

Serious Emotional Disturbances: Children's Fight for Community-Based Services Through Medicaid Litigation

*"[C]hildren 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."*¹

I. INTRODUCTION

There is a crisis in the mental health care system in the United States.² Children with mental illnesses endure long waiting lists in order to gain access to short-term, fragmented, and inappropriate services instead of receiving long-term, individualized, and coordinated medical care.³ Inadequate care affects many aspects of a child's life.⁴ A child with an untreated mental health disorder may endure unnecessary time in a hospital, delay in accessing medical treatment, misdiagnoses, difficulty in school, or removal from his family.⁵

1. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 24 (D. Mass. 2006) (summarizing inadequacy of in-home services and resulting negative implications for children with serious emotional disturbance).

2. PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, *ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA* 3, 22 (2003), available at <http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf> [hereinafter PRESIDENT'S NEW FREEDOM COMM'N] (stating mental health system "fragmented and in disarray"); U.S. DEP'T OF HEALTH AND HUMAN SERVS., *MENTAL HEALTH: A REPORT OF THE SURGEON GEN.* 73 (1999), available at <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf> (labeling United States mental health system "*de facto* mental health system"); Lois A. Weithorn, *Envisioning Second-Order Change in America's Response to Troubled and Troublesome Youth*, 33 HOFSTRA L. REV. 1305, 1319-23 (2005) (arguing mental health system disjointed and not actually systematic).

3. See Leigh Mello, *Department of Mental Health Continuing Care Services*, in 2 LEGAL RIGHTS OF INDIVIDUALS WITH DISABILITIES ch. 19, § 19.1 (2002) (reporting budget deficit causing long waiting lists for continuing services); PRESIDENT'S NEW FREEDOM COMM'N, *supra* note 2, at 35 (explaining every consumer needs individualized plan); ARIEL FRANK ET AL., *THE EXPERIENCES OF MASSACHUSETTS FAMILIES IN OBTAINING MENTAL HEALTH CARE FOR THEIR CHILDREN* 1 (2002), <http://www.ppal.net/downloads/speakout2.pdf> (summarizing survey answers from parents of children with mental illnesses in Massachusetts).

4. Gail B. Nayowith, *Before It's Too Late: Ending the Crisis in Children's Mental Health*, 185 PRAC. L. INST. 477, 485 (2000) (including suicide, crime, and drug use among effects of untreated mental health disorders).

5. MARK GHALY, *THE MASSACHUSETTS MENTAL HEALTH POLICY FORUM, ISSUE BRIEF: CHILDREN'S MENTAL HEALTH IN THE COMMONWEALTH* 1 (2002), <http://masshealthpolicyforum.brandeis.edu/publications/pdfs/14-May02/IB%20ChildMentalHealth%2014.pdf> (defining "stuck kids" as children who cannot leave hospitals due to lack of appropriate placements); see Mello, *supra* note 3, at § 19.5 (stating qualification for treatment does not guarantee treatment if not immediately available); see Nayowith, *supra* note 4, at 485

Children with serious emotional disturbances (SED) are particularly vulnerable to the problems in the mental health care system because a child with SED may require many different types of treatment throughout the different stages of his illness.⁶ During an emergency crisis, a child may need intensive inpatient treatment; however, when the child is no longer in an emergency situation, community-based or outpatient programs may be more appropriate.⁷ After receiving the appropriate treatment in the hospital, a child often becomes “stuck” in the hospital because appropriate outpatient programs are unavailable.⁸ The required services are frequently unavailable when the patient needs them, and children are hospitalized or institutionalized longer than necessary.⁹

Across the country, advocates for mentally ill children sue state agencies and persuasively argue that the states are legally required to remedy the mental health care system by implementing community-based or wraparound services.¹⁰ Cases arise under the Americans with Disabilities Act (ADA), the Individuals with Disabilities Education Act (IDEA), and the Medicaid Act.¹¹ This Note will focus on the cases brought under the early and periodic screening, diagnostic, and treatment services (EPSDT) requirement of the Medicaid Act.¹²

Part II of this Note will examine “stuck kids” and wraparound services, as they relate to the legal arguments made by child advocates.¹³ Part III will briefly explain the cases brought on behalf of emotionally disturbed children under the ADA and IDEA.¹⁴ In Part IV, the Medicaid Act and the EPSDT requirements are explained.¹⁵ Additionally, Part IV will highlight the significant cases shaping the legal interpretations of EPSDT requirements and how they relate to community-based care for children with serious emotional

(listing effects of untreated mental health problems).

6. *Rosie D.*, 410 F. Supp. 2d at 34 (noting special assessment needs of children suffering from SED).

7. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 23-26 (D. Mass. 2006) (discussing extensive needs of children with SED).

8. See *infra* text accompanying notes 31-34 (explaining stuck kids phenomenon).

9. See Weithorn, *supra* note 2, at 1309-10, 1363-67 (describing stuck kids).

10. See Weithorn, *supra* note 2, at 1364-67 (noting advocates' efforts to remove children from institutions); see also *infra* note 36 and accompanying text (defining wraparound services).

11. Individuals with Disabilities Education Act, 20 U.S.C. §§ 1400-1482 (2006); Medicaid Act, 42 U.S.C. §§ 1396-1396v (2006); Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213 (2006); see Weithorn, *supra* note 2, at 1363-67, 1425-35 (explaining cases brought under IDEA, ADA, and Medicaid Act). See generally Lucy W. Shum, *Educationally Related Mental Health Services for Children with Serious Emotional Disturbance: Addressing Barriers to Access through the IDEA*, 5 J. HEALTH CARE L. & POL'Y 233 (2002) (highlighting use of IDEA to obtain educationally related services for youths).

12. 42 U.S.C. § 1396d(r) (making early and periodic screening, diagnostic, and treatment services mandatory).

13. See *infra* Part II (reviewing stuck kids and wraparound services).

14. See *infra* Part III (examining cases brought under ADA and IDEA).

15. See *infra* Part IV (explaining Medicaid Act and EPSDT requirements).

disturbances.¹⁶ This Note will then analyze, in Part V, the winning arguments of child advocates and the unreliable relief that states provide after Medicaid-eligible children win in court.¹⁷

Part VI discloses the conclusion that the advocates' arguments for individualized, community-based services for all children are morally and legally correct, but difficult to implement through court action due to economic and administrative reasons.¹⁸ Advocates will continue to win cases, but courts will most likely only require states to meet the minimal requirements of the Medicaid Act.¹⁹

II. STUCK KIDS AND THE WRAPAROUND MOVEMENT

For the past sixty years, the United States's policy has moved towards deinstitutionalizing the mental health system and moving it back into the community.²⁰ Critics argue that the deinstitutionalization of America's mental health system was handled poorly.²¹ In 1963, Congress allocated federal funds to build and staff community-based mental health centers by enacting both the Community Mental Health Centers Act and the Mental Retardation and Community Mental Health Centers Construction Act.²² Through these Acts, Congress hoped to eventually "render traditional mental hospitals obsolete" and to provide effective care in the community for individuals who would otherwise spend their lives in state institutions.²³ Many state hospitals and institutions were closed, yet the care in most of the new replacement community-based facilities remained insufficient.²⁴ Even worse, the federal government consistently under-funded the mental health care system after it initially decreased federal funding in the 1970s.²⁵ People who previously

16. See *infra* Part IV (highlighting significant EPSDT cases).

17. See *infra* Part V (analyzing child advocates arguments and state remedies).

18. See *infra* Part VI (concluding court remedies not effective for relief).

19. See *infra* Part VI (predicting minimal requirements of Medicaid Act insufficient remedy).

20. See Weithorn, *supra* note 2, at 1465-66 (explaining deinstitutionalization efforts in second half of the twentieth century).

21. See Weithorn, *supra* note 2, at 1463-73 (arguing American deinstitutionalization process poorly implemented).

22. See Weithorn, *supra* note 2, at 1466-67 (citation omitted) (discussing congressional action in deinstitutionalization procedures).

23. See Gerald N. Grob, *Deinstitutionalization: The Illusion of Policy*, in HEALTH CARE POLICY IN CONTEMPORARY AMERICA 48, 52-53 (Alan I. Marcus & Hamilton Cravens eds., 1997) (discussing history of mental health care policy in United States); Weithorn, *supra* note 2, at 1466-67 (summarizing policy goals).

24. See Weithorn, *supra* note 2, at 1468 (summarizing the history of community-based mental health care in United States).

25. Charles G. Ray & William Kanapaux, *Community Mental Health Centers at the 40-Year Mark: The Quest for Survival*, in MENTAL HEALTH, UNITED STATES, 2002 9, 10-11 (Ronald W. Manderscheid & Marilyn J. Henderson eds., 2002), available at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA04-3938/Chapter02.asp> (highlighting federal government's decreased role in mental health care in 1970s). In 1981, President Reagan's administration discontinued the revitalization of the mental health care system by repealing the Mental Health Systems Act enacted in 1980. See Mental Health Systems Act, Pub. L. No. 96-

received care in state hospitals could not always find adequate care in these new community-based facilities.²⁶ Those lacking adequate care instead moved in and out of mental hospitals, visited emergency rooms during emotional crises, stayed in medical wards until beds in the psychiatric ward were vacated, and became entangled in the criminal justice system.²⁷ Many individuals with mental illnesses became worse off in the under-funded, deinstitutionalized system than they were in the pre-existing institutionalized system.²⁸

Despite efforts to deinstitutionalize, the use of inpatient services by mentally ill children increased as the federal government focused on expanding community-based services.²⁹ Children seeking community-based mental health services faced exceptionally long waiting lists and became “stuck” in improper levels of care due to difficulties in accessing services.³⁰ Quickly, a phenomenon known as “stuck kids” or “kidlock” began to emerge.³¹ “A ‘stuck kid’ is a child who, although ready for discharge from a psychiatric facility, hospital, or residential treatment center, is unable to leave that facility because an appropriate placement is not available.”³² Consequently, children are either

398, §§ 201-204, 95 Stat. 560 (1980) (repealed 1981) (granting federal funding of community-based mental health programs while focusing on poorly-served populations); Weithorn, *supra* note 2, at 1468-69 (discussing history of federal involvement in mental health care system). When amounts are corrected for inflation, the federal government has not increased funding for mental health services in the past two decades. Weithorn, *supra* note 2, at 1468-69 (discussing stagnated funding of mental health care system in United States).

