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

PLAINTIFFS' EIGHTEENTH STATUS REPORT

I. Introduction and Overview

On May 16, 2012, the defendants filed their lengthy and comprehensive Report on Implementation, (Doc. 577) (hereafter "Compliance Report") that describes in substantial detail their view of the status of each requirement of the Judgment. Unlike previous semi-annual reports that have focused on activities undertaken during the prior six months, this one addresses all of the defendants' implementation activities over the past five years. In addition, this report addresses the issue of compliance with the entire Judgment. [1]

By most measures, there is little doubt that the defendants have made considerable progress over the past five years in transforming the children's mental health system in Massachusetts. The Executive Office of Human Services (EOHHS), through its Children's

[1] The defendants' Report is unclear and inconsistent on the issue of compliance. On the first page, it asserts that the defendants "have fully complied with each requirement of the Judgment." On the last page, it contradicts this claim, and acknowledges that the defendants "are in substantial compliance with all tasks set forth in that judgment,"– *except where open items are identified in the preceding [110 pages].*" Compliance Report at 111 (emphasis added). Given this concluding statement, it appears that the defendants are not alleging that they are in compliance with the Judgment, at least at this time. However, it is unclear which provisions and obligations they consider outstanding or, in their terms, "open."

Behavior Health Initiative (CBHI), have demonstrated a commitment to comply with the Court's Orders, to develop and fund the remedial services required by those Orders, and to implement structural reforms to the delivery of mental health services for class members. As described in their Compliance Report, pp. 15-30, and as documented in Exhibits 1-28 that are attached to the Report, the defendants have disseminated an impressive array of educational and outreach materials to MCEs, primary care clinicians, health care providers, child-serving agencies, schools and, most importantly, families and youth about the expanded EPSDT program. The progress in implementing the Judgment is most clearly evidenced by various quantitative measures, such as the significant increase in the number of children and youth who are screened for a behavioral health condition, the number of mental health assessments (CANS) conducted, the number of youth who receive certain remedial services, and the number of staff and other resources devoted to providing and monitoring remedial services. On a qualitative level, strengths and improvements within the service system have been noted as part of the Court Monitor's ongoing Community Service Review (CSR) process. These accomplishments required significant planning, infra-structure development and inter-agency coordination, as described in the Compliance Report, pp. 31-102 (screening, pp. 30-38; assessment, pp. 40-52; service delivery, pp. 53-100) and Exhibits 29-72. They would not have occurred without the vigilant direction and supervision of the Court, the oversight and assistance of the Court Monitor, the leadership and considerable dedication of the defendants and particularly the Compliance Coordinator, and the involvement of the plaintiffs. On behalf of the tens of thousands of class members in this case, the plaintiffs acknowledge and appreciate these efforts and accomplishments.

But progress is not the same as compliance. In order for the Court to relinquish its jurisdiction of this case, it must determine both that: (1) the defendants have fulfilled all of their obligations set forth in the Judgment and are fully complying with the EPSDT and other relevant provisions of the Medicaid Act; and (2) that they have established a durable remedy which ensures that the prior violations of federal law will not reoccur. *Board of Education v. Dowell,* 498 U.S. 237 (1991); *Horne v. Flores,* 557 U.S. 433 (2010).

Given the Court's instructions at the last status conference on March 20, 2012, the Plaintiffs' Eighteenth Status Report primarily responds to the defendants' assertions of compliance and proposes next steps to resolve areas of disagreement concerning compliance. It first addresses outstanding issues of compliance with the Medicaid Act, and then identifies ten areas under the Judgment where compliance has not been demonstrated, including requirements related to screening, assessment, the delivery of Intensive Care Coordination (ICC), effective mobile crisis and crisis stabilization services, and the monitoring of system practice, provider performance and child outcomes. The plaintiffs suggest that the parties confer as soon as possible about these issues and, with the assistance of the Court Monitor, develop disengagement criteria for each outstanding requirement of federal law and the Judgment.

