UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

ROSIE D., *et al,*	)	
Plaintiffs,	)	
v.	)	Civil Action No. 01-30199-RGS
CHARLES BAKER, *et al.*	)	
Defendants.	)	

PLAINTIFFS' MEMORANDUM IN SUPPORT OF ITS MOTION TO MODIFY THE JUDGMENT TO INCORPORATE OUTPATIENT THERAPY

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I. Introduction

This Court's 2006 liability decision concluded that effective service coordination was a critical component of home-based services, a form of medical assistance under Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) provision and a medically necessary service for youth with Serious Emotional Disturbance (SED) that was previously absent in Massachusetts. *Rosie D. v. Romney,* 410 F. Supp. 2d 18, 29, 39 (D. Mass. 2006). As this Court noted, "[t]he testimony of guardians, clinicians, and program administrators confirmed again and again the devastating consequences of this service deficiency." *Id*. at 39.

The plaintiffs' proposed remedial plan, submitted in response to that decision, envisioned an array of home-based services procured, coordinated, and monitored by care planning teams and overseen by specially-trained intensive care managers. *See* Pls. Final Remedial Plan, filed August 28, 2006, Doc. 338. So too did the remedial plan ultimately approved by the Court. *Rosie D. v. Patrick*, 497 F. Supp. 2d 76 (D. Mass. 2007). However, during post-Judgment implementation of the remedy, the defendants expanded the list of providers expected to deliver service coordination to class members with SED, including not only Intensive Care Coordinators, but also In Home Therapy (IHT) providers and traditional outpatient therapists.

As discussed in detail below, defendants' decision resulted in a significant, material change in the Court's Remedial Plan – one which left thousands of youth reliant on Outpatient Therapy for access to, and coordination of, remedial services.[1] Plaintiffs' Motion for Modification seeks to memorialize this unilateral change in service delivery and, in so doing, ensure that *Rosie D*. class members receive adequate coordination, regardless of the entity designated to provide the service. The plaintiffs proposed modification is tailored to resolve the

[1] Studies conducted by the Commonwealth, as well as Outpatient Therapy utilization data, demonstrate that there are be thousands of children who rely on this traditional, office-based therapy for referrals to, and coordination of, remedial services. *See* Doc. 723 at 5-6, 8 n. 6 (Plaintiffs' Proposal on Outpatient Therapy).

problem created by this change in fact, by clarifying that outpatient providers tasked with delivering service coordination to youth with SED must perform the same basic activities specified for "Care Managers" under the Judgment.[2] It is necessary to effectuate to a central purpose of the Judgment – providing adequate service coordination to class members with SED. Continuing to enforce the Court's Judgment, without such a modification, would be detrimental to the public interest.

II. Background

A. Defendants' Failure to Deliver Medically Necessary Service Coordination

In 2006 the Court considered the complex behavioral health needs of a class of children and youth with SED. To be effectively treated, these class members needed multiple providers supporting them across home, community, and educational settings. They frequently had one or more state agencies involved in their care, and the acuity of their needs often led to behavioral health crises, increasing their risk of hospitalization or other out-of-home placement. As the Court observed in its liability decision:

> children with SED are particularly challenging to treat because of the severity of their needs and the number and intensity of services they require. The danger for these children, given their complex problems, is that they will not only receive insufficient services, but that a lack of coordination among the service providers will undermine the effectiveness of the treatment that they do receive.

Rosie D., 410 F. Supp. 2d at 32.

[2] "Care Managers" are required to perform the roles and responsibilities described in paragraphs 20-29 of the Judgment, including: "(1) assisting in the identification of other members of the care planning team; (2) facilitating the care planning team in identifying the strengths of the child and family, as well as any community supports and other resources; (3) convening, coordinating, and communicating with the care planning team; (4) working directly with the child and family; (5) collecting background information and plans from other agencies, subject to the need to obtain informed consent; (6) preparing, monitoring, and modifying the individual care plan in concert with the care planning team; (7) coordinating the delivery of available services referral to, and coordination of, medically necessary covered services described in Section D." Judgment at ¶ 22.

After more than six weeks of trial, during which defendants presented existing methods of service coordination and delivery by managed care entities, state agencies and outpatient therapists, this Court found that the Commonwealth had "failed, in the overwhelming majority of instances, to give this essential assistance to children with SED." *Id.* at 39. After an extensive discussion of the importance of service coordination for all children with SED, and its central role in remedying the EPSDT violations identified at trial,[3] the Court concluded that "[i]t is impossible to overstate the importance of active, informed case management or, as it is sometimes called, service coordination for children with SED." *Id.* at 39.

