**UNITED STATES DISTRICT COURT**
**DISTRICT OF MASSACHUSETTS**
**Western Division**

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| ROSIE D., et al.,<br><br>Plaintiffs,<br><br>v.<br><br>DEVAL L. PATRICK, et al.,<br><br>Defendants | C.A. No.<br>01-30199-MAP |

## REPORT ON IMPLEMENTATION

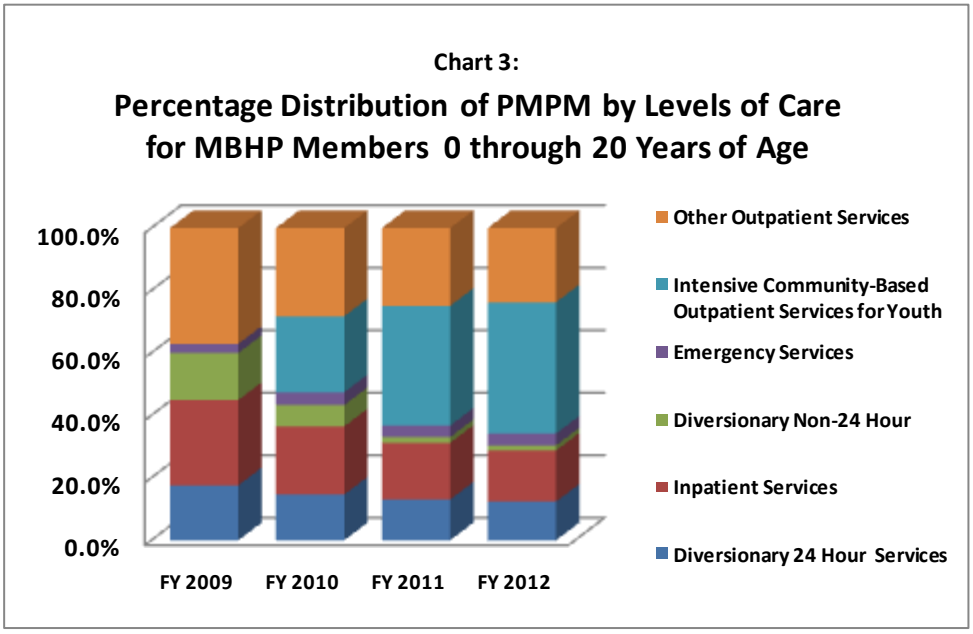
The Defendants hereby submit this Report on Implementation ("Report") pursuant to paragraphs 37(c)(i), 38(d)(i), 39(c)(i), and 47(b) of the Judgment dated July 16, 2007 in the above-captioned case ("Judgment"). This Report covers the period since December 5, 2012, and is organized in three parts: Part One: An Overview of Recent Activity; Part Two: Status of Activities Pursuant to the Plaintiffs' Proposed Criteria for Disengagement and Requests for Data; and Part Three: Response to Certain Data Requests . Except where indicated, it should be read as a supplement and update to the December 5, 2012 report.

## I. PART ONE: AN OVERVIEW OF RECENT ACTIVITY

### 1. Change in Behavioral Health Service Utilization Since Implementation of the Remedy Services – An Analysis Prepared by the Massachusetts Behavioral Health Partnership (MBHP).

A recent analysis of behavioral health spending for MBHP members under the age of 20 for the State Fiscal Years (SFY) 2009 through 2012 shows a significant *decrease* in spending on inpatient and outpatient services and a significant *increase* in spending on home and community-based services.

The chart and table below display these findings. Both express spending in terms of costs *"per member, per month" or "PMPM".*[1] The chart and table do not report the actual values of the PMPM costs for the various BH services, but reports the changing *proportion* of spending on various BH services for members under the age of 20.




[1] To calculate the PMPM, total cost of delivering a particular service to an insured population for a year is divided by the number of members in the insured population, and the total number of months the members were covered during the year. For example, 100 people covered by a health plan for one year represents 1200 "member months." A hypothetical cost of $12,000 to deliver primary care to these 100 people for one year translates to $10 PMPM.

This chart shows that spending on psychiatric hospitalization and outpatient therapy has declined over this period, while spending on intensive home- and community-based services (the remedy services, exclusive of MCI) has increased substantially. [2]

These same data are displayed below in a table.

