No. 19-1262
Consolidated with No. 19-1767

United States Court of Appeals for the First Circuit

ROSIE D., by her parents John and Debra D.; TYRIEK H., by this mother Christine H.; JOSHUA D., by his mother Emelie D.; SHEENA M., by her mother Deborah D.; DEVIN E., by his grandmother Barbara E.; ANTON B., by his mother Lisa A.; SHAUN E., by his grandmother Jacquelyn E.; JERRY N., by his mother Susan P. on behalf of themselves and all others similarly situated,

Plaintiffs-Appellees

NATHAN F. by this mother Tracey F.; SAMUEL L.; JOSE M.; TERRENCE M.; MARC ST. L.; NATISHA M.; SARAH B.; FORREST W.; JASON S.; SHENTELLE G.; CHRISTINE Q.; KIRSTIN P.; CHRIS T.; CHELSEA T.; RALPH B.; TEVIN W.; DANIELLE H.; JANICE B.; KRISTIN H.,

Plaintiffs.

v.

CHARLES BAKER, Governor of Massachusetts; MARYLOU SUDDERS, Secretary of Executive Office of Health and Human Services; MICHAEL HEFFERNAN, Secretary of Executive Office of Administration and Finance; DANIEL TSAI, Assistant Secretary for MassHealth,

Defendants-Appellants

On Appeal from an Order of the U.S. Dist. Ct., Dist. of Massachusetts

Brief of Amici-Curiae National Health Law Program, American Academy of Pediatrics, Massachusetts Chapter of the American Academy of Pediatrics, Judge David L. Bazelon Center, and National Center for Youth Law in Support of Plaintiffs-Appellees

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, *amici curiae* National Health Law Program, American Academy of Pediatrics, Massachusetts Chapter of the American Academy of Pediatrics, Judge David L. Bazelon Center, and National Center for Youth Law disclose that they have no parent corporations and are nonprofit entities that issue no stock. Accordingly, no publicly held corporation owns 10 percent or more of their stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Federal Statutes and Regulations

Other Sources

INTEREST OF AMICI CURIAE

The *amici* file this brief pursuant to Fed. R. App. P. 29. The parties have consented to its filing.[1]

Founded in 1969, the National Health Law Program (NHeLP) advocates, educates, and litigates at the federal and state levels to further its mission of improving access to quality health care for low-income individuals. For 50 years, our work has focused, in particular, on ensuring access and coverage for low-income children and youth. To this end, NHeLP has advocated in all branches of government to achieve robust implementation of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions. Given its mission and its work, NHeLP has a strong interest in the outcome of this case.

The American Academy of Pediatrics (AAP) is an organization of 67,000 pediatricians committed to protecting the well-being of America's children, including by engaging in broad and continuous efforts to prevent harm to the health of infants, children, adolescents, and young adults caused by a lack of access to health coverage and care. The Academy's *Bright Futures Guidelines* have been

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[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amici curiae* states that no counsel for a party authored this brief in whole or in part and no person, other than *amici curiae*, their members, or their counsel made a monetary contribution to its preparation or submission.

widely embraced as the nationwide standard of care and used to meet the EPSDT screening requirements.

The Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) represents over 1600 pediatricians across the Commonwealth. Our members are dedicated to improving the quality of life for infants, children, and adolescents by providing the highest quality health care and advocating for them and their families. A signature initiative of the MCAAP is the state's Children's Mental Health Task Force, a coalition of pediatricians, child psychiatrists, psychologists, social workers, insurance representatives, policy advocates, various commissioners, legislators, employer groups, nurses, and groups from the education and correctional services community working together to improve children's mental health in Massachusetts.

The Judge David L. Bazelon Center is a national legal advocacy organization that works to advance the rights and dignity of adults and children with mental disabilities, and to ensure that they have access to the services and supports they need for full participation in community life. Through litigation and public policy advocacy, the Center promotes equal opportunity for people with mental disabilities in all areas of life, including health care, education, housing, community living, employment, parental and family rights, and other areas. The Center dedicates much of its resources to working on behalf of children who need mental health services to allow them to thrive and grow into healthy adults with full lives.

