[ORAL ARGUMENT NOT YET SCHEDULED]

Nos. 16-7065, 16-7085 & 16-7100

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

OSCAR SALAZAR, *et al*.,

Plaintiffs-Appellees,

v.

DISTRICT OF COLUMBIA, *et al*.,

Defendants-Appellants.

On Appeal from the United States District Court for the District of Columbia

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BRIEF OF THE LEGAL AID SOCIETY OF THE DISTRICT OF COLUMBIA, CHILDREN'S LAW CENTER, BREAD FOR THE CITY, AND WHITMAN-WALKER CLINIC, INC., D/B/A WHITMAN-WALKER HEALTH AS *AMICI CURIAE*, SUPPORTING PLAINTIFFS/APPELLEES AND URGING AFFIRMANCE

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Amici submit the following information in accordance with D.C. Cir. R. 28(a)(1):

A. Parties and *Amici*. All parties and *amici* appearing before the district court and in this Court are listed in the Brief for Plaintiffs/Appellees, except that the *amici* joining this brief are the Legal Aid Society of the District of Columbia, Children's Law Center, Bread for the City, and Whitman-Walker Clinic, Inc. d/b/a Whitman-Walker Health.

B. Rulings under Review. References to the rulings at issue are listed in the brief for Plaintiffs/Appellees.

C. Related Cases. Related cases are listed in the brief for Plaintiffs/Appellees.

/s/ *Jonathan H. Levy*
Jonathan H. Levy

CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1 and D.C. Cir. R. 26.1, counsel certifies that no signatory to this brief has a parent corporation and that no publicly held corporation owns 10 percent or more of the stock of any of the signatories.

/s/ *Jonathan H. Levy*
Jonathan H. Levy

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GLOSSARY

ACA	Patient Protection and Affordable Care Act of 2010, Pub. L. No. 11-148, 124 Stat. 119 (2010)
CLC	Children's Law Center
CMS	Centers for Medicare and Medicaid Services
EPSDT	Early and Periodic Screening, Diagnostic and Treatment

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IDENTITIES AND INTERESTS OF THE *AMICI*

The Legal Aid Society of the District of Columbia (Legal Aid) is the District's oldest and largest general civil legal services program. Legal Aid provides free legal advice and representation to individuals and families living in poverty in housing, family/domestic violence, public benefits, and consumer law matters. It

also engages in non-litigation advocacy and outreach, as well as affirmative and appellate litigation, to achieve structural solutions. Its Public Benefits Unit helps low-income District residents facing improper denials and terminations of crucial safety net benefits. Legal Aid has recently encountered and assisted a growing number of individuals unlawfully deprived of Medicaid coverage by the District. Legal Aid submitted declarations regarding its clients' experiences to the district court in the proceedings below and continues to represent individuals harmed by the District's ongoing violations of federal Medicaid law.

Children's Law Center (CLC) fights so every child in the District can grow up with a loving family, good health, and a quality education. With 100 staff and hundreds of pro bono lawyers, we reach 1 out of every 9 children in the District's poorest neighborhoods – more than 5,000 children and families each year. CLC's attorneys serve as guardians *ad litem* to children in the District's neglect system. CLC also has medical-legal partnerships with health care systems throughout the District, where we work with clinical treatment teams to address non-medical barriers to children's health. We multiply our impact by advocating for city-wide solutions that benefit all children. CLC has extensive experience with the health care needs of low-income families and children. Many of our clients encounter Medicaid application, recertification, renewal, and EPSDT issues. CLC works to

ensure that District children have timely access to all medically necessary services to which they are legally entitled.

Bread for the City is a nonprofit organization that provides low-income residents of the District with comprehensive services, including supplemental food, clothing, medical care, social services, and civil legal services. Bread for the City's Legal Clinic, Social Services Program, and Medical Clinic are involved at various stages of the application and appeals process to ensure that District residents are able to obtain and maintain Medicaid and other public health insurance coverage, which is critical to their well-being. Bread for the City and the community members we serve have an interest in this case to ensure that all the due process rights of Medicaid beneficiaries in the District are protected and that Medicaid benefits are received in a timely manner as required under the law.

Whitman-Walker Clinic, Inc., d/b/a Whitman-Walker Health (Whitman-Walker) is a nonprofit, community-based Federally Qualified Health Center serving Washington, DC's metropolitan area. Established in 1973, Whitman-Walker was one of the first to engage in HIV/AIDS treatment and prevention research and is nationally renowned for its commitment to LGBT health. Whitman-Walker offers an integrated model of care, including primary medical care, HIV and LGBT specialty care, behavioral health services, dental, health and wellness services, public benefits and insurance navigation assistance, and legal services. Whitman-

Walker is home to one of the nation's oldest medical-legal partnerships and is active in legal matters of concern to people living with HIV, the LGBT community, and our patients, including access to health care, insurance issues, and protections against discrimination. In calendar year 2016, Whitman-Walker provided services to 18,000 individuals and served as the health home to nearly 9,000 patients, one third of whom are insured by Medicaid.