26. See Weithorn, *supra* note 2, at 1469 (explaining repercussions of mental health deinstitutionalization process).

27. See Weithorn, *supra* note 2, at 1469 (discussing consequences of mental health deinstitutionalization process).

28. See Weithorn, *supra* note 2, at 1310 (quantifying detrimental effects of mental health deinstitutionalization process).

29. See Weithorn, *supra* note 2, at 1362-63 (highlighting increased usage of inpatient services).

30. *Oversight Hearing on Children’s Mental Health: Hearing Before the Joint Committee on Mental Health and Substance Abuse*, 184th Gen. Court (Mass. 2006), available at http://www.mass.gov/Eeohhs2/docs/dmh/g_mhsa_3_6_06.pdf (testimony of Elizabeth Childs, Comm’r, Mass. Dep’t of Mental Health) (explaining Massachusetts established Children’s Mental Health Commission for examining medical services waiting lists); Mello, *supra* note 3, at § 19.5 (stating qualifying for program does not guarantee placement because of long wait for services); Weithorn, *supra* note 2, at 1363-64 (discussing waiting lists for children with mental illnesses); GHALY, *supra* note 5, at 12-13 (explaining Massachusetts established Children’s Mental Health Commission to examine waiting lists for medical services).

31. See Nayowith, *supra* note 4, at 481 (describing “kidlock” as primary problem in New York mental health crisis); Weithorn, *supra* note 2, at 1362-67 (discussing “stuck kid” phenomenon). Statistics on the number of stuck kids are often used as an indicator of how well the mental health system in a state is functioning. GHALY, *supra* note 5, at 5. “[T]he number of stuck kids is directly proportional to the demand [for children’s mental health services and] inversely proportional to service availability. *Id.* at 5. The number of “stuck kids” has drastically risen between 1998 and 2003, suggesting that access to mental health services has become increasingly difficult. *Id.* at 5; see *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52 (D. Mass. 2006) (discussing rise of “stuck kids” from thirty-two to 138 per year).

32. CTR. FOR PUB. REPRESENTATION, A REPORT ON HOME-BASED SERVICES FOR CHILDREN IN MASSACHUSETTS WITH SERIOUS EMOTIONAL DISTURBANCE I (2005), available at http://www.centerforpublicrep.org/uploads/y5/Ge/y5GefQLI95VohqpMf5P2g/Expert_summary.PDF (reporting study results indicating need for children’s home-based services in Massachusetts); GHALY, *supra* note 5, at 5 (accounting for difficulty in accessing services with “stuck kid” theory); “Stuck kids” fill the

in hospital settings longer than medically necessary because there are no alternative community-based treatment facilities available, or they are left without adequate treatment during crisis episodes because there are no spaces available to them in hospitals.³³ As a result, children's mental health services are primarily available to children in crisis situations who are in immediate and serious need of care.³⁴ To stop the cycle of crisis-orientated care, child advocates fight for access to individualized, appropriate, and community-based services before children's symptoms reach an emergency level.³⁵

The term "wraparound" emerged in the 1980s to describe "the application of an array of comprehensive community-based services to individual families."³⁶ Wraparound services provide individually designed, team-based treatment

limited number of available acute care beds, which in turn creates extensive waiting lists for emergency teams who need to place seriously disturbed children in institutional settings. CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 1. Children in emotional crises wait for beds in a psychiatric setting while they receive treatment in non-psychiatric emergency rooms or pediatric units of hospitals where they risk receiving inappropriate treatment or no treatment at all. GHALY, *supra* note 5, at 5.

33. *Oversight Hearing on Children's Mental Health: Hearing Before the Joint Committee on Mental Health and Substance Abuse*, 184th Gen. Court (Mass. 2006), available at http://www.ppal.net/documents/Oversight_hearing_on_childrens_mh.pdf (testimony of Lisa Lambert, Assistant Dir., Parent/Prof'l Advocacy League) (discussing work with "stuck kids" when member of Children's Mental Health Commission in Massachusetts). Mentally ill children are often "episodic" and need the flexibility to move between different levels of care. LISA LAMBERT, *MEDICAID BEHAVIORAL HEALTH CARE FOR CHILDREN AND ADOLESCENTS: KEY CONSIDERATIONS AND ESSENTIAL ELEMENTS 2* (2005), <http://www.ppal.net/documents/MedicaidBehavioralHealthandkids.pdf> [hereinafter LAMBERT, *KEY CONSIDERATIONS*] (reiterating importance of choice among range of providers). Children become stuck when they cannot receive varying treatments in differing settings. *Id.*

34. *Child's Oversight Hearing Testimony*, *supra* note 30 (noting lack of mental health services unless child in crisis); GHALY, *supra* note 5, at 10 (asserting eligibility for services based on "duration of symptoms, severity of symptoms, and disease burden"). In 1999, the National Institute of Mental Health estimated that, in any given year, "one in [ten] children and adolescents" suffered from a serious emotional disturbance and that fewer than "one in five of these children" actually received the treatment they needed. FRANK ET AL., *supra* note 3, at 5 (reporting results of survey questioning parents about access to mental health care).

35. PRESIDENT'S NEW FREEDOM COMM'N, *supra* note 2, at 35-36 (recommending individualized plans of care in order to achieve recovery); FRANK ET AL., *supra* note 3, at 1 (advocating "less reliance on crisis care"). Evidence suggests that children with SED are less likely to experience episodes that require hospitalization if they receive proper case management services and home support. *Rosie D.*, 410 F. Supp. 2d at 52 (acknowledging increase in "stuck kids" due to inadequate services); see CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 6 (noting residential care avoided when "integrated and intensive services [offered] at home").

36. John VanDenBerg et al., *History of the Wraparound Process*, FOCAL POINT (Research and Training Ctr. on Family Support and Children's Mental Health, Portland, Or.), Fall 2003, at 2, 4-5 available at <http://www.rtc.pdx.edu/PDF/fpF0302.pdf> (describing basic elements of wraparound process). California's Welfare and Institutions Code defines wraparound services as "community-based intervention services that emphasize the strengths of the child and family and includes the delivery of coordinated, highly individualized unconditional services to address needs and achieve positive outcomes in their lives." CAL. WELF. & INST. CODE § 18251(d) (2001). Wraparound plans often include the following: family and child involvement; crisis stabilization and planning; strengths and needs assessment; wraparound team formation; and wraparound service plan development and implementation. See *Katie A. v. Bonta*, 433 F. Supp. 2d 1065, app. A (C.D. Cal. 2006) (listing components of wraparound services and federal statutory authorization), *rev'd* *Katie A. v. L.A. County*, 481 F.3d 1150 (9th Cir. 2007).

plans for every patient.³⁷ Every wraparound plan is flexible, meeting the unique needs of each child and often focuses on keeping the child with his or her family.³⁸ Home-based services are often priced lower than crisis-orientated services so they are both more responsive to the patient and cheaper for the state's budget.³⁹ A few states offer comprehensive wraparound services to children through the state Medicaid program; however, most states do not offer comprehensive programs to children with mental illness.⁴⁰ Mentally ill children, their families, and advocates have brought winning litigation against state agencies demanding that states provide mentally ill children with the individualized, community-based care they need.⁴¹ Advocates hope that the mental health system will eventually offer: home and community-based care, family partnerships, comprehensive services and supports, cultural competence, individualized care, evidence-based practices, coordination of service delivery, early identification and intervention, and accountability.⁴²

III. THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT AND THE AMERICANS WITH DISABILITIES ACT

Congress passed the Individuals with Disabilities Education Act in 1975 to create a nationwide policy addressing special education needs and to integrate disabled children into the public education system.⁴³ Cases brought under the IDEA are largely ineffective at obtaining in-home services for children with SED because claims brought under the IDEA generally must be education related.⁴⁴ “[H]earing officers and courts have been reluctant to hold schools

37. *Katie A.*, 433 F. Supp. 2d. at app. A (describing wraparound services).

38. DEBORAH POTTER & VIRGINIA MULKERN, HUMAN SERVICES RESEARCH INSTITUTE, WRAPAROUND SERVICES 1, 5 (2004), available at http://www.cshp.rutgers.edu/cle/products/SEDBriefIVWraparound_Services.pdf (explaining wraparound programs supported by Surgeon General and New Freedom Commission); VanDenBerg et al., *supra* note 36, at 6 (discussing wraparound services); see LAMBERT, KEY CONSIDERATIONS, *supra* note 33, at 2 (advocating flexible care for children in Massachusetts).

39. CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 19-20 (arguing Massachusetts could significantly cut costs by implementing wraparound services). Home-based services generate significant cost savings because “expensive services, such as inpatient hospitalization, residential treatment programs, out-of-home placements and repeated reliance on emergency services[.]” are used less often. *Id.*

40. See *Katie A.*, 433 F. Supp. 2d at 1076 (explaining state's funding and use of wraparound services). Successful wraparound programs include: The Alaska Youth Initiative, Wraparound Milwaukee, Community-Based Intensive Services in Rhode Island, Chicago's Kaleidoscope Program, the Willie M. Program in North Carolina, and the Mental Health Services Program for Youth. CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 21-24 (highlighting community-based programs); VanDenBerg et al., *supra* note 36, at 4-5 (noting wraparound services in Alaska and North Carolina).

