UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al., Plaintiffs, v. CHARLES BAKER, et al., Defendants.	C.A. No. 01-30199-MAP

Plaintiffs' Reply to Defendants' Opposition to Motion to Approve and Order Disengagement Measures, Actions to Improve Access to Remedial Services, and Provisions on Outpatient Services

I. Introduction

Defendants' Opposition to Plaintiffs' Motion to Approve and Order Disengagement Measures, Actions to Improve Access to Remedial Services, and Provisions on Outpatient Services (Doc. 858)(hereafter "Opposition" and "Motion") grossly misrepresents the plaintiffs' renewed Motion, and fails to acknowledge the factual and procedural context in which it is filed.

First, the defendants mischaracterize the legal basis for the Motion, ignoring detailed arguments regarding the Court's authority to enforce, modify and clarify its own Judgment, and suggesting instead that the Motion rests entirely on defendants' failure to achieve agreed upon disengagement standards. On the contrary, the plaintiffs have clearly set forth detailed legal arguments regarding: 1) why the Court should adopt the Disengagement Measures as exit criteria pursuant to its authority to clarify the standards for substantial compliance; 2) why modification of the Judgment is appropriate based on significant changes in Defendants' ability to ensure timely access to services, and the impact of their decision to rely on outpatient therapists as care coordinators for thousands of SED youth; and 3) why enforcement of EPSDT, and the defendants' own Medicaid access standards, is required in order to remedy ongoing violations of federal law.

The Opposition also fails to address the myriad undisputed data presented by the plaintiffs – and generated by the State – demonstrating the need for further orders to ensure compliance with the Judgment. Instead, the defendants inexplicably assert that the plaintiffs have failed to present any admissible evidence that demonstrates the need for remedial actions, or provide other evidence of ongoing violations of federal law. This is simply wrong.

The defendants' argument disregards years of efforts to address well-documented failings in implementation of the Judgment through the disengagement process. It ignores months of

judicial admonitions to describe concrete remedial actions to redress delays in timely access to services,[1] and statements by the Court concerning the importance to class members of effective care coordination, regardless of which "hub" defendants use to deliver it.[2] Finally, the defendants' arguments appear divorced from the current posture of the case, and the concurrent filing of the Plaintiffs' Opposition to Defendants' Motion for Substantial Compliance and to Terminate Monitoring and Court Supervision (hereafter "Pls.' Opp. to Substantial Compliance")(Doc. 857)which the plaintiffs incorporate here by reference.

Contrary to the defendants' assertions, and as discussed in more detail below, the plaintiffs have demonstrated the basis for, and the necessity of, further orders, as well as the extent to which those proposed orders are reasonably tailored to address noncompliance or changed circumstances that warrant modification of the Judgment. Additionally, the Motion details multiple sources of legal authority under which the Court may issue those orders, including the availability of enforcement vehicles other than a motion for contempt.

II. The Court Can and Should Enforce Its Orders Without the Necessity for Holding State Officials in Contempt.

A. There Is Ample Admissible Evidence of Noncompliance with the Judgment and with the Medicaid Act.

Both the Motion, and the Opposition to Substantial Compliance, rely on systemic data created by the defendants which undisputedly demonstrates ongoing violations of the reasonable promptness provisions of the Medicaid Act, which is part of the Judgment.[3] *See, e.g.*, Doc. 847

[1] *See, e.g., Rosie D.* Tr. at pp. 6-7:24-11(January 16, 2018) ("[W]hat I'm really looking for is concrete steps that the defendants are taking that have a realistic possibility of making a substantial difference in terms of access.").
[2] *Rosie D.* Tr. at p. 50:4-12 (April 6, 2017) ("Okay, we're going to do intensive care coordination, but we're not going to do it with the same acronym. … They still have to do extensive care coordination. If they fail to do that, then they're in violation of the remedial order.")
[3] The Court's liability decision found a violation of EPSDT and the reasonable promptness provisions of the Medicaid Act. *Rosie D. v. Romney*, 410 F.Supp.2d 18, 53 (D. Mass. 2006). As a result, its Judgment required that the defendants ensure all remedial services are provided promptly. *Rosie D. v. Patrick*, 497 F. Supp. 2d 76 (D. Mass. 2007)

at 5-6; Doc. 858 at 20-24. Throughout their pleadings, the plaintiffs describe persistent noncompliance with the State's own Medicaid access standards, which the defendants do not – and cannot – deny.[4]