All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a); D.C. Cir. R. 29(b).[1]

SUMMARY OF THE ARGUMENT

The District of Columbia is unlawfully delaying and denying Medicaid to many of its low-income residents. The question on appeal is whether the district court abused its authority to remedy these violations of law by modifying the settlement order in a long-standing ongoing class action challenging the District's Medicaid practices. The answer is no.

As the District has itself previously expounded, the district court had significant flexibility in exercising its discretion to modify this institutional consent

[1] No counsel for a party authored this brief in whole or in part. No party or counsel for a party contributed money that was intended to fund preparation or submission of this brief. No person other than *amici curiae*, their members, or their counsel contributed money that was intended to fund preparation or submission of this brief. *See* Fed. R. App. P. 29(b)(5).

decree based on changed circumstances. The key factors in the court's exercise of that discretion are equity and the public interest. Because the District's challenged practices deprive impoverished individuals of the critical Medicaid coverage to which they are entitled under federal law, and thus often prevent them from obtaining necessary medical care, both equity and public policy strongly favor modification of the Settlement Order entered in this case in 1999. Any associated cost is justified by the resulting benefits to health and life and is, at any rate, mandated by Congress (which funds the lion's share of associated expenses) for any state that chooses to participate in Medicaid. In addition, the April 4, 2016 Order under review (the "Modification") was necessary to ensure that the remaining provisions of the Settlement Order would be meaningful and effective in light of changed circumstances, namely the District's widespread and systematic failure to timely provide Medicaid coverage to eligible District residents.

ARGUMENT

I. THE DISTRICT COURT HAD BROAD DISCRETION TO SERVE EQUITY AND THE PUBLIC INTEREST BY MODIFYING THE SETTLEMENT ORDER.

The key legal principles for modification of any institutional consent decree, including the specific Settlement Order here, are set forth in *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367 (1992) and have been applied by this Court in earlier proceedings in this very matter, *see Salazar v. District of Columbia*, 633 F.3d

1110 (D.C. Cir. 2011), and advocated for by the District itself in these proceedings, *see, e.g.*, ECF 1481 (District's May 20, 2009 motion to modify the Settlement Order by terminating it); ECF 1503 (District's reply in support of that motion); ECF 1870 (District's September 20, 2013 motion to modify); ECF 1879 (District's reply in support of that motion). Thus, the parties agree that requests to modify a consent decree in institutional reform litigation are evaluated under a "flexible" standard. *See, e.g.* ECF 1481, at 4; ECF 1503, at 3, 8; ECF 1870, at 15. As the District has asserted, "modification of an order [is permitted] if prospective application of the judgment no longer is equitable or for any other reason that justifies relief," ECF Doc. 1870, at 14, and "'it should generally be easier to modify an injunction in an institutional reform case than in other kinds of cases,'" ECF 1481, at 4 (quoting *United States v. Western Electric Co.*, 46 F.3d 1198, 1203 (D.C. Cir. 1995)). Relief is justified on equitable principles and to further the public interest. *See, e.g.*, *Rufo*, 502 U.S. at 381 ("[T]he public interest is a particularly significant reason for applying a flexible modification standard in institutional reform litigation because such decrees reach beyond the parties involved directly in the suit and impact on the public's right to the sound and efficient operation of its institutions.") (Internal quotations omitted.); *accord* ECF 1481, at 41; ECF 1503, at 5, 8; ECF 1870, at 4, 14, 17. Modification is appropriate "when enforcement of the decree without modification would be detrimental to the public interest." *Rufo*, 502 U.S. at 384.

Modifications are a two-way street: "the court may relieve the party of the decree's constraints" or "tighten the decree in order to accomplish its intended result." *Western Electric*, 46 F.3d at 1202 (citation omitted); *accord United States v. Secretary of HUD*, 239 F.3d 211, 216 n.5 (2d Cir. 2001) ("modifications . . . that increase the obligations imposed by a consent decree are also permissible"). But the District erroneously views modification as a one-way mechanism with a "flexible standard" only for modifications in the District's favor and a much more rigid standard for modifications the District opposes. This view is contrary both to the District's prior position in this very litigation and to *Western Electric*.[2]

For example, in 2009, when the District sought a modification to terminate the Settlement Order entirely, it quoted *Rufo* as applying a "flexible modification standard" to effectuate "the public interest." ECF 1481, at 41; *see also* ECF 1503, at 3. Even more recently, in seeking to modify the Settlement Order in 2013, the District insisted that "[i]n a modification inquiry, public interest . . . may be considered." ECF 1870, at 17; *see generally* ECF 1870 (referring to the "public

[2] The District claims that the Modification here improperly "deprives the District of the benefit of the bargain it negotiated." District Br. 20; *accord id.* at 16-18, 20-21, 36. But *any* modification of a consent decree by definition deprives one party or the other of the benefit of the bargain it made. The District's argument that depriving a party of the benefit of its bargain renders any modification an abuse of discretion is therefore contrary to *Rufo*, which holds that a consent decree can be modified – and one or both parties deprived of the benefit of their bargains – when circumstances change and equity and the public interest require modification.

interest" seven times). Now, however, the District criticizes the district court's conclusion that "it was 'in the public interest to ensure that . . . children and adults do not lose the vital services provided by Medicaid coverage,'" District Br. 15, 34 (quoting ECF 2110, at 53-54), and advocates an *in*flexible standard under which the court was required to "defer to local government administrators" and prohibited from assessing its own (broader) view of "the public interest," District Br. at 29, 35.

