UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D. et al.,	)	
	)	
on behalf of themselves and all others similarly situated,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**NO. 01-CV-30199-MAP**
	)	
MITT ROMNEY et al.,[1]	)	
	)	
Defendants.	)	
	)	

DEFENDANTS' APRIL 18, 2005 TRIAL MEMORANDUM

This memorandum is filed in compliance with the Court's March 28, 2005 request for trial memoranda summarizing applicable law and the parties' anticipated factual presentations.

SUMMARY OF APPLICABLE LAW

For adults eligible for Medicaid under Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., states are required to pay for only seven mandatory types of care and services, 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1)-(5), (17) and (21), and can choose whether or not to pay for twenty optional types of care and services, 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(6)-(16), (18)-(20), (22)-(27). States have a broader obligation for children under age 21 eligible for Medicaid under Title XIX: to pay for all types of care and services in all 27 mandatory and

[1]Pursuant to FRCP Rule 25(d)(1), defendants request substitution of the following as defendants: Mitt Romney, Governor; Ronald P. Preston, Secretary of the Executive Office of Health and Human Services; and Eric A. Kriss, Secretary of the Executive Office for Administration and Finance. The position of Commissioner of the Division of Medical Assistance has been abolished.

optional categories, whether or not included in the State Medicaid Plan. That obligation is imposed by 42 U.S.C. § 1396d(a)(4)(B), which requires states to pay for early and periodic screening, diagnostic and treatment ("EPSDT") services for children, and by 42 U.S.C. § 1396a(a)(43), which establishes certain requirements for the state's administration of its EPSDT obligations. EPSDT services are defined as screening, vision, dental, and hearing services, and (the catchall) "[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). The catchall, by referring back to § 1396d(a), incorporates the twenty seven categories of services listed there as part of the state's obligation to Medicaid-eligible children.

The state's obligation to pay for services is limited to services that are "medically necessary" for the recipient. See 42 U.S.C. § 1396 (medical assistance is "to meet the costs of necessary medical services"); 42 C.F.R. § 440.230(d) (state Medicaid agencies "may place appropriate limits on a service based on such criteria as medical necessity"). Massachusetts has implemented the requirement of medical necessity by regulation, 130 C.M.R. § 450.204, which defines a service as "medically necessary" if "(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity, and (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly. . . ."

Massachusetts pays for EPSDT services in compliance with these federal requirements.

130 C.M.R. §§ 450.141-450.149. The Massachusetts EPSDT program pays for both periodic and interperiodic visits to health care providers by recipients. Periodic visits are for the purpose of performing exams, assessments, screening, and laboratory work, 130 C.M.R. §§ 450.141, 450.143(B). Interperiodic visits are any visits for screening or treatment in addition to those required by the periodic visit schedule, 130 C.M.R. §§ 450.141, 450.143(C), and there is no limit to the number of such visits that a recipient may make, other than medical necessity, 130 C.M.R. § 450.145(C)(1). Under the Massachusetts program, EPSDT diagnosis and treatment services consist of "all medically necessary services" listed in 42 U.S.C. §§ 1396d(a) and (r) that are "required to correct or improve conditions discovered as a result of a medical screening," and "reimbursable for MassHealth Standard members under age 21 years, if the service is determined by the Division to be medically necessary." 130 C.M.R. § 450.144(A). Medically necessary services not specifically listed in any regulation, service code list, or contract will still be paid for by the Massachusetts Medicaid program, provided that the requester obtains prior authorization, § 450.144(A)(2).

OVERVIEW OF DEFENDANTS' PROOF

Plaintiffs contend that this case is "about children with serious psychiatric disabilities and emotional disturbances who need, but are not receiving, medically necessary, home-based mental health services," which plaintiffs define as "comprehensive assessments, case management, crisis services, behavioral supports and specialists, and clinical teams that are planned, arranged, and monitored by an integrated treatment team." Pl. Trial Memo., p. 1. Plaintiffs further contend that "the Mental Health Services Program for Youth (MHSPY) and the Coordinated Family Focused Care (CFFC) are the only two programs that offer home-based services to children in the Commonwealth." Pl. Trial Memo., p. 1, n. 3. Plaintiffs contend that

because of the alleged lack of home-based services, "[h]undreds of children each year remain unnecessarily institutionalized ("stuck") in psychiatric facilities and inpatient programs, costing over $20,000,000 in medically unnecessary hospitalizations." Pl. Trial Memo., p. 2. Plaintiffs conclude that defendants "have violated their duties under EPSDT and the Medicaid Act." Pl. Trial Memo., p. 15.