**Table 9: Percentage Distribution of PMPM by Levels of Care for MBHP Members 0 through 20 Years of Age**

| Category of Care | FY 2009 | FY 2010 | FY 2011 | FY 2012 |
|---|---|---|---|---|
| Diversionary 24 Hour Services | 17.6% | 14.7% | 13.1% | 12.4% |
| Inpatient Services | 27.3% | 21.8% | 18.2% | 16.3% |
| Diversionary Non-24 Hour | 15.0% | 6.8% | 1.8% | 1.6% |
| Emergency Services | 3.0% | 4.1% | 3.7% | 3.8% |
| Intensive Community-Based Outpatient Services for Youth | 0.0% | 24.3% | 38.4% | 42.0% |
| Other Outpatient Services | 37.1% | 28.3% | 24.9% | 23.8% |
| **Total** | **100.0%** | **100.0%** | **100.0%** | **100.0%** |

As shown in Table 9 and Chart 3, Intensive Community-Based Outpatient Services for Youth constituted the largest portion of spending in SFY2011 (38.4%) and SFY2012 (42%). Also shown is the decrease in spending on Diversionary 24 Hour Services and Inpatient Services from 44.9% in SFY2009 to 28.7% in SFY2012.

2. **Family Satisfaction Survey Data.**

In January 2013 the Defendants conducted a survey of a random sample of the families of 400 youth currently receiving ICC for at least four months. The Family Feedback survey was provided in both English and in Spanish, and consisted of 10 questions and opportunities to add

[2] Part of the large change between SFY2009 and SFY2010, when the remedy services began, is due to an influx of a new type of MassHealth Member, those with commercial insurance and MassHealth as secondary coverage. These new members, numbering about 40,000, reduced the PMPM spending on outpatient therapy and psychiatric hospitalization, because these services were paid for by their commercial insurance. However, the data for SFY2010 and 2011 and 2012 are "apples to apples" comparisons, since the Members with commercial insurance exist in similar proportions in each of the three years.

comments. Of the 400 families invited, 154 responded for a relatively high response rate of 38.5%. Here is a sampling of the responses (see Exhibit 1 for the complete report):

- 73% of participants strongly agreed or agreed: "My child is better at handling daily life."
- 77% strongly agreed/agreed: "My child gets along better with family members."
- 69% strongly agreed/agreed: "My child is doing better in school and/or work."
- 68% strongly agreed/agreed: "My child is better able to do things he or she wants to do."
- 89% strongly agreed/agreed: "My family got as much help as we needed for my child."
- 97% strongly agreed/agreed: "The services my child and/or family received were right for us."

Below is a sampling of comments that family members included in their survey response.. (All participants' comments are included in the complete report, attached as Exhibit 1):

- *"I know without these services my child would not be able to live in our home. I was at my witts[3] end before we recieved services and did not think we would be able to go on. Now my child is doing so much better. I have learned so much on how to be a good advicate for my daughter and our family."*
- *"The team was very helpful to us and they didn't leave us hanging when the case was closed. they made sure we had help outside the agency."*
- *"My son is stable, and thriving and doing things that he enjoys again. He has much support from a Therapeutic Mentor, personal counselor, in home therapist and clinicians at his*

[3] Except for the removal of any identifying information about the client, all comments are unedited.

*school who check in with him on a regular basis to hold him accountable, to attending school, getting along with his brothers and using coping skills to manage his feelings."*

- *"We re still receiving services so have not completed programs etc. Otherwise I would have rated things higher. Thus far we are progressing and very happy with the changes we are seeing."*
- *" [My child] is doing so much better in school and at home, because of the help we have had from CSA and in home therapy."*
- *"My daughter is in residential now and this is no reflection upon the ICC services. That is why my answers are a little skewed in terms of my daughters emotional well being. She is very sick at this time but the ICC did help us so much."*
- *"I don't know what I would have done if I didn't find the services of the i.c.c. team. I feel a lot more confadent in handling my child's issue with them behind me with their support."*

3. **Timely Access to Services.**

**[** Most families are able to access remedy services without delay. However, IHT, IHBS and TM providers in some regions have waiting lists. MassHealth's contracted health plans continue to add to their networks of providers for these services, including working with existing provider agencies to expand into additional service areas.