II. Compliance with Medicaid Requirements

A. Medically Necessary Services

The Medicaid Act requires States to provide children with all medically necessary services that are covered by the Act. 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4), 1396d(r)(5). The Court concluded in its initial liability decision that the Commonwealth was violating these sections. *Rosie D. v. Patrick,* 410 F. Supp. 2d 25, 52-53 (D. Mass. 2006). The Court

held that the determination of which services were medically necessary for each child was made by the child's clinician. *Id.* at 26.

The Judgment sought to remedy these violations, and to ensure that all Medicaid-eligible children with SED received medically necessary home-based services with the frequency, intensity, and duration that met needs, as described in each child's individual treatment plan. Judgment ¶ 25 (care planning team identifies and arranges for all medically necessary services), ¶ 28 (care plan sets forth the specific services needed, including the frequency and intensity of each service). The Judgment further requires that the Commonwealth collect and generate data to demonstrate that children are receiving the services set forth in their Individual Care Plan with the intensity, frequency, and duration required by the Plan to meet the child's needs. Judgment ¶ 46(d)(i). The Compliance Report concedes that the Commonwealth has not developed the data collection system that it proposed, has not otherwise collected information about the provision of the services set forth in the Individual Care Plans and, most significantly, has no evidence whether children actually are receiving all of the services with the intensity, frequency, and duration, recommended by their treatment professionals and reflected in their treatment plans. Compliance Report at 83. Absent this critical information, it is impossible for the Court to determine that the defendants are complying with the most fundamental EPDST requirement – to provide children with medically necessary services.[2]

[2] Because the defendants have produced *no* information whatsoever on this key statutory obligation, the Court need not decide at this point what type or quantity of evidence would be sufficient to demonstrate compliance with this requirement. Instead, it should leave it to the parties and the Court Monitor to discuss this matter, at least in the first instance. *See* Section V(A), *infra.* While it may not be necessary to prove that each class member is receiving all of the services that s/he needs, it remains an open question whether evidence of compliance is best gathered on an aggregate or individual level, using some type of sampling process.

B. Services Which Correct or Ameliorate Mental Health Conditions

As the Court recognized, the core purpose of the EPSDT mandate is to correct or ameliorate disabling conditions for children. *Rosie D.*, 410 F. Supp. 2d 21-22, 25. This purpose is to be achieved through the provision of Medicaid services that, to the extent possible and within limits of reasonableness, achieve the desired purpose – preventing, correcting, or improving disabling conditions. Thus, whether the treatment results in desired outcomes is a critical issue with respect to the fundamental obligation to provide medically necessary services to children.

The Judgment requires objective outcome data. Judgment, ¶ 46(e). The Court made clear at the last status conference that outcomes were one of its central concerns. March 20, 2012 Status Conference, Tr. at 11 ("[I]t's more important to be able to say and … to get hold of whether the children are getting into the services, getting access to the services and they're actually improving"). The defendants acknowledge that the data collection which they proposed has not been developed, that alternative approaches using the CANS instrument have not been realized, and that, at least at this point in time, there is no reliable information about the impact of the remedial services which the Judgment requires. Compliance Report at 85. Absent this information, and a method to assess whether the basic purpose of the EPSDT program is being achieved, the Court cannot determine compliance with the EPSDT mandate.

C. Reasonably Prompt Services

In its liability decision, the Court also found that the defendants were not providing medically necessary services promptly. *Rosie D.*, 410 F. Supp. 2d at 27-28, 52. Once remedial services were implemented, the Court oversaw a prolonged discussion and issued

several orders concerning waiting lists for various remedial services, particularly the core service, Intensive Care Coordination. This judicial oversight, as well as the defendants' considerable efforts, has resulted in significant improvement in the protracted ICC waiting lists. Nevertheless, as their most recent CSA report for March 2012 demonstrates, approximately 12% of youth are still waiting longer than the recently adopted 14-day maximum of ICC, with a significant number of youth waiting more than 30 days and some more than 60 days. Moreover, 28% are not provided ICC services promptly, as defined by the defendants' own performance specifications. As a result, the evidence today demonstrates that the defendants are not providing ICC services promptly.

