UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., *et al.*, **Plaintiffs,** **v.** **DEVAL PATRICK, *et al.*,** **Defendants.**	**CIVIL ACTION** **NO. 01-30199-MAP**

INTERIM REPORT ON IMPLEMENTATION

The Defendants hereby submit this Interim Report on Implementation ("Report") as requested by the Court at the February 12, 2010 hearing in preparation for the hearing scheduled for May 18, 2010.

The Defendants hereby report as follows:

1. STATUS OF DISCUSSIONS WITH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) REGARDING CRISIS STABILIZATION

As reported in the February 11, 2010 Interim Report on Implementation, although the Centers for Medicare and Medicaid Services (CMS) denied the Commonwealth's proposed Medicaid State Plan Amendment (SPA) to establish Crisis Stabilization services, it expressed willingness to continue to work with the Commonwealth "to develop an approvable payment methodology to ensure that the State can receive Federal funding for its expenditures on such services."

In response to this offer, the Defendants spoke by telephone with budgetary and program staff from the Central and New England Regional offices of CMS on March 16, 2010. During the call, CMS staff forcefully re-stated the agency's position that Federal Financial Participation is not available for any room and board costs except hospital, psychiatric residential treatment facility intermediate care facility for people with mental retardation or skilled nursing facility services. The Defendants asked if all provisions of the proposed SPA, other than the payment methodology, were approvable. CMS staff acknowledged that they had not thoroughly reviewed the remainder of the SPA.

At Massachusetts request, CMS agreed to provide Massachusetts with State Plans it has approved for services CMS believes are similar to Crisis Stabilization, On April 23, 2010, we received a list of these approved SPAs: Minnesota SPA# 05-010, North Carolina SPA# 07-003 and North Dakota SPA# 07-002. The Defendants have requested copies of these approved SPAs including approved rate methodologies from these states.

Once received, the Commonwealth will review the SPAs to determine whether the services approved conform to the description of Crisis Stabilization in the Judgment and whether the approved SPAs provide models that MassHealth could adopt to achieve an approvable SPA for Crisis Stabilization.

2. CARE COORDINATOR CASELOADS IN INTENSIVE CARE COORDINATION

Recent Trends

Review of weekly reports of average caseloads across the ICC providers from February 1, 2010 through April 30, 2010, shows a largely consistent pattern of caseload distribution among Care Coordinators (see Exhibit 1). During this period, approximately 30% of the Care Coordinators had caseloads of eight or fewer youth, approximately 60% had caseloads of nine to fourteen youth and approximately 10% had caseloads of 15-18. The trends over this time period show a recent drop in Care Coordinators with the caseloads in the lowest range, growth in Care Coordinators with caseloads in the middle range and very slight growth in Care Coordinators with caseloads in the highest range. The most recent report on ICC caseloads, covering the last week of April, continues the trend -- showing 24% of Care Coordinators with caseloads in the lowest range, 66% with caseloads in the middle range and 10% with caseloads in the highest range. The Defendants believe this trend reflect the maturing skills of previously-hired Care Coordinators who were initially carrying very low caseloads.

Discussions Between the Parties

The Plaintiffs, Defendants and Court Monitor met on April 23, 2010, to discuss the issue of caseloads in Intensive Care Coordination, as well as other agenda items. As referenced in the Plaintiffs' Thirteenth Status Report (at footnote 5), the Plaintiffs prepared a written proposal prior to the meeting to address several of what the Plaintiffs characterized as the Defendants' "most pressing concerns". The Plaintiffs report that the proposal was rejected and no written

alternative was offered. On the contrary, the Defendants have only continued to reject the Plaintiffs' longstanding desire for a caseload cap

Although neither party changed its position during the meeting, the discussion was very substantial, fully explicating the parties' concerns and perspectives. The Defendants continue strongly to maintain that the parties' common goal of assuring that children receive the ICC services that they need is best met by providing the program clinicians with the first opportunity to make judgments about the number of children a particular ICC Care Coordinator can serve at any one time. The determination of how many children a Care Coordinator can effectively work with in ICC is a complex matter impacted by many variables specific to the Care Coordinator, youth and family, and is therefore best made at the program level by the Program Director and the Care Coordinator's supervisor, in accordance with the ICC Guidelines established by the Defendants, rather than requiring (and allowing) the ICC providers and MCEs to manage to a fixed number – or caseload cap – as Plaintiffs would prefer.

The Defendants maintain that such program level decision should be closely monitored and managed to ensure that children receive high quality ICC services. The MCEs, closely monitored by the Defendants, engage in network management activities designed to ensure that this is so.

These activities include:

- Use of nationally recognized, state-of-the-art assessment tools for evaluating whether ICC services are being delivered in accordance with high-fidelity Wraparound model.

- The Wraparound Fidelity Index 4.0 (WFI-4) is a 40-item instrument used to assess adherence to the Wraparound model. In Massachusetts, the WFI-4 is being completed through brief, confidential telephone interviews with the parent/caregiver. These interviews are being conducted by a vendor, Consumer Quality Initiatives (CQI), contracted, by MBHP. Interviews began on January 2, 2010 and will continue until 20 have been completed for each CSA (total of 640) or until June 30, 2010. As of April 29th, 418 interviews had been conducted. A final report is expected to be available in September.
- The Team Observation Measure (TOM) is a 20-item instrument used to assess adherence to standards of high-fidelity Wraparound, during care plan team meetings. The MCEs have required the CSAs to observe every individual facilitating a Care Plan Team (CPT) meeting twice (at minimum) between January 2, 2010 and June 30, 2010, and use this information both to manage the programs and to improve skill-based supervision on an individual level. As of April 29th, the CSAs have observed 220 CPT facilitators.