Similarly, when the District sought modification, it noted that the district court could modify the Settlement Order for "any . . . reason that justifies relief," including "[c]hanges to . . . factual circumstances that render continued application of a consent order inequitable or contrary to the public interest." ECF 1870, at 14. Now, however, the District asserts that "[t]he district court simply lacked authority" to modify. District Br. 16.

Such gamesmanship – particularly when engaged in by a governmental entity seeking to continue to unlawfully deny health insurance to its own low-income residents – should not be countenanced. Instead, this Court should follow *Rufo* and *Western Electric* by applying the same flexible modification standard, based on equity and public interest. Applying such a standard requires affirmance here, as the district court properly focused on the equities and the public interest, and the evidence showed an extremely compelling "reason that justifies relief," ECF Doc. 1870, at 14, namely the widespread, systematic, and unlawful deprivation of

Medicaid coverage by the District resulting in serious harms to health and threats to human life.[3]

II. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN WEIGHING THE EQUITIES AND CONSIDERING THE STRONG PUBLIC INTEREST AT STAKE.

This Court follows *Rufo* by evaluating consent decree modifications in light of the equities and the public interest. *E.g.*, *Gov't of Province of Manitoba v. Zinke*, No. 16-5203, 2017 U.S. App. LEXIS 3829, at *20 (D.C. Cir. March 3, 2017) (applying *Rufo* and granting modification of consent decree upon finding that "the modification serves the public interest"); *NLRB v. Harris Teeter Supermarkets*, 215 F.3d 32, 35 (D.C. Cir. 2000) (*Rufo* requires "equity analysis"). Based on that analysis, it should affirm the Modification here because the district court appropriately weighed the equities and considered the public interest.

[3] The District also asserts that the district court abused its discretion by "shoehorn[ing] *new* claims that the District is not complying with the ACA [the Patient Protection and Affordable Care Act of 2010] into what remains of this lawsuit," because "the ACA did not even exist at the time" the Settlement Order was entered. District Br. 22 (emphasis in original). This argument is based entirely on the false premise that the Modification enforces requirements first imposed by the ACA. But in fact, the Medicaid provisions enforced by the Modification are the provisions requiring timely action on applications and proper notice prior to termination, s*ee* 42 U.S.C. § 1396a(a)(8); 42 C.F.R. §§ 431.200, 431.201, 431.206, 431.210, 435.912(c)(3)(ii), and those requirements pre-date the ACA and were enforced by the Settlement Order, *see* Settlement Order 3-21 (¶¶ 6-35).

The District suggests that the Modification is an abuse of discretion because of its cost. *See* District Br. 18, 36. But the Modification will terminate as soon as the District demonstrates its ability to "mak[e] timely eligibility determinations on applications and provid[e] adequate notice to Medicaid recipients," ECF 2109, at 3, and therefore the cost of complying with the Modification is no more than the cost of complying with federal Medicaid law. *See Rio Grande Community Health Ctr., Inc. v. Armendáriz*, 792 F.3d 229, 232 n.2 (1st Cir. 2015) (state not harmed by being compelled to use Medicaid funds for their intended purpose).[4]

The District's complaints about cost are inconsistent with the equities and the public interest in this case. Almost every injunction against the government, including consent decrees, results in costs. The key question is not whether a

[4] The fact that the Modification will terminate when the District demonstrates its ability to comply with Medicaid renewal and application requirements also negates the District's concerns regarding "federalism" and the need for "local control." *See* District Br. 21, 26-28, 35. The terms of the Modification appropriately limit its duration to the duration of the District's inability to comply with federal law. *See* ECF 2109, at 3. And, at any rate, there is no "local control" with respect to prompt processing of Medicaid applications; federal law requires such processing and, under the Supremacy Clause, that law controls. *See Harris v. McRae*, 448 U.S. 297, 301 (1980) ("Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of [the Medicaid Act]."); *Katie A. v. Los Angeles County*, 481 F.3d 1150, 1157 (9th Cir. 2007) (rejecting state's "federalism" objection to class-wide injunctive relief requiring provision of Medicaid services because "the order itself required only that defendants supply the services that the court found to be required under federal law").

modification imposes costs, but whether those costs are inequitable or are justified by the resulting individual and public benefits. *See Nat'l Treasury Employees Union v. Horner*, 854 F.2d 490, 499 (D.C. Cir. 1988) (rejecting government's claim of prohibitive cost in the absence of cost-benefit analysis). The district court properly found that the benefits of the Modification were justified because of the large number of individuals systematically and wrongfully deprived of Medicaid coverage by the District's unlawful practices and the serious (sometimes life-threatening) consequences of those deprivations.

