

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

KIRK T. <u>et al.</u>	:	
	:	
Plaintiffs,	:	CIVIL ACTION
	:	
	:	NO. 99-3253
v.	:	
	:	
FEATHER O. HOUSTOUN	:	
	:	
Defendant.	:	
	:	

MEMORANDUM

BUCKWALTER, J.

June 23, 2000

Presently before the court is the Plaintiffs’ Motion for Summary Judgment. For the reasons given below, the motion is Granted in part and Denied in part.

I. BACKGROUND

This class action’s central claim is that the Defendant, in her role as the Secretary of the Department of Public Welfare of the Commonwealth of Pennsylvania (“DPW”), has failed to adequately provide behavioral health rehabilitative services (“BHR Services”) to children qualified for and in need of such services.¹ The Plaintiffs allege that eligible children throughout

1. Children receiving BHR Services are at risk children, who might otherwise require psychiatric hospitalization or residential placement. They typically exhibit behaviors such a physical or verbal aggression, self-injurious behaviors, oppositional or defiant behaviors, property destruction, hyperactivity, cruelty to animals, fire setting and the like.

the state are being harmed by the Defendant's policies and inactions with regard to the provision of BHR Services. Several of the Plaintiffs have allegedly waited months in order to obtain prescribed services and many children who do receive treatment do so at a level below that determined to be medically necessary.

The DPW has overall responsibility for the administration of the Medicaid program within the Commonwealth. In most parts of the state, Medical Assistance recipients benefit from either traditional "fee-for-service"² or "managed care". In a fee-for-service plan, the recipient may obtain Medical Assistance services from any provider enrolled in the Medicaid program. The provider is then paid directly by the DPW. In a managed care system, the DPW contracts with licensed Managed Care Organizations ("MCO") and pays "prepaid capitation payments or insurance premiums" to the MCO for covered services. The MCO, in turn, contracts with and pays providers to deliver services to its enrolled members.

The Secretary of the Department of Health & Human Services ("HHS") is authorized to waive certain state plan requirements in order to allow the state to provide Medical Assistance in ways that are "cost effective and efficient and not inconsistent with the purposes of" Title XIX. 42 U.S.C. § 1396n(b). The Health Care Financing Administration ("HCFA") reviews state waiver requests before granting or denying them. The DPW applied for and received two separate waivers that allowed Pennsylvania to implement mandatory managed care

2. The general types of BHR Services that are provided include:

1) Mobile Therapy ("MT"), a psychotherapy provided in the home or other community setting rather than in a clinic.

2) Behavioral Specialist Consultation ("BSC"); a consultation provided in selected cases by a mental health professional who assists the primary clinician and team in addressing particularly challenging problems that require complex behavioral interventions as well as data collection and analysis; and

3) Therapeutic Support Staff ("TSS"); provided by a "para-professional" who works one-on-one with a specific child and family, to help the child achieve the goals and objectives identified in a treatment plan.

systems in the southeast (“HealthChoices Southeast”) and southwest (“HealthChoices Southwest”) regions of Pennsylvania. With the exception of one county in the HealthChoices Southwest coverage area, the MCO that the DPW contracted with to provide BHR Services is the county or county entity. The counties, in turn, subcontract with behavioral health MCOs, which arrange for BHR Services delivery. In the parts of Pennsylvania not included in either HealthChoices program, the vast majority of recipients of BHR Services use the “fee-for-service” method.

The three count Complaint requesting declaratory and injunctive relief against the Defendant for her administration of BHR Services was filed on June 25, 1999. Count I charges the Defendant with failing to provide BHR Services with “reasonable promptness” to qualified Medicaid participants in violation of Title XIX of the Social Security Act. 42 U.S.C. § 1396a(a)(8). Count II charges the Defendant with violating 42 U.S.C. 1396a(a)(10)(B) by failing to provide comparable behavioral services to all categorically needy Medicaid recipients. Count III charges the Defendant with violating the provisions of the HCFA waiver by failing to ensure that the contractors managing BHR Services within the HealthChoices program have an adequate network of BHR providers. On September 28, 1999 the Court dismissed Defendant’s Motion to Dismiss (the “September, 1999 Order”). The Defendant’s Motion challenged the Plaintiffs’ rights to privately enforce the provisions of the Medicaid Act that were in dispute in Counts I and III. On October 15, 1999 the Court certified Plaintiffs’ as a class to represent all “Pennsylvania Medical Assistance recipients under the age of twenty-one who are eligible for Behavioral Health Rehabilitation Services”.