The National Center for Youth Law (NCYL) is a private, non-profit organization that uses the law to help children in need nation-wide. For more than 40 years, NCYL has worked to protect the rights of low-income children and to ensure that they have the resources, support, and opportunities necessary for healthy and productive lives. NCYL provides representation to children and youth in cases that have a broad impact and has represented many children with unmet mental health needs in class action litigation. NCYL also engages in legislative advocacy to provide children with unmet mental health needs a voice in policy decisions and spearheads policy projects designed to increase stakeholder knowledge of effective trauma-informed mental health services and supports.

SUMMARY OF ARGUMENT

After consulting with medical professionals, MassHealth determined that necessary Treatment for children with serious emotional disturbances includes Intensive Care Coordination (ICC) services within 14 days. MassHealth acknowledges that federal Medicaid laws require it to set a timeliness standard and ensure that processes are in place to allow for timely receipt of ICC services. Nevertheless, it argues there is no basis in the law for a court to require MassHealth to actually comply with the standard. This argument ignores 42 U.S.C.

§ 1396a(a)(8), which requires the State to furnish medical assistance, such as ICC, to individuals with reasonable promptness, and 42 U.S.C. §§ 1396a(a)(43) and 1396d(r)(5), and the implementing regulation, 42 C.F.R. § 441.56(e), which require state Medicaid agencies to ensure timely initiation of EPSDT Treatment. Regardless of whether the statute or the regulation is used as the guide, states must ensure that treatment services are provided with reasonable promptness.

Amici focus on the EPSDT provisions. Since they were added to the Medicaid Act in 1967, these provisions have entitled children to both early detection of health problems *and* timely treatment of those problems.

ARGUMENT

MassHealth participates in Medicaid and, as such, must provide Medicaid-enrolled individuals under age 21 with EPSDT. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r)(5). As this case illustrates, some Medicaid-eligible children have serious emotional disturbances that require the comprehensive evaluation and treatment services that EPSDT covers. After consulting with medical professionals from the New England Council of Child and Adolescent Psychiatry, MassHealth determined that the necessary treatment for these children includes providing ICC services within 14 days of the initial request for the services or referral to the first face-to-face appointment with an ICC provider. Br. of the Defs.-Appellants (Defs' Br.) at 35, 40 (Nov. 14, 2019), ECF No. 117515805.

MassHealth acknowledged at the time that compliance with the standard is a requirement of federal EPSDT law: "Fourteen (14) days is the Medicaid standard for the timely provision for services established in accordance with 42 CFR 441.56(e)." MassHealth, *MBHP Provider Alert 114, Intensive Care Coordination – Announcement of Revised Program Specifications* (April 10, 2012), https://www.masspartnership.com/pdf/alerts/Alert%20114%20ICC%20Revised%20PS%20FIN%2041012.pdf. "The 14-day standard begins from the time at which the family has been contacted." MassHealth, *MBHB Provider Alert 122, In-Home Therapy Therapeutic Mentoring In-Home Behavioral Services: Announcement of Revised Performance Specifications Relating to Referral Response Time Access Standards, and Maintenance of a Waitlist* (Aug. 31, 2012), https://www.masspartnership.com/pdf/HNEALERT17RevisedIHT_TM_IHBS_PS_FIN83112.pdf.

The District Court found there is no dispute that MassHealth is not meeting the 14-day standard. Defs' Br. Addendum 43, 74. Nevertheless, MassHealth asks the Court to end the judicial oversight of the case. MassHealth argues that, while it can be required to set the standard and ensure that processes are in place to allow for timely receipt of ICC and other EPSDT remedial services, there is no basis in federal Medicaid law for a court to require MassHealth to actually comply with the timeliness standard. *See* Defs' Br. at 41, ECF No. 117515805. Under this argument, the family and child have the right to know about EPSDT and receive timely and periodic screening to detect problems. But for the crucial services actually needed to treat their emotional conditions, the child can wait. Acceptance of this argument would mean that federal EPSDT law, which was enacted to ensure that children's mental and physical conditions are found *and* treated as early and effectively as possible, does not actually require timely treatment for a child identified with serious emotional disturbances.

