

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

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

MEMORANDUM OF DECISION

January 26, 2006

PONSOR, D.J.

I. INTRODUCTION

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

or her clinician.

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

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

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

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

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

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

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

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

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

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

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

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

For the reasons set forth below, the court finds that

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

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

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

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

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

The second aspect of Defendants' Medicaid violation

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

The undisputed evidence offered at trial made it clear

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

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

II. THE STATUTORY ENVIRONMENT

A. The Medicaid Act and Regulations.

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

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

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

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

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

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

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

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

1. EPSDT.

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

provision of

[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.

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

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

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

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

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

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

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

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

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

services, including any medical or remedial services . . . for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." 42 U.S.C. § 1396d(a)(13) (emphasis added). Thus, if a licensed clinician finds a particular service to be medically necessary to help a child improve his or her functional level, this service must be paid for by a state's Medicaid plan pursuant to the EPSDT mandate. See §§ 1396d(a)(13), 1396d(r)(5); Pediatric Specialty Care, 293 F.3d 472.

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

necessary' EPSDT services").

Congress' firm intent to ensure that Medicaid-eligible children actually receive services is powerfully underlined by provisions in the statute that place explicit duties on states to: (a) inform eligible children of the availability of early and periodic screening, diagnostic, and treatment services, (b) provide or arrange for screening services "in all cases where they are requested," and (c) arrange for whatever corrective treatments are discovered to be needed. See § 1396a(a)(43); see also 42 C.F.R. § 441.56(a)(1), -.61, -.62 (2005).

The requirement that states inform eligible children of EPSDT services has both procedural and substantive implications. States must draft guidelines by which the information regarding EPSDT services is to be transmitted; they must also ensure that effective notice, in fact, reaches children and their families. See 42 C.F.R. § 441.56(a)(1) (2005). If a state's scheme for informing children of their rights is ineffective or conveys out-of-date or inaccurate information, the state is not in compliance with the law. See Health Care for All v. Romney, Civ. No. 00-10833RWZ, 2005 WL 1660677, at *14 (D. Mass. July

7, 2005) (Zobel, J.) (concluding that the state violated its duty to inform children of EPSDT services where notices sent to children and their families contained "incorrect or outdated guidance on obtaining services"); cf. Pediatric Specialty Care, 293 F.3d at 481 ("The state may not shirk its responsibilities [under § 1396a(a)(43)] to Medicaid recipients by burying information about available services in a complex bureaucratic scheme."); John B., 176 F. Supp. 2d at 802 ("The State must assure that the contractors provide adequate outreach efforts"); Chisholm, 133 F. Supp. 2d at 901 (concluding that the state's system for providing access to psychological services for Medicaid-eligible children rarely resulted in children successfully receiving the services and fell "woefully short of complying with federal law").

Moreover, in Health Care for All, the court noted that the Act requires a proactive approach. The statute effectively requires states to identify obstacles to the effective conveyance of information and to "develop measures to mitigate the negative impact of such potential influences." 2005 WL 1660677 at *14.

2. Reasonable Promptness.

The statute also requires states to provide medical attention in a timely manner. Assistance must be "furnished with reasonable promptness to all eligible individuals." § 1396a(a)(8); see also Doe ex rel. Doe v. Chiles, 136 F.3d 709, 718 (11th Cir. 1993) (finding that because "[t]he language of the statute is undoubtedly cast in mandatory rather than precatory terms," the reasonable promptness clause imposes a binding obligation).

The accompanying Medicaid regulations require state agencies to "[f]urnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures." 42 C.F.R. § 435.930 (2005). In addition, the state agency "must set standards for the timely provision of EPSDT services which meet reasonable standards of medical . . . practice, . . . and must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the request for screening services." Id. § 441.56(e).

Although the statute does not specifically define "reasonable promptness," courts facing this question have found defendants in violation of the provision when eligible individuals are placed on waiting lists for medically

necessary services. See, e.g., Sobky v. Smoley, 855 F. Supp 1123, 1148 (E.D. Cal. 1994) (discussing the history of the "reasonable promptness" language and noting that it is intended to prevent states from "establish[ing] waiting lists for individuals eligible for assistance" (quotation omitted)). Courts have also found a failure to comply with the statute where a state fails to establish guidelines for the timely provision of services recommended after a screening. See Kirk T. v. Houstoun, Civ. No. 99-3253, 2000 US Dist. LEXIS 8768, at * 14 (E.D. Pa. June 23, 2000) (finding the defendant in violation of the "reasonable promptness" provision where the state lacked "some method of measuring timeliness," thus making it "impossible to tell whether the state is in compliance with the Medicaid statute").