III. Compliance with the Provisions of the Judgment

When measured against the requirements and purposes of the Court's remedial order, there are several important aspects of the service system where compliance has not yet been demonstrated. In the screening, assessment and treatment of youth with behavioral health needs, and the effective delivery and coordination of certain remedial services, including ICC and mobile crisis interventions, there is compelling evidence that the system is not yet in compliance with the Judgment. In other areas, such as crisis stabilization, performance standards, data collection and youth outcomes, there simply is no evidence at all, or plainly insufficient evidence, that substantial compliance has been achieved. As a result, it is premature to consider disengagement from these terms of the Judgment, or for the Court's supervision of this case. These provisions, and the additional efforts required to achieve compliance, are discussed below in the order in which they appear in the Judgment.

A. Follow-up on Positive Screening (Judgment, ¶ 10)

In ¶ 10 of the Judgment, the defendants committed to a renewed emphasis on screening, including quality improvement initiatives to inform primary care providers about effective use of screening tools, to increase the number of screens for behavioral health issues, to evaluate behavioral health information generated by the screening, and "most particularly, to make referrals for follow-up behavioral health clinical assessment."

Unless youth who receive a positive screen for a behavioral health condition are offered treatment, or a referral for treatment, by their primary care clinician, a core purpose of the EPSDT mandate – to prevent or ameliorate a condition – is not met. The defendants' preliminary data on follow-up to behavioral health screens, disseminated in March 2012, indicates that, on average, only about one-quarter (25%) of all children and youth who receive a positive behavioral health screen from a primary care clinician working with a managed care entity actually receive behavioral health services. Compliance Report at 91-92. While the referral or treatment rate is considerably higher for primary care clinicians not part of managed care organizations, that rate has not improved over the past four years. *Id.* at 91. Most importantly, about one-quarter (25%) of all children and youth who receive a positive behavioral health screen from a primary care clinician working with a managed care entity actually receive follow-up behavioral health services within 90 days. *Id* . Assuming the data is reliable, this is a surprisingly low rate of follow-up and treatment.

This recent data – already two years old – is the first information collected by the MCEs on the rate of follow-up from positive EPSDT screens. It demonstrates that while the rate of screening for behavioral health conditions has significantly increased over the past five years, the impact of this enhanced screening has not translated into an increase in

treatment responses to positive findings. Thus, both the provision of the Judgment and the basic purpose of EPSDT's screening mandate have not been fulfilled.

B. CANS and the Assessment Process (Judgment, ¶ 16)

The CANS is intended to be a cornerstone to the assessment, treatment, and evaluation process for SED children. The Judgment clearly sets forth the defendants' obligations regarding the implementation of the assessment process, including: (a) the initiation of the assessment process; (b) the use of the CANS as part of all clinical assessments; (c) the availability of medically necessary services during the assessment process and plan development; (d) conducting a more intensive home-based assessment done upon ICC referral; and (e) the assessment process and transitional discharge planning. Judgment, ¶ 16(a-e). But approximately half of all youth receiving CBHI services, especially those treated by outpatient providers, do not have a CANS.

Moreover, the defendants have a clear mandate to complete a CANS when youth with behavioral health issues are being discharged from hospitals, CBATS, and DMH facilities and programs "with the goal of identifying children for whom ICC may be appropriate. For those identified children, a referral for those services will be a component of a discharge treatment plan." Judgment, ¶ 16(e). But there is no evidence of whether, or to what extent, DMH or acute hospitals use the CANS as required by the Judgment. Moreover, as the defendants' monthly CSA data indicates, there are remarkably few referrals from DMH to ICC, including referrals from any DMH inpatient or residential settings.

The defendants also are not using the CANS to evaluate the impact and effectiveness of home-based services, as they have promised for years. Nor is there any

real prospect that it will be used for this purpose in the near future. As the defendants acknowledge, "…EOHHS does not anticipate simple answers about service impact from the CANS." Compliance Report at 56, 85. As of the end of 2011, EOHHS had not identified methodologies, subgroups of children, services or providers to evaluate the impact of services or the outcomes for youth in this case. The defendants further concede that "if and when" CANS can be used for this purpose they will need several years of data to conduct an effective analysis. *Id.* at 56.