This failure is compelling, admissible evidence of an inability to provide medically necessary services with reasonable promptness, as required by EPSDT. Additionally, Plaintiffs' Opposition to Substantial Compliance cites to the specific provisions of the Judgment where continued jurisdiction is needed to achieve compliance with CANS assessments, delivery of care management, and adherence to program specifications and standards. *See* Doc. 857 at 18-24 (incorporating the facts and arguments contained in plaintiffs' original motions and supporting memoranda on Disengagement Measures (Doc. 762 and 768), Outpatient Services (Docs. 777 and 778), and Actions to Improve Access (Doc. 836). The defendants' assertion that this evidence is not adequately connected to or well-suited to determining compliance with, the Court's remedial order is misplaced. *See* Doc. 858 at 5, 8.

Over the past year, the Court has received detailed briefings on excessive wait times for Intensive Care Coordination (ICC), In-Home Therapy (IHT), and other remedial services.[5] It has heard the parties acknowledge, and received reports demonstrating, the extent to which existing

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> The court's liability decision was anchored on its finding that the requirements of the Medicaid statute's EPSDT and "reasonable promptness" provisions had not been satisfied for very many class members. The remedy for this violation necessarily requires a number of initiatives by Defendants that are not explicitly spelled out in either of the violated provisions. … The court has the responsibility to insure that Defendants take whatever actions are reasonably necessary to remedy the violations found in its judgment on liability.

Id. at 79.

[4] The defendants' own September 13, 2017 Status Report on Implementation (Doc. 813) included data evidencing noncompliance with the access requirements for ICC and IHT in the Joint Disengagement Measures, and, by implication, with their own Medicaid access standard and Medicaid performance specifications created pursuant to the Judgment. *See* Doc. 813-1. This admission was confirmed in the defendants' November 17, 2017 Status Report on Implementation. Doc. 820 at 1.

[5] *See, e.g.,* Doc. 820; Doc. 822; Doc. 836; Doc. 836 Exhibits 1-3; Doc. 847.

service system capacity is unable to keep up with demand for critical services like IHT.[6] The FY2017 State Outpatient Report (Doc. 828-1), and the Monitor's own independent review of outpatient services, have called into question the adequacy of existing care coordination for youth in outpatient therapy.[7] And the client review process created by defendants – the Massachusetts Practice Review (MPR) – has identified persistent, systemic problems with the delivery of ICC and IHT, including the adequacy of assessments, treatment planning, and care coordination.[8]

As a result, there is no shortage of data before the Court documenting noncompliance with the Judgment, and ongoing violations of the federal Medicaid provisions it was intended to remedy. This data is generated by the State and its contractors. For years it has been routinely shared with the Court, the Monitor, and the plaintiffs as evidence of the status of implementation.[9] Both the State and its managed care agents routinely rely on this information in conducting quality assurance activities, and monitoring the remedial service system. As such, it is clearly admissible under Rule 801(d)(2)(B).[10]

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[6] *See, e.g.,* Rosie D. Tr. pp. 31:19-32:3; 33:15-21; 36:22-37:10; 39:5-10 (October 4, 2017); Defendants' Report on Actions Related to Joint Disengagement (Doc. 826 at 4) ("Rather, limited system-wide ICC capacity is driving the current access problem."); Doc. 847 at 5 (citing Plaintiffs' Memorandum to Improve Access to Remedial Services, Doc. 836 at 3; 836-1 (defendants' monthly IHT provider access report).

[7] *See* Plaintiffs' Thirty-Fifth Status Report (Doc. 828 at 8-10) for a detailed discussion of the FY2017 Outpatient Report findings.

[8] Plaintiffs' Opposition to Substantial Compliance documents those specific areas of the Judgment in which continuing jurisdiction of the Court is necessary to achieve compliance. For instance, plaintiffs identify, and provide exhibits demonstrating the need for continuing jurisdiction over, provisions governing comprehensive assessments (Judgment ¶¶13-16); the core services of ICC and IHT (*Id.* ¶¶ 19-20, 33, 38); and adherence to program specifications and practice requirements (*Id.* ¶38(c)). As noted above, the plaintiffs also point to the defendants' failure to provide medically necessary services with reasonable promptness, as defined by program specifications (*Id.* at ¶38) and state Medicaid access standards required under 42 C.P.R. §440.56(e).