As part of its analysis, the Court opined that youth with SED need a "properly-trained and empowered person" to perform these coordination functions in order to ensure the benefits of treatment planning are actually realized. *Id.* at 31. It went on to specifically describe the type of service coordination that would be adequate to meet the needs of children with SED:

> Such services, in most cases, will necessarily entail designation of a trained individual who (1) meets regularly with the child and his or her family, (2) coordinates necessary diagnostic efforts to ensure that the child's disability is understood, (3) oversees the formulation of a plan to address the child's needs, and (4) takes primary responsibility to ensure that the plan is carried out (by whatever state or private contract agencies may be involved) and appropriately modified as the child's needs evolve.

Id. at 38. In response to these findings, the parties proposed detailed criteria for the provision of service coordination, which were adopted in the Court's final Judgment.[4]

[3] Noting that children with SED have complex service needs, often involving multiple agencies and providers and, as a result, "centralized, knowledgeable, and painstaking service coordination is essential; without it, a child's life becomes a chaos of ineffective, overlapping plans and goals." *Rosie D.,* 410 F. Supp. 2d at 31.

[4] These criteria are enumerated under Section C of the Judgment, titled "Intensive Care Coordination and Treatment Planning."

B. The Importance of Service Coordination Under the Judgment

A central purpose of the Court's Remedial Order was to redress identified EPSDT violations by making service coordination available to all Medicaid-eligible youth with SED. In approving the proposed Judgment, the Court observed that:

> Intensive 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., 497 F. Supp. 2d at 79 (emphasis added). The Court's view of class members' need for, and entitlement to, these services is further evidenced by its decision to approve the defendants' proposed Judgment with specific modifications,[5] including broad eligibility for remedial services. *Id*. at 78-79 (proposed judgment and clinical criteria inappropriately focused on a subset of SED children); *see also Rosie D. v. Romney*, 474 F. Supp. 2d 238, 240 (D. Mass. 2007) (confirming that the Judgment and its remedial services are applicable to all children with SED under either the IDEA or SAMSHA definition of SED).[6]

The Court's 2007 Judgment devoted an entire section to service coordination and service planning, including specific provisions that defined the key roles and responsibilities of care managers, and the specific activities they would be expected to undertake. Judgment at ¶¶ 20-

[5] "Plaintiffs are concerned that the "clinical criteria" in Paragraphs 17 and 18 of Defendants' proposed judgment will substantially reduce the population of SED children ultimately eligible to receive services under the remedial order. The phrasing of Defendants' proposed judgment creates an ambiguity that might permit the clinical criteria to undermine the remedial order's broader eligibility standards. The court shares this concern." *Rosie D.*, 497 F. Supp. 2d at 78.

[6] "First, since the Medicaid statute does not itself define a child suffering from a "serious emotional disturbance" ("SED"), the governing definition for an eligible SED child under the remedial plan will be the definition set forth in the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1401(3)(A)(i) and its implementing regulations *or* the definition set forth in the regulations governing the Substance Abuse and Mental Health Services Administration ("SAMHSA") of the United States Department of Health and Human Services.[1] Any child satisfying the SED criteria used in the IDEA *or* by SAHMSA, or both, will be eligible for services. While, of course, Defendants will be free to make clinical decisions based on the needs of the individual children, no language in Defendants' proposed plan (if any) appearing categorically to narrow the definition of class of children eligible for services will have any force or effect. It is worth noting that Defendants disavow any narrowing of the class of eligible children under their proposal, beyond what is set out in the IDEA or by SAHMSA. This proviso clarifies that point." *Rosie D.*, 474 F. Supp. 2d at 240.

29. It did not address Outpatient Therapy; nor did it envision the delivery of remedial service coordination by outpatient providers. However, after the Judgment was approved, the defendants implemented a system in which Outpatient Therapy played an important role in the delivery of remedial services. They did so despite the Court's findings on the limitations of the existing services system, and over the plaintiffs' repeated objections. The resulting *de facto* modification of this Court's Order has never been formally incorporated into the Judgment.

C. Defendants De Facto Modification of Service Coordination

Following entry of the Court's Judgment and Remedial Plan (Doc. 367-2), the defendants determined that – in addition to Intensive Care Coordinators – outpatient therapists and In Home Therapy providers would also have responsibility for providing service coordination to class members with SED. Doc. 777 at 1-2. It then made access to other remedial services dependent on receipt of one of these three coordination services or "hubs." Not only does this decision mean that children and youth could not directly access remedial services like Therapeutic Mentoring, Family Support and Training, and In Home Behavior Therapy, it also meant that outpatient therapists must provide referrals to, and support the provision of, remedial services for any youth not in IHT or ICC. For these children, outpatient therapists become the gatekeeper for accessing remedial services. By placing outpatient therapists in this role, the defendants materially altered the Court's plan for the delivery of a key remedial service, and raised several serious concerns regarding overall implementation of the remedy, including whether or not youth in Outpatient Therapy would receive all medically necessary services.