The district court found that, at minimum, "thousands of Medicaid beneficiaries" have been harmed by "the District's failure[s]" to timely process Medicaid applications, timely renew Medicaid benefits, and provide adequate notice prior to termination. ECF 2110, at 13-14. The District's own documents showed that, as of December 2015, approximately 4,500 Medicaid applications (many covering entire families) had been pending for well over the 45 days permitted by federal law. *Id*. at 14-17 (citing ECF 2070-2, at 3). In addition to these widespread delays in application processing, the district court also found that "a significant number of Medicaid beneficiaries have been harmed" by improper terminations. *Id.* at 40. One technological problem led to "enrollment numbers . . . declining by the thousands" and another impacted close to 400 households. *Id*. at 24-25. Separately, the "failure to efficiently send and process benefits renewal forms" led to widespread

erroneous terminations. *Id.* at 40. The District itself expressed concern about "interrupt[ing] care due to administrative processing" delays, ECF 2070-15, at DHCF 1849, and acknowledged that technological errors prevented it from sending renewal forms, *see* ECF 2070-2, at 3. Overall, the district court found that "severe technical and logistical problems in the processing of initial Medicaid applications and in the Medicaid benefits renewal process" had "affected thousands of Medicaid beneficiaries and . . . deprived many District residents of necessary medical care to which they are entitled." *Id.* at 3.

The district court's findings rested not only on the uncontested evidence of broad, systemic problems with enrollments by the District but also on a "wealth of individual narratives," *id.* at 36, documenting numerous specific Medicaid enrollment failures. *See* ECF 2070-27, 2070-29, 2070-30, 2070-46, 2070-47, 2102-6, 2102-7, 2102-8, 2102-9, 2102-10, 2102-11, 2137-3. Many of the affected individuals were not enrolled for months. *See* ECF 2070-27, 2070-29, 2070-30, 2070-46, 2070-47, 2102-8, 2137-3. The findings are further supported by declarations from what the court characterized as "several of the District of Columbia's most reliable and experienced legal aid and public health organizations," ECF 2110, at 27, discussing scores of additional individuals and families who were

similarly impacted, *see* ECF 2070-22, 2070-23, 2070-24, 2070-25, 2070-26, 2070-28, 2093-1, 2102-2, 2125-1; *see also* ECF 2102-4, 2102-5.[5]

Moreover, these declarations emphasize that these violations are not isolated, but are, instead, both recurring and systemic. ECF 2070-25, at ¶¶ 10-11 (Whitman-Walker Health declaration, opining that problems of, among other things, "long delays in processing eligibility determinations for Medicaid" "are not anomalies but" result from "broader systemic issues"); ECF 2070-23, at ¶ 4 (separate Whitman-Walker Health declaration attesting that approximately 25% of the Medicaid applications and renewals the organization submits require active intervention by staff to ensure timely and appropriate processing); ECF 2070-22 at ¶ 22 (Bread for the City declaration providing opinion based on staff experience "that Medicaid-eligible individuals are often unable to secure or maintain Medicaid coverage for themselves and their families due to administrative failures of DHS" and describing significant cost incurred by organization due to supplying medications for uninsured patients); *see also* ECF 2070-24, at ¶ 18; ECF 2070-28 at ¶ 4 (observing similar systemic issues). Indeed, the district court repeatedly rejected the District's efforts

[5] Because these organizations interact with only a fraction of the hundreds of thousands of District residents eligible for Medicaid and have no systemic means of identifying everyone affected by the District's failures with respect to Medicaid applications and renewals, the record necessarily does not include all such individuals.

to paint these violations as "individual errors," finding that they instead illustrated "systemic issue[s] plaguing the [District's] Medicaid system." ECF 2110, at 21.

The District itself concedes both that these problems are ongoing, *see* District Br. 12 (conceding that it has failed to "'*entirely* remediate the problems'") (quoting ECF 2110, at 21) (emphasis added by the District), and that they are serious, *see* ECF 2110, at 16 ("There are individuals who are not getting Medicaid that [sic] should be.") (quoting ECF 2070-3, at DHCF 34). Those concessions are consistent with *Amici*'s ongoing provision of legal assistance to individuals deprived of necessary medical care due to the same violations of Medicaid law at issue in this case. The district court thus correctly found that the District's failures to enroll Medicaid-eligible individuals were "ongoing" and "systemic problems" that need to be redressed. ECF 2110, at 21, 36, 37, 40, 54.[6]

The district court also correctly found that these unlawful denials of Medicaid coverage caused great harm because they "deprived many District residents of necessary medical care to which they are entitled." ECF 2110, at 3; *see also id.* at

[6] The District does not avoid its obligation to all of these Medicaid-eligible individuals by asserting that it has made "progress" towards complying with the Settlement Order and Medicaid law. *See* District Br. 11, 12, 14. Progress is not compliance. And enrolling some Medicaid-eligible individuals while leaving others out in the cold is neither legally nor morally sufficient. Indeed, the district court repeatedly found that what little progress the District had made was insufficient to adequately protect the health of poor District residents. *See* ECF 2110, at 20, 47, 54.