**Intensive Care Coordination** – At the end of March, there were 3,598 youth using ICC. Of the 672 youth enrolled in March, 93% had access to services within 14 days of their request.

**In-Home Therapy** – At the end of March, there were 8,020 youth using IHT. 172 youth were waiting, 51% for less than two weeks, 25 % for two to four weeks, 15% for four to eight weeks, and 8% for eight to twelve weeks. 349 were choosing to wait. ("Choosing to wait"

means that capacity exists in nearby IHT providers, but the family is choosing to wait for services to become available through a particular provider agency.)

**In-Home Behavioral Services** – At the end of March, there were 1,029 youth using IHBS. 32 youth were waiting, 9% for less than two weeks, 12% for two to four weeks, 3% for four to eight weeks, 22% for eight to twelve weeks, and 25% waiting for over twelve weeks. 60 were choosing to wait.

**Therapeutic Mentoring** – At the end of March, there were 6,482 youth using TM. 75 youth were waiting, 50% for less than two weeks, 17% for two to four weeks, 20% for four to eight weeks, 11% for eight to twelve weeks and 3% for over twelve weeks. 260 were choosing to wait.

**Family Support and Training** – At the end of March, there were 434 youth enrolled in FS&T (affiliated with either an outpatient or IHT clinical hub service). Four youth were waiting; three for less than two weeks and one for two to four weeks. 7 youth were choosing to wait.

4. **Mobile Crisis Intervention (MCI) Access and Quality Indicators.**

**Access -** In February,[4] there were 1788 encounters, with an average response time of 35 minutes. 83% of all encounters occurred within 60 minutes of the call to MCI.

**Location of Encounter** - 56% of these encounters occurred in a community location.

**Disposition –** 17% of the encounters in February resulted in a psychiatric admission.

5. **Use of Remedy Services by MassHealth Members Under 21.**

[4] February 2013 is the most recent month for which MCI data reports are currently available.

Since the inception of remedy services, clinicians have screened 414,839 children and youth for behavioral health conditions. 55,658 children and youth have received clinical assessments including completion of a CANS. 81,438 have received at least one remedy service. 73,938 have received at least one remedy service other than MCI. 16,340 have used ICC and 22,622 have used IHT.

6. **Highlights of Remedy Services Management.**

**a. Wraparound Coaches**

Over the past year, the Defendants have been building an in-state ICC coaching capacity to replace the out-of-state coaches contracted through Vroon Vandenberg, LLP (VVDB). The Defendants procured Technical Assistance Collaborative (TAC) to select, train and manage the in-state coaches in partnership with the Defendants. Together, the Defendants and TAC developed a coaching plan, defined selection criteria and produced communications materials for the CSAs and other stakeholders. TAC solicited applications from potential coaches and, together with the Defendants, reviewed the applications, interviewed candidates and selected seven coaches, three of whom work as Care Coordinators and four as Family Partners. The coaches, all current employees of CSAs, will work part-time, approximately 29 hours per month, coaching staff of other CSAs.

The coaches will begin working in July. The focus of the first six months will be an assessment of current CSA practice and review of the final coaching plans prepared by VVDB. TAC will convene the coaches monthly so that they can learn from one another and coordinate their coaching activities with each other, TAC and the Defendants. The Defendants have retained VVDB, in particular Jim Rast and Susan Boehrer, to consult with the coaches by phone.

The CSA assessments will be completed by December, and will form the basis for the specific coaching activities for the following six months.

b. **The System of Care Practice Review.**

Since the last Report to the Court, the Defendants procured TAC to manage the Systems of Care Practice Review ("SOCPR") process. In partnership with the Defendants and in consultation with the University of South Florida,[5] TAC has developed a plan for a full year of 124 case reviews across the state.