The defendants' decision departed from the purpose of the Judgment in several ways. First and foremost, the use of outpatient providers as care managers deviated from the

Judgment's focus on evidence-based, high fidelity Wraparound,[7] a model delivered by specially trained Intensive Care Coordinators (ICC) operating as part of a Care Planning Team. Doc. 367-2 at 11-14. Second, this change depended upon a traditional, office-based service model that the Court had already found to be inadequate for meeting the complex service needs of class members with SED. *Rosie D.*, 410 F. Supp. 2d at 38-39, 52-53. Finally, defendants' decision was likely to affect thousands of youth with SED whose access to court-ordered remedial services would now depend upon outpatient providers' ability to perform the range of activities identified by the Court as essential to adequate care coordination.

As more information about the inadequacy of outpatient service coordination became available from studies conducted during the disengagement process, the plaintiffs reiterated their objections to this significant and material change in implementation of the Judgment. *See, e.g.,* Doc. 695, Plaintiffs' 27th Status Report; Doc 723, Plaintiffs' Proposal on Outpatient Therapy; Doc. 740, Plaintiffs' Report on Appropriate Service Coordination in Outpatient Therapy; and Doc. 751, Plaintiffs' 32nd Status Report.

D. The Limitations of Outpatient Service Coordination for Youth with Serious Emotional Disturbance.

Outpatient Therapy is offered by a single clinician, operating on her own or within an outpatient clinic, with no mandatory program requirements or national quality standards. Inherent limitations in the office-based, outpatient model make the delivery of adequate service coordination difficult, especially within a system of home-based services. For instance, prior to negotiated rate changes in 2016, outpatient providers had little or no ability to bill for

[7] At trial, the Court heard evidence about the efficacy of Wraparound Treatment Planning for those with multiple providers and state agency or special education involvement, and its implementation in several pilot programs providing intensive care coordination for youth with SED in Massachusetts. *Rosie D.,* 410 F. Supp. at 39-43. The Court made specific findings regarding these pilot programs in its liability decision, and repeatedly referred to them when evaluating whether class members were receiving appropriate service coordination. *Id.* at 38. ("Except for a very few children fortunate enough to qualify for three state programs in limited geographical areas, however, a child with SED in the Commonwealth does not receive adequate case management services").

communications with state agency staff, schools, or other clinicians – activities which are critical to effective service coordination. *See* Doc. 740 at 5-6. While remedial service providers received extensive training in system of care principles, the delivery of home-based services, and expectations for the provision of effective service coordination, outpatient providers were only peripherally involved in implementation of the Judgment. Despite these limitations, the Commonwealth established Outpatient Therapy as a gatekeeper for other remedial services, with responsibility for providing referrals, over-seeing treatment delivery, and coordinating care for a subset of class members with SED. *See* Docs. 847 at 7, Motion to Approve and Order Disengagement Measures, Actions to Improve Access to Remedial Services, and Provisions on Outpatient Services; 847-5, DiGravio Aff. at ¶¶ 13-14.

The parties' early disengagement efforts focused on class members who relied on outpatient therapists for access to, and coordination of, remedial services.[8] Studies conducted by the defendants, their managed care agents, and the Court Monitor all reflected outpatient therapists' limited ability to make appropriate referrals, to communicate with collateral providers/agencies, and to effectively coordinate service delivery.[9] A study of 50 youth with SED in Outpatient Therapy, conducted in September of 2013, showed that a significant number of children in the sample needed the intensity of wrap-around treatment planning offered by ICC, but yet remained in Outpatient Therapy. *See* Doc. 723 at 5. State reviewers also found close to 60% of outpatient therapists' records did not demonstrate appropriate levels of care coordination. *Id.* at 5. A subsequent study of youth with SED in Outpatient Therapy revealed strikingly low levels of referrals to remedial services. *Id.*

[8] *See* Doc. 620-2, Joint Memorandum on Disengagement Criteria.
[9] The defendants expected Outpatient Therapy to provide all service coordination activities for children and youth who are not otherwise receiving ICC or IHT. Unfortunately, the defendants' own outpatient study demonstrated that it did not. *See* Docs. 723 at 5-6; 695 at 6-8 (outpatient study finds few service coordination activities and few referrals to other remedial services).