- MCEs will review the WIFI and TOM reports with each CSA to provide comprehensive feedback to ICC providers on areas of strength and need related to Wraparound fidelity.

- The Monitor plans to undertake Case Reviews which are expected to provide in-depth information on the quality of ICC services.

- Next fall and winter, MassHealth will conduct parent and youth satisfaction surveys.

During the April 23, 2010 meeting the Defendants, discussed the steps currently being taken to manage the ICC program according to the performance specifications and the ICC Operations Manual. Those steps include the following[1]:

Establishing and communicating caseload guidance
Requiring weekly caseload reports through June, 2010; thereafter monthly
Ensuring that MCEs review caseload data with individual ICC providers and during monthly management meetings.
Ensuring that MCE Technical Assistance teams discuss caseloads with ICC providers who have Care Coordinator caseload(s) that approach the upper range of the guideline to determine the reason, the likely duration and actions the provider intends to take to reduce the caseload. In addition, the MCE Technical Assistance teams engage in an ongoing dialogue with the provider about assuring the delivery of high quality ICC services.

[1] In deference to the Plaintiff's request, we have eliminated what we originally identified as our subjective understanding of the Plaintiff's suggested action items, and have left only the steps currently being undertaken by the Defendants.

Ensuring that if, in the judgment of the MCE TA team, the ICC is not providing high quality ICC services for any reason, the team may engage in more frequent and intensive monitoring, including at weekly intervals, and may also require other corrective action. Staff of MassHealth's Office of Behavioral Health meet weekly with the MCEs to review management of the remedy services.
Ensuring that if, in the judgment of the MCE TA team, a provider is not assuring the delivery of high quality ICC services, the MCEs institute a corrective action plan.
Ensuring, that if a provider fails to successfully implement a corrective action plan, the MCEs inform MassHealth.
Ensuring that the MCEs have the discretion to terminate their contract with the provider or to keep working with the provider in an effort to help the provider improve performance. MCEs inform MassHealth of proposed changes to the service network. MassHealth manages its MCEs to assure compliance with all contract provisions, including those related to provision of ICC and other Remedy services.

To summarize, the Defendants believe that the current guidance is the most appropriate and useful management tool for assuring the delivery of high quality Intensive Care Coordination in Massachusetts. As previously stated, the Defendants oppose caseload limits as an overly blunt tool that can interfere with both quality and effective program management. It is also an unnecessary tool, given the Commonwealth's use of the "best practice" quality measurement tools, Wraparound Fidelity Index 4.0 (WFI-4) and the Team Observation Measure (TOM), described above. A review of the caseload data illustrates that the current policy of caseload guidance is working. The Defendants are confident that they have effective tools in place to

ensure, and to demonstrate to the Court, that children and youth enrolled in ICC are receiving high-quality services.

3. ACCESS TO REMEDY SERVICES

The MCEs, through their network management activities, continually monitor access to the Remedy services and work with providers on strategies to address any access issues.

As a part of these network management activities, the MCEs, working collaboratively with ICC and In Home Therapy (IHT) providers, developed *Guidelines for Managing Referrals to ICC* and *Guidelines for Managing Referrals to In Home Therapy*. These Guidelines clarify provider responsibilities to MassHealth members when the provider cannot offer an appointment as quickly as called for in MassHealth's Performance Specifications..

Intensive Care Coordination

During the monthly Technical Assistance meetings with individual ICC providers, the MCE staff ask about factors impacting access, including numbers of referrals and enrollments, Care Coordinator caseloads and agency hiring and training of new staff. As Exhibit 2, illustrates, ICC providers continue to hire Care Coordinators at a rate similar to the rate of enrollment growth.

This late Winter/early Spring, MCEs began hearing more consistently from ICC providers that there were varying degrees of waits for appointments for ICC services, and various criteria used to determine what constituted "waiting: for ICC services.
In response to this information and to the concern expressed at the February 12, 2010 Status Conference by the Court, the Court Monitor, and the Plaintiffs; the Defendants began developing a new data report to gather accurate information on waits for ICC appointments. The Defendants are nearing completion of that task. The challenge has been to balance the need for an accurate representation of access issues with the need to minimize the administrative burden on ICC provider agencies. The Defendants have worked hard to develop a report that builds on providers' existing reporting systems. This has required significant work on the part of the Defendants, the MCEs and provider representatives.

The Defendants anticipate having reliable and actionable data about appointment wait times beginning this summer. With accurate data on the extent and location of access issues, MassHealth can effectively manage its contracted MCEs to fulfill their contractual responsibility to ensure adequate access, and the MCEs will have the necessary information to work with providers to address barriers to access.

In-Home Therapy

MassHealth's MCEs report a mixed picture of access to In Home Therapy (IHT). Some providers report that they have more referrals than their current service capacity. Other providers report a lack of referrals and express concerns about the long term viability of the

service for their agency. The MCEs are working with IHT providers on these issues, and the Defendants are researching options for a monthly Access Report for IHT, similar to the ICC Access Report.

The Defendants plan to use the experience of implementing the ICC Access Report to inform their work on the IHT Report. It will be important to resolve technical issues with the smaller group of ICC providers before launching the IHT Access Report with the much larger group of IHT providers.

RESPECTFULLY SUBMITTED,

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Date: May 17, 2010

I hereby certify that a true copy of this document was served electronically upon counsel of record through the Court's electronic filing system on today's date.

/s/ Daniel J. Hammond
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