41. *Infra* Part III (explaining ADA and IDEA); *infra* Part IV (discussing federal Medicaid Act).

42. PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, SUBCOMMITTEE ON CHILDREN AND FAMILY, POLICY OPTIONS 2 (2003), available at http://www.mentalhealthcommission.gov/subcommittee/children_family020703.doc (announcing vision for mental health care for children).

43. Individuals with Disabilities Education Act, 20 U.S.C. § 1401 (2006); see Weithorn, *supra* note 2, at 1425-35 (discussing use of IDEA to litigate for community-based services).

44. See generally TAMMY SELTZER, BAZELON CENTER FOR MENTAL HEALTH LAW, TEAMING UP: USING

responsible for providing in-home . . . services . . . [unless an] advocate [has] a strong case that these services are necessary for educational purposes.”⁴⁵

The IDEA statute does however provide a legal definition of serious emotional disturbance that advocates and courts commonly borrow.⁴⁶ A child has a serious emotional disturbance, and is classified as a “child with a disability” under the IDEA, when a doctor diagnoses the child with a mental illness and the child also displays impaired functioning that is expected to last for one year or more.⁴⁷ Children with mental illnesses such as attention deficit disorder, schizophrenia, depression, and bi-polar disorder may be classified as SED.⁴⁸

Children with emotional disturbance exhibit specific characteristics or behavior, including: difficulty with daily living tasks, difficulty meeting basic needs, extreme vulnerability to stress, increased tendency toward substance abuse, episodes of aggression, acting out or risk-taking that endangers themselves or others, depression or suicidal thoughts, actions or attempts, inability to form or sustain personal relationships, difficulty functioning in school, day care, or another normative setting, [and] bizarre thoughts and behaviors.⁴⁹

Like most children with a mental illness, children with SED require extensive and long-lasting medical and support services.⁵⁰

Congress enacted the ADA in 1990 to promote “equality of opportunity, full participation, independent living, and economic self-sufficiency” for people with disabilities.⁵¹ Lawsuits brought under the ADA are based on equal protection and disability theories that promote participation in society, independence, and self-reliance.⁵² A 1999 case decided under Title II of the

THE IDEA AND MEDICAID TO SECURE COMPREHENSIVE MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH 9 (2003), available at <http://www.bazelon.org/issues/children/publications/teamingup/report.pdf> (discussing case law and litigation strategies for obtaining mental health services for children).

45. See SELTZER, *supra* note 44, at 9 (explaining cases seeking in-home behavioral services through IDEA).

46. 20 U.S.C. § 1401(3)(A)(i) (defining “child with a disability” as including child suffering from serious emotional disturbance); see *Rosie D. v. Romney*, 474 F. Supp. 2d 238, 240 (D. Mass. 2007) (requiring state’s incorporation of IDEA’s definition of SED when determining eligibility for Medicaid services).

47. *Rosie D. v. Patrick*, 497 F. Supp. 2d 76, 77 (D. Mass. 2007) (defining child with disability); *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 32-33 (D. Mass. 2006) (defining SED). A child must be diagnosed with a psychiatric condition listed in the Diagnostic and Statistical Manual of Mental Disorders IV in order to have SED. Nayowith, *supra* note 4, at 486. See generally AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS IV (4th ed. 1994) (defining mental disorders).

48. Nayowith, *supra* note 4, at 486 (listing mental disorders developing into SED).

49. Nayowith, *supra* note 4, at 486 (explaining behaviors associated with SED).

50. See Nayowith, *supra* note 4, at 486 (discussing treatment for SED).

51. Americans with Disabilities Act, 42 U.S.C. § 12101(a)(8), (b)(1)-(3) (2006) (mandating nondiscrimination for people with disabilities).

52. See Weithorn, *supra* note 2, at 1425-26 (discussing how IDEA and ADA used in litigation for

ADA, *Olmstead v. L.C.*,⁵³ spurred attention, policy, and legislation aimed at moving institutionalized individuals into the community.⁵⁴ In *Olmstead*, the Supreme Court recognized that states must manage assistance “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”⁵⁵ The Court ruled that states have an obligation to make “reasonable modifications” in order to provide community-based services to people interested in utilizing them and capable of functioning in community settings.⁵⁶ Subsequently, President George W. Bush issued an Executive Order instructing several federal agencies to assist states in implementing the Supreme Court’s mandate in *Olmstead*: to help states transition eligible individuals away from institutions and into community settings.⁵⁷ Scholars suggest that the Medicaid program may need restructuring in order for the *Olmstead* mandate to be successful.⁵⁸

IV. MEDICAID AND THE EPSDT SERVICES

Congress passed the federal Medicaid Act in 1965 under Title XIX of the Social Security Act to help ensure that American citizens have adequate health insurance.⁵⁹ Today, Medicaid programs throughout the nation provide public health insurance for over fifty-five million low-income individuals, including the elderly, disabled, low-income workers, and children.⁶⁰ Although most Medicaid recipients are families with children, the majority of funding is spent

community-based services).

53. 527 U.S. 581 (1999).

54. *Id.*; 42 U.S.C. § 12132 (disallowing exclusion of disabled person from publicly operated programs); see Weithorn, *supra* note 2, at 1430–34 (explaining impact of ADA and *Olmstead* decision).

55. *Olmstead*, 527 U.S. at 592 (internal quotations omitted) (quoting 28 C.F.R. § 35.130(d) (1998)) (ruling states must attempt integration of disabled individuals into community).

56. *Id.* at 592, 602–03. See generally 28 C.F.R. § 35.130(b)(7) (requiring states make “reasonable modifications” of programs unless modifications would “fundamentally alter” program).

57. Exec. Order No. 13,217, 66 Fed. Reg. 33,155 (June 18, 2001) (instructing federal agencies to assist states in transitioning individuals from institutions to community-based programs); see also Weithorn, *supra* note 2, at 1433 (discussing Executive Order in aftermath of *Olmstead* case).

58. See Weithorn, *supra* note 2, at 1430–34 (discussing effects of *Olmstead* case). See generally Sara Rosenbaum et al., *Olmstead v. L.C.: Implications for Medicaid and Other Publicly Funded Health Services*, 12 HEALTH MATRIX 93 (2002) (explaining effects of *Olmstead* case on Medicaid); Sandra L. Yue, *A Return to Institutionalization Despite Olmstead v. L.C.? The Inadequacy of Medicaid Provider Reimbursement in Minnesota and the Failure to Deliver Home-and-Community-Based Waiver Services*, 19 LAW & INEQ. 307 (2001) (discussing Minnesota community-based Medicaid services after *Olmstead* decision).

59. Medicaid Act, 42 U.S.C. §§ 1396–1396v (2006) (codifying Medicaid funding to states); Social Security Act, 42 U.S.C. Ch. 7, Subch. XIX (2006) (granting money to states for medical assistance programs); THE KAISER FAMILY FOUND., KAISER COMM’N ON MEDICAID AND THE UNINSURED, THE MEDICAID PROGRAM AT A GLANCE, 1 (2007), available at <http://www.kff.org/medicaid/upload/7235-02.pdf> [hereinafter MEDICAID AT A GLANCE] (providing basic overview of Medicaid program).

60. MEDICAID AT A GLANCE, *supra* note 59, at 1 (describing basic overview of Medicaid program). In 2005, Medicaid spending accounted for “nearly one-fifth of all personal health care spending in the United States.” *Id.*

on the elderly and disabled.⁶¹ Most individuals covered by Medicaid cannot access private health insurance because they cannot afford it, their employers do not offer it, or they are excluded due to a disability or chronic illness that private insurers do not cover.⁶²

States participating in Medicaid programs must meet minimum federal requirements to remain eligible for federal funding.⁶³ States, however, have ample discretion to determine medical assistance available under Medicaid as long as they act reasonably and consistently with the objectives of the Act.⁶⁴ Disagreements about coverage between the state administrative agency and recipients commonly ensue when the Medicaid statute does not precisely define a requirement.⁶⁵ For instance, the Omnibus Budget Reconciliation Act of 1989 made EPSDT services mandatory for children under the age of twenty-one; however, it is unclear whether the requirement includes wraparound services.⁶⁶ The Medicaid Act does not explicitly state that enrollees have a federal right to medical benefits, but many recipients have sued state officials for discrimination under 42 U.S.C. § 1983 in attempting to enforce the EPSDT provision and their right to community-based services.⁶⁷ Not all Medicaid

61. MEDICAID AT A GLANCE, *supra* note 59, at 1 (summarizing allocation of spending under Medicaid Act). In 2003, seventy percent of Medicaid spending benefited elderly and disabled recipients. *Id.* In 2003, spending was \$1,410 per child, \$11,659 per disabled individual, and \$10,147 per elderly enrollee. *Id.* (describing financial expenditures of Medicaid program).

62. MEDICAID AT A GLANCE, *supra* note 59, at 1-2 (explaining why Americans use Medicaid instead of private health insurance).

63. *Harris v. McRae*, 448 U.S. 297, 308 (1980) (noting Medicaid Act state compliance obligation). States are not required to provide Medicaid benefits to their citizens and can choose not to participate in the federal Medicaid program. *See generally* 42 U.S.C. § 1396a; Lourdes A. Rivera, *Overview of Federal Medicaid Rules*, NAT'L HEALTH L. PROGRAM, Mar. 3, 2004, <http://www.healthlaw.org/library.cfm?fa=detail&id=79237&appView=folder>. Federal Medicaid contributions to states' Medicaid programs are based on each state's per capita income and can vary from fifty percent to seventy-six percent of the Medicaid expenditure for each state. MEDICAID AT A GLANCE, *supra* note 59, at 1 (summarizing Medicaid program). To receive any federal funding, state Medicaid programs must provide: "inpatient and outpatient hospital services, physician, midwife, and certified nurse practitioner services, laboratory and X-ray services, nursing home and home health care for individuals aged 21+, EPSDT for children under age 21, family planning assistance and supplies, and rural health clinic/federally qualified health centers." *Id.* at 2. States may also receive matching funds from the federal government for optional services like dental visits, prescription drugs, and physical therapy. *Id.*; Rivera, *supra* note 63, at 9.