In response to these studies, and at the urging of the Court, the parties negotiated a series of actions designed to improve service coordination for class members relying on Outpatient Therapy. *See* Doc. 740 at 5, Plaintiffs' Report on Appropriate Service Coordination in Outpatient and In-Home Therapy Services. As a result of these negotiations, outpatient guidelines were developed, reimbursement rates were improved, and evaluation studies were conducted. *Id.* at 5-7. Despite agreeing to these activities, the defendants maintained that none of the negotiated requirements concerning Outpatient Therapy were mandatory or enforceable, including the expectation that youth with SED in Outpatient Therapy receive service coordination consistent with the Judgment.[10] When the defendants refused to incorporate these new actions in the 2007 Remedial Order, the plaintiffs sought formal modification of the Judgment. Doc. 777.

E. Prior Motions to Modify and Incorporate Provisions on Outpatient Therapy.

The plaintiffs filed their first Motion to Modify and Incorporate Provisions on Outpatient Therapy in 2017.[11] Docs. 777, 778. This Motion was filed alongside Plaintiffs' Motion to Approve and Order the Joint Disengagement Measures. Doc. 762, 768. Both Motions were denied without prejudice in the Court's Memorandum and Order of September 27, 2017. Doc. 815. In its decision, the Court expressed its belief that the defendants were committed to making "vigorous efforts to implement these [disengagement] measures," which included efforts to monitor the provision of outpatient care coordination. *Id.* at 2. In the event these disengagement efforts did not come to fruition, the Court explicitly stated its intention to take

[10] *See, e.g.*, Doc. 786, Defendants' Opposition to Plaintiffs' Motion to Modify.

[11] These negotiated improvements sought to ensure that class members who rely on outpatient therapists for care coordination receive the same coordination activities required under the Judgment, albeit with lesser intensity. *See* Doc. 777, Attachment A, ¶ A. Implementation involved the issuance of Outpatient Guidelines, conducting training for outpatient providers, monitoring quality outcomes for youth in outpatient services, and establishing parity in rates paid for care coordination activities required by the Judgment. Id., ¶¶ A, B, C.

further actions, including issuing a formal ruling or amending the Judgment, if necessary. Doc. 815 at 2.[12]

On the issue of adequate service coordination for youth in outpatient therapy, the Court observed that formal modification was not required for it to exercise its equitable authority and oversight:

> The Remedial Order sets forth Defendants' responsibility to address the Medicaid violations identified by the court in its Memorandum of Decision (Dkt. No. 331), including the assurance of adequate care coordination. As the court made clear at the April 6, 2017 status conference, this care coordination measure is critical, regardless of what label (Outpatient Therapy or otherwise) is placed upon the program component that will carry it out. No formal modification of the Judgment is necessary to ensure full compliance with this crucial, substantive provision of the Remedial Order.

Id. at 2.

By the spring of 2018 very few, if any, of the objective benchmarks set out in the Joint Disengagement Measures, including those concerning Outpatient Therapy, had been achieved. *See, e.g.,* Docs. 847 at 3; 877 at 28-30. As a result, the Court directed the defendants to formally present their evidence of substantial compliance, and suggested the plaintiffs refile their affirmative motions to enforce and modify the Judgment. Doc. 844 at 4, Scheduling Order, June 14, 2018.

On August 6, 2018, the plaintiffs filed a consolidated, renewed Motion to Approve and Order Disengagement Measures, Actions to Improve Access to Remedial Services, and Provisions on Outpatient Services. Doc. 847. With regard to outpatient services, the plaintiffs urged the Court to clarify that the defendants' unilateral decision to deliver service coordination using outpatient therapists necessarily required defendants' to ensure that those providers comply with basic requirements for that remedial service, as set forth in the Judgment. Doc. 847-3. On

[12] *See also* Doc. 881 at 2 (recounting the court's denial of plaintiffs' 2017 motions, without prejudice, at a time "when Defendants' progress in compliance appeared, at least in several areas, to be encouraging.")

February 7, 2019, the Court found there to be substantial noncompliance with its Judgment and continuing violations of federal law, and denied the defendant's request to terminate monitoring and reporting. Doc. 877. But when the defendants filed their notice of appeal, the Court denied the plaintiffs' pending Motion without prejudice, due to a lack of jurisdiction. Doc. 881 at 1 (but noting the strength and "force" of plaintiffs' arguments). *Id.* at 4, 6.