Defendants intend to refute these contentions with proof in the following five areas:

(1) Services are Available Statewide. The Massachusetts Medicaid program pays for the specific services that plaintiffs contend are lacking (comprehensive assessments, case management, crisis services, behavioral supports, and integrated treatment teams), and those services are available throughout the state, not just through MHSPY and CFFC.

(2) Children Receive Services. Plaintiffs' proof focuses on 43 children, the eight named plaintiffs and 35 subjects of plaintiffs' clinical review. Summary evidence as to those children receiving services from MBHP (the majority) will show that all services requested for those children have been authorized.

(3) The Particular Service Delivery Model that Plaintiffs Favor is Not Available Statewide, Nor Is It Required to Be. The MHSPY and CFFC programs are both "systems of care," a type of delivery system for children's behavioral services. Experts differ over the efficacy of the system of care approach. Massachusetts has therefore chosen to move deliberately in this area, and to test the system of care approach on a limited scale before deciding whether and how to adopt it statewide. This is a reasonable policy choice fully in accord with Medicaid law, since the state's obligation under EPSDT is to provide services, not particular service delivery systems, and since in any case the system of care approach cannot be considered medically necessary in light of the current state of research about its efficacy.

(4) Plaintiffs' Clinical Review Does Not Establish that Services are Inadequate. As previewed in Defendants' First Motion in Limine, plaintiffs' clinical review does not establish that Massachusetts is failing to pay for medically necessary services.

(5) Defendants' Efforts to Support and Enhance Children's Mental Health are Solving the "Stuck Kid" Problem. Plaintiffs contend that their Medicaid claims will solve the problem of "stuck kids," that is, children who remain hospitalized in inpatient psychiatric units when they no longer have a clinical need for that level of care (Pl. Trial Memo., pp. 2, 7, 15). Solving the "stuck kids" problem has been a primary focus of state policy for the past several years, and the multiple initiatives defendants have implemented to address that problem have resulted both in decreases in the average number of children "stuck" in inpatient care, and in the average length of time awaiting discharge. Defendants' initiatives, many of which go beyond the Medicaid program and involve other state agencies and state funds, are a more promising approach to the problem than plaintiffs' suggested solution.

I. THE SPECIFIC SERVICES THAT PLAINTIFFS CLAIM ARE LACKING ARE IN FACT AVAILABLE STATEWIDE.

A Medicaid recipient in Massachusetts, rather like a government employee, has a choice among healthcare options: she can choose a doctor or other health provider whom she likes and who is contracted with the state (her "primary care clinician" or "PCC"), in which case her behavioral health is provided by the Massachusetts Behavioral Health Partnership ("MBHP"); alternatively, and depending on where she lives, she can choose among four managed care organizations ("MCOs") that provide both medical and behavioral health services (BMC/HealthNet, Cambridge Health Alliance, Neighborhood Health Plan, and Fallon Health Plan). The Massachusetts Medicaid program specifies by contract with MBHP and with each

MCO the behavioral health services required to be covered. In general, these contracts are the same, although the MBHP contract contains some specific provisions reflective of the fact that MBHP provides behavioral health services for most children in the state's care or custody.[2] In addition to the numerous categories of behavioral health services defined by the contracts, other medically necessary services will be paid for by the Massachusetts Medicaid program so long as the requester obtains prior authorization, § 450.144(A)(2).

Plaintiffs claim that the Massachusetts Medicaid program fails to provide "comprehensive assessments, case management, crisis services, behavioral supports and specialists, and clinical teams that are planned, arranged, and monitored by an integrated treatment team," Pl. Trial Memo., p. 1. To the contrary, all of these services are available statewide pursuant to the Massachusetts Medicaid program's contracts with MBHP and the MCOs.