C. Intensive Care Coordination (Judgment, ¶¶ 19-24, 28)

The defendants must provide medically necessary Intensive Care Coordination to all youth with SED, including a care manager who facilitates an individualized, child-centered, family-focused care planning team. Judgment, ¶¶ 19-24. They also must ensure that the care coordinator performs certain identified functions, that an Individual Care Planning team is properly assembled, that the team determines and coordinates the needed services, and that the entire process operates consistent with wraparound requirements and System of Care principles.

1. Care Coordination

The ICC care manager's role is to coordinate multiple services, with links between child-serving agencies and programs, so that a youth receives the services according to his/her changing needs. Judgment, ¶ 20. Basic responsibilities include identifying members of the care planning team; facilitating the team's identification of child and family strengths, as well as community supports; convening, coordinating and communicating with the care planning team; working with the child and family; collecting information from other agencies; preparing, monitoring and modifying the

individualized care plan in concert with the team; coordinating the delivery of services; collaborating with other caregivers on behalf of the child; and facilitating transition planning, including planning or aftercare or alternative supports when in-home services are no longer needed. Judgment, ¶ 21.

The regional Community Service Reviews (CSRs) for 2010-12 indicate significant problems in the way care managers communicate, coordinate and ensure the provision of integrated services, as well as their collaboration with state agencies.[3] Across the Commonwealth, care coordination was deemed "good" in only 44% of cases. Statewide CSR Report at 47. The most recent CSR for Western Massachusetts found delays between intake and actual start of services, an issue that also was identified in Central Massachusetts. Western Mass. CSR at 55; Preliminary Central Mass. CSR at 61.[4] In the Central region, inconsistent ICC communication across agencies was identified. Preliminary Central Mass. CSR at 63. In addition, families reported difficulties understanding the purpose of ICC, and found it hard to manage communications with multiple providers. *Id.* Other ongoing problems include maintaining continuity of care, especially when multiple agencies are involved. *Id.* at 61.

To ensure effective care coordination, ICC care managers must be trained in the wraparound process for providing services within a System of Care. ¶ 22. This process

[3] Throughout this response, the plaintiffs cite the Monitor's *Rosie D.* Annual Report (the 2010-11 Statewide CSR); the Western Mass. CSR, based on a September 2011 review; the Northeastern Mass. CSR, based on an October 2011 review; the Southeastern Mass. CSR, based on a December 2011 review; and the preliminary Central Mass. CSR, based on a March 2012 review. The plaintiffs are providing the Court and the defendants with a hard copies and a CD of these reports. The Court Monitor has conducted reviews in the Boston and Metro Boston regions in 2012, but the data has not yet been made available.

[4] Both Western and Central regions also continue to have extensive waitlists for ICC services. *Id.* Access problems in these regions have persisted over time, as demonstrated by provider specific reports and waiting list outlier reviews. *See, e.g.*, CSA Monthly Provider Report, March 2012, attached as Exhibit 1.

must be consistent with the principles and values of the Child-Adolescent Services System Program (CASSP). While care managers were initially trained and coached by national experts, the system now relies primarily on internal training by agency staff who are not specifically reimbursed for these activities or the time new staff spend in training. Many ICC care managers are not licensed mental health professionals, or under the supervision of licensed professional, as required by ¶ 22 of the Judgment. Failure to ensure appropriately trained and supervised care managers can have a significant, negative impact on the quality of ICC services and wraparound fidelity, contribute to poor clinical assessments, and result in inappropriate treatment interventions. Delays in access to and provision of care, poor transitional planning, premature discharges and an inability (or failure) of teams to respond with the urgency and intensity needed to address youths' pressing needs still hinder, if not impede, the provision of wraparound services.

2. Team Composition and Coordination

ICC care planning teams must be family-centered and include interested persons and entities such as family members, providers, case managers from other state agencies with which the child is involved, and natural supports such as neighbors, friends, and clergy. Judgment, ¶ 23. However, the CSRs consistently have found deficiencies in team formation and functioning, identifying the former as needing improvement and the latter as weak.[5] Despite recommendations from the Monitor designed to achieve greater compliance in these areas, problems with team composition and functioning have persisted across the state.[6] For instance, out-patient providers often are not well-

[5] *See*, Statewide CSR Report at 54.