III. The Court Has Authority to Modify Its Judgment.

The plaintiffs' recent Motion for Modification of Court Monitoring and Reporting discussed both the Judgment's good cause standard for modification and the case law supporting modification pursuant to Fed. R. Civ. P. 60(b)(5). Doc. 911 at 9-12. The plaintiffs incorporate that analysis, and the modification arguments set out in Plaintiffs' Memorandum in Support of their Motion to Modify the Judgment to Incorporate Timeliness Standards, filed on December 21, 2020, by reference. As discussed below, both Paragraph 50 of the Judgment and Rule 60(b)(5) s provide the Court with a vehicle for approving the requested modification here.

A. Modification under Paragraph 50 of the Judgment.

Both the Court's remedial order and the language of the Judgment make clear that its terms may be modified for good cause. Judgment, ¶ 50; *Rosie D.,* 474 F. Supp. 2d at 240. This good cause standard provides a flexible alternative to the formal requirements of Fed. R. Civ. P. 60(b)(5). As such, it is well within the discretion of the Court to determine the necessity of such modifications. *See In re Pearson*, 990 F.2d 653, 657 (1st Cir. 1993) (federal courts have broad equitable authority to clarify or interpret their own orders, even when those orders are entered with the consent of the parties). This Court's continuing jurisdiction over the remedial order, and its equitable authority to ensure compliance with the purpose of that order, make exercise of this good cause standard appropriate.

In 2009, the defendants invoked this flexible standard to support their request to modify the July 1, 2009 deadline for initiating remedial services set forth in ¶ 38(d) of the Judgment. The defendants' Motion to Modify the Judgment, Doc. 431, claimed fiscal considerations provided good cause to delay the initiation of services. After careful consideration and unsuccessful efforts to reach a compromise, the Court allowed the motion, presumably under ¶ 50 of the Judgment, since it did not engage in an analysis of the Rule 60(b)(5) procedural requirements for modification. Mem. and Order of February 27, 2009, Doc. 443 at 6.

Given the defendants' unilateral decision to rely upon Outpatient Therapy to provide service coordination to thousands of children with SED, and to authorize the delivery of other remedial services, there is good cause to modify the Judgment to require this form of service coordination to comply with the requirements of the Judgment.

B. Modification under Rule 60(b)(5).

Rule 60(b)(5) permits a party to obtain relief from a judgment or order if "applying it prospectively is no longer equitable." *See also*, *Rufo v. Inmates of Suffolk Cty. Jail,* 502 U.S. 367, 384 (1992)(interpreting Rule 60(b)(5) to include situations where "enforcement of the decree, without modification, would be detrimental to the public interest."). The party seeking relief from, or modification of, a judgment or order on these grounds bears the initial burden of establishing that a significant change in law or factual circumstances warrants relief. *Rufo,* 502 U.S. at 383-84 (1992); *see also King v. Greenblatt*, 149 F.3d 9, 21-22 (1st Cir. 1998) (concluding evidence of a significant change in philosophical approach to treatment of, and conditions of confinement for, sexually dangerous persons amounts to the significant change in facts required by *Rufo)*. *Rufo* further instructs that the changes must not have been anticipated at the time the consent decree was entered or the order was issued. *Id*. at 385. If this initial burden is met, the

court must then consider whether the proposed modification is "suitably tailored to resolve the problems created by the change in circumstances." *Rufo*, 502 U.S. at 383, 393.

In 2009, the Supreme Court affirmed the *Rufo* standard for equitable relief in *Horne v. Flores*, 557 U.S. 433 (2009), describing the relevant inquiry as "whether 'a significant change either in factual conditions or in law' renders continued enforcement of the judgment 'detrimental to the public interest.'" *Id*. at 453 (citing *Rufo*, 502 U.S. at 384). The Supreme Court emphasized that district courts must be flexible, and allow modifications based upon a range of changed circumstances, including where such revisions will promote compliance with federal law and further the public interest. *Id*. at 450; *see also Boston Chapter, NAACP, Inc. v. Beecher*, 295 F. Supp. 3d 26, 30 (D. Mass. 2018) (ordering modification of consent decree and concluding "'flexible standard' in Rule 60(b) applies to consent decrees").

1. Rule 60(b)(5)'s Flexible Standard Is Grounded in Courts' Equitable Authority to Oversee Their Own Orders, and Supports Modification When Necessary to Protect the Public Interest.

Rule 60(b) is not limited to modifications that terminate court-ordered obligations. District and circuit courts nationwide have recognized that the "broad and flexible equitable powers which Rule 60(b) codifies, may allow a district court to tighten a decree as well." *Salazar by Salazar v. District of Columbia.*, 896 F.3d 489, 498 (D.C. Cir. 2018) (internal citations omitted); s*ee also FTC v. Trudeau*, 662 F.3d 947, 952 (7th Cir. 2011) (citing *United States v. United Shoe Mach. Corp.*, 391 U.S. 244, 252 (1968) to explain that the district court "may modify the decree so as to achieve the required result with all appropriate expedition"), *Baez v. N.Y.C. Hous. Auth.*, No. 13CV8916, 2018 WL 6242224, at *3 (S.D.N.Y. Nov. 29, 2018) (granting plaintiffs' revision to consent decree).