A. Comprehensive assessments. The first line of defense against behavioral health problems, as with children's health problems in general, is regular visits to a pediatrician or other health care provider. Medicaid recipient children are entitled to pediatric preventive health-care visits according to the following minimum schedule, based on the child's age: one to two weeks; one month; four months; six months; nine months; 12 months; 15 months; 18 months; and then every year until the child's 21st birthday. At each visit, the health care provider is required to carry out a developmental and behavioral assessment at which, among other things, the provider screens the member for delays or differences in functioning in various areas, utilizes (as appropriate) specific developmental and behavioral screening instruments, and (also as

[2]That is, children in the care or protective custody of the Department of Social Services ("DSS") or the custody of the Department of Youth Services ("DYS").

appropriate) refers the child's parent or guardian to Early Intervention services, the Massachusetts Department of Education for special education services, and for behavioral health services. In addition to the minimum schedule, Medicaid recipient children are entitled to additional health care visits to determine the existence of suspected illness, or a change or complication in a preexisting condition. And, to improve the effectiveness of these visits, Massachusetts has created a Child Psychiatry Access Project to improve access to child psychiatry for primary care providers through an arrangement that gives them a telephone consultation with a child psychiatrist within 30 minutes of request during business hours.

Once a child is referred to a behavioral health provider there are additional assessments. For example, MBHP requires all providers to prepare an individualized written assessment covering a wide variety of topics for any child entering treatment.[3] Moreover, MBHP pays for the following specialized assessments as medically necessary: (1) diagnostic evaluations (assessment of the child's level of functioning for the purposes of diagnosis and developing a treatment plan); (2) psychological testing; (3) medication visits (for psychopharmacological assessment); (4) testing services provided by developmental behavioral pediatricians; (5) assessments for safe and appropriate placement (for children in DSS custody who may have committed sexual offenses and arson); (6) comprehensive child and adolescent assessments

[3]Pursuant to MBHP's contract with the Massachusetts Medicaid program, the individualized written assessment must include (but is not limited to) review and assessment of the child's history of presenting problems, chief complaints and symptoms, past behavioral health history, past medical history, family social history and linguistic and cultural background, history of placements outside the home (for children in state care and custody), current substance use, mental status exam, previous medication trials and current medications including any allergies, diagnosis and clinical formulation, level of functioning, strengths, family strengths, and primary care clinician's name. As they intend to do at trial, defendants focus here on the MBHP contract, and omit reference to the parallel provisions of the four MCO contracts, merely for brevity.

protocol (a specialized diagnostic evaluation for the purpose of obtaining comprehensive clinical information about children in the care and or custody of DSS); and (7) special education psychological testing.

B. Case Management. The Massachusetts Medicaid program provides case management services as appropriate for a particular member's need. Under the MBHP contract, for example, any knowledgeable source can refer a child for case management services. MBHP is then required to assess the child for case management if any of a variety of clinical risk factors are present.[4] Depending on the results of that assessment, MBHP then determines whether the child is appropriate for one of three levels of case management of varying intensity. Intensive clinical management involves assignment of a clinician responsible for coordinating all aspects of the child's care; there is a specialized component of that program for special needs populations, including youth in crisis. Care coordination, a less intense level of case management, focuses on ensuring access to care and on facilitating communication among various providers. Targeted outreach focuses on addressing issues with a child's appropriate use of services, ability to keep appointments, and responsiveness. In addition, MBHP pays for Transitional Care Units which

[4]The clinical risk factors requiring assessment for care management for covered individuals under 19 years of age are (1) two admissions to a 24 hour level of behavioral health care during the past 12 months, (2) unresponsiveness of a covered individual and the family with whom the covered individual lives after the provision of three months of Family Stabilization Team Services; (3) for a covered individual aged 3 to 8, evidence of a new diagnosis or evaluation for a major mental illness which places the covered individual at risk for use of 24 hour level of behavioral health care; (4) a parent of a child or adolescent with a history of substance abuse and/or mental illness that puts the child at risk; (5) a history of trauma; (6) a failed out-of-home placement during the past 6 months; (7) multiple state agency involvement necessitating intensive care coordination; (8) multiple utilization of emergency room and emergency services program services without follow-through on treatment plan which is likely to result in the need for a 24 hour level of behavioral health care, and (9) evidence of a covered individual with a chronic or otherwise complex medical condition who is at greater risk because of a co-existing behavioral health diagnosis or issue.

offer "aggressive case management" for certain children in the care or custody of DSS.

The MBHP contract is also set up so as to facilitate case management by promoting contacts among the various family members, clinicians, and others such as teachers who are familiar with a child and her needs. In particular, the contract defines as covered services (1) family consultation (providing payment to providers when they contact a child's family to identify and plan for additional services, coordinate a treatment plan, review the child's progress, and revise the treatment plan as required), (2) case consultation (providing payment to providers when they contact other clinicians for the same purposes), and (3) collateral contacts (providing payment for similar contacts with school and day care personnel, and state and human services agency staff).