[6] *See, e.g.,* Southeastern Mass. CSR at 48; Western Mass. CSR at 48; Preliminary Central Mass. CSR at 51, finding only 54% of teams with acceptable structure and only 58% functioning at an acceptable level.

integrated into the team or do not even participate in team meetings.[7] In addition, schools are not engaged in teams or team-planning processes.[8] There is little evidence that care planning teams are including relevant state agency staff. In the Northeast, care coordinators identified inadequate team participation as a barrier to their work. Northeastern CSR at 54. Sustainable natural supports are also missing from the team process. Statewide CSR at 62. As the Court Monitor concluded in the Northeastern review, "Continued efforts to promote engagement of natural supports in the team-based process are needed." Northeastern CSR at 55.

Providers' failure to comply with the Judgment's service expectation for team composition and coordination can have profound implications for youth and the provision of medically necessary services, while also signaling larger systemic issues with implementation. For instance, similar issues in Western Massachusetts led the Monitor to observe:

> "Overall, the system cannot be considered to be performing well because of the number of foundational system of care practices that were found to need improvement or are weak. Nearly 30% of teams were not adequately formed with the right people to address youth and family needs. Over half of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results, and were not engaged in collaborative problem-solving at a level necessary to impact positive change for youth and families."

Western Mass. CSR at 48.

Similarly, in the Southeast the Monitor found that team functioning, coordination and collaboration were "[o]f particular concern" and among the areas which needed

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[7] *See, e.g.,* Northeastern CSR at 56: "Outpatient participation in team processes was limited and inconsistent." *See also*, Southeastern CSR at 54.

[8] *See*, Statewide CSR at 62-63; Western Mass. CSR at 55; Northeastern CSR at 54, 56; Preliminary Central Mass. CSR at 62.

"concerted attention." Her report also concludes that, "…over 40% of teams were functioning in a limited manner, were splintered or inconsistent in their planning and evaluating results and were not engaged in collaborative problem-solving in ways that could impact positive change for youth and families." Southeastern Mass. CSR at 48.

3. Assessments

In order to guide the development of an Individualized Care Plan (ICP) that meets the youth's needs, the ICC must use planning tools such as a CANS standardized instrument, a comprehensive home-based assessment, and other clinical tools. Judgment, ¶ 24**.** The ICP must be updated as needed to reflect youth's progress. Further assessments, such as the CANS or other tools, can be used to better identify the child's changing needs.

The defendants acknowledge that providers need more training on how to integrate the CANS in the treatment planning discussion with families, and how to use the CANS to track progress in treatment. Compliance Report at 21. These failures to monitor progress and to assess and respond to immerging concerns have broad implications for youths' access to medically necessary care and for overall compliance with standards for wraparound system practice. This issue was first identified in the statewide CSR, which concluded that only 35% of teams had a good understanding of youths' strengths, needs and risks. Statewide CSR at 39. More recent reviews suggest noncompliance in this area persists. For instance, in Central Massachusetts, teams are not meeting to address changes and to develop accountable strategies to impact youth's progress and well-being. Preliminary Central Mass. CSR at 63. In Southeastern Massachusetts the Monitor found that over 40% of youth and 32% of families were not

well assessed or understood, which she notes to be "a foundation for providing effective supports and services for youth and families." Southeastern Mass. CSR at 48. Similar system practice failures were identified as areas of noncompliance in Western Massachusetts as well.[9]

Given the Judgment's requirement that youth in ICC have comprehensive home-based assessments, *see* ¶ 16(d), it is problematic that the CSR finds many ICC-involved youth do not have mental health assessments guiding their care and treatment.[10] The defendants' failure to collect evidence regarding providers' practice in this regard makes any determination of compliance in this area premature.

The Court Monitor's statewide CSR for 2010-2011 recommended corrective action to improve teams' use of, and reliance on, current assessments to inform treatment planning, especially when a youth's complex needs or co-morbid conditions require specialized modes of treatment. Yet findings concerning teams' failure to complete and/or procure comprehensive home-based assessments continue in many regions in the 2011-2012 reviews. For example, in Western Massachusetts, care planning teams still lacked a solid understanding about youths' clinical and mental status, impacting the team's ability to develop pertinent and effective services, strategies, and interventions. As a result, services were misaligned. Western Mass. CSR at 54.