This argument ignores the entire history of EPSDT. Since 1967, the federal Medicaid EPSDT provisions have entitled low-income children to a broad range of services that will ensure both early detection of their health problems and timely, comprehensive care to treat them.

I. EPSDT was enacted to so that health conditions will be identified and treated promptly.

In 1964, a Selective Service study found that about one-third of 18-year-olds failed to qualify for military duty because of untreated health conditions, including a large portion of draftees rejected for emotional and mental reasons. *See* President's Task Force on Manpower Conservation, *One-Third of A Nation: A Report on Young Men Found Unqualified for Military Service* 11 (Jan. 1, 1964). Concerned, the Department of Health, Education, and Welfare convened the Program Analysis Group, which engaged in further study and estimated that 62 percent of the serious conditions found by the Selective Service could be prevented or corrected through the provision of comprehensive and continuous health care. *See* Patricia Butler, Nat'l. Health Law Prog., *An Advocate's Guide to Early and Periodic Screening, Diagnosis and Treatment*, Clearinghouse Rev. 1 (May 1975) (citing U.S. Dep't of Health Educ. & Welf., Off. of the Assistant Sec. for Program Coordination, *Rpt. of the Program Analysis Group on Child Health* at V.1 (1966)). The Group envisioned a program "to provide early case finding and treatment of congenital and other chronic disorders in children." *Id*. (citing *Rpt. of the Program Analysis Grp.* at III.18). The Program Analysis Group's recommendations were included in the Child Health Act of 1967. *See* Child Health Act of 1967, H. Rep. No. 5701, § 301 (1967). When he introduced the Act, President Johnson emphasized the need for timely screening and prompt treatment:

> The problem is to discover, as early as possible, the ills that handicap our children. There must be continuing follow-up and treatment so that handicaps do not go untreated.

President Lyndon B. Johnson, Welfare of Children, H.R. Doc. No. 54, 90th Cong., 1st Sess. (1967), 113 Cong. Rec. 2883 (Feb. 8, 1967). Thereafter, Congress amended the Medicaid Act to require states to provide

> such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary[.]

Social Security Amendments of 1967, Pub. L. No. 90-248, § 302(a), adding 42 U.S.C. § 1396d(a)(4)(B) (eff. July 1, 1969); *see also Id*. at § 302(2) (adding 42 U.S.C. § 705(a)(7), Maternal and Child Health provisions requiring states to provide "for early identification of children in need of health care and services, and for health care and treatment needed to correct or ameliorate defects or chronic conditions discovered thereby, through provision of such periodic screening and diagnostic services, and such treatment, care and other measures to correct or ameliorate defects of chronic conditions, as may be provided in regulations of the Secretary.").

Legislative history shows that Congress intended states to engage in aggressive efforts to identify children and address their mental and physical conditions as quickly and comprehensively as possible:

> Organized and intensified case-finding procedures will be carried out in well-baby clinics, day care centers, nursery schools, Headstart centers in cooperation with the Office of Economic Opportunity, by periodic screening of children in schools, through follow-up visits by nurses to the homes of newborn infants, by checking birth certificates for the reporting of congenital malformation and by related activities.

H. R. Rep. No. 544, 90th Cong., 1st Sess. 127 (1967).

The U.S. Department of Health Education and Welfare issued regulations and guidance documents to implement the 1967 amendments. To implement the statute and congressional intent, states were required to ensure that Medicaid-eligible children's needs were identified and that they received necessary services and treatments promptly. *See, e.g.*, 36 Fed. Reg. 21,409 (Nov. 9, 1971) (promulgating

45 C.F.R. § 249.10, requiring states to "assure that individuals under 21 years of age who are eligible for medical assistance receive the services. . . ."). The Department's *Medical Assistance Manual* provided lengthy discussion of the history of EPSDT and explained the basic EPSDT obligations. The agency noted that, with the 1967 amendment,

> Congress intended to require States to take aggressive steps to screen, diagnose and treat children with health problems. . . . Senate and House Committee reports emphasized the need . . . to make services available so that young people can receive medical care before health problems become chronic and irreversible damage occurs.