[9] Given this long-standing, collective reliance on waiting list data, access reports, and annual MPR reviews, and the state's exclusive control over this information, is it remarkable that the defendants would now seek to disavow the accuracy and reliability of that data for purposes of measuring compliance. *See* Doc. 858 at 8, n.4.

[10] The applicable test is "whether the surrounding circumstances tie the possessor and the document together in some meaningful way." *Pilgrim v. Trusts of Tufts College,* 118 F.3d 864, 870 (1st Cir. 1997) (holding Report was non-hearsay adoptive admission where "party accepted and acted upon evidence"), *abrogated on other grounds*, *Crowley v. L.L. Bean, Inc.,* 303 F.3d 387 (1st Cir. 2002), *citing United States v. Paulino,* 13 F.3d 20, 24 (1st Cir. 1994).

The defendants seek to minimize the import of other evidence, including declarations provided by the Parent Professional Advocacy League (PPAL)(Doc. 847-4) and the Association of Behavioral Health (ABH)(Doc. 847-5). Although they question the *per se* admissibility of these affidavits, they do not dispute the first-hand knowledge and long-standing roles these organizations have played in the implementation and monitoring of the Judgment.[11] With regard to Ms. Lambert's affidavit, the defendants wrongly suggest that the reliability or ultimate admissibility of her testimony turns on the identification of individual youth and families who confidentially reported problems accessing medically necessary services, or whether the State h ad notice and opportunity to remedy their problems. *See* Doc. 858 at 9, 11. Yet even without the testimony of key stakeholders like PPAL and ABH, there is quantitative, undisputed evidence of noncompliance sufficient to justify invoking this Court's inherent authority to clarify, modify and enforce its Judgment.

B. The Court Need Not Make a Formal Finding of Contempt in Order to Enforce Its Judgment.

The Opposition claims, rather remarkably, that the Court is powerless to enforce its Judgment absent a motion for contempt and a finding of contemptuous conduct, even if it otherwise finds a violation of either its Judgment or federal law. This novel argument claims support in the First Circuit's decision in *Ricci v. Patrick*, 544 F.3d 8, 22 (1st Cir. 2008). But the Court held in *Ricci* that a district court may enforce its own remedial order, having determined that the defendants have failed to comply with a material requirement of the Judgment, or that an identified federal-law violation in the original Judgment is ongoing. Plaintiffs agree. Nowhere

[11] *See, e.g.,* Doc. 847-4 ¶¶ 1-5; Doc. 847-5 ¶¶ 2-5.

does the Court suggest that a petition for civil contempt is the only vehicle through which this enforcement can occur.[12]

None of the cases cited in the Opposition support their contention that the ***only*** method for a court to enforce its own order is through a contempt action. Defs' Opp. at 4-5. In contrast, the Motion describes in detail the Court's authority to enforce its Judgment, and to fashion relief that will secure the federal rights of class members. Pls.' Motion at 11-13. Courts have inherent authority to protect their judgments and enforce their own orders without making a finding of civil contempt. *S.E.C. v. AmeriFirst Funding, Inc.,* 2010 WL 997388, *8 (N.D. Tex. Mar. 18, 2010) (enforcing order "without finding that . . . [the target had] acted contemptuously), *citing Degen v. United States,* 517 U.S. 820, 827 (1996) ("A federal court has at its disposal an array of means to enforce its orders .... [I]ts powers include those furnished by federal rule and by inherent authority . . . . The details of these steps are committed to the discretion of the District Court."). Therefore, the absence of a motion for contempt does not preclude the Court from taking actions necessary to clarify, modify or enforce its Judgment, or to remedy any ongoing violations of federal law.

III. The Court Can and Should Modify Its Judgment to Require Specific Actions to Ensure Compliance with the Judgment.

A. There Is Ample Evidence of Changed Circumstances to Warrant Modification.

The plaintiffs have laid out in detail, over multiple pleadings, the legal and factual basis for modification, including the extent to which the proposed orders concerning timely access to remedial services and provisions on outpatient services are reasonably tailored to achieve the objectives of the Judgment. *See* Doc. 777 at 2-5; Doc. 847 at 10-11, 17-18. Those arguments are not repeated here. However, the plaintiffs do address the defendants' attempt to reframe the

[12] Since this Court's Judgment was not a consent decree, any prudential limitations on subsequent orders to enforce a consent decree are not relevant here.

change in circumstances prompting these motions, and the assertion that there is no evidence warranting modification.