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[9] "Only half of the teams were adequately using clinical and related information to increase the teams' understanding of the youth's issues at a scope and depth needed to design the right set of interventions and supports." Western Mass. CSR at 48.

[10] In Western Massachusetts, only 13 of 24 youth had a mental health assessment in the fall of 2011, a decline from the previous year when 18 out of 22 youth had such an assessment. 2011 Western Mass. CSR at 13; 2010 Western Mass. CSR at 12. The numbers went down even more in Central Mass., where only 12 out of 24 had a mental health assessment in 2012, in contrast to 17 out of 24 in 2011. 2012 Preliminary Central Mass. CSR at 24; 2011 Central Mass. CSR at 12. In the Southeast, 15 out of 22 youth had an assessment performed in the most recent CSR, as opposed to 17 out of 24 in the earlier review. Dec. 2011 Southeastern CSR at 13; March 2011 Southeastern CSR at 13.

4. Treatment Planning

Each Individualized Care Plan (ICP) must describe a child's strengths and needs; proposed treatment goals, objectives, and timetables, including moving to less intensive levels of service; specify the services, including frequency and intensity; incorporate a crisis plan; and identify the providers of each service. Judgment, ¶ 28**.** Yet despite these requirements, the CSRs consistently find multiple deficiencies in youths' ICPs.

As noted above, only 35% of teams sampled statewide in 2010 had a good understanding of the child's strengths, needs and risks. The ICPs also failed to address frequency and intensity of services, as required by the Judgment. Statewide CSR at 63. In the second year of the CSR, many of these system deficiencies continued, resulting in a failure to identify meaningful needed services in the appropriate frequency, intensity, and/or duration. For instance, in Central Massachusetts treatment was found to be inadequate and lacking in the depth needed to impact long-term changes. Preliminary Central Mass. CSR at 62. In Western Massachusetts, youths' goals were found to be simplistic and superficial. Western Mass. CSR at 54. These treatment planning failures represent more than a documentation problem. As noted by the Monitor, "[w]eak planning was found in reducing mental health symptoms, impacting behavioral changes, increasing youth's social connections, addressing substance abuse recovery or relapse and assuring successful transitions." *Id*. at 48.

Equally important in ICP development is the quality of transitional and discharge planning. Yet these aspects of ICC performance also are repeatedly called into question by CSR findings. For example, case reviews in Southern Massachusetts demonstrate a lack of continuity in goals when youth transition from ICC to outpatient services, where

they risk being discharged before their treatment needs are met, and as a result, wind up requiring more intensive interventions. Southeastern Mass. CSR at 54. Specifically, the Monitor concluded that, "[p]lanning transitions for youth was unacceptable for over half of the youth (53%), and transitions were not managed well for 36%." *Id*. at 48. Case reviews in the Northeast found little or no discharge planning to transition youth when they step down from more intensive inpatient programs or facilities. Northeastern CSR at 56. And most recently in Central Massachusetts, teams were observed to terminate services prematurely due to a lack of understanding of youth and family needs, a narrow view of goals, and services not implemented at the intensity needed. Preliminary Central Mass. CSR at 62.

As demonstrated by the Monitor's CSR evaluations over the past two years, the number and persistence of deficiencies within the ICC care coordination service, and the weakness of overall system practice across the state, contradict the defendants' assertions of compliance with the Judgment, while further demonstrating the need for clear standards which will aid the parties in determining what level of system performance is sufficient for the provision of medically necessary care to class members and the overall sustainability of the remedy. [11]

D. Access to Remedial Services Coordinated by Outpatient Therapists (Judgment, ¶¶ 16, 33)

In their initial design of the children's mental health system, the defendants created the concept of a "hub" service, and then designated outpatient treatment, In-Home Therapy

[11] Characterizing overall system practice in Western Massachusetts as "very weak" the Court Monitor concluded that "[f]or roughly half of the youth, the system is not providing dependable, quality services." Western Mass. CSR at v. Similarly, in Central Massachusetts 50% of cases reviewed had unacceptable practice performance, leading the Monitor to find that "[p]erformance was not at a level where families can depend on system practices to be functioning well." Preliminary Central Mass. CSR at 66.