The Fourth Circuit made the historical antecedents, and thus the spirit, of Rule 60(b)(5) clear by stating that a "court's ability to modify a consent decree or other injunction springs from

the court's inherent equitable power over its own judgments" and that "[t]he hallmark of equity, of course, is its flexibility." *Thompson v. U.S. Dep't Of Hous. & Urban Dev.*, 404 F.3d 821, 830 (4th Cir. 2005); *see also United States v. City of Miami,* 2 F.3d 1497, 1509 (11th Cir.1993) ("[A] district court's decision on a request to terminate or modify a consent decree is an exercise of that court's equitable power...."); *SEC v. Worthen*, 98 F.3d 480, 482 (9th Cir.1996) ("With respect to permanent injunctions, we have held that Rule 60(b)(5) represents a codification of preexisting law, recognizing the inherent power of a court sitting in equity to modify its decrees prospectively to achieve equity." (internal quotation marks omitted). The Supreme Court also spoke to the inherent flexibility of equitable remedies in *Freeman v. Pitts*, stating, "[t]he essence of a court's equity power lies in its inherent capacity to adjust remedies in a feasible and practical way to eliminate the conditions or redress the injuries caused by unlawful action." 503 U.S. 467, 487 (1992).

2. Modification Is Appropriate to Effectuate the Purpose of the Judgment.

Modification is especially appropriate when necessary to effectuate the purpose of the decree or judgment. Courts have recognized that Rule 60(b) allows for the imposition of further remedial measures proposed by plaintiffs, so long as those measures serve the underlying purpose and goals of the remedial order. *Judicial Watch, Inc. v. Adams,* No. 3:17-CV-00094-GFVT, 2020 WL 5412476, at *8 (E.D. Ky. Sept. 9, 2020) (extending period of court oversight by five years where "due to Defendants' delayed actions," plaintiffs were not able to sufficiently monitor voter registration and roll purging in order for court to determine compliance in the time frame originally contemplated by the consent decree). As the Second Circuit held in *Juan F.,* modifications containing remedial measures may be "necessary to ensure timely implementation of the decree and provide for the plaintiff class the protections and services originally agreed to

by the parties and ordered by the court." 37 F.3d at 879 (2d Cir. 1994) (holding that, to the extent district court's sua sponte change is considered a modification of the consent decree, its modification comports with the *Rufo* standard and was not an abuse of discretion).

The D.C. Circuit in *Salazar* similarly instructed that a "district court must retain the authority to prevent evasion and ensure effectuation of the order it entered. But any such fortification of the injunction's terms must be in service of the consent decree's original intended result." 896 F.3d at 498 (internal citations omitted). When defendants have evaded the purpose of the judgment through their own actions, "a significant change in the circumstances [exists] that warrants additional relief to [achieve] the intended result of the Final Judgment." *Texas v. Calvin*, No. 4:14-CV-00654-O, 2020 WL 3485582, at *2 (N.D. Tex. Mar. 3, 2020) (holding that modification of final judgment was warranted where the defendant did not act in conformance with the obligations of the judgment such that additional measures and specificity were required); *see also N.E. Ohio Coal. for the Homeless v. Husted*, No. 2:06-CV-896, 2013 WL 4008758, at *9 (S.D. Ohio Aug. 5, 2013) (granting plaintiffs' motion to modify and finding that "[w]hen parties state, as they did here, that a consent decree is designed to achieve a particular result and it fails to obtain that result, that unforeseen failure can be a significant changed circumstance").

3. Plaintiffs May Seek Modification Under Rule 60(b)(5).

Rule 60(b) allows for the imposition of further remedial measures proposed by plaintiffs, so long as those measures serve the underlying purpose and goals of the remedial order. The Second Circuit acknowledged this principle in *Juan F. By & Through Lynch v. Weicker*, 37 F.3d 874, 879 (2d Cir. 1994), and rejected defendants' suggestion that the *Rufo* modification standard can benefit only defendants seeking relief from burdensome requirements, concluding instead

that "*Rufo* 's flexibility is designed to permit details in complicated decrees, much as this one, to be adapted to changing conditions so that the public interest can be preserved.") ~~37 F.3d 874, 879 (2d Cir. 1994)~~; *see also*, *Judicial Watch, Inc,*. 2020 WL 5412476, at *8; *Salazar*, 896 F.3d at 498.