64. *Alexander v. Choate*, 469 U.S. 287, 303 (1985) (explaining states retain discretion in choosing "amount, scope, and duration" of Medicaid coverage); *Beal v. Doe*, 432 U.S. 438, 444-45 (1977) (noting Pennsylvania need not provide funding for all procedures, including abortions); *Athol Mem'l Hosp. v. Comm'r of the Div. of Med. Assistance*, 772 N.E.2d 569, 573 (Mass. 2002) (commenting state agency administering Medicaid has "special expertise" in Medicaid affairs).

65. *See generally* Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement: Federal Rights Remain Under Threat and Must Be Strengthened*, 22 HEALTH AFF. 145 (2003), available at <http://content.healthaffairs.org/cgi/reprint/22/1/145> (explaining certain recipients have benefit rights enforceable by suit).

66. 42 U.S.C. § 1396d(r) (mandating states provide EPSDT services for Medicaid eligible children).

67. *See* 42 U.S.C. § 1983 (granting remedy against states for deprivation of civil rights); *Wilder v. Va. Hosp. Ass'n.*, 496 U.S. 498, 524 (1990) (holding recipients can enforce rights under Medicaid Act through § 1983); *see also* *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282-83 (2002) (citation omitted) (holding "Congress must

benefits are enforceable under § 1983, but courts generally agree that Medicaid-eligible children have a federal right to EPSDT services enforceable under § 1983.⁶⁸

The EPSDT benefits are essentially a comprehensive health program for Medicaid-eligible children under the age of twenty-one.⁶⁹ The statute requires the state to ensure that screening services are provided to children in four areas: medical, vision, dental, and hearing.⁷⁰ If a disorder or illness is detected at a screening, the state must provide adequate diagnostic services and treatment “whether or not such services are covered under the [s]tate plan.”⁷¹ The state must therefore provide any “medically necessary” treatment for a child, whether it cures or simply ameliorates a disorder, and the state must ensure that the child actually obtains the necessary services.⁷² Furthermore, states must

have intended that the provision in question benefit the plaintiff”); *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997) (establishing “*Blessing* test” used to determine existence of enforceable right).

68. *Watson v. Weeks*, 436 F.3d 1152, 1162 (9th Cir. 2006) (holding children have federal right enforceable under § 1983); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 602-06 (5th Cir. 2004) (holding right to EPSDT services enforceable under § 1983); *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Servs.*, 293 F.3d 472, 478-79 (8th Cir. 2002) (holding children have federal right to EPSDT services because of mandatory statutory language); *Westside Mothers v. Haveman*, 289 F.3d 852, 863 (6th Cir. 2002) (recognizing plaintiff’s right of action under § 1983); Frederick H. Cohen, *An Unfulfilled Promise of the Medicaid Act: Enforcing Medicaid Recipients’ Right to Healthcare*, 17 LOY. CONSUMER L. REV. 375, 391-92 (2005) (arguing Medicaid Act should be enforceable under § 1983). *But see Gonzaga*, 536 U.S. at 283, 290-91 (finding violation of Family Educational Rights and Privacy Act not privately enforceable under § 1983); *ASW v. Oregon*, 424 F.3d 970, 975-78 (9th Cir. 2005) (allowing parents cause of actions when state reduced adoption assistance payments); *Sanchez v. Johnson*, 416 F.3d 1051, 1052 (9th Cir. 2005) (holding § 1396a(a)(30)(A) of Medicaid Act unenforceable by private person under § 1983).

69. THE KAISER FAMILY FOUND., KAISER COMM’N ON MEDICAID AND THE UNINSURED, *EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES 1* (2005), available at <http://www.kff.org/medicaid/7397.cfm> [hereinafter EPSDT SERVICES] (summarizing EPSDT service requirements).

70. 42 U.S.C. §§ 1396d(r)(1)–(4) (codifying screening services state must provide children). The screenings are “prevention-oriented” to increase the likelihood of finding and curing conditions that may affect a child’s natural growth and development. EPSDT SERVICES, *supra* note 69, at 1. States may determine the appropriate intervals at which to provide screenings, as long as the screenings meet “reasonable standards of medical and dental practice.” 42 U.S.C. § 1396d(r)(1)(A). The medical screenings “at a minimum [must] include—(i) a comprehensive health and developmental history (including assessment of both physical and mental health development), (ii) a comprehensive unclothed physical exam, (iii) appropriate immunizations . . . , (iv) laboratory tests . . . , and (v) health education.” § 1396d(r)(1)(B).

71. 42 U.S.C. § 1396d(r)(5) (requiring diagnosis and treatment of any ailment found in Medicaid-eligible child). 42 U.S.C. § 1396d(a) enumerates seven categories of care and services that states must cover for all adult and children enrollees. There are twenty-one other categories listed in § 1396d(a) that are optional benefits for adults, but under the EPSDT, the optional benefits must be provided by the state if they are “medically necessary” for a child recipient. *Dickson*, 391 F.3d at 589-90 (interpreting statute and legislative history as including *all* services enumerated in § 1396d(a) required for children).

72. *John B. v. Menke*, 176 F. Supp. 2d 786, 800 (M.D. Tenn. 2001) (citations omitted) (holding “[s]tate . . . bound by federal law to provide ‘medically necessary’ EPSDT services”); *Chisholm v. Hood*, 110 F. Supp. 2d 499, 508 (E.D. La. 2000) (requiring states to confirm whether children needing personal care services actually receives them); *Frew v. Gilbert*, 109 F. Supp. 2d 579, 674 (E.D. Tex. 2000) (explaining state must ensure child obtains EPSDT services and not just offered services).

effectively notify Medicaid recipients about their EPSDT program.⁷³

Over the last decade, courts have held that community-based services are mandatory under the EPSDT provision of the Medicaid Act.⁷⁴ Courts in Pennsylvania, California, and Massachusetts have addressed the problem of inadequate home-based and community-based services for Medicaid-eligible children with SED and imposed requirements to ensure state adherence to Medicaid mandates.⁷⁵

A. Pennsylvania

Two cases in Pennsylvania, *Larry K. v. Snider*⁷⁶ and *Kirk T. v. Houstoun*,⁷⁷ changed Medicaid billing schemes to enable clinicians to deliver, and receive adequate compensation for, community-based services to children with SED.⁷⁸ Larry K. was an eight-year-old boy who lived in a mental hospital because the state refused to pay for residential treatment unless his parents relinquished custody of him to the state's foster care system.⁷⁹ Although clinicians recommended residential treatment for Larry K., the services were essentially unavailable because the state's Medicaid fee schedule did not reimburse providers for residential services.⁸⁰ The parties settled the case when the Commonwealth of Pennsylvania agreed to pay for medically necessary "in-

73. 42 U.S.C. § 1396a(a)(43)(A); *Stanton v. Bond*, 504 F.2d 1246, 1250 (7th Cir. 1974) (recognizing EPSDT requires state to "aggressively notify, seek out and screen persons under 21"); *Memisovski ex rel. Memisovski v. Maram*, No. 92 C 1982, 2004 WL1878332, at *50 (N.D. Ill. Aug. 23, 2004) (explaining state's "affirmative obligation" to ensure EPSDT services provided "in a timely and effective manner"); *Salazar v. District of Columbia*, 954 F. Supp. 278, 318-23, 330-34 (D.D.C. 1996) (declaring district violated EPSDT statute for reporting failures).

74. 42 U.S.C. § 1396d(r) (requiring screening and diagnostic services for Medicaid eligible children). *See generally* *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (ruling Massachusetts must provide "in-home behavioral support" services for children with serious emotional disturbances); *Emily Q. v. Bonta*, 208 F. Supp. 2d 1078 (C.D. Cal. 2001) (mandating California provide home or community based therapeutic behavioral services (TBS) under Medicaid plan).

75. *See Rosie D.*, 410 F. Supp. 2d at 52 (ruling state violated EPSDT by not offering "medically necessary" services to children with SED). *See generally* *Katie A. v. Bonta*, 433 F. Supp. 2d 1065 (C.D. Cal. 2006) (ruling wraparound services fit definition of services and required under EPSDT), *rev'd* *Katie A. v. L.A. County*, 481 F.3d 1150 (9th Cir. 2007); *Emily Q.*, 208 F. Supp. 2d 1078 (ruling state must provide children with SED with therapeutic behavioral services); *Kirk T. v. Houstoun*, No. 99-3253, 2000 WL830731 (E.D. Pa. June 27, 2000) (ruling state must ensure children receive prompt care by abiding by timelines).

76. No. 91-680 (E.D. Pa. Jan. 6, 1993) (settlement agreement) (on file with Bazelon Center for Mental Health Law).

77. No. 99-3253, 2000 WL830731 (E.D. Pa. June 27, 2000).

78. CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 24 (reporting settled lawsuits in Pennsylvania helped SED children obtain needed services); *see also* SELTZER, *supra* note 44 (explaining cases bringing action under Medicaid requesting community-based services).

79. Bazelon Center for Mental Health Law, *Litigation Strategies to Prevent Custody Relinquishment*, <http://www.bazelon.org/issues/children/custody/litigation.htm#larry> (last visited Nov. 7, 2007) [hereinafter *Litigation Strategies*] (explaining relevant facts of *Larry K.*).