II. LEGAL STANDARD

Under Federal Rule of Civil Procedure 56(c), the test is whether there is a genuine issue of material fact and, if not, whether the moving party is entitled to judgment as a matter of law. Gray v. York Newspapers, Inc., 957 F.2d 1070, 1078 (3d Cir.1992). In evaluating a summary judgment motion, the court may examine the pleadings and other material offered by the parties to determine if there is a genuine issue of material fact to be tried. Fed. R. Civ. P. 56(c); see also Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986). When considering a motion for summary judgment, a court must view all evidence in favor of the non-moving party. See Bixler v. Central Pa. Teamsters Health and Welfare Fund, 12 F.3d 1292, 1297 (3d Cir. 1993).

A movant “bears the initial responsibility of informing the court of the basis for its motion, and identifying those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any which it believes demonstrate the absence of a genuine issue of material fact”. Celotex, 477 U.S. at 323. A fact is material if it might affect the outcome of the suit under the governing substantive law. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986). For the dispute over the material fact to be genuine, “the evidence must be such that a reasonable jury could return a verdict in favor of the non-moving party.” Id. To successfully challenge a motion for summary judgment, the non-moving party cannot merely rely upon the allegations contained in the complaint, but must offer specific facts contradicting the movant’s assertion that no genuine issue is in dispute. Kline v. First West Government Securities, 24 F.3d 480, 485 (3d Cir. 1994).

III. DISCUSSION

A. Count I: Reasonably prompt provision of Medicaid Services

The Plaintiffs seek summary judgment on Count I based on Defendant's failure to provide BHR Services with reasonable promptness to eligible individuals. It appears that Plaintiffs' claim only concerns the lack of timeliness in providing TSS to eligible children, as opposed to other types of BHR Services. "All individuals wishing to make an application for medical assistance under a state plan shall have opportunity to do so, and such assistance shall be furnished with reasonable promptness to all eligible individuals". See 42 U.S.C. § 1396a(a)(8). The Plaintiffs suggest several failures of the Defendant that would allow the court to grant them summary judgment. One of these includes the Defendant's failure to establish comprehensive time lines that would allow the Court to measure whether services are being provided timely. Secondly, Plaintiffs argue that summary judgment should be granted with respect to the "reasonably prompt" provision because Defendant has not adhered to the limited time lines that were established.

The Plaintiffs encourage the Court to use 42 C.F.R.441.56(e) as its guide in establishing whether DPW provides reasonably prompt TSS services. Under this regulation, the agency, after consultation with recognized medical and dental organizations involved in child health care, 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. See, 42 C.F.R.441.56(e). As the Defendant points out, this regulation does not specifically implement §

1396, which may limit its applicability.³ However, in the absence of another guide by which to base timeliness, the Court may compare the Defendant's provision of services against this standard.⁴

Plaintiffs and Defendant dispute whether there has been adequate consultation with medical providers as required by regulation. Plaintiffs claim that the groups consulted by Defendant in seeking to establish appropriate time lines did not include medical providers. Defendant answers this contention by stating that the DPW's regular consultations with the Medical Assistance Advisory Committee ("MAAC") were sufficient to satisfy the requirement of consulting with medical organizations that provide child health care.⁵ The Plaintiff does not offer contradictory evidence suggesting that either the MAAC did not meet or that it did not include the appropriate medical authorities. The Court finds that Defendants have adequately consulted with medical organizations through the MAAC. This finding does not require that Plaintiffs' Motion be denied.

3. This subpart implements sections 1902(a)(43) and 1905(a)(4)(B) of the Social Security Act, by prescribing State plan requirements for providing early and periodic screening and diagnosis of eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and providing treatment to correct or ameliorate defects and chronic conditions found. See 42 C.F.R.441.50. § 441.56(e) falls within this subpart.

4. This regulation applies to a broad array of services that can be provided to children. Therefore, an outer limit of six months should not necessarily be considered a timely initiation for TSS.