28-29 (observing that "these are real people – poor and sick people and their children – who are being denied the health care and the dignity of receiving health care to which they are entitled by law"). As a general matter, the deprivation of health care coverage for individuals who are poor constitutes irreparable harm because it cannot be adequately remedied after the fact by retroactive coverage or reimbursement of costs. *See, e.g., Blum v. Caldwell*, 446 U.S. 1311, 1316 (1980) ("the denial of necessary medical benefits . . . could well result in . . . death or serious medical injury"); *Massachusetts Ass'n of Older Americans v. Sharp*, 700 F.2d 749, 753 (1st Cir. 1983) ("Termination of [Medicaid] benefits that causes individuals to forego . . . necessary medical care is clearly irreparable injury.").

And the record includes examples of individuals deprived of Medicaid coverage for lengthy periods during which they were forced to go without necessary medical services. In many cases, serious harm to health or even risk to life was the obvious result. *See, e.g.*, ECF 2070-22, at ¶ 12 (year without blood pressure medications); *id.* at ¶ 15 (inability to obtain mammogram); *id.* at ¶ 16 (untreated osteoarthritis); ECF 2070-23, at ¶ 13a (no dialysis, causing life-threatening symptoms); ECF 2070-24, at ¶ 6e (mother unable to access medical care for severely disabled child and six other children); ECF 2070-47, at ¶¶ 3, 23 (disabled child unable to see doctors or obtain medications); ECF 2102-6, at ¶¶ 1, 5, 8 (senior unable to get prescriptions); ECF 2137-3, at ¶¶ 2-5 (family of four "did not receive any

medical services" for over four months). The district court's findings regarding the severity of the harm here, including its finding that "a significant number of very sick people, or elderly people, or parents of children, are suffering from the time their benefits lapse erroneously until the District can fix the error," ECF 2110, at 30, are thus both correct and fully supported by the record.

When, as here, violations of federal law mean that a six-year-old with a critical kidney condition cannot see a specialist, *see* ECF 2070-27, at ¶ 9, individuals are deprived of the basic human dignity of supplies to manage incontinence, *see* ECF 2070-22, at ¶¶ 20-21, and an HIV patient cannot obtain literally "life saving medications," ECF 2070-23, at ¶ 9b; *accord* ECF 2070-25, at ¶ 11, injunctive relief aimed at preventing and ameliorating these gross injustices, and, ultimately, unnecessary losses of health and life, is equitable and strongly promotes the public interest. Given the District's concessions that modification of the Settlement Order may be based on "any . . . reason that justifies relief," ECF 1870, at 14, and this Court's observation that "Paragraph 71 of the Settlement Order provides for modification 'at any time for any reason,'" *Salazar v. District of Columbia*, 633 F.3d 1110, 1122 (D.C. Cir. 2011), the district court did not abuse its discretion in concluding that the equitable and public interests in the health and lives of Medicaid-eligible individuals justified the costs associated with its Order.

III. THE MODIFICATION MAKES THE SETTLEMENT ORDER EFFECTIVE.

The District argues that the Modification is an abuse of discretion because it is insufficiently related to the Settlement Order's provisions regarding Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. This assertion lacks merit because: (1) the discretion to modify is not limited to the EPSDT (and other prospective) provisions of the Settlement Order; (2) at any rate, the Modification is directly related to the EPSDT (and other prospective) provisions in several ways; and (3) modifications of the Settlement Order need not be limited to children.

A. The Court's Discretion to Modify the Settlement Order is not Limited to Provisions with Prospective Effect.

The District cites *Twelve John Does v. District of Columbia*, 841 F.2d 1133, 1138 (D.C. Cir. 1988) for the proposition that Rule 60(b)(5) provides for modification of "an order or judgment . . . only to the extent that it has prospective application," and then notes that *parts* of the "order or judgment" modified here are no longer prospective. District Br. 18-19. But the District concedes that the "order or judgment" at issue – the Settlement Order – has remaining prospective application. District Br. 16, 25-26 (conceding that Settlement Order's EPSDT provisions are prospective for this purpose). Once this baseline requirement is met,

the modification of the "order or judgment" requires only the existence of changed circumstances and the exercise of the court's equitable discretion with consideration of the public interest.

Contrary to the District's suggestion in this appeal, the district court was *not* limited to modifying only the prospective portion of the "order or judgment" but rather had discretion to modify any part of the "order or judgment," including non-prospective parts. Indeed, the Supreme Court upheld the revival of a lapsed consent decree provision in *Chrysler Corp. v. United States*, 316 U.S. 556, 563-64 (1942) (upholding trial court's grant – in 1942 – of a motion to reinstate and extend a consent decree provision that had lapsed according to its express terms on January 1, 1941). In doing so, the Supreme Court focused on a term of the consent decree that expressly provided for modification, *id.* at 562, as the Settlement Order does here, Settlement Order 44 (¶ 71) ("[E]ither party shall have the right to move the Court for a modification of this Order *at any time for any reason*.") (emphasis added). The Supreme Court focused not on which particular part of the consent decree had prospective effect but whether the modification "served to effectuate or to thwart the basic purpose of the *original consent decree*." *Chrysler Corp.*, 316 U.S. at 562 (emphasis added).