Here the plaintiffs' proposed modification is intended to serve the public interest by effectuating this Court's remedial Order and Judgment, and preventing any evasion of its stated purpose to provide adequate service coordination to class members with SED. The modification consists of a footnote which can be embedded within the Judgment's existing description of Court-ordered service coordination.[13] It does not create different obligations for the defendants, but instead simply memorializes the range of providers to whom the defendants already have assigned responsibility for the delivery of service coordination to class members. The proposed modification makes clear that those providers are expected to perform the same basic tasks required of care managers, thus fulfilling a central purpose of the Judgment.

As discussed in Section IV, *infra*, the proposed modification responds to a significant and material change in fact, precipitated by defendants' post-judgment decision to expand the list of providers tasked with coordinating remedial services for class members. It does so in a way that is tailored to address the specific change at issue, to remedy the harm it creates, and to assure that the service coordination needs of class members with Outpatient Therapy are met. Importantly, this modification also provides the Court with a mechanism for oversight of all class members' access to service coordination, regardless of which provider performs this vital function. *See* Section V, *infra*.

[13] *See* Section V, *infra*.

IV. The Defendants' Reliance on Outpatient Therapy to Provide Service Coordination for Children with SED Constitutes a Material Change of Fact Justifying Modification.

By creating three clinical "hubs" from which class members received service coordination (ICC, IHT and Outpatient Therapy), and upon whom they must depend to access other remedial services, the defendants fundamentally altered the structure and delivery of remedial home-based service system. Since the earliest phases of implementation, the plaintiffs have expressed serious reservations about this change in design. The Court's Remedial Order clearly did not intend for Outpatient Therapy to become the avenue by which thousands of class members with SED accessed remedial services, and certainly not envision it being a source of the most critical component of the remedy – service coordination. *Rosie D.*, 497 F. Supp. 2d at 79. To the contrary, the Court's Judgment painstakingly details the role and responsibilities of care managers. This specificity was intended to address findings in its liability decision that these components were integral to the delivery of adequate service coordination for youth with SED, and, except for a handful of pilot programs, notably absent in the Commonwealth. *Rosie D.,* 410 F. Supp. 2d at 31, 38-9. Given these findings, and the resulting remedial order, both the plaintiffs and the Court were surprised by the defendants' decision to take an existing, office-based service that the Court had already found to be unable to meet the intensity of class members' behavioral health needs, and task it with coordinating home-based services for thousands of youth with SED.

The plaintiffs objected to this approach from the outset. The idea that outpatient providers could – without additional training, resources, or funding – suddenly coordinate care for youth with intense and complex needs, and facilitate their access to newly created home-based services was at best unrealistic, and at worst doomed to fail. Implementation of this

decision validated the plaintiffs' concerns, and left thousands of class members reliant on a substandard service coordination model, poorly equipped to support and coordinate the delivery of remedial services. Not only was this change contrary to the public interest, it departed from a central objective and fundamental purpose of the Judgment – ensuring all youth with SED and complex treatment needs had access to effective, evidence-based service coordination. As a result of this decision, the Commonwealth avoided meeting specific service coordination standards set forth by the Court, and compromised the delivery of medically necessary treatment for a significant subset of *Rosie D.* class members. *Rosie D.*, 497 F. Supp. 2d at 79.

Without modification of the Judgment, Outpatient Therapy will continue in this service coordination role without minimal standards or court oversight to ensure its delivery of effective care to class members. Such an outcome would be both inequitable and detrimental to the public interest. For these reasons, the defendants' decision to rely on Outpatient Therapy as a source of service coordination is akin to significant factual changes recognized by this and other Circuits' modification jurisprudence, and by the Supreme Court in *Rufo*. *See* Section III, *supra*.

V. The Proposed Modification Is Necessary to Ensure Compliance with the Judgment and Is Suitably Tailored to Achieve Its Purpose

A. Modifying the Judgment to Require Standards for Outpatient Therapy Is Necessary to Ensure Eligible Class Members Receive Adequate Service Coordination

The defendants' decision to add Outpatient Therapy as a service coordination 'hub' resulted in a cascading set of consequences, ending with a subset of *Rosie D.* class members receiving inadequate, to non-existent, service coordination, and certainly not the type of coordination the Court found was needed in its liability decision and Judgment. It left a group of outpatient providers poorly suited for and largely unprepared to fulfill the role assigned to them, and provided no formal mechanism to ensure these children and youth are appropriately referred

to, and benefiting from, the home-based services to which they were entitled under the Judgment.

