. Flores*, 557 U.S. 433 (2009), a federal court has jurisdiction to adjudicate an alleged violation of substantive federal law. Once such a violation has been found, the court may retain jurisdiction to oversee the implementation of a remedial order—but only while the adjudicated violation remains ongoing and until the provisions of the remedial order are satisfied. *Id.* at 450. In these cases, federal courts must take great care to "ensure that 'responsibility for discharging the State's obligations [is] returned promptly to the State and its officials' when the circumstances warrant." *Horne*, 557 U.S. at 450, quoting *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 442 (2004). Federal-court oversight will "exceed appropriate limits" if its focus strays from eliminating a condition that the court identified as violating federal law. *Milliken,* 433 U.S. at 282. To continue judicial oversight beyond this point is to transgress not only the limitations imposed by federalism, but also to intrude upon the separation of powers. *Horne,* 557 U.S. at 450-451, citing *Frew*, 540 U.S. at 441 (where a federal decree extends past considerations necessary and reasonable to remedy a federal-law violation, it may "improperly deprive future officials of their designated legislative and executive powers"). The *Horne* court went on to observe that "as public servants, the officials of the State must be presumed to have a high degree of competence in deciding how best to discharge their governmental responsibilities." 557 U.S. at 442.

A district court in this circuit properly took notice of these concerns when it considered a motion by defendants, pursuant to Fed. R. Civ. P. 60(b)(5), to terminate an ongoing consent decree arising from conditions in the state's residential mental-health facilities, on the ground

that the purposes of the decree had been met.[25] In *Consumer Advisory Board v. Harvey*, 697 F. Supp. 2d 131 (D. Me. 2010), the court found that, under the tenets of *Horne*, "perpetual oversight of state government programs is improper absent a record of ongoing violations of federal law." *Id.* at 137. It noted that, in deciding whether continued enforcement of a decree is appropriate, "the Court must consider whether the objectives of the Decree have been satisfied and whether a durable remedy has been implemented." *Id.* at 138, quoting *Horne*, 129 S. Ct. at 2595 ("If a durable remedy has been implemented, continued enforcement of the order is not only unnecessary, but improper."). Reviewing the actions that the State of Maine had taken in response to the decree, the court noted that because the record showed that "Defendants have the commitment and mechanisms to continue to provide a system that will protect the class members' rights under the Constitution and federal law," "continuing to monitor Defendants

[25] To reiterate: the Commonwealth is not asking to modify or terminate the Judgment in this case, and accordingly the dictates of Fed. R. Civ. P. 60(b) do not apply. Even under that standard, however, the Court is divested of authority to continue to enforce a remedial decree when the defendants have already effectuated it.

Horne and *Consumer Advisory Board*, like most cases in this area, arose when the state defendant sought relief from a district court's remedial decree, in the form of an order to terminate the operation of the decree. As both of those courts observed, the proper vehicle for making such a request was a motion to modify the judgment, pursuant to Fed. R. Civ. P. 60(b)(5). As noted above, the Commonwealth is making no such request here, as the Judgment itself, as written, already provides for the relief—termination of monitoring and reporting requirements—that the Defendants seek. Therefore, those cases' discussion of the requisite showing a movant must make to modify a remedial decree have no application to this case. Those cases' more general discussion of the factors constraining a court's equitable power to continue to enforce its own judgment are very much on point, however, as they caution strongly against perpetuating judicial oversight where, as here, a remedial order has been complied with.

(footnote continued)

for compliance with the Consent Decree's numerous requirements is inequitable." *Id.*[26]

This Court has repeatedly acknowledged these principles as well. In its February 22, 2007, Memorandum and Order Regarding Remedy, the Court, citing *Lewis v. Casey*, 518 U.S. 343, 362 (1996), recognized the "sovereignty of the Commonwealth and the competence of its officials," and emphasized the Court's obligation to "defer to the judgment of [state] authorities" and "to avoid extensive intrusiveness." *See* Docket No. 354, p. 3. Then, in its July 16, 2007, Memorandum and Order Regarding Judgment, the Court stated it had "no desire to retain jurisdiction any longer than required to insure implementation of the remedy" and invited the Commonwealth "to move to terminate the court's jurisdiction at any time that a remedy is securely in place …." Docket No. 368, p.8.