80. *Id.* (noting lack of services in Pennsylvania fee schedule); *see also* CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 24 (discussing state requirements under the Medicaid Act).

home support and therapy, counseling or clinically supervised activity” that allowed children with serious emotional disorders to remain at home or in the community.⁸¹ The state also agreed to distribute materials explaining how providers could be reimbursed after providing these services.⁸²

The state’s system for reimbursement was ineffective and children did not promptly receive home-based treatments.⁸³ Accordingly, another lawsuit was filed on behalf of Medicaid-eligible children who waited for months or over a year to receive the wraparound services promised by the state.⁸⁴ In this second lawsuit, *Kirk T. v. Houstoun*, the court agreed with plaintiffs that the state did not provide behavioral health rehabilitative services with “reasonable promptness” because the state did not define timelines for clinicians offering services or provide adequate staffing for the services.⁸⁵ As part of the settlement agreement in *Kirk T.*, Pennsylvania: required that children wait no more than sixty days between the date they request assistance and receive services, devised a tracking mechanism to ensure the timeliness standard was being met, and increased the number of therapeutic staff available to provide wraparound services.⁸⁶ As a result of these two cases, home-based, school-based, and community-based behavioral services are now frequently utilized in Pennsylvania by Medicaid providers.⁸⁷

81. *Litigation Strategies*, *supra* note 79 (explaining settlement agreement).

82. *Litigation Strategies*, *supra* note 79 (analyzing ruling favoring state-provided home treatment over parents relinquishing custody). The state issued two bulletins to the Medicaid providers throughout the state. *Id.* “The first directive added important wraparound services to the Medicaid schedule and specified the procedures for receiving payment.” *Id.* The second bulletin explained how residential treatment facilities could qualify for payment from the Medicaid system. *Id.* The wraparound services included on the Medicaid fee schedule included: “mobile therapy, therapeutic staff support, behavioral specialist consultant, individual diagnostic personalty evaluation, comprehensive neuropsychological evaluation, cognitive retraining, and psychological evaluations.” *Id.*

83. CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 24 (reasoning “administrative paperwork, approval requirements and inadequate reimbursement rates” made Medicaid fee schedules ineffective).

84. *Kirk T. v. Houstoun*, No. 99-3253, 2000 WL 830731, at *1 (E.D. Pa. June 27, 2000) (alleging plaintiffs “waited months in order to obtain prescribed services); Parents Involved Network of Pennsylvania, *Summaries of Court Decisions with Implications for Children’s Mental Health Services*, <http://www.pinofpa.org/resources/fact-20.html> (last visited Nov. 7, 2007) (discussing cases regarding children’s mental health).

85. *Kirk T.*, 2000 WL 830731, at *2-6 (granting plaintiffs summary judgment because Pennsylvania not providing services with “reasonable promptness”). 42 U.S.C. § 1396a(a)(8) requires states to allow any individual an opportunity to apply for medical assistance and that the state provide medical assistance with “reasonable promptness to all eligible individuals.” 42 U.S.C. § 1396(a)(8). A state is not explicitly required to formulate timelines for providing services once they are found necessary, however, courts have authority to impose time limits. *Smith v. Miller*, 665 F.2d 172, 179-80 (7th Cir. 1981) (ruling court has authority to impose time limits for pre-authorizations and automatic approval for violations); *Kessler v. Blum*, 591 F. Supp. 1013, 1032 (S.D.N.Y. 1984) (requiring twenty-one day time limit on pre-approval requests).

86. *See* Parents Involved Network, *supra* note 84 (discussing settlement agreements of Pennsylvania cases involving EPSDT standards).

87. CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 24 (explaining current state of Pennsylvania Medicaid fee schedule and reimbursement scheme).

B. California

Two cases in California, *Emily Q. v. Bonta*⁸⁸ and *Katie A. v. Bonta*,⁸⁹ have helped shape the scope of mental health entitlement under the EPSDT program.⁹⁰ *Emily Q. v. Bonta* was a class action brought on behalf of seven Medicaid-eligible children suffering from “intensive mental health needs.”⁹¹ In 2001, the United States District Court for the Central District of California issued a permanent injunction requiring California, under the EPSDT requirements, to provide therapeutic behavioral services (TBS) to all class members.⁹² The injunction further required hospital staff to certify that all alternatives, including TBS, were considered before a child was placed in an out-of-home facility.⁹³ Furthermore, under the EPSDT notice provision, the court required the state to notify all Medicaid recipients under the age of twenty-one that mental health services were available and provide information on where and how to obtain the services.⁹⁴ Due to state actions discouraging the use of TBS and the under-utilization of TBS throughout California, litigation of the case continued until a court order on February 28, 2006, denied the state’s motion for relief.⁹⁵ The 2006 *Emily Q.* order is significant for two

88. 208 F. Supp. 2d 1078 (C.D. Cal. 2001).

89. 433 F. Supp. 2d 1065 (C.D. Cal. 2006), *rev'd* Katie A. v. L.A. County, 481 F.3d 1150 (9th Cir. 2007).

90. *See id.*; *Emily Q.*, 208 F. Supp. 2d at 1078; *Litigation Strategies*, *supra* note 79 (analyzing various cases extending entitlement to community-based services).

91. *Emily Q.*, 208 F. Supp. 2d at 1080-82 (describing plaintiff class).

92. *Id.* at 1092, 1102-04 (listing procedures defendant ordered by court to adopt). TBS are mental health services for children that require a trained individual to work with a child one-on-one in his home or community. *Id.* at 1083, 1090. TBS is directed at children who would live in locked group homes or mental hospitals if these services were not available. *Id.* at 1083.

93. *Id.* at 1083-84 (reciting requirements enumerated by court).

94. *Emily Q. v. Bonta*, 208 F. Supp. 2d 1078, 1096-98 (C.D. Cal. 2001) (explaining notice requirements). Under the Medicaid Act, a state’s medical assistance plan must inform all individuals who are under the age of twenty-one and eligible for medical assistance about the availability of early and periodic screening, diagnostic, and treatment services. 42 U.S.C. § 1396a(a)(43)(A) (2006). The order of injunctive relief in *Emily Q.* required the state to provide notice of mental health treatments in three ways: (1) in brochures mailed to all recipients under the age of twenty-one; (2) to all eligible children under the age of twenty-one at the time they are admitted to a mental hospital or when they are being considered for admission; and (3) a list of supplemental mental health services—treatments not itemized in the state plan, but covered when “medically necessary”—explaining where to obtain the services and the procedures to gain coverage for the services. *Emily Q.*, 208 F. Supp. 2d at 1096-99.

95. MANJUSHA P. KULKARNI, NAT’L DISABILITY RIGHTS NETWORK, MARCH 2005 Q AND A 2 (2006), <http://www.healthlaw.org/library.cfm?fa=detail&id=105451&appView=folder> (follow “Q & A: Emily Q. EPSDT Case” hyperlink) (explaining significance of *Emily Q.* decision). In January 2002, the state of California began auditing all TBS claims, which significantly reduced the use of TBS throughout the state. Melinda Bird, *Emily Q.’s Story: Using Medicaid Litigation to Expand Positive Behavior Interventions for Children in the Mental Health System*, 5 WHITTIER J. CHILD & FAM. ADVOC. 87, 107 (2005). In October 2003, the plaintiffs in *Emily Q.* filed a motion to modify and clarify the judgment due to Medicaid providers underutilization of TBS. *Id.* at 110. The plaintiff’s expert estimated that only children with SED who were at risk of out-of-home placements or who had psychiatric hospitalization were gaining access to TBS instead of the five to ten percent of the population that would benefit from it. *Id.* at 110-11. In 2004, the plaintiff’s request for further relief was granted when the court “ordered the state to adopt an expedited authorization

reasons: it confirmed that Medicaid eligible individuals can enforce rights to EPSDT services under 42 U.S.C. § 1983 and sustained the courts' authority to enforce injunctive remedies against a state for violations of the EPSDT provision.⁹⁶

Katie A. v. Bonta was a class action brought on behalf of foster children living in residential treatment facilities who could have lived at home or in the community if wraparound services and therapeutic foster care were covered by Medi-Cal, California's Medicaid program.⁹⁷ When granting a preliminary injunction for relief, the United States District Court for the Central District of California rejected the state's argument that wraparound programs are "'approaches,' 'processes,' or 'philosophies'" not covered under the Medicaid Act.⁹⁸ The court held that wraparound services are actually services required under EPSDT regardless of whether they are explicitly listed in § 1396d(r) or § 1396d(a) of the Medicaid statute.⁹⁹ The court's holding relied on three theories encompassed in previous case law.¹⁰⁰ First, a service does not have to be specifically listed in the EPSDT statute for it to be required.¹⁰¹ Second, other states—including Arizona, Nebraska, Pennsylvania, and Wisconsin—fund wraparound services with Medicaid; therefore, these wraparound services must be within the scope of EPSDT mandates.¹⁰² Third, the court noted that the only limitation on EPSDT services is that they must be "medically necessary" as determined by the recipient's physician and not by the government.¹⁰³ The

procedure for TBS" and instructed the parties to develop a plan to increase the use of TBS. *Id.* at 111-12. The parties were unable to reach a settlement and a special master was appointed to the case in 2005 to determine if access to TBS could be significantly increased without addressing the overarching problems in the children's mental health system. *Id.* at 114.

96. See KULKARNI, *supra* note 95, at 5 (discussing significance of *Emily Q.* case).

97. *Katie A. v. Bonta*, 433 F. Supp. 2d 1065, 1067-69 (C.D. Cal. 2006) (summarizing parties and provision of medical assistance for foster children in California), *rev'd* *Katie A. v. L.A. County*, 481 F.3d 1150 (9th Cir. 2007).

98. *Id.* at 1071 (citations omitted). The defendants argued that, under the EPSDT standards, they were only required to provide services and claimed wraparound was a philosophy about how to deliver medical care, not a service. *Id.* at 1071. The plaintiffs introduced evidence breaking down wraparound into nine component services: engaging the child and family, immediate crisis stabilization, strengths and needs assessment, wraparound team formation, wraparound service plan development, wraparound service plan implementation, ongoing crisis and safety planning, tracking and adapting the wraparound service plan, and transition. *Id.* at app. A. The district court found that wraparound was a service covered by EPSDT because each step in the wraparound process could be defined as a service. *Id.* at 1072-73.