Reviewers will be trained in early June and will conduct the first round of case reviews later in the month. Additional weeks of case reviews are scheduled for October 2013, and January, March and May of 2014. The sample of cases to be reviewed will be evenly divided between those of youth using ICC and those of youth using IHT, with the exception of the June review, for which the sample will be youth using IHT only. As requested by the Plaintiffs, the SOCPR tool has been modified slightly to capture certain data elements for youth using IHT.

c. **Learning About IHT Practice.**

The Defendants are dedicating significant staff resources this year to learning more about current clinical practice in IHT in order to support continuous quality improvement. As described above, half of the SOCPR reviews will be of cases of youth using IHT services. In addition, the Defendants will conduct an online survey of IHT providers about the clinical models they use in the IHT service and will conduct focus groups with small groups of IHT

[5] The University of South Florida is the developer of the SOCPR.

clinicians to learn more about current clinical practice. The learning from these activities will inform the development of future IHT trainings and other quality improvement initiatives.

d. **The Wraparound Fidelity Index (WFI) and Team Observation Measure (TOM).**

The annual WFI telephone interviews of 600 parents/caregivers of children and youth using ICC are currently taking place, with the final report due late this summer. The Defendants' contracted health plans ensure that CSA supervisors use the Team Observation Measure, twice a year, to assess the performance of each Care Coordinator during a Care Planning Team meeting. Data from both the WFI and TOM are sent to Eric Bruns, Ph.D., at Portland State University, to be entered into his national WFI and TOM databases.

e. **Rate Reviews.**

The Executive Office of Administration and Finance has recently approved MassHealth's request for a 22.79 % rate increase in the ICC rate (i.e., the rate paid to ICC providers for services rendered pursuant to their MassHealth provider agreements). It is scheduled to go into effect on August 1, 2013. Last year, MassHealth requested and received authorization to raise the FS&T rate by 18.3% for State Fiscal Year 2013 (SFY13), with an additional 1% increase to go into effect in SFY14.

## II. PART TWO: STATUS OF ACTIVITIES PURSUANT TO THE PLAINTIFFS' PROPOSED CRITERIA FOR DISENGAGEMENT AND REQUESTS FOR DATA.

The Plaintiffs' Proposed Criteria for Disengagement have gone through multiple rounds of refinement, with full participation of the parties and the Court Monitor. The document is

currently with the Plaintiffs, to further refine the specification of one data element in the Access section. The current draft of the document, including completion dates for each of the items, is attached as Exhibit 2.

## III. PART THREE: RESPONSE TO DATA REQUESTS IN PART V OF THE DISENGAGEMENT CRITERI AND REQUESTS FOR DATA.

1. **Data on the percentage of youth with a positive screen who receive follow-up behavioral health services within 90 days of the screening.**

   a. **Primary Care Clinician (PCC) Plan -** MassHealth's Primary Care Clinician (PCC) Plan collects this data point and shares it with large primary care providers. Due to system upgrades being made to MassHealth's claims and encounter database, no data are currently available beyond March 31, 2012. More recent data should be available in July. [6]

   b. **Managed Care Organizations (MCOs) –** The MCOs collected data during calendar years 2010 and 2011 as part of a two year Quality Improvement goal across MassHealth's MCOs. Follow-up was defined more narrowly than in the PCC plan, as including only a claim for a service from a behavioral health provider. The baseline rates, prior to the Quality Improvement cycle, ranged from 22% to 30% for the three MassHealth MCOs with the largest MassHealth enrollment, and were unavailable for the two smallest plans.

      - In CY2010 the rates of follow-up ranged from 23% to 33% for the three largest plans and from 2% to 5% for the two smallest plans.

[6] The last data, reported in the December 2012 Report to the Court, were for the period 10/1/2011 – 3/31/2012 and showed that 53.48% of youth with a positive screen received a follow up service, defined as either a follow-up visit in the primary care practice for the behavioral health concern, or a claim for a service from a behavioral health provider.

2. **CANS compliance data.**

   a. **Outpatient Therapy –** There has been a small improvement in CANS compliance in Outpatient Therapy. In February 2013, 59.6% of clinical assessments in Outpatient Therapy included completion of a CANS. The average for October through February was 56%.

   b. **IHT –** For SFY2013, Quarter 2 (10/1/2012 – 12/31/12), CANS compliance in IHT for the three largest plans are 100%, 96% and 83%. For the three smallest plans, the compliance rates are 81%, 65% and 32%.

   c. **ICC -** For SFY2013, Quarter 2 (10/1/2012 – 12/31/12), CANS compliance in ICC for the three largest plans are 100%, 100% and 76%. For the three smallest plans, the compliance rates are 72%, 70% and 35%.

   d. **Inpatient -** For SFY2013, Quarter 2 (10/1/2012 – 12/31/12), CANS compliance or Inpatient Units for the three largest plans are 21%, 15% and 11%. For the three smallest plans, the compliance rates are 8%, 0% and 0%.

   e. **Community Based Acute Treatment (CBAT) -** For SFY2013, Quarter 2 (10/1/2012 – 12/31/12), CANS compliance for CBAT programs for the three largest plans are 52%, 41% and 31%. For the three smallest plans, the compliance rates are 60%, 12% and 0%.

   f. **Department of Mental Health Residential Programs –** DMH cannot collect CANS compliance data electronically, but must conduct a paper record review. DMH conducted a review of all discharges in the period April 2011 through

November 2012. During that time there were 96 discharges, for whom 64 (67%) had completed CANS in their clinical records.