A reasonable promptness violation may also turn on the nature of the services provided. In Boulet v. Cellucci, plaintiffs received access to some services in a prompt manner, but were denied access to the specific services they had requested. The court held that "the assistance must correspond to the individual's needs" and that the requirement of prompt provision of services "is not

satisfied by other services the plaintiffs are receiving or might be offered." Boulet v. Cellucci, 107 F. Supp. 2d 61, 79 (D. Mass. 2000) (Woodlock, J.).

3. Equal Access.

Finally, states must satisfy the "equal access" provision of the Medicaid statute. See Ark. Med. Soc'y, 6 F.3d at 522. Section 1396a(a) (30) (A) requires states to:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a) (30) (A) (emphasis added); see also 42 C.F.R. § 447.204 (2005).

The purpose of the equal access provision and its corresponding regulations is "to prevent gross disparity between the availability of [a] service to Medicaid patients and its availability to those who can afford to pay privately." King v Sullivan, 776 F. Supp. 645, 655 (D.R.I. 1991) (stating that "[t]he 'sufficiency' of a state's reimbursement payments is measured against the payments that

a health care facility can demand from non-Medicaid patients").

B. EPSDT Caselaw.

Since the enactment of the EPSDT provisions of Medicaid in 1989, courts have regularly been called on to judge whether a state is meeting its obligations to Medicaid-eligible children and have frequently found states in violation of the law. See Health Care for All, 2005 WL 1660677 (finding for plaintiff in an EPSDT suit against Massachusetts based on lack of access to Medicaid-covered dental services); see generally Collins, 349 F.3d 371; Pediatric Specialty Care, 293 F.3d 472; John B., 176 F. Supp. 2d 786 (involving enforcement of a consent decree, but basing decision on defendants' failure to comply with federal law); Chisholm, 133 F. Supp. 2d 894 (E.D. La. 2001); Salazar v. District of Columbia, 954 F. Supp. 278 (D.D.C. 1996).

Three of these cases are particularly helpful in illustrating how courts have enforced the EPSDT provisions of the Medicaid Act; they involve treatments and services for children who, like the class of plaintiffs here, suffer from chronic behavioral and psychiatric conditions. Collins

found that the state of Indiana was required to provide long-term treatment in psychiatric residential treatment facilities to children with mental illness. Pediatric Specialty Care held that Medicaid's EPSDT provisions require the state of Arkansas to provide early intervention day treatment when a physician recommends such treatment.

Chisholm concluded that federal law obliges the state of Louisiana to offer autistic children behavioral and psychological services, rendered by licensed psychologists.

A common analytical approach emerges from these three decisions. First, each court analyzes whether the services or treatments sought by the plaintiffs are covered under the Medicaid Act. Second, the court examines whether the state in fact provides the sought-after services. There are several elements to this second inquiry. For example, if a competent and credible diagnosis shows that a child requires a specific treatment, courts will find that the state has an obligation to provide it; a state's attempts at substitutes will be viewed with skepticism, especially where their availability or adequacy is doubtful. Additionally, even if the state offers the service or treatment on paper, courts will examine whether children can, in practice, actually

access these services. Where a state has failed to provide treatments and services covered by Medicaid, a court will proceed to consider an appropriate remedy, giving the state the opportunity initially to fashion its own remedial proposal.

In this case, the court's conclusion that Defendants have failed to provide mandated EPSDT services to the plaintiff class rests on this analytical platform. Indeed, the first inquiry is easily disposed of, since Defendants do not substantially contest the claim that service coordination and in-home support services for the plaintiff class are covered by Medicaid.² The heart of the dispute in this case is whether the relevant services are actually being provided. On this point, as the following findings will demonstrate, Plaintiffs have proved by more than a preponderance of the evidence that thousands of seriously

² Defendants do vigorously dispute Plaintiffs' argument that they are entitled to "intensive home-based services," a phrase that Defendants contend describes only one of several possible methods of service delivery and not an actual treatment. With equal vigor, however, Defendants assert that Massachusetts already does provide the specific array of substantive clinical interventions, including service coordination and in-home supports, that they admit Medicaid statute's EPSDT provisions require. The strong weight of the evidence offered at trial emphatically rebuts the latter assertion.

emotionally disturbed children in the Commonwealth are simply not receiving the EPSDT services they are entitled to under federal law.

III. FINDINGS OF FACT

A. Preliminary Issues.

Before weighing the quantum of proof, it is important to note four points.