(IHT) and ICC as "hubs." Compliance Report, Ex. 20. The designation is significant since it means that: (1) the hub is responsible for planning, approving, coordinating, and monitoring of all mental health services; and (2) several remedial services, including In-Home Behavioral Services -- Therapeutic Mentoring Services, and Family Support and Training Services (Judgment, ¶ 33) – can only be provided and authorized through the "hub."

While the designation of ICC and IHT as hubs has been relatively smooth, depending on traditional outpatient therapists to be the coordinators, managers, monitors, and authorizers of other remedial and support services has been problematic. As noted repeatedly by the CSR process, out-patient therapists are often not well integrated into youth's care planning.[12] Aspects of outpatient service delivery were found to be "incongruent" with the system of care approach. Following the recent case reviews in the Southeastern region, the Monitor concluded that "[t]here appear to be systemic disincentives to outpatient providers to coordinating care, or providing services at the intensity and modality needed." Southeastern CSR at 54. The failure to address structural barriers, such as limitations on out-patient therapist reimbursement for activities related to the team process and the number of cases outpatient therapists must maintain create additional disincentives for their providing active care coordination and their participating in care planning teams.[13]

The combination of limited outreach and education efforts to outpatient providers, and their documented noncompliance with the Judgment's requirements to utilize CANS

[12] *See, e.g.*, Statewide CSR at 63; Northeastern CSR at 56; Western Mass. CSR at 55.

[13] *See, e.g.,* Northeastern CSR at 56. The fee-for-service model governing outpatient therapy is not well suited to care coordination activities. Reimbursement for collateral consultation can be limited.

for diagnostic assessments and treatment planning, also raise questions regarding the present ability of outpatient therapists to adequately identify youths' strengths and needs and connect them with medically necessary home-based services. Judgment, ¶¶ 15, 16(b),(c). According to the defendants' reports, only half of all assessments done by outpatient therapists use the CANS.[14] There is no evidence that outpatient therapists are sufficiently familiar with In-Home Behavioral Services, Therapeutic Mentoring Services and Family Support and Training or that they regularly refer to, and oversee the provision of, these services for SED youth whom they are treating. Instead, there is a host of concerns identified by the CSR process regarding the ability of outpatient providers to perform the hub function.[15] Additionally, outpatient providers are not trained in, nor necessarily familiar with, foundational aspects of the new service system which are core requirements of the Judgment, including program specifications and the principles of wraparound care.

Finally, for the reasons noted above, few outpatient therapists can provide the time necessary to effectively coordinate and monitor the ongoing delivery of one or more remedial services. As a result, the critical assumption with the defendants' model – that outpatient therapists would provide an alternative to care coordination by an ICC care manager or an IHT therapist – has simply not occurred.

[14] CANS data indicates that only about half of all youth who receive behavioral health services actually get an appropriate assessment using the CANS instrument required by the Judgment. Compliance Report, Ex. 63. Since youth who receive assessments from ICC and IHT are provided the mandated CANS assessment almost all of the time, the 50% who do not receive an appropriate assessment are presumably all served by outpatient therapists.

[15] *See, e.g.*, Southeastern CSR at 54, noting that "[o]utpatient providers were reported to be reluctant to fulfill the role of being a 'hub' for services."

E. Interagency Roles and Responsibilities (Judgment, ¶¶ 7, 12, 30)

The Judgment recognizes the importance of the role of EOHHS agencies and other public agencies in the fulfilling the purposes of EPSDT and remedying the violations related to fragmentation of services and failure to coordinate treatment. The defendants are charged with informing public and private agencies about home and community-based services (Judgment, ¶ 7); developing protocols for referrals for EPSDT screenings, assessments and home-based service to better enable agencies to connect youth with these needed supports and services (*Id.* at ¶ 12); and ensuring EOHHS agency representatives are part of the care planning teams of youth with multiple agency involvement. *Id. at* ¶ 30. The defendants' obligation is to ensure that these agencies: (1) identify, refer and connect children with SED to EPSDT screenings, assessments and remedial services; (2) participate in ICC planning and service delivery; and (3) coordinate treatment plans for children with multi-agency involvement.