U.S. Dep't of Health Educ. & Welf., *Medical Assistance Manual* § 5-70-20 (June 28, 1972). Among the EPSDT basics: States were required to "actively seek out eligible individuals" to inform them of EPSDT and help them obtain screening and treatment. State Medicaid agencies were to implement comprehensive screening and diagnostic services, statewide, "so that young people who are eligible for Medicaid services will have access to a coordinated, integrated evaluation process and health care system." *Id*. at 5-70-20A. Screening was to occur periodically, at pre-set intervals, and otherwise when further evaluation was needed. Diagnostic referrals were to be made "without delay," and states were to follow-up to make sure the evaluation occurred. *Id.* at 5-70-20F. States were to enlist a range of health providers so that EPSDT can achieve "early casefinding and diagnosis, as well as *prompt and effective treatment*. . . ." *Id.* (emphasis added).

With the EPSDT amendments, Congress and the federal Medicaid agency clearly intended states to undertake aggressive activities to reach and inform families of the EPSDT benefit and to provide low-income children and youth with services to ensure both early identification and treatment of problems. This set the EPSDT laws apart from the rest of the Medicaid program because it marked a clear departure from Medicaid's role as a "vendor payment" program that paid providers upon submission of a claim.

II. Over the years, the EPSDT provisions have been amended and implemented in various ways, always with the intention of requiring states to ensure timely identification and treatment of children's health conditions.

A few years after it added EPSDT to Medicaid, Congress became concerned that states were not taking the necessary steps to ensure that children and youth were actually receiving screening and needed treatment. As a result, Congress established a penalty that would reduce by one percent federal funding for the state's Aid to Families with Dependent Children program for any quarter during which a state failed to inform families of EPSDT, provide or arrange for requested screens, or arrange for corrective treatment of health problems found. *See* Social Security Act of 1972, Pub. L. No. 92-603, § 403(g) (implementing 42 U.S.C. § 603(g)). The federal agency promulgated requirements relating to timely provision of services for purposes of implementing the penalty. Among other things, application of the penalty was to be determined, in part, by assessing whether the state was meeting quantified timeframes—screening within 60 days of request; referrals to treatment within a reasonable time, normally within 60 days of screening; and treatment initiated within 180 days after the initial request for screening. *See* 45 C.F.R. § 205.146(c) (1974) (removed as obsolete, 62 Fed. Reg. 64301 (Dec. 5, 1997)). Federal guidance documents confirmed that a state would be held "penalty liable" if it did not meet the timely service delivery requirement, whether the recipient requested EPSDT services directly from the state or elsewhere (*e.g.*, after a "walk-in" to a provider). The guidance also noted that documenting a delay in services due to the scarcity of providers would not be enough to avoid the penalty; rather, timely service delivery "mean[t] seeing that the recipient gets to the . . . office for diagnosis and treatment within the specified time frame." U.S. Dep't of Health Educ. & Welf., *Medicaid Requirement for State Programs of Early and periodic Screening, Diagnosis, and Treatment of Individuals under 21: Policy Interpretation Program and Penalty Provisions* at 8, 13-15 (Aug. 1979).

Although Congress repealed the penalty provision in 1981, it reaffirmed its intention that "States should continue to develop fully effective EPSDT programs." Omnibus Budget Recon. Act of 1981, Pub. L. No. 97-35 § 2171, at 965. And it amended the Medicaid Act to require states to inform all Medicaid recipients under age 21 of EPSDT, provide or arrange for requested screening services, and provide or arrange for corrective treatment of health problems found as a result of the screen. *Id*. (adding 42 U.S.C. § 1396a(a)(44), subsequently re-designated as § 1396a(a)(43)).