99. *Id.* at 1074, 1078 (concluding wraparound services included in EPSDT); see also 42 U.S.C. § 1396d(a) (listing services state must provide under Medicaid Act); 42 U.S.C. § 1396d(r) (defining EPSDT).

100. *Katie A.*, 433 F. Supp. 2d at 1074 (reasoning EPSDT requires wraparound and therapeutic foster care).

101. *Id.* (contending services not listed may be included in statute); see also *Collins v. Hamilton*, 349 F.3d 371, 376 (7th Cir. 2003) (requiring state to include "psychiatric residential treatment facilities" under § 1396d(a)(16)); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472, 480-81 (8th Cir. 2002) (holding state must provide early intervention day treatment as rehabilitative service defined in § 1396d(a)(13)); *Emily Q. v. Bonta*, 208 F. Supp. 2d 1978, 1090-91 (C.D. Cal. 2001) (requiring therapeutic behavioral services under EPSDT).

102. See *Katie A.*, 433 F. Supp. 2d at 1076 (describing how other states use and fund wraparound services).

103. See *Katie A. v. Bonta*, 433 F. Supp. 2d, 1076-77 (C.D. Cal. 2006) (discussing "medically necessary"

court stated that it would be appropriate for a physician to find wraparound services necessary because they are an integral part of the mental health system and often the most effective community-based intervention for children.¹⁰⁴

In March 2007, the United States Court of Appeals for the Ninth Circuit reversed and remanded the *Katie A.* decision.¹⁰⁵ The Ninth Circuit found that the district court erroneously required the state to provide individually covered services as bundled packages in a wraparound program.¹⁰⁶ On remand, the Ninth Circuit ordered the district court to employ a two-step analytical approach.¹⁰⁷ First, the court must determine whether the state is providing all necessary health services required under the EPSDT provisions.¹⁰⁸ If the state does not provide adequate services, the court must then determine if the sole remedy is to bundle the services into a single package while allowing the state discretion in formulating the remedial plan.¹⁰⁹

C. Massachusetts

In *Rosie D. v. Romney*, the United States District Court for the District of Massachusetts outlined the services that the Commonwealth of Massachusetts must provide to children with SED to meet the EPSDT standards.¹¹⁰ In a class action brought on behalf of children with SED at risk of hospitalization, the court held that the state failed to provide EPSDT services and meet the “reasonable promptness” requirement of the Medicaid Act.¹¹¹ The court acknowledged Massachusetts’s use of some wraparound-based services for Medicaid-eligible children.¹¹² The district court, however, held that Massachusetts did not meet the “reasonable promptness” requirement because

standard), *rev'd* *Katie A. v. L.A. County*, 481 F.3d 1150 (9th Cir. 2007); *see also* *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989) (ruling “Medicaid statute . . . create[s] presumption in favor” of attending physician’s judgment determining medical necessity).

104. *Katie A.*, 433 F. Supp. 2d at 1076 (summarizing expert opinions of wraparound services and noting lack of evidence showing wraparound services not necessary).

105. *Katie A. v. L.A. County*, 481 F.3d 1150, 1163 (9th Cir. 2007) (reversing and remanding based on interpretation of Medicaid Act). The Ninth Circuit held that the district court’s factual findings were not erroneous and that it applied the proper standard for issuing injunctive relief. *Id.* at 1156.

106. *Id.* at 1159 (ruling improper to require state to package individual services).

107. *Id.* at 1161 (requiring two step analytical approach on remand).

108. *Id.* at 1161 (describing both steps of analysis).

109. *Katie A.*, 481 F.3d at 1161 (directing two step analysis on remand).

110. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52-54 (D. Mass. 2006) (listing services required under EPSDT). The court outlined an analytical approach to determine whether the state is required to provide the requested services. *Id.* at 28-32. First, the court will analyze whether the services or treatments are covered under the Medicaid Act. *Id.* Second, the court will determine whether the state in fact provides the services sought by looking at whether children can access the services or if the state provides substitutes for recommended treatments. *Id.* Third, where the state fails to provide a service, the court creates a remedy. *Id.*

111. *Id.* at 23 (holding state inadequately provided EPSDT services). The *Rosie D.* court stated that if a competent medical provider determined that a certain treatment—whether community-based or traditional—was needed, the state must provide it under the EPSDT program. *Id.* at 29.

112. *Id.* at 27-28 (acknowledging Massachusetts’s use of wraparound services).

it failed to provide all necessary services to all recipients needing them.¹¹³ When determining whether a state provides services, the court considers whether children can actually access services and will view substitution of services with skepticism.¹¹⁴ The *Rosie D.* court found the state liable because it failed to make comprehensive assessments of children with SED and lacked clinical oversight and ongoing case management services.¹¹⁵ Furthermore, by merely “patch[ing] together long-term care out of short-term programs,” Massachusetts did not provide adequate in-home behavioral support services for children with SED.¹¹⁶ The court also held that where a state fails to provide a service, “a court will [first] proceed to consider an appropriate remedy, giving the state the opportunity initially to fashion its own remedial proposal” before granting plaintiff’s permanent injunctive relief.¹¹⁷

The parties in *Rosie D.* were unable to negotiate a remedy themselves, and eight months after the court’s ruling, they requested that the court make a final ruling on the remedy settlement.¹¹⁸ The defendants’ proposed remedial plan limited eligibility for community-based services to those children at risk of institutionalization, allowed MassHealth to determine the medical necessity of services for each child and lacked firm deadlines to ensure timely delivery of needed services.¹¹⁹ Conversely, the plaintiffs requested that the state make

113. *Id.* (stating nature of services provided by state may influence “reasonable promptness” standards). Even if a state provides some services to a recipient in a prompt manner, it will violate the “reasonable promptness” provision of the Medicaid Act if it fails to provide the services sought or needed by each individual recipient. *Id.* (citing *Boulet v. Cellucci*, 107 F. Supp. 2d 61, 79 (D. Mass. 2000)) (explaining “reasonable promptness” standard). The District Court for the District of Massachusetts held in *Boulet* that medical assistance provided to a recipient “must correspond to the individual’s needs” and the state cannot satisfy “reasonable promptness” standards by offering the recipient alternative services. *Boulet*, 107 F. Supp. 2d at 79.

114. *Rosie D.*, 410 F. Supp. 2d at 28-29 (explaining court’s considerations when evaluating state-provided services).

115. *Id.* at 52-53 (discussing services Massachusetts failed to provide to children with SED).

116. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52-53 (D. Mass. 2006) (reciting inadequacies of state’s services for children with SED).

117. *Id.* at 29, 54 (allowing court to conform to EPSDT standards before issuing permanent injunctive relief).

118. Plaintiffs’ Report to the Ct. and Final Remedial Plan at 1, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (requesting court intervention in remedial planning phase); Defendants’ Aug. 29, 2006 Mem. of Law Regarding the Remedy Process at 2, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (arguing court should adopt defendants’ remedial plan because it complies with Medicaid statute). Judge Ponsor held a hearing on December 12, 2006, where he heard arguments from both parties before making a final ruling on the settlement agreement. Stephanie Barry, *Court Battle Delays Treatment for Troubled Kids*, MASSLIVE.COM, Dec. 12, 2006, http://www.masslive.com/weblogs/print.ssf?/mtlogs/mass_theRepublican/archives/print214893.html.

119. Aff. of Knute Rotto at 2-6, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (discussing eligibility for home-based services and who should determine medical necessity of services); Aff. of Dr. James Greer at 2, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (arguing eligibility criteria offered by defendants inconsistent with EPSDT goals); Aff. of Marci White at 2, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (stating rigid timelines necessary for success of remedy proposal).

community-based services available to a larger percentage of children before their conditions escalated to high risk status and that Care Planning Teams should determine what services are “medically necessary.”¹²⁰ The plaintiffs also designed “incremental timelines,” to ensure efficient implementation of needed services.¹²¹ Before selecting one of the proposed plans, the court first determined whether the defendants’ remedial plan met the minimum requirements of the Medicaid Act.¹²² On February 22, 2007, Judge Ponsor found the state’s proposed remedial plan adequate and adopted it.¹²³

Child advocates have successfully fought for children with SED in Pennsylvania, California, and Massachusetts.¹²⁴ The next section will look at the components of a successful action for wraparound programs under the

120. Aff. of Knute Rotto, *supra* note 119, at 4-5 (contending Care Planning Team better suited than MassHealth personnel to determine “medically necessary” services); Aff. of Dr. James Greer, *supra* note 119, at 2 (arguing children need home-based services before at risk of out-of-home placement).

121. Aff. of Marci White, *supra* note 119, at 2-4 (discussing need for timeliness in implementing remedy). The Commonwealth argued that it could save money if it limited the number of children receiving the newly implemented community-based care to a small percentage of at-risk children. Aff. of Knute Rotto, *supra* note 119, at 2-3. The plaintiffs, however, contended that the state’s costs would remain high if they failed to provide community-based services to a larger percentage of children with SED because community-based services cost less than traditional services and preventative treatment reduces instances of long-term treatment. *Id.* at 3; *see* CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 19-20 (arguing wraparound more cost efficient than institutionalization). Overall cost is also a consideration when deciding who should authorize treatments. Aff. of Knute Rotto, *supra* note 119, at 5. The state wanted to maintain control over all treatment decisions and ensure that only MassHealth personnel determine whether MassHealth should cover a service. *Id.* at 4-5. The plaintiffs instead hoped the state would allow treatment teams, working directly with the children, to determine if services are “medically necessary.” *Id.* at 5. The plaintiffs argued that these teams were better positioned to evaluate the cost-effectiveness of a desired service. *Id.* Other wraparound providers, like Wraparound Milwaukee and Choices, followed the plaintiff’s proposed model. *Id.*

122. *See* *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 29 (D. Mass. 2006) (allowing state to attempt to create adequate remedy proposal before court imposed remedy); Defendants’ Aug. 29, 2006 Mem. of Law Regarding the Remedy Process, *supra* note 118, at 2 (arguing court should adopt state remedial plan if it meets Medicaid requirements).