B. The Modification is Directly Related to the Prospective EPSDT Provisions.

At any rate, as explained by both the district court and the Class, ECF 2110, at 43, 52; Class Br. 21-22, 44-49, the Modification *is* directly related to the prospective EPSDT provisions of the Settlement Order. The EPSDT provisions of the Medicaid Act require state Medicaid programs to cover, among other services, "well-child visits," which include children's periodic routine physical examinations, lead screening risk assessments, vision screenings, and oral health assessments. *See* 42 U.S.C. §§ 1396a(a)(43)(B), 1396d(r)(1)-(4); ECF 2094-22 (*DC Medicaid HealthCheck Periodicity Schedule*). In addition, under the EPSDT rubric, Medicaid must cover treatment to correct or ameliorate any medical need identified during a screen or laboratory test, even if a state has chosen not to cover such treatment for an adult. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(r)(5). Thus, through its EPSDT provisions, the Medicaid Act "assure[s] the availability and accessibility of health care resources for the treatment, correction and amelioration of the unhealthful conditions of individual Medicaid recipients under the age of twenty-one." *S.D. v. Hood*, 391 F.3d 581, 586 (5th Cir. 2004) (citing CMS State Medicaid Manual § 5010.B).

The Settlement Order contains two sections devoted to EPSDT. The "EPSDT Services" section (Section V) contains detailed provisions implementing the requirement that the District "shall provide or arrange for the provision of early and

periodic, screening, diagnostic and treatment services (EPSDT) when they are requested by or on behalf of children." Settlement Order 21 (¶ 36); *see id.* at 21-35 (¶¶ 36-53). The "EPSDT Notice" section (Section VI) contains detailed provisions requiring the District to "effectively inform all pregnant women, parents, child custodians, and teenagers . . . of the availability of [EPSDT] services and the need for age-appropriate immunizations against vaccine-preventable diseases." *Id.* at 36 (¶ 54); *see id.* at 36-39 (¶¶ 54-60).

As the district court and the Class Brief explain, because EPSDT services are provided as part of the larger Medicaid program, the only way to receive such services is to apply, be approved for, and be enrolled in Medicaid. *See* ECF 2110, at 43; Class Br. 21, 46-47; s*ee also EPSDT Billing Manual* § 2.4, at 9 and §12.1, at 41. For this reason, the District's widespread failures to timely enroll Medicaid-eligible individuals (including children) clearly and directly thwart the prospective Settlement Order provisions requiring the District to provide EPSDT services to such children. This is especially true given the District's admission that roughly 40% of its Medicaid enrollees are children. *See* District Br. 6. While the District derides this conclusion as merely based on "common sense," District Br. 30, even the District cannot, and does not, dispute that none of the EPSDT services required to be provided under the Settlement Order can be accessed by a child who is not enrolled in Medicaid due to the District's unlawful actions.

This connection is apparent in the District's systemic failure to enroll newborns at birth. As noted above, EPSDT services include periodic well-child visits and screenings for infants on the day of the child's birth and again at ages 3-5 days, and 1, 2, 4, 6, 9, and 12 months. *See* ECF Doc. 2094-22; Settlement Order 21-22 (¶¶ 36, 37(a), (b)). The District admitted that technological problems had "led to the failure to automatically account for certain life changes that can affect Medicaid coverage, such as the birth of a baby," requiring the District to "'manually add[] newborns and additional household members to the [family's] case,'" a process plagued by delays and errors. ECF 2110, at 26 (quoting ECF 2070-15, at DHCF 1850); *see* ECF 2070-16, at DHCF 51 (District emails admitting "a significant backlog in . . . life event processing"); ECF 2125-1, at ¶ 7; ECF 2125-2, at 2. Any newborn affected by these issues for even a few days would necessarily be deprived of the Medicaid enrollment necessary to receive EPSDT services, including at least two well-child visits: one on the day of birth, and a second when the child is 3-5 days old. Indeed, the record contained stories of several infants deprived of Medicaid coverage due to these violations. *See* ECF 2125-1, at ¶¶ 4-6 (because of District errors, two infants lacked Medicaid coverage for the first several months of their lives); *see* ECF 2070-24, at ¶ 15(b) (District's renewal errors left another infant

without Medicaid coverage for several months, resulting in her mother being unable to take her to the pediatrician).[7]