The federal agency, now called the Department of Health and Human Services, again promulgated regulations to implement the statute. *See* 48 Fed. Reg. 38,011, 38,015, 1983 WL 116184(F.R.) (Aug. 22, 1983). In addition to implementing the informing and screening requirements, the agency focused on the timely provision of treatment services, stating: “We believe that Federal regulations should still include a set of requirements directed at assuring that services are delivered to children in timely fashion. This implements Congressional intent that States continue to develop fully effective EPSDT programs while paperwork reporting requirements are reduced.” *Id*. The agency proposed 42 C.F.R. § 441.56(e), requiring that states set standards for “timely delivery” of services, that the standards “meet reasonable standards of medical and dental practice,” that they be arrived at “after consultation with recognized medical and dental organizations involved in child health care,” and that states “demonstrate that processes are in place to ensure timely delivery of services generally within an outer limit of 6 months from request.” *Id.* As finalized, the regulation requires the state Medicaid agency to

> set standards for the timely provision of EPSDT services which meet reasonable standards of medical and dental practice, as determined by the agency after consultation with recognized medical and dental organizations involved in child health care, and must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the request for screening services.

42 C.F.R. § 441.56(e) (promulgated at 49 Fed. Reg. 43,654, 43,660-61, 1984 WL 130277(F.R.) (Oct. 31, 1984).

Unlike previous EPSDT timeliness requirements, 42 C.F.R. § 441.56(e) ties timely provision of treatment services to medical standards of care, as set by the professionals who provide that care, while still maintaining a quantified outside limit for when treatment must be initiated. As the federal agency noted, "[p]eriodicity and timeliness requirements should be set based on professional judgment since that best reflects what is required in order for proper medical treatment to be provided. The regulations reflect that approach." 49 Fed. Reg. at 53,660.

The Department's responses to commenters' concerns about the timeliness requirements show that the agency's intent was to require states to not just set standards and have processes but to ensure that needed treatments are actually provided in a timely manner. For example, some commenters objected to allowing an outer limit of six months for the provision of EPSDT services, concerned that such a delay between screening and treatment was unreasonable and without medical or other foundation. As a result of these comments, the agency amended § 441.56(e) "to make clear that the 6 month limit does not begin on the date the screening is provided but rather on the date on which the screening is requested, and ends with the initiation of necessary treatment. Thus, within 6 months of the request for service, the screening, problem identification, and initiation of treatment should occur." 49 Fed. Reg. at 43,660-61. Moreover, the agency found the need for the six-month outer limit "to ensure a minimum national standard" but further stated: "[W]e believe that requiring States to establish time standards which meet reasonable standards of medical and dental practice will ensure that States adopt the shortest possible time-span for each step of the EPSDT cycle compatible with efficient administration of the Medicaid program." *Id*. at 43,661. Notably, some commenters also expressed concern that the regulation could be taken for a requirement that states needed only demonstrate that processes are in place for delivery of timely care. *Id.* But that was not the intent. According to the Department, the regulation is intended "to make clear that States must employ methods to ensure timely delivery and assure providers' compliance with their agreements." *Id*.

Still, states fell short. Congress again stepped in, amending the EPSDT provisions in 1989 to clarify and strengthen states' obligations to ensure that children receive early screening *and* necessary treatment. *See* Section 6403 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403 (Dec. 19, 1989). Among other things, Congress clarified that states must provide services necessary to "correct or ameliorate" health conditions and also established the scope of EPSDT benefits by removing the Secretary's authority to define EPSDT services and defining them in the statute. Thus, states must now ensure coverage of "other necessary health care, diagnostic services, treatment and other measures described in section 1905(a) [42 U.S.C. § 1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan," *id*. § 1396d(r)(5). States must also "arrang[e] for (directly or through referral to appropriate agencies, organizations, or individual) corrective treatment" that a child needs. *Id.* at § 1396a(a)(43)(C). *See, e.g.*, *Katie A. ex rel. Ludin v. Los Angeles Co.*, 481 F.3d 1150, 1162 (9th Cir. 2007) (citing (a)(43) as "[r]equiring the State actually to provide EPSDT services that have been found to be medical necessary").