Outpatient Therapy was not designed to provide care coordination for class members with SED, who typically need or receive services from multiple providers or state agencies. Doc. 847 at 7. As discussed in Section II.D., *supra*, studies by the defendants and the Court Monitor raised concerns about the nature and quality of service coordination being delivered by outpatient therapists, and their ability to overcome inherent limitations in the service model. While the defendants eventually agreed to take some actions to improve Outpatient Therapy. they did not ensure Outpatient Therapy would provide service coordination as required by the Judgment. There is no ongoing, systemic effort to monitor or improve the remedial service coordination provided by outpatient therapists. Such oversight is critical if the purpose of the Judgment is to be realized.

Without formal modification, the defendants will continue to provide service coordination that is inconsistent with the requirements in the Judgment, the Court will continue to be without a clear mechanism to ensure that all beneficiaries of its Judgment receive needed treatment, and the defendants will continue to argue that any reforms to Outpatient Therapy are beyond this Court's jurisdiction.[14] The Commonwealth's decision to rely on Outpatient Therapy to authorize and coordinate remedial services for thousands of *Rosie D.* class members should be incorporated in the Court's Judgment and Outpatient Therapists should be required to comply with the Judgment's provisions on service planning when coordinating case for youth with SED.

[14] *See, e.g.,* Doc. 786, (Defendants Opposition to Plaintiffs' Motion to Modify the Judgment to Incorporate Provisions on Outpatient Therapy; Doc. 788, Plaintiffs' Reply to Defendants' Response in Opposition.

B. Plaintiffs' Proposed Modification Is Suitably Tailored to Address the Inadequacy of Outpatient Service Coordination and to Achieve a Central Purpose of the Remedial Order

The Court's Remedial Order and Judgment already describe the essential components of service coordination for youth with SED. The plaintiffs proposed modification is designed to stay within, and be wholly consistent with, this structure. Simply put, the proposed footnote includes outpatient therapists within the existing definition of a "care manager," and obligates them to perform the same basic roles and activities for which care managers are already responsible under the Judgment. Judgment, ¶¶ 20-29. By identifying the range of providers who are expected to coordinate remedial services for class members, the modification makes clear who is a care manager and what standards are applicable to all care managers under the Judgment. Since not every youth with SED will require the same intensity of service coordination, this expectation can be implemented consistent with individual medical necessity. The proposed modification reads as follows:

> The definition of Care Manager includes any professional who serves as the primary service coordinator in Intensive Care Coordination, In Home Therapy or Outpatient Therapy. All Care Managers are required to perform the roles and responsibilities described in paragraphs 20-29, to the extent medically necessary, including referral to, and coordination of, covered services described in Section D.

Despite the plaintiffs' longstanding objections, Outpatient Therapy has been, and will likely continue to be, a part of the Commonwealth's system for providing access to, and coordination of, remedial home based services. Defendants voluntary changes to Outpatient Therapy are insufficient to ensure the delivery of even minimally-adequate service coordination, and do not direct outpatient providers to perform the all the functions of a care manager when coordinating remedial services for youth with SED. Moreover, there is no systemic effort to monitor or improve the provision of service coordination to class members who rely on

outpatient providers for access to, and oversight of, remedial services. Therefore, in order to secure this key remedial benefit for all class members, and to effectuate the central purpose of the Judgment, the Court should require that outpatient providers perform the basic functions of a care manager when coordinating remedial services for Medicaid-eligible children and youth with SED. The requested modification is necessary to afford the Court clear authority to oversee and enforce these standards, and to secure access to adequate service coordination for all class members. *Id*. at 18.[15]

VI. Conclusion

For the reasons discussed above, this Court should modify the Judgment as set forth herein, and in Plaintiffs' Motion to Modify the Judgment to Incorporate Outpatient Therapy.

December 21, 2020

RESPECTFULLY SUBMITTED,
THE PLAINTIFFS,
BY THEIR ATTORNEYS,

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[15] As the Court observed in its February 7, 2019 decision, "Defendants in recent years have begun to rely, or purport to rely, on other system components, specifically In-Home Therapy ("IHT") and Out Patient therapy ("OP"), to provide intensive care coordination for the children. Where this tactic has been used, the evidence demonstrates that the care coordination has not been provided in a timely fashion for roughly the same proportion, or an even greater proportion, of children needing ICC services." Doc. 877 at 6.

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CERTIFICATE OF SERVICE

I hereby certify that on December 21, 2020, I electronically filed the foregoing document using the CM/ECF system. I certify that the counsel of record are registered as ECF filers and that they will be served by the cm/ecf system to: Daniel J. Hammond, Daniel.Hammond@mass.gov and Douglas Martland, Douglas.Martland@mass.gov

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