5. The Defendant declares that the MAAC was consulted in establishing BHR Services both when the BHR fee for service plan was implemented in 1994, and when the HealthChoices programs were implemented in 1997-98. According to 42 C.F.R. § 431.12(d), the MAAC must include--

- (1) Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care;
- (2) Members of consumers' groups, including Medicaid recipients, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and
- (3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

1. Has the Defendant established time lines to measure reasonable promptness?

Regardless of whether the regulation or merely the statute is used as a guide, services must still be provided with reasonable promptness. Plaintiffs argue that it is the failure of Defendant to properly establish comprehensive guidelines to ensure that the authorization of BHR Services occurs promptly that leads to the law's violation. If the regulation were to govern, this contention would be true. For example, in the counties with mandatory managed care, the Defendant requires that MCOs provide TSS services within seven days of authorization. But the Plaintiffs object to the lack of temporal guidelines which can lead to long delays between a request for services, and an authorization of services. "Where the state agency fails to promulgate regulations establishing an express time for responding to requests for prior approval, as the defendant has failed to do, courts are uniquely suited to determining what is reasonable" under the Medicaid Act". Even in the absence of a specific regulation requiring the establishment of "time limits" for the provision of Medicaid services, courts have approved decrees or imposed time limits for the processing of prior authorization requests for Medicaid-covered services. See Kessler v. Blum, 591 F.Supp. 1013 (S.D.N.Y.1984); Smith v. Miller, 665 F.2d 172, (7th Cir. 1981). It should be noted, however, that the courts in these cases found objectionable the lack of a time line by the agencies after the necessity of the Medicaid services had already been decided but before the treatment was provided. In this case, the Defendant has at least created a post-authorization time line for MCOs in the HealthChoices regions. The Defendant complains of Plaintiffs' interference with the procedures it has established in order to treat BHS. But the particular steps that Defendant implements, while crucial to the overall success of the Medicaid program, do not necessarily result in compliance

with the law. Defendant may be 100% correct when it maintains that every step it requires before authorizing services is necessary, but if it has not instituted standards by which to measure whether treatment's initiation would be considered timely, it can have no basis to determine whether services are being provided with reasonable promptness.

2. Has the Defendant complied with the time lines it has established?

This Court stated in its September 1999 Order that it might be reasonable to use time limits established by the Department in its contracts with MCOs as a baseline for measuring whether DPW is in substantial compliance with § 1396a(a)(8). As discussed above, the only time limit that Defendant has established is a seven day period in which clinical interventions should occur after the necessity of BHR services is approved. This is not the standard by which Plaintiffs ultimately think reasonable promptness should be measured. They do provide evidence of the Defendant's own studies in which the vast majority of TSS eligible children are not being accommodated within seven days of authorization. Defendant does not actually contest this assessment. Instead she asserts that they have established procedures that assure prompt provision of services. Noticeably, the Defendant does not point to which procedures these are or how she measures timeliness in the provision of services. Even though the Defendant adequately consulted and established standards for screening potential TSS recipients, these consultations have failed to establish adequate measures of timeliness. The Defendant is correct in assessing that the seven day contractual standard does not necessarily equate to compliance with § 1396, but in the absence of any other measure, the Court believes it is a useful guide at this stage of the litigation. The Court is sympathetic to Defendant's position that Plaintiffs are "asking for too much" and that her policies are designed to sufficiently screen individuals before prescribing

TSS services. However, the fact the screening policies are necessary does not suspend the need for the timely initiation of services. This Court might ultimately decide that Plaintiffs' suggested thirty day (30) comprehensive time line is unrealistic. However, at this juncture, there seems to be no dispute that many children within the HealthChoices regions are not receiving reasonably prompt TSS services as defined by DPW's own guidelines. Until the state develops some method of measuring timeliness, it will be impossible to tell whether the state is in compliance with the Medicaid statute. Therefore, summary judgment will be granted to Plaintiffs on Count 1 concerning the reasonably prompt administration of TSS services.

B. Count II: Discrimination against the categorically needy

Count II of the Complaint alleges that the DPW has violated 42 U.S.C. § 1396a(a)(10)(B), generally known as the "comparability of services" provision. That section provides "... the medical assistance made available to any [categorically needy individual] shall not be less in amount, duration or scope than the medical assistance made available to any other such individual". The waiver by HCFA that allowed DPW to place Medicaid recipients in the mandatory managed care programs exempts compliance with this provision. Therefore, Plaintiffs' are challenging the comparability of services provided within the ranks of the categorically needy outside of the HealthChoices regions (the fee-for-services counties).