The U.S. Department of Health and Human Services included guidance on the 1989 changes in its *State Medicaid Manual* (which replaced the HEW *Medical Assistance Manual*), describing EPSDT as "A Comprehensive Child Health Program" which "consists of two, mutually supportive, operational components: assuring the availability and accessibility of required health care resources and helping Medicaid recipients and their parents or guardians effectively use them. . . . These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to systematically . . . [a]ssess the child's health needs through initial and periodic examinations and evaluation, and [a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly." U.S. Dep't of Health and Human Services, *State Medicaid Manual* § 5010B.

The federal agency has also discussed the interplay between the Medicaid EPSDT requirements and Americans with Disabilities Act/*Olmstead* requirements. In a guidance letter to states, for example, the agency noted EPSDT's twofold purpose: the first, to ensure that all eligible children receive preventive care so that problems are diagnosed as early as possible and, the second, "to ensure that children receive the services they need to treat identified health problems." Letter to State Medicaid Dirs. from Timothy Westmoreland, Dir., U.S. Dep't of Health and Human Serv. Ctr. for Medicaid and State Oper., *Olmstead Update No. 4* at 10 (Jan. 10, 2001), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd011001a.pdf.

Most recently, the Department issued *EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014).[2] According to the *Guide*, the EPSDT benefit is "designed to assure that children receive early detection and care so that health problems are averted or diagnosed and treated as early as possible." *Id*. at 1; *see also id*. ("The goal of EPSDT is to assure that individual children get the health care they need when they need it–the right care to the right child at the right time in the right setting."). The federal agency continues: "The

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[2] While it does not establish new policy, the Guide serves the important purpose of compiling federal EPSDT policy guidance over the years into one place. CMS, *EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* 2 (June 2014).

affirmative obligation to connect children with necessary treatment makes EPSDT different from Medicaid for adults . . . [and] . . . is a crucial component of a quality child health benefit" *Id.* at 5. The federal agency summarizes the State's obligations to ensure that children receive necessary treatment promptly as follows:

> Services under the EPSDT benefit, like all Medicaid services, must be provided with "reasonable promptness" [quoting 42 U.S.C. § 1396a(a)(8)]. The state must set standards to ensure that EPSDT services are provided consistent with reasonable standards of medical and dental practice. The state must also ensure that services are initiated within a reasonable period of time. . . [referring to 42 C.F.R. § 441.56(e)]. Because states have the obligation to "arrang[e] for . . ., corrective treatment" . . ., a lack of providers does not automatically relieve a state of its obligation to ensure that services are provided in a timely manner [quoting 42 U.S.C. § 1396a(a)(43)(C)].

Id. at 12. Clearly, "regardless of whether the regulation or merely the statute is used as a guide, services must still be provided with reasonable promptness." *Kirk T. v. Houstoun*, No. 99-3253, 2000 WL 830731, at *3-4 (E.D. Pa. 2000).

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Thus both Congress, in enacting the EPSDT provisions of the Medicaid Act, and the Department of Health and Human Services, the agency responsible for overseeing the states' compliance with these provisions, have made clear that the EPSDT statute and its legislative and administrative history establish that "the EPSDT obligation is . . . extremely broad," *Katie A.*, 481 F.3d at 1154, and that the State's "obligations with respect to EPSDT services require more proactive steps, such as actual provision of services . . . in a timely fashion." *Clark v. Richman*, 339

F. Supp. 2d 631, 646-47 (M.D. Pa. 2004); *Id.* at 640, 647 (citing 42 C.F.R. § 441.56(e)).

CONCLUSION

For the foregoing reasons, *amici* ask the Court to affirm the opinion of the district court.

Date: December 19, 2019

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font. I certify that the foregoing brief complies with the requirements of Fed. R. App. P. 32(A)(7)(B) and 29(a)(5), and that the total number of words in this brief is 4104 according to the count of Microsoft Word, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

/s/ Martha Jane Perkins
Martha Jane Perkins

CERTIFICATE OF SERVICE

I certify that on December 19, 2019, I served the counsel of record in this case by electronically filing the foregoing brief with the Clerk of the Court using the ECF/CM system.

/s/ Martha Jane Perkins
Martha Jane Perkins