As noted above, lengthy waiting lists and insufficient provider capacity to ensure timely access to remedial services[13] are well-documented problems, particularly for ICC. Doc. 847 at 5-6, 16. In 2010, the defendants succeeded in enlarging the State Medicaid access standard for ICC from 3 to 14 days, and yet waiting lists remain a persistent barrier to treatment, impacting youth and families across the state. *Id.* at 16-17. The defendants' inability to meet even this expanded access standard,[14] and their recent unwillingness to take meaningful actions to improve access,[15] are more than sufficient to trigger the Court's authority to clarify, modify or enforce its Judgment, and in so doing to remedy ongoing violations of federal law. *Id*. at 14-15.

Similarly, the defendants' decision to create three clinical "hub" services, and to delegate responsibilities for referral to, and oversight of, remedial services to IHT and outpatient therapists, significantly altered the way in which care coordination was intended to be delivered under the Court's Judgment.[16] Doc. 777 at 3-5. The defendants now seek to reframe this debate as an effort by the plaintiffs to re-litigate the Court's final Judgment, yet the opposite is true. The plaintiffs originally advocated for all service coordination to be delivered through ICC, consistent with the Judgment, and have long expressed concern that outpatient therapy – a

[13] Timely access to remedial services in general, and to Intensive Care Coordination (ICC) and In-Home Therapy (IHT) in particular, are governed by: (1) the State's own EPSDT 14 day access standard; (2) the reasonable promptness provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(8); and (3) the Court's Judgment.

[14] The EPSDT regulations at 42 C.F.R. § 441.56(e) (1984) require that the State Medicaid Agency "must set standards for the timely provision of EPSDT services, which meet reasonable standards for medical and dental practice ... and must employ processes to ensure timely initiation of treatment…."

[15] *See Rosie D*. Transcript, p. 23:15-20; 27: 24-28:1 (April 26, 2018) ("And what I keep hearing is, "Well, we don't know how to solve the problem, and we keep trying this and we're trying that."); 32 6-7 ("I am coming away with no confidence that we have a plan to deal with the access issue.").

[16] In approving the Final Judgment, the Court observed that "[I]ntensive care coordination is a crucial element of the remedial plan adopted by the court. The absence of this service for most class members constituted one of the major shortcomings in Defendants' Medicaid service network; the deficiency was at the root of the court's finding that a violation of the Medicaid statute had occurred. *Rosie D. v. Patrick*, 497 F. Supp. 2d 76, 78 (D. Mass. 2007).

service this Court originally determined to be inadequate to meet the needs of youth with SED[17] – would be unable to deliver this key remedial service consistent with the requirements of the Judgment. *See, e.g.*, Doc. 777 at 1-2, 4. The State's own reports and analysis of care coordination in outpatient therapy have borne out this concern.[18] And despite agreed upon disengagement measures, the defendants have increasingly distanced themselves from any affirmative obligation to ensure that youth in outpatient have access to medically necessary remedial services, including adequate coordination, making the Court's ability to incorporate basic service coordination requirements for outpatient therapy even more critical. Doc. 857 at 29, n. 18.

B. The Proposed Orders Are Sufficiently Tailored to Address the Changed Circumstances.

In response to the Motion, the defendants offer a blanket assertion that proposed actions to address wait times for ICC and IHT are unlikely to succeed. Doc. 858 at 16. Yet somewhat inexplicably, the defendants go on to state that, at least as to certain aspects of these proposed orders (recommended increase in the IHT rate and recommended adoption of a day rate for ICC), the Commonwealth has already taken steps to adopt them. *Id*. at 15-16. Notably, the Opposition omits the rate at which ICC providers will be reimbursed per day because that proposal is so far below what the State previously paid during the two year pilot.[19] ABH has submitted an