The evidence before the district court also established deprivations of EPSDT services beyond infant well-child visits. For example, the Settlement Order requires that children be promptly referred for and provided with corrective treatment for physical and mental health conditions. *See* Settlement Order 21-22 (¶¶ 36, 37(c), (d)); 42 U.S.C. § 1396d(4)(5). Due to the District's improper terminations of Medicaid coverage, several children were unable to receive this critical care. *See, e.g.*, ECF 2070-27, at ¶ 9 and ECF 2093-1, at ¶¶ 31-41 (six-year-old with a serious kidney condition unable to obtain needed specialist care when he lost Medicaid coverage for more than five months due to an improper termination at renewal); ECF 2070-47 at ¶¶ 3-5, 23 (child diagnosed with ADHD, sensory processing disorder, childhood anxiety, eczema, and other environmental allergies unable to see doctors or obtain medication, due to the District repeatedly losing recertification forms); ECF 2110, at 29 (citing ECF 2070-30) (lapse in coverage for child with autism due to District's failure to timely process renewal form); ECF 2110, at 27-28 (citing ECF 2070-24, at ¶ 6(e)) (lapse in coverage for several children, including one with severe health conditions, due to District's failure to process renewal form).

[7] These delays in granting Medicaid eligibility to newborns remain a problem, requiring the ongoing involvement of several of the *Amici*.

The record also includes evidence of more than a dozen additional children who went without Medicaid coverage (and thus without access to EPSDT services) for several months or even several years due to application and renewal processing violations by the District. *See* ECF 2070-22, at ¶ 11 (teenager went two years without Medicaid after District failed to process five separate applications); ECF 2071-5, at 8 (daughter of domestic violence survivor unable to obtain EPSDT-covered immunizations due to several months' delay in processing application); ECF 2070-24, at ¶ 15(c) (child required emergency room treatment because District failed to enroll her for over a year); *id.* at ¶ 6(b) (improper termination at renewal caused months-long gap in coverage, during which children were unable to access medical and dental care); *id.* at ¶ 6(c) (children went without Medicaid for over four months due to improper termination at renewal); ECF 2070-23, at ¶ 11(b) (child's Medicaid lapsed for several months due to errors processing renewal); *id.* at ¶ 11(c) (same); ECF 2102-8, at ¶¶ 3-7 (young child went without Medicaid for over four months due to error processing renewal); ECF 2137-3, at ¶¶ 2-7 (two children went without Medicaid for over four months due to failure to timely process renewal); ECF 2093-1, at ¶¶ 4-16 (child went without Medicaid for more than two months during delay in application processing); ECF 2102-2, at ¶ 8 (District's failure to inform mother of application processing delay left her unable to take child to medical appointments for three months); *id.* at ¶ 9 (database showing two young children not enrolled more

than two months after application). These numerous examples more than support the district court's factual finding that a "deeply personal calamity . . . befell many Medicaid applicants and beneficiaries when they and their children were unable to get the care to which they were entitled." ECF 2110, at 14.

In the face of this mountain of evidence, the District quibbles that the district court's opinion discusses only four specific examples of affected children, which the District then attempts to disregard or minimize. District Br. at 31-32. But this Court's review considers the entire record, not just specific facts mentioned in the opinion below. "'[I]f the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it.'" *United States v. Wyche*, 741 F.3d 1284, 1292 (D.C. Cir. 2014) (quoting *Anderson v. Bessemer City*, 470 U.S. 564, 573-74 (1985)).

The District also attempts to deemphasize the number of individuals harmed by touting its allegedly high overall rate of enrollment of Medicaid-eligible children. District Br. 31-32. Such rates can be misleading, however, because they include individuals harmed by the enrollment and termination errors described above but whom the District belatedly finds eligible and enrolls "retroactively" to the date of application or termination. *See* District Br. 8-9; ECF 2110, at 19, 23, 30 (describing "retroactive" enrollment). But "retroactive" enrollment is no substitute for timely enrollment. While timely enrollment means that beneficiaries can immediately

access Medicaid-covered services (including EPSDT services), "retroactive" enrollment means only reimbursement for out-of-pocket payments that most low-income individuals cannot afford to make in the first place. Thus, as a practical matter, "retroactive" enrollment typically means going without covered services. As the district court properly recognized, "the end result is that a significant number of very sick people, or elderly people, or parents of children, are suffering from the time their benefits lapse erroneously until the District can fix the error." ECF 2110, at 30. *See, e.g.*, Ashley Storms & Kate Lewandowski, *Beyond Enrollment: Ensuring Stable Coverage for Children in Medicaid and CHIP*, New England Alliance for Children's Health, at 1 (Aug. 2013) (even a short coverage gap is "associated with delays in seeking needed health care" and thus "negatively impacts the well-being of children and families").

Finally, the District's claim that the Modification is insufficiently related to the Settlement Order's prospective mandate to provide EPSDT services ignores additional prospective provisions which justify the Modification. First, the EPSDT Section of the Settlement Order entitles the Class to certain relief if the District's "participant ratio" drops below specified levels. *See* Settlement Order 26-34 (¶¶ 43-46, 48). The "participant ratio" is the number of Medicaid enrollees receiving the required EPSDT services divided by the total number of enrollees who could receive such services (*i.e.*, child enrollees). *See* CMS State Medicaid Manual 5360.B. By

unlawfully failing to enroll eligible children, the District reduces the total number of child enrollees and thus reduces the number of individual children it must provide with services in order to meet the "participant ratio" goals in the Settlement Order.