123. Mem. and Order Regarding Remedy at 2-4, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (No. 01-CV-30199-MAP) (adopting and modifying defendant’s proposed plan). *See generally* Stephen Smith, *Mentally Ill Children to Get Help at Home: Judge Approves Plan to Bolster State Services*, BOSTON GLOBE, Feb. 24, 2007, at 1A (discussing Judge Ponsor’s ruling in *Rosie D.*). The court deferred to the state because it demonstrated that its remedial plan “promptly and effectively” addressed the issues in the case-at-bar. Mem. and Order Regarding Remedy, *supra*, at 3. The court, however, emphasized that if the state imposed “unreasonable delays or inadequate measures,” then it would evaluate alternative remedies. *Id.* Furthermore, the court made the remedial plan contingent on four conditions: the state must use the definition of SED stated in the IDEA or by the Substance Abuse and Mental Health Services Administration (SAMHSA), the state must comply with court-imposed timelines, the state may not unilaterally modify the terms of the remedy, and the state can submit a request for modification to the court. *Id.* at 4-6; *see supra* notes 37-38, 42-44 and accompanying text (discussing IDEA). Judge Ponsor believed the state overestimated the \$459 million cost to implement the plan, but still chose the state’s proposal, reasoning that the state was ultimately responsible for the consequences of its inaccuracies. Mem. and Order Regarding Remedy, *supra* note 123, at 4 (stating reasons for adopting defendant’s plan). In July 2007, Judge Ponsor adopted the defendant’s proposed judgment subject to modifications concerning the definition of SED and the court’s continued jurisdiction. *See generally* *Rosie D. v. Patrick*, 497 F. Supp. 2d 76 (D. Mass. 2007).

124. *Supra* Part IV.

Medicaid Act and evaluate the effectiveness of injunctive relief.¹²⁵

V. ANALYSIS

Advocates have successfully demonstrated that Medicaid-eligible children who require wraparound services are entitled to court ordered injunctive remedies against states by arguing that the EPSDT program requires wraparound.¹²⁶ Courts impose remedies if plaintiffs prove that the requested community-based or wraparound treatment needs to be included in the state's Medicaid program and that the state does not adequately provide the service to the plaintiff class.¹²⁷ Many of the cases establish the validity of advocates' arguments and courts' agreements that, ethically and legally, state agencies must provide comprehensive mental health services to children who have SED.¹²⁸ Federal courts order state agencies to comply with these remedies; however, in practice, the remedies often leave plaintiffs with insufficient relief.¹²⁹

A. *The EPSDT Program Mandates Wraparound*

Congress created a "prevention oriented" EPSDT program to ensure that children receive treatment before their mental illnesses become serious or high risk.¹³⁰ Wraparound, like EPSDT, is "prevention oriented" because it breaks the cycle of crisis-oriented care and treats children before their symptoms reach an emergency level.¹³¹ The goals for community-based programs are similar to Congress's goals for the EPSDT program because they increase the quality of life for children with SED, reduce instances of institutionalization, and effectively ameliorate symptoms associated with SED.¹³²

125. See *infra* Part V (analyzing effectiveness of suits brought under EPSDT requirement of Medicaid Act).

126. See *supra* note 75 (listing recent cases holding community-based services mandatory under EPSDT provisions). Federal courts have established that children with serious emotional disturbances have a federal right to wraparound services, assertable under 42 U.S.C. § 1983. *Supra* notes 60-61 and accompanying text (detailing cases upholding actions brought under § 1983 to enforce EPSDT rights).

127. See *Rosie D.*, 410 F. Supp. 2d at 52-54 (analyzing previous EPSDT cases); *supra* note 110 (discussing analytical approach used in EPSDT cases).

128. See *supra* note 75 (enumerating EPSDT cases where courts required state agencies to practice comprehensive mental health services).

129. See *infra* text accompanying notes 146-157 (discussing problems associated with state action inconsistent with court ordered remedy).

130. See EPSDT SERVICES, *supra* note 69, at 1-2 (outlining EPSDT program).

131. PRESIDENT'S NEW FREEDOM COMM'N, *supra* note 2, at 35-36 (recommending individualized plans of care to achieve recovery); FRANK ET AL., *supra* note 3, at 1 (advocating "less reliance on crisis care"). Evidence suggests that children with SED who receive case management and home support services are less likely to experience episodes requiring hospitalization. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52 (D. Mass. 2006); CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 6 (noting residential care avoided when "integrated and intensive services" offered at home).

132. *Katie A. v. Bonta*, 433 F. Supp. 2d, 1065, 1076-77 (C.D. Cal. 2006) (summarizing experts' opinions

The EPSDT program, as proven by Medicaid-eligible plaintiffs, encompasses wraparound intervention.¹³³ Congress did not expressly mandate wraparound in the Medicaid Act; therefore, states must only provide community-based treatments if they fit within the definition of “service” and if a physician finds the treatment “medically necessary.”¹³⁴ Both the testimony of medical professionals and results of clinical studies conclude that wraparound services are “medically necessary” for some children diagnosed with SED.¹³⁵ The district court in *Katie A. v. Bonta* noted that a reasonable physician could find wraparound “medically necessary” because it is an integral part of mental health care and is often the most effective treatment available.¹³⁶ The court also found that each component of wraparound treatment is a service covered by EPSDT.¹³⁷ Furthermore, wraparound treatment must be within the scope of EPSDT because Medicaid programs pay for wraparound treatment in many states.¹³⁸

of wraparound services), *rev'd Katie A. v. L.A. County*, 481 F.3d 1150 (9th Cir. 2007); *Rosie D.*, 410 F. Supp. 2d at 50-51 (defending plaintiff's clinical study of thirty-five children showing wraparound ameliorates symptoms of SED); *see Litigation Strategies*, *supra* note 79 and accompanying text (noting plaintiff in *Larry K.* could remain at parents' home if he received wraparound treatment); *supra* text accompanying note 1 (quoting *Rosie D. v. Romney*).

133. *See supra* note 75 (discussing recent cases holding community-based services mandatory under EPSDT provisions).

134. 42 U.S.C. § 1396d(a) (2006) (defining medical assistance and listing required care and services); § 1396d(r)(1) (codifying EPSDT program); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 589-90 (5th Cir. 2004) (holding twenty-eight categories of care enumerated in 42 U.S.C. § 1396d(a) mandatory for children); *Katie A.*, 433 F. Supp. 2d at 1071-73 (noting defendant argues “philosophy” or “approach” not covered under EPSDT); *Rosie D.*, 410 F. Supp. 2d at 26 (discussing “medically necessary” standard); *supra* note 71-72, 92 and accompanying text (explaining requirements of EPSDT program include “medically necessary” treatments). If the plaintiff proves that wraparound is “medically necessary,” the state must provide the services regardless of whether it is covered under the existing state plan or explicitly listed in 42 U.S.C. § 1396d(a). 42 U.S.C. 1396d(r)(5) (requiring diagnosis and treatment of *any* ailment found in Medicaid-eligible children). The Medicaid statute also presumes that an attending physician, rather than a state legislature or insurance company, determines whether a treatment is “medically necessary.” *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989) (ruling presumption favors physicians determining if treatment necessary); *Katie A.*, 433 F. Supp. 2d at 1076-77 (discussing “medically necessary” standards).

135. *Katie A.*, 433 F. Supp. 2d at 1076-77 (summarizing experts' opinions of wraparound services); *Rosie D.*, 410 F. Supp. 2d at 50-51 (defending plaintiff's clinical study of thirty-five children); *see Bird*, *supra* note 95, at 110-14 (summarizing plaintiff's utilization of experts and special master in *Emily Q.*).

136. *Katie A.*, 433 F. Supp. 2d at 1076-77 (summarizing expert opinion).

137. *Id.* at 1071-73 (holding wraparound services not a philosophy). Plaintiffs in *Katie A.* proved wraparound are services by breaking down an existing wraparound program into nine components resembling services often covered under EPSDT. *Id.* at app. A. (holding wraparound is service not philosophy); *see supra* note 98 and accompanying text (summarizing nine services included in wraparound). The Ninth Circuit Court of Appeals ruled that the district court broadly interpreted the statute and remanded the case to determine whether the best remedy for the plaintiffs was for the state to package each service into a wraparound program. *Katie A. v. L.A. County*, 481 F.3d 1150, 1162-63 (9th Cir. 2007). The question of whether wraparound itself is a required service or whether states are only required to provide each component of wraparound separately is still uncertain both nationally and in the Ninth Circuit. *Id.*; *supra* notes 96-100 (explaining reason for remand).

138. *See Katie A. v. Bonta*, 433 F. Supp. 2d 1065, 1076 (C.D. Cal. 2006) (describing how other states use and fund wraparound services), *rev'd Katie A. v. L.A. County*, 481 F.3d 1150 (9th Cir. 2007); *supra* text accompanying note 102 (listing states that include wraparound in Medicaid program).