[17] *Rosie D*., 410 F. Supp. 2nd 18, 38-39, 52-53 (D. Mass. 2006).
[18] *See, e.g.,* Plaintiffs' Report on Outpatient Therapy (Doc. 723); Plaintiffs' Report on Appropriate Service Coordination in Outpatient Therapy (Doc. 740) and Plaintiffs' 32nd Status Report (Doc. 751); *see also*, FY2017 Outpatient Report (Doc. 857-14).
[19] On the one hand, the Opposition suggests that most CSAs are breaking even, and, therefore, should have sufficient funds to invest in staff recruitment. Yet persistent waiting lists, and the defendants' own repeated identification of workforce problems, suggest otherwise. Doc. 858 at 19 ("…stagnant capacity caused by workforce shortages is precisely the issue constraining access to IHT and ICC."). *See, e.g.* Rosie D. Tr. pp. 8:23-9:1(January 16, 2018)(Mr. Simons: "The big problem is serious workforce shortages which have an impact on our program on multiple dimensions, not just access.")

affidavit declaring that this proposed rate is insufficient to sustain or advance the initial benefits in staffing and improved provider capacity seen under the day rate pilot. Doc. 847-5 ¶¶6-7.[20]

Other key aspects of the plaintiffs' proposed orders remain unaddressed, including actions to expand IHT service capacity, manage ICC providers with persistent access problems, and conduct a comprehensive rate review for IHT and other remedial services, evaluating whether the current rate structure allows providers to deliver remedial services as defined by the Judgment and consistent with the State's own program specifications. Doc. 847-5 ¶¶9-12.

The plaintiffs' proposed orders are responsive to this Court's request for concrete actions designed to improve timely access to services, address identified barriers to expanding provider capacity, and respond to unmet demand for remedial services. They are narrowly tailored to address changed circumstances, promote compliance with federal law, and achieve the purpose of the Judgment. Finally, the proposed orders are realistic, based on an expectation of incremental progress over time, and measured – in large part – using terms and data sources previously agreed to by the parties.

IV. Conclusion

The Court has already recognized the potential need for further orders to secure compliance with its Judgment, including modification, when it denied the Plaintiffs' initial Motions without prejudice:

> This court manifestly possesses the power to enforce these measures [and the State's access standards] to the extent necessary to ensure compliance with the Remedial Order. The fact that these measures [and access standards] have been agreed to voluntarily – as an expression of good faith on the part of both parties – does not in any way undercut the court's responsibility to ensure that the Remedial Order is fully complied with through

[20] As noted in earlier pleadings, the plaintiffs' efforts to enforce these statutory provisions, and to assure compliance with the Court's Judgment, do not convert their Motion and Proposed Order into a legal claim under § 1396a(a)(30)(A). Doc. 842 at 8-9. Nor do they seek to revisit this Court's 2006 ruling regarding private rights of action to increase rates. Thus, the defendants' legal arguments about the private enforceability of this section of the Act are irrelevant, given the Court's inherent authority to enforce its Judgment. Doc. 858 at 14.

the implementation of the disengagement measures [and access standards].

Id. at 3. [21]

Since that time, the undisputed facts and evidence make clear that youth and families are not receiving medically necessary services with reasonable promptness, as defined by the State's own Medicaid access standard, program specifications, and federal Medicaid law. While the defendants have long argued disengagement efforts in this case are purely voluntary – and even aspirational – this Court has recognized them to be an embodiment of the final phase of compliance with the Court's original remedial order.[22]

For these reasons, and in order to secure the full benefit of its Judgment for youth with SED and their families, the Court should exercise its authority to clarify the standards for compliance by ordering the proposed Disengagement Measures (Doc.847-1), enter a further order to enforce timely access to remedial services (Doc. 847-2), and modify its Judgment to ensure SED youth who rely on outpatient therapy for care coordination receive that service consistent with the basic requirements and expectations set out in the Judgment. (Doc. 777-1).

RESPECTFULLY SUBMITTED,
THE PLAINTIFFS,
BY THEIR ATTORNEYS,

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[21] In its opinion, the Court noted that "[I]f developments over the coming months suggest that a formal ruling or amendment to the Judgment is necessary, one or both of the motions may be refiled." Order re: Plaintiffs' Motion to Approve Joint Disengagement Measures, September 27, 2017 (Doc. 815).
[22] *Rosie D*. Tr. 20:1-5 (April 6, 2017)

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was filed electronically through the Electronic Case Filing (ECF) system to all counsel of record.

Dated: September 24, 2018 /s/ Steven J. Schwartz