The Plaintiffs' basic argument is that there are vast differences in wait time for the initiation of BHR treatment among BHR eligible children living in the non-HealthChoices regions of the Commonwealth. They claim that these discrepancies discriminate among individuals who are categorically needy in violation of § 1396a(a)(10)(B). See Rodriguez v. City of New York, 197 F.3d 611 (2d Cir. 1999) (holding that states are precluded from discriminating

against or among the categorically needed). The Second Circuit reiterated that § 1396a(a)(10)(B) does not require a state to fund a benefit that it currently provides to no one, but that the section only is applicable in situations where the same benefit is funded to some recipients but not others. Id. at 616. Courts have granted summary judgment to other Medicaid plaintiffs when recipients were placed on waiting lists while others were provided services. See Sobky v. Smoley, 855 F.Supp. 1123, 1142 (E.D. Cal. 1994) (holding that state's undisputed failure to fund enough methadone maintenance slots for all of the categorically needy who were eligible violated § 1396a(a)(10)(B)). In the present case, the Plaintiffs have presented evidence that some BHR eligible children are waiting for BHR services longer than others in at least several "fee for service" counties. However, the Court can not determine, based upon the evidence placed before it, how widespread this problem is in the fee-for-service counties. The mere fact that some children are waiting longer than others does not entitle the Plaintiffs to summary judgment. The Court can also not conclusively find that the reason for the discrepancy is due to budgetary limitations, bureaucratic requirements or other reasons. Therefore, summary judgment can not be granted to the Plaintiffs on Count II.

C. Count III: Violations of the HCFA Waiver

Count III charges the Defendant with violating provisions of the waiver granted to DPW by failing to ensure that its MCO contractors have adequate networks of BHR Services providers. According to federal regulations, the state must obtain assurances from each contractor that it has the ability to provide the services under the contract efficiently, effectively, and economically and that it furnishes the health services required by enrolled recipients as promptly as is appropriate. See 42 C.F.R. §§ 434.50 and 434.52. The Defendant has established

mechanisms to monitor the MCOs with which it contracts. Unfortunately, these MCOs appear to be telling the Defendant that they are not able to provide services as promptly as appropriate. The Court finds the requirements of § 434.52 to be not merely procedural, but substantive. The evidence suggests that there are several reasons, including those beyond the control of the state, why services are not promptly delivered. But there is no material dispute that the only assurances received by the state are that its contracting MCO's are having a difficult time delivering prompt BHR Services. Therefore, summary judgment will be awarded to Plaintiffs on Count III.

IV. CONCLUSION

The expansion of the Medicaid program that required coverage of BHR Services in the early 1990s has created significant challenges for states attempting to comply with the Act's provisions. The Department has responded well in many ways to these new challenges. However, it has not adequately provided prompt treatment to many within the Plaintiff class. One reason for this problem is that the Department has never established adequate time lines by which to measure the prompt initiation of BHR Services. Secondly, there is a lack of timeliness in the provision of BHR Services within the HealthChoices' counties. The Court has not decided that the state must revise its guidelines for prescribing BHR Services. It also has not concluded that the state must pay more to ensure a greater numbers of available TSS services or lower the qualifications for TSS staff members. Nevertheless, the Plaintiffs are entitled to summary judgment on Counts I and III of their Complaint because they have produced undisputed evidence that services are not being provided promptly.

An appropriate order follows.

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FEATHER O. HOUSTOUN	:	
	:	
Defendant.	:	
	:	

ORDER

AND NOW, this 23rd day of June, 2000, after careful consideration of the Plaintiffs' Motion for Summary Judgment (Docket No. 30), the Defendant's Response thereto (Docket No. 33); the Plaintiffs' Reply (Docket No. 35) and the Defendant's Sur-reply (Docket No. 38); it is hereby **ORDERED** that the Motion is **GRANTED** in part and **DENIED** in part. More specifically, it is **FURTHER ORDERED** that Summary Judgment is Granted as to Counts I and III of the Plaintiffs' Complaint and Denied as to Count II.

BY THE COURT:

RONALD L. BUCKWALTER, J.