If the EPSDT program incorporates wraparound services, the Medicaid Act compels a state to provide wraparound to recipients under the age of twenty-one.¹³⁹ In order to adequately provide EPSDT services, a state must inform Medicaid recipients of available services and also provide the services with “reasonable promptness.”¹⁴⁰ *Emily Q. v. Bonta* explains that a state does not comply with the Medicaid Act if it does not advise recipients about how and where to obtain mental health therapy.¹⁴¹ The *Emily Q.* court enlarged the notification requirement by directing California to distribute a brochure that included not only regularly covered mental health services, but also services that the state paid for on a “medically necessary” basis, like wraparound.¹⁴²

When analyzing whether a state provides treatments with “reasonable promptness,” a court determines whether every Medicaid-eligible child can actually access “medically necessary” services and may view substitution of physician recommended therapy with skepticism.¹⁴³ After *Rosie D. v. Romney*, a state fails to comply with the EPSDT requirements if it does not provide community-based services recommended by physicians or provide treatment to children with SED before they reach emergency levels.¹⁴⁴ Moreover, because courts and medical professionals conclude that wraparound is “medically necessary” for many children with SED, injunctive relief is warranted if a state under-staffs community-based facilities, excludes wraparound from its Medicaid billing scheme, discourages medical providers from utilizing wraparound, or places children on unacceptably long waiting lists before they receive any treatment for their mental illness.¹⁴⁵

B. Injunctive Remedies Generate Unreliable Relief

Both *Rosie D.* and *Emily Q.* establish that when a state fails to provide a “medically necessary,” community-based treatment, a court has authority to instruct the state to make them available.¹⁴⁶ Court ordered injunctive relief,

139. 42 U.S.C. § 1396d(r) (mandating states must provide EPSDT services to Medicaid-eligible children).

140. See *supra* note 73 (discussing notification requirements); *supra* note 85 (explaining “reasonable promptness” requirement).

141. *Emily Q. v. Bonta*, 208 F. Supp. 2d 1078, 1096-98 (C.D. Cal. 2001) (holding state must provide brochure explaining mental health services to all child recipients).

142. *Id.* (requiring California to inform recipients about supplemental treatment available only when physician deems “medically necessary”).

143. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 28-29 (D. Mass. 2006) (explaining court’s analysis of “reasonable promptness”); see *supra* note 85 (explaining EPSDT “reasonable promptness” requirement).

144. *Rosie D.*, 410 F. Supp. 2d at 52-53 (discussing services Massachusetts failed to provide to children with SED).

145. *Rosie D.*, 410 F. Supp. 2d at 41-42 (finding wraparound programs in Massachusetts have long waiting lists); see Bird, *supra* note 95, at 111-12 (discussing plaintiff’s request for further relief in *Emily Q.*); *supra* notes 71, 77, 85 and accompanying text (explaining California’s and Pennsylvania’s inadequate delivery of wraparound to Medicaid eligible children); *supra* note 84 and accompanying text (discussing *Kirk T. v. Houston* and Pennsylvania’s remedy for waiting lists for treatment).

146. *Rosie D.*, 410 F. Supp. 2d at 29, 54 (discussing case law authorizing federal court to enforce

however, is not always effective in yielding relief to the plaintiff class.¹⁴⁷ Negotiating a remedy is a lengthy process because states lack resources or administrative systems needed to create community-based programs and courts will generally prefer to enforce a state's proposed remedy over a plaintiff's.¹⁴⁸

Even after winning a suit, many Medicaid-eligible children do not receive necessary treatment for several years after the judgment because negotiations regarding appropriate remedies often take extended periods of time.¹⁴⁹ It took the parties in the *Emily Q.* case four years to reach a settlement, and after more than a year of negotiations, parties in *Rosie D.* could not reach an agreement.¹⁵⁰ The plaintiffs often disagree with the state about timelines for implementing new programs, the percentage of children with mental illnesses that can access wraparound, the definition of SED, and whether administrative or medical personnel will authorize treatments.¹⁵¹ Children desperately in need of comprehensive services lack adequate mental health programs throughout the negotiation process.¹⁵²

Even when the parties reach a settlement, the state does not always provide the needed programs due to budgetary and administrative restrictions.¹⁵³ States commonly defend inaction and blame high costs of administering community-based programs even though advocates argue, and judges agree, that the community-based programs are less expensive than crisis-oriented care.¹⁵⁴ In Pennsylvania, for example, after the settlement in *Larry K. v. Snider*, children still faced months on waiting lists before obtaining needed services and brought a second law suit, *Kirk T. v. Houstoun*, to guarantee that the children would

injunctive remedy against state); *Emily Q.*, 208 F. Supp. 2d at 1093-1116 (holding California must provide TBS to children under Medicaid); see KULKARNI, *supra* note 95, at 2 (explaining *Emily Q.* significant because it upholds court authority to enforce injunctive remedy against state).

147. See *supra* note 123 (discussing court's adoption of state's proposed remedial plan in *Rosie D.*).

148. See Bird, *supra* note 95, at 110 (explaining *Emily Q.* plaintiff's motion to modify settlement because of underutilization of TBS); *supra* note 123 (discussing adoption of state's proposed remedy plan in *Rosie D.*). See generally *Kirk T. v. Houston*, No. 99-3253, 2000 WL 830731 (E.D. Pa. June 27, 2000) (finding many children not receiving reasonably prompt services pursuant to established guidelines).

149. See Bird, *supra* note 95, at 110-112 (explaining remedial process in *Emily Q. v. Bonta*); *supra* notes 118-121 and accompanying text (explaining negotiations in *Rosie D. v. Romney*).

150. See Bird, *supra* note 95, at 106-10 (indicating relief granted in *Emily Q.* in 2001, then special master appointed in 2005 for negotiations); see Barry, *supra* note 118 (discussing hearing held one year after negotiations began in *Rosie D.*).

151. See *supra* notes 118-121 (discussing negotiation process in *Rosie D. v. Romney*).

152. See generally Bird, *supra* note 95 (discussing *Emily Q.* case); Barry, *supra* note 118 (discussing *Rosie D.* case).

153. See generally CTR. FOR PUB. REPRESENTATION, *supra* note 32 (suggesting paperwork and approval requirements made Medicaid fee schedule ineffective in Pennsylvania); Bird, *supra* note 95 (discussing *Emily Q.* case).

154. Mem. and Order Regarding Remedy, *supra* note 123, at 4 (discussing Massachusetts budget for implementing changes mandated in *Rosie D.*); CTR. FOR PUB. REPRESENTATION, *supra* note 32, at 19-20 (arguing Massachusetts could have significant cost savings by implementing wraparound services); see *supra* note 39 and accompanying text (discussing advocates economic arguments for wraparound); *supra* note 121 (discussing program cost in Massachusetts).

receive community-based services.¹⁵⁵ Similarly, in California, the plaintiffs in *Emily Q. v. Bonta* needed to seek further relief from the court when the state's audit of Medi-Cal discouraged medical providers from using TBS.¹⁵⁶ Court ordered injunctive relief does not guarantee that states provide community-based programs, and advocates often continue litigation to gain the services that Medicaid-eligible children deserve.¹⁵⁷

The United States Supreme Court ruled that courts should defer to remedial decisions made by state agencies to avoid intrusions on state sovereignty.¹⁵⁸ Courts must adopt a state agency's proposal if it minimally addresses the issue presented even if winning plaintiffs submit specific remedial requests not included in the state's proposal.¹⁵⁹ In *Rosie D.*, Judge Ponsor noted that if a state does not provide a Medicaid covered service, a court should give the state the "opportunity initially to fashion its own remedial proposal."¹⁶⁰ The *Rosie D.* court adopted the state's plan when the parties disagreed over proposed remedial plans, and the *Emily Q.* court gave California the right to draft the final version of a brochure notifying children about available services.¹⁶¹ Although state remedial plans instigate positive change in the mental health care system, they do not incorporate the extensive organizational schemes envisioned by child advocates.¹⁶²

VI. CONCLUSION

The mental health care system in the United States is in disarray. State employed mental health care providers often overlook "stuck kids" suffering from mental illnesses who remain on long waiting lists and only receive treatment when they require emergency care. State officials must guarantee access to community-based programs incorporating wraparound treatment to ensure that Medicaid-eligible children receive acceptable mental health treatment.

The EPSDT provisions of the Medicaid Act comprise a comprehensive

155. See *supra* text accompanying notes 80-85 (considering Pennsylvania cases).

156. Bird, *supra* note 95, at 111-12 (discussing plaintiff's request for further relief in *Emily Q.*).

157. See generally CTR. FOR PUB. REPRESENTATION, *supra* note 32 (discussing home-based services for children in Massachusetts); Bird, *supra* note 95 (discussing *Emily Q.* case).

158. See *Lewis v. Casey*, 518 U.S. 343, 362 (1996) (holding courts should adopt state proposals when forming remedial plans); Mem. and Order Regarding Remedy, *supra* note 123, at 3 (discussing Supreme Court instruction for constructing remedial plans against states).

159. See Mem. and Order Regarding Remedy, *supra* note 123, at 3 (adopting state remedial plan).

160. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 29 (D. Mass. 2006) (summarizing analytical approach for courts to enforce EPSDT standards).

161. *Emily Q. v. Bonta*, 208 F. Supp. 2d 1078, 1096-98 (C.D. Cal. 2001) (allowing state to create, subject to court review, brochures satisfying newly established notice requirements); see Mem. and Order Regarding Remedy, *supra* note 123, at 3 (adopting state's proposed remedial plan in *Rosie D.*).

162. See *supra* notes 119-121 and accompanying text (discussing discrepancies between plaintiff's and defendant's proposals).

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medical insurance program for children and focus on preventing and ameliorating childhood illnesses. Wraparound treatment, considered necessary by medical professionals, reduces crisis episodes in children with SED and can be divided into component parts corresponding to EPSDT definition's of service. The EPSDT provisions of the Medicaid Act unequivocally encompass wraparound treatments, and states participating in the federal Medicaid program must provide community-based programs to mentally ill children based on their physicians' assessments.

Although child advocates have established that wraparound is part of the EPSDT program, their plight is not over. Courts cooperate with child advocates but still defer to state sovereignty when ordering injunctive remedies. The injunctive relief granted by courts has significantly changed the programs available to Medicaid-eligible children, but state bureaucracy and budgetary concerns still greatly hinder the development of the mental health care systems in the United States.

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