3. **Quality Improvement Activities.**

   a. **Outpatient** – MassHealth is engaged in extensive efforts to resolve technical issues with the electronic CANS Application. The agency expects the issues to be resolved by the end of SFY2014. At that time, MassHealth and its health plans intend to move to deny payment for any clinical assessment made in outpatient setting that does not include completion of a CANS.

   b. **IHT –** MassHealth's health plans continue to work with providers through network management activities to ensure completion of the CANS.

   c. **ICC –** See above.

   d. **Inpatient** – MassHealth's health plans are in the process of planning a coordinated, intensive effort in SFY2014 to significantly improve CANS compliance by staff of Inpatient and CBAT programs.

   e. **CBAT** – See above.

   f. **DMH** – DMH managers are working with staff of IRTPs and other continuing care programs to improve CANS compliance. DMH will conduct another record audit for all discharges occurring between July 1 and December 31, 2013.

4. **WFI –** See above, Section I, paragraph 6.

5. **SOCPR reports on ICC and IHT** - See above, Section I, paragraph 6.

**6. MCI pre-/post- report.**

This report, attached as Exhibit 4, displays BH service utilization prior to and following an MCI encounter, during the period between April 2012 and the end of June 2012. Notable highlights include:

- MCI appears to be effective in helping families engage in BH services. While only 70% of the youth using MCI had a BH service in the previous 90 days, after the encounter, 90% had utilized a service within 90 days after the encounter, 80% within 15 days.
- Receiving remedy services[7] within the 90 days before the MCI encounter is associated with timely access to BH services after the encounter. 96% of youth using remedy services prior to the MCI encounter subsequently utilized a follow-up service within 15 days of the encounter; 99% within 90 days.

**7. Data on average length of stay for youth receiving services from Community-Based Acute Treatment (CBAT) programs.**

- For the first two quarters of SFY13 (July – December, 2012), the average length of stay (LOS) in CBAT programs for all children and youth under the age of 20 was, for the three largest plans 8, 11 and 13 days respectively. For two of the three smallest plans, the average was 3 and 6 days.
- For the 0-12 age group, the average LOS was 8, 14, and 15 days for the three largest plans and 3 and 10 for two of the three smallest plans.

[7] Any remedy service, other than MCI.

- For the 13-18 age group, the average LOS was 8, 12, and 12 days for the three largest plans and 0 for two of the three smallest plans, signifying no utilization in this age group.
- For the 19-20 age group, the average LOS was 1, 5[8] and 8.5 days for the three largest health plans and 0 for two of the three smallest plans, signifying no utilization in this age group.

**8. Data on the number and percentage of youth who receive MCI services for more than three days.**

Due to resource constraints, MassHealth is unable to produce data on the number and percentage of youth who receive MCI services for more than three days. It does, however, receive reports from each of MassHealth's health plans setting out the average length of encounter (LOE) in MCI.

- In SFY12 Q2 (October – December 2011), before expansion of the MCI service to seven days, the average LOE in MCI was 1.8, 1.9 and 2.4 days in the three large health plans and 2.2 and 3.3 in two of the three smaller health plans.
- In SFY13 Q3 (January – March 2013), after expansion of the MCI service to seven days, the average LOE in MCI was 1.8, 2 and 2.4 days in the three large health plans and 1, 2, and 2.5 in the three smaller health plans.

MCI providers report that the longer length of the MCI service allows them to do more extensive work with a small subset of families who need more help connecting or re-

[8] These two low numbers reflect the utilization of one member each.

connecting to BH services for their child. They also report that the vast majority of families decline offers to continue to work with MCI clinicians beyond the initial three-day encounter.

Respectfully submitted,

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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.

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