Thus, where the Defendants have completed all of the tasks set out for them in the 2007 Judgment and, moreover, where they have created and maintained an integrated system of care that acts as a durable remedy for the violations of the Medicaid Act that the Court found after trial in 2006, the principles of federalism and separation of powers compel this Court to terminate the active monitoring and reporting requirements and to discontinue active judicial oversight of the Judgment.

III. To the Extent that Plaintiffs Dispute Defendants' Compliance with the Judgment, Their Proper Remedy Was to File a Complaint for Contempt—a Step They Have Not Taken During the Eleven Years the Judgment Has Been in Effect.

Finally, as noted above, the Defendants have maintained, since the date of their May 2012 filing, that they have been, and continue to be, in substantial compliance with the

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[26] The *Consumer Advisory Board* court also rejected the suggestion that the standard for terminating judicial review was different for consent decrees than for litigated judgments: "federalism concerns remain at the forefront regardless of whether the consent decree from which state officials seek prospective relief was entered as the result of a trial or a settlement" (citing *Frew*, which involved a consent decree, and *Horne*, which did not). *Id.* at 138.

Judgment. To the extent that Plaintiffs contend that the Defendants are, or have been, out of compliance with the Judgment, the proper vehicle to test that assumption was to have filed a motion for contempt to cure the purported violation. *See Hawkins v. Dep't of Health & Human Servs. for N.H.*, 665 F.3d 25, 30 (1st Cir. 2012) ("It is well settled in the law that a motion for contempt is the proper way to seek enforcement of [the] decree.").

But here the Plaintiffs never filed a motion for contempt, never made a showing "with clear and convincing evidence" that the Defendants were out of compliance with any aspect of the remedial decree, and never demonstrated any relationship between any asserted (but unproved) non-compliance and any proposed supplemental order by the Court. *See id.* at 31-32. And even if the Plaintiffs had cleared those three hurdles, there was still a fourth—that the Court, before making any finding of contempt, had to address MassHealth's defense that it has been in substantial compliance with the Judgment since 2012. *See id.* at 31 n.7 ("Even if the plaintiff is able to prove each of the elements [of contempt], a court may exercise its discretion and decline to make a finding of contempt where the defendant has been substantially compliant with the terms of the underlying order"). The Plaintiffs have not met this burden and the Court has never found Defendants out of compliance with the Judgment.

Indeed, it was not until 2017 that the Plaintiffs filed a request to modify the Judgment – and then it was a motion to add new obligations not found in the original court order. Even that motion, however, was not accompanied by a sufficient evidentiary showing that either (a) there was good cause to modify the Judgment (as set forth in the Judgment itself, at para. 50), or (b) there had been a "significant change either in factual conditions or in law" that warranted modification of the decree (as required by *Ricci v. Patrick*, 544 F.3d 8, 20-21 (1st Cir. 2008)). The Court properly denied that motion. Given the Defendants' compliance with the Judgment in all respects, and the Plaintiffs' failure to prove otherwise, the Court should end monitoring

and close the active phase of this litigation.

CONCLUSION

For the reasons set forth above, the Court should find that the Commonwealth has substantially complied, in all material respects, with this Court's 2007 Judgment. Accordingly, the Court should give effect to Paragraph 52 of that Judgment, and should forthwith terminate all of the Defendants' monitoring and reporting requirements under the Judgment, and should bring to a close all active judicial oversight of the Commonwealth in this matter.

Respectfully submitted,

MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

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Date: August 6, 2018

CERTIFICATE OF SERVICE

I, Daniel J. Hammond, Assistant Attorney General, hereby certify that the foregoing document, which was filed through the ECF system, will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on August 6, 2018.

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