C. Crisis Services. Massachusetts maintains a statewide network of Emergency Services Program providers who provide the following crisis services seven days per week, twenty-four hours per day: (1) crisis screening (in-person assessment of an individual presenting with a behavioral health emergency, including assessment of the need for hospitalization, conducted by appropriate clinical personnel; (2) medication evaluation (assessment for and prescription of psychopharmacological medication by a psychiatrist or R.N. clinical specialist); (3) short-term crisis counseling (to stabilize the emergency); (4) crisis stabilization (short term behavioral health treatment in a structured, therapeutic environment with 24-hour observation and supervision for individuals who do not require a hospital level of care), and (5) specialing (therapeutic services provided to an individual on a one-to-one basis to maintain the individual's safety).[5] MBHP is required to ensure that covered individuals have immediate, unrestricted

[5]MBHP also provides community crisis stabilization (short term psychiatric treatment in a structured, community based therapeutic environment as an alternative to hospitalization) and

access to these services through direct self-referral (presentation at an emergency facility), MBHP's toll-free telephone line, or referral by others. The response time for a face-to-face evaluation cannot exceed one hour from notification of the need for services. Emergency services providers must provide crisis screening prior to all hospital admissions to determine whether a hospital admission is necessary.

D. Behavioral Supports and Specialists. A non-exhaustive list of services available under MBHP's contract that can fairly be described as providing "behavioral supports" includes the following: (1) community support program (an array of services, including outreach and supportive services, delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals to individuals with a history of, or at risk of, hospitalization); (2) community crisis stabilization (previously described); (3) family stabilization team services (services to provide short-term flexible support to assist caregivers in stabilizing children and adolescents in their home setting, to prevent hospitalization and allow children to move from hospitals to less restrictive settings); (4) partial hospitalization (short day programming, available seven days per week, within a stable therapeutic milieu and including daily psychiatric management); (5) community-based acute treatment for children (mental health services in a secure setting, on a 24-hour basis, as an alternative to inpatient services); (6) enhanced residential care (a program that enhances the clinical programming in certain DSS residential programs); (7) specialing (previously described) and (8) the transitional care units (previously described).

E. Integrated Treatment Teams. MBHP is required to maintain a multidisciplinary

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specialing through providers in addition to emergency services providers.

clinical staff and to ensure that its providers coordinate their efforts with state agency and local educational authority staff. After assessments are completed, a multidisciplinary treatment team is assigned to each covered individual for purposes of reviewing the assessment and initial treatment plan. Many MBHP services are provided by multidisciplinary teams; examples are community support program services, family stabilization team services, and emergency services program services. MBHP is required to institute biweekly medical-psychiatric rounds to discuss and develop plans for individuals with complex cases presenting both medical and psychiatric aspects. The treatment team is also involved in discharge planning.

In sum, the Massachusetts Medicaid program pays for "comprehensive assessments, case management, crisis services, behavioral supports and specialists, and clinical teams that are planned, arranged, and monitored by an integrated treatment team," Pl. Trial Memo., p. 1. Moreover, in the event that a child needs a service not expressly provided for by contract, the Massachusetts Medicaid program will still pay for the service provided that the requester obtains prior authorization to document the medical need for the requested services, 130 C.M.R. § 450.144(A)(2).

II. THE 43 CHILDREN WHO ARE THE FOCUS OF PLAINTIFFS' PROOF ARE RECEIVING ALL REQUESTED SERVICES.

Plaintiffs' proof that medically necessary services are supposedly lacking focuses on 43 children: the eight named plaintiffs, and the 35 children who were the subjects of plaintiffs' clinical review. Defendants will present summary evidence with respect to those children who receive services from MBHP (37 of the 43) that every request for services on their behalf has been authorized. Defendants many also call witnesses to describe the services provided to particular children in more detail to respond to plaintiffs' case.

III. THE PARTICULAR SERVICE DELIVERY MODEL THAT PLAINTIFFS FAVOR IS NOT REQUIRED TO BE AVAILABLE STATEWIDE.

In opposing defendants' summary judgment motion, plaintiffs asserted that they "have never asked this Court to compel the defendants to expand MHSPY or to provide any other particular program for those services – only that the services be fully available and effectively delivered," Pl. Oppos. to Def. Mtn. for S.J., pp. 1-2. To the extent that plaintiffs' claim is only that particular services – assessments, case management, crisis services, behavioral supports, and integrated treatment teams – are lacking, defendants' proof is as described above in Points I and II. However, because plaintiffs' Trial Memorandum, by identifying MHSPY and CFFC as "the only two programs that offer home-based services to children in the Commonwealth," Pl. Trial Memo., pp. 1 n. 3, 11, appears to identify those two programs as something that the Commonwealth is wrongly failing to provide on a statewide basis, defendants intend to offer this further response.