First, the comprehensiveness of Plaintiff's evidence is prodigious. Plaintiffs offered evidence in seven different categories: (a) testimony of parents or custodial relatives of several of the named plaintiffs; (b) testimony of clinicians who have served or are serving specific class members; (c) testimony of agency personnel who provide, or attempt to provide, services to seriously emotionally disturbed children within the Commonwealth generally; (d) reports and testimony of expert clinicians who studied the Commonwealth's overall system for delivering services to these children; (e) analysis of the services received by a sample of thirty-five randomly selected seriously emotionally disturbed children who are class members but not named plaintiffs; (f) documents containing data submitted to the Massachusetts legislature by Defendants on the actual

utilization of existing services; and (g) testimony from directors of programs that currently are providing, for a very limited number of class members, medical services that, in fact, fully comply with Medicaid requirements. Finally, a hastily enacted and ineffective state Benefit Clarification, apparently intended to convey the impression that Defendants are complying with Medicaid requirements, served only to highlight the deficiencies in Defendants' service delivery system.

Defendants' counsel's determined efforts to prick holes in this imposing corpus of evidence failed to reduce, to any significant degree, its credibility and powerful impact. Logistical, financial, and ethical restrictions, for example, reduced Plaintiffs' ability to extract and analyze a sample of class members that was identified in accordance with the strictest academic requirements for perfect randomness. Nevertheless, the thirty-five children analyzed were chosen in a reasonably fair manner designed to minimize bias. The credible evidence demonstrated that the vast majority of this group needed, but was not receiving, clinical interventions such as comprehensive assessments, service coordination, crisis intervention, and in-home

supports that Defendants concede are required under the Medicaid statute. This evidence, though only one portion of Plaintiffs' case, was vividly probative.

Short of bringing to court a parent or guardian of every one of the thousands of class members, and offering testimony by an expert clinician for each child, it is hard to imagine how a more meticulously constructed case could have been offered on behalf of the plaintiff class. Moreover, Defendants' failure or inability to offer their own opposing concrete evidence showing actual delivery of services to the class members speaks volumes.³ Defendants' witnesses did provide fairly detailed evidence of the general design of the system intended to provide children in the Commonwealth with EPSDT services, along with descriptions of the way the system was supposed to work. Defendants, however, offered little objective data on the actual amount or quality of service delivered to class members or its clinical impact. The available data tended to show that EPSDT services -- outside a few, limited geographic areas -- were simply not being provided

³ This observation should not be interpreted as a criticism of Defendants' counsel. The quality of advocacy on both sides was outstanding.

effectively to children with serious emotional disturbances in the Commonwealth.

Second, before embarking on a recital of the court's findings of fact, it is important to trace the temporal boundaries of the evidence. Before trial, Plaintiffs sought a ruling barring Defendants from offering any evidence regarding activities or services after September 30, 2004, the date discovery closed. In response, Defendants argued that the court should have a full and accurate picture of the efforts made by the state to comply with the Medicaid statute even after that date. The court concluded that, in determining liability, it would generally consider only evidence pre-dating September 30, 2004, with exceptions for good cause, but might consider evidence of later conduct if liability were found and it became necessary to consider an appropriate remedy. Therefore, the findings of fact set forth in this memorandum with respect to liability are based mainly on information current as of September 30, 2004.⁴

Third, in rendering its findings of fact the court has

⁴ The cut-off was obviously necessary. Permitting Defendants to offer evidence acquired after the close of discovery would leave Plaintiffs unprepared to challenge the newly-acquired material.

chosen, for the most part, to discard the label "intensive home-based services" used by Plaintiffs as a short-hand for the amalgam of clinical interventions they claim the EPSDT portions of the Medicaid statute require Defendants to provide. The term generated an unhelpful, time-consuming, and largely irrelevant dispute over whether the phrase describes a discrete clinical intervention (i.e., an actual form of treatment) or merely one method or system for delivering medical treatment. Rather than enter into this semantic debate, the court has looked behind the phrase to the array of actual clinical interventions that constitute, in the terms of the Medicaid statute, "medically necessary" services for class members.

Viewed from this perspective, the evidentiary landscape is greatly simplified. Plaintiffs' reasonable medical needs are not dramatically different from the needs of anyone else with a significant medical problem. Children with serious emotional disturbances must be made aware of the availability of services and their entitlement to them; they need comprehensive assessments of the nature of their disabilities; each child also requires the development of a clinical plan to address the disability, and he or she needs

a properly-trained and empowered person to monitor implementation and (when necessary) modification of the plan to ensure that its benefits are actually realized. This is not, in the well-worn phrase, rocket science; diagnosing maladies, prescribing treatments, and monitoring outcomes is at the heart of what clinicians do. Yet on the whole these medical services are not being provided, or are being provided inadequately, to the thousands of vulnerable children with serious medical needs who comprise the plaintiff class.

While children with serious emotional disturbances are, in most respects, no different from other persons with medical problems, certain unique features of their clinical environment make scrupulous attention to their medical needs especially critical. First, the complexity of their problems may require a range of services from different providers (for example, medication monitoring, behavioral supports, and crisis intervention) in different arenas (for example, home, school, or community). 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.