Second, the Settlement Order "sets forth . . . detailed procedures for providing notice to eligible Medicaid beneficiaries regarding the availability and nature of EPSDT services." ECF 2110, at 12. Such notice must be given orally and in writing to "all pregnant women, parents, [and] child custodians . . . who have been determined to be eligible for Medicaid benefits." Settlement Order 36 (¶ 54). This provision is thwarted when the District unlawfully fails to process Medicaid applications and, as a result, a pregnant woman, parent, or custodian is not "determined to be eligible for Medicaid benefits" and is therefore deprived of the required notices.

Third, anticipating that Medicaid-eligible individuals whose enrollment was unlawfully delayed or denied may be forced to pay out-of-pocket for medical services that should have been covered, Section VII of the Settlement Order, which remains in full prospective force, requires the District to "provide corrective payments to Medicaid recipients who have incurred out-of-pocket medical expenses that should have been paid by Medicaid." Settlement Order 40 (¶ 62). The record demonstrates that this provision was ineffective for many beneficiaries who could not afford to pay out-of-pocket during these periods and therefore had to forego

necessary medical services entirely. *See, e.g.*, ECF 2070-27, at ¶ 9 (6-year-old with serious kidney condition unable to see specialist because mother "could not pay the cost of the visit"); ECF 2070-47, at ¶ 23 (mother of disabled child "had to cancel his medical appointments" and could not "get his medication prescribed by his doctor"); ECF 2137-3, at ¶¶ 2-5 (two children and their parents unable to "receive any medical services" for nearly five months due to lapse in Medicaid coverage); ECF 2070-46, at ¶¶ 3, 10 (woman recovering from severe car accident "unable to attend [her] prescribed rehabilitation therapy" or "fill [her] prescription," causing her "legs [to] go into painful spasms"). The Modification effectively modifies Section VII to require the District to provide actual coverage during these periods, rather than ineffective after-the fact reimbursement.

C. The Modification's Inclusion of Adults is Neither Inequitable nor Harmful to the Public Interest.

The District asserts that the Modification is over-inclusive because it provides relief for adults in addition to children, while EPSDT benefits are limited to children. District Br. 34-37. That claim must be rejected, because the Settlement Order includes prospective provisions that apply directly to adults and are not fully effective without the Modification. Specifically, the Settlement Order requires provision of EPSDT notice to pregnant women, parents, and caretakers of children, as well as reimbursement of expenses incurred by any Medicaid beneficiary unlawfully deprived of coverage. *See* Settlement Order 37 (¶ 56), 40 (¶ 62).

Including adults within the scope of the Modification ensures that these adult-directed provisions function properly despite the District's unlawful denials and terminations of Medicaid coverage.

Moreover, children represent about 40% of all Medicaid beneficiaries, *see* District Br. 6, and it was within the district court's broad discretion to require the District to provide the same remedies to adults and children in the interests of equity, financial economy, and simplicity of administration. The record indicates that fashioning the remedy to include adults reduces the administrative burden associated with implementing the ordered relief. The District itself represented that, to activate provisional Medicaid eligibility for applications pending more than 45 days, as required by the Modification, it would have to run an automated "batch job" to identify all delayed applications. *See* ECF 2113-1, at ¶ 8. Because children typically appear on an application not alone but with their parents, *see* DC Health Link Application for Families, at 2, https://dchealthlink.com/sites/default/files/v2/forms/DC_Health_Link_Standard_Application_for_Help_Paying_for_Health_Coverage_201509.pdf (instructing the applicant to include information about children under 21 who live in the household), implementing the Modification just for children would require the District to manually review each application identified by the batch job to activate provisional eligibility for the child and not for the adversely affected parent. This would not

only constitute an immense administrative burden but would also lead to the anomalous result that the District, having identified a family application unlawfully pending for more than 45 days, would remedy the violation only for the children while allowing the improper deprivation of coverage to continue unabated for the parent. The district court soundly reasoned that a result more consistent with the "public interest" would be to craft a remedy that ensured that both "children and adults do not lose the vital services provided by Medicaid coverage." ECF 2110, at 54.

CONCLUSION

For the foregoing reasons, A*mici* respectfully request that the Court uphold the legal rights of impoverished individuals living in the District of Columbia by affirming the district court's April 4, 2016 order.

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CERTIFICATE OF COMPLIANCE

I hereby certify that:

(1) This brief complies with the type-volume limitation of Fed. R. App. P. 29(d) & 32(a)(7)(B) because it contains 6,760 words, excluding the parts of the brief exempted by 32(a)(7)(B)(iii), and

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CERTIFICATE OF SERVICE

I hereby certify that on April 3, 2017, I caused a true copy of the foregoing brief of *Amici Curiae* to be delivered electronically via the Court's CM/ECF system to:

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