The MHSPY and CFFC programs are both "systems of care," a type of delivery system for children's mental health services developed approximately 15 years ago by, among others, Dr. Robert Friedman, a rebuttal expert for plaintiffs. The Massachusetts MHSPY program is a small system of care serving approximately 70 children, one of a number of such systems created with private and federal grant funding in the mid 1990s; Worcester Communities of Care ("WCC"), another small system of care, was also started, with federal funding, a few years later. However, subsequent research by, among others, Dr. Leonard Bickman and Dr. Michael Foster, experts for defendants, has called into question the efficacy of the system of care model, and in particular has suggested that systems of care cost more, yet do not necessarily lead to better clinical outcomes for children than traditional service delivery. The efficacy of systems of care

is currently a hot topic for research; one researcher is Dr. Peter Metz, the director of WCC and a child psychiatrist with twenty years' experience treating children in central Massachusetts, who will also testify for defendants.

Plaintiffs are quite right to point out (Pl. Trial Memo., pp. 9-10, n. 14) that Dr. Bickman and Dr. Metz disagree in general over the efficacy of systems of care: Dr. Bickman, based on the substantial research he has conducted and which he will describe, is pessimistic about systems of care; Dr. Metz is not. Where they agree, however, is that the current state of research in this area would not justify statewide adoption of the system of care approach. Dr. Metz will describe the research that has led him to this conclusion.

Massachusetts is committed to the principle that its Medicaid services should reflect evidence-based practice standards and empirically demonstrated treatments, as Ron Preston, Secretary of the Commonwealth's Executive Office of Health and Human Services and a defendant in this case, will testify. Accordingly, the state has moved deliberately in the area of systems of care in light of the current research. It has not adopted a statewide system of care; doing so would be inconsistent with an evidence-based approach. Rather, the CFFC program, which began in July 2003, is an effort to determine whether a system of care can successfully treat children with more severe behavioral health disorders than are treated by the MHSPY program, and on a larger scale than MHSPY. An evaluation of that effort is on-going.

Massachusetts' decision to move deliberately with respect to development of systems of care is thus clearly reasonable as a matter of policy in light of the current knowledge base in this area. It is also fully in accord with Medicaid law. The state's EPSDT obligation is to pay for services, not particular service delivery systems. Moreover, even if a system of care is considered a "service," it cannot be considered to meet the criteria for a medically necessary

service (and in particular, the requirement that there be "no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly,"130 C.M.R. § 450.204[2]), given the current state of the research. Medicaid law cannot therefore be read to require adoption of a system of care approach to children's behavioral health.

IV. PLAINTIFFS' CLINICAL REVIEW LACKS PROBATIVE VALUE.

Dr. Stephen Magnus and Dr. Richard Goldstein will explain why plaintiffs' clinical review lacks probative value.

V. DEFENDANTS' EFFORTS TO SUPPORT AND ENHANCE CHILDREN'S MENTAL HEALTH ARE SOLVING THE "STUCK KID" PROBLEM.

Secretary Preston will describe the initiatives that the Executive Office of Health and Human Services, including the Massachusetts Medicaid program and other agencies that provide services to children, have implemented to solve the problem of children who remain hospitalized in inpatient psychiatric units when they no longer have a clinical need for that level of care. Some of these initiatives aim at reducing over-reliance on hospitalization for children experiencing serious emotional disturbance; others aim at decreasing the length of time required to transition children from inpatient care to appropriate community placements. These initiatives have resulted in steady and continuing progress in the form of fewer children "stuck" in inpatient care and shorter average lengths of time awaiting discharge. Secretary Preston and others will explain why these initiatives are a more promising approach to the "stuck kids" problem than the solution that plaintiffs appear to seek, i.e., interpretation of the Medicaid law as requiring statewide adoption of the system of care approach.

Respectfully submitted,

THOMAS F. REILLY
ATTORNEY GENERAL

Attorney for Defendants

____/s/ Deirdre Roney_____
Deirdre Roney, BBO No. 652886
Assistant Attorney General
Government Bureau
One Ashburton Place - Room 2019
Boston, Massachusetts 02108
(617) 727-2200, Ext. 2093

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