The interagency protocols provided for by the Judgment are the primary vehicles for the implementation of interagency participation and coordination. Protocols describing each agency's responsibilities and procedures for training, referring, and coordinating delivering remedial services are in place for DCF, DMH, DYS, DDS and DPH. MassHealth has incorporated these protocols in the Community Service Agency Operations Manual. But despite the development of these protocols, significant concerns persist as to whether agency-involved children with SED are able to access and benefit from remedial services.[16] These deficiencies suggest a failure to remedy one of the

[16] For instance, in Central Massachusetts, the Monitor finds that "continuity of care for a number of youth reviewed was problematic, especially when multiple agencies were involved," while also noting that the strength and quality of teaming was inconsistent, with schools not engaged in many of the cases reviewed. Preliminary Central Mass. CSR at 61-62.

Court's central findings – that the lack of coordination between state agencies and service providers undermines treatment effectiveness for SED children. *Rosie D.*, 410 F. Supp. 2d at 24, 32.

Some EOHHS agencies make very few referrals to ICC or other remedial services. For instance, since the delivery of remedial services began, and through the present day, referrals from DMH and DYS have been inexplicably low – averaging 1% or less of total ICC referrals. *See* Ex. 1, Report 1. The failure to connect agency-involved children with remedial services is particularly problematic given the large number of youth with mental illness served by these agencies.[17] Referrals from schools to ICC are similarly low, with a year-to-date percentage of only 7% in fiscal year 2012. *Id.*[18]

Moreover, when agency-involved children do access ICC or IHT (usually via family/self-referral), EOHHS agency participation and planning coordination is questionable. Child-serving agencies are not active participants in care planning, and ICC engagement of external team members is weak or absent. As the Court Monitor observed, "Teams and families often struggle with schools, DCF, DYS and others they are involved with not knowing about care planning teams and the wrap-around model of care." Statewide CSR at 68.

Lack of participation and coordination with schools and early education providers raises similar concerns. A great majority of children with SED are involved with special

[17] This is particularly true of the Department of Mental Health, which provided evidence at trial concerning the approximately 15,000 youth it served with SED. It is almost inconceivable that only 1% of all children referred to ICC are referred by a DMH case manager, a DMH residential program, a DMH intensive residential treatment program, a DMH inpatient facility, or otherwise involved with DMH.

[18] Statewide and regional CSRs also reflect low levels of referral and ongoing involvement by DYS, DMH and DDS.

education. The defendants have conducted outreach to schools and prepared guidance for school personnel. However, more often than not, participation of educators necessary to develop and coordinate effective care plans is missing. *See* Statewide CSR at 62; Northeastern CSR at 54; Preliminary Central Mass. CSR at 62.

F. Mobile Crisis Intervention (Judgment, ¶ 32(a))

The Court recognized that children struggling with acute mental and behavioral health issues are often subject to unnecessary emergency room treatment and in-patient admissions because of the lack of medically necessary crisis services in the community. As a result, the Judgment requires implementation of a service designed to deliver a "…mobile, on-site, face-to-face therapeutic response…for purpose of identifying, assessing, treating, and stabilizing the situation in community settings…." ¶ 32(a).

Despite improvements in the delivery of MCI over time, the Commonwealth has not achieved the fundamental criteria and purpose of the service: to deliver crisis interventions in the community, and thereby avoid unnecessary institutionalization or out-of-home placement. Data on the location of mobile crisis intervention illustrates this longstanding concern, finding that roughly half of all crisis interventions still take place in a hospital, and not in the community as required by the Judgment, by national standards, and by the defendants' own program specifications. Rather than continuing to improve over time, the percentage of community-based – as opposed to hospital-based – interventions has remained largely static. Between November 2009 and November 2011, the percentage of community interventions ranged from 51% to 57% statewide. In December 2011, the best month on record since services began, 41% of all MCI

encounters, or 707 crisis interventions, occurred in a hospital setting.[19]

In addition to statewide averages, there are specific implementation concerns across the provider service system. In the third quarter of 2011, four MCI teams delivered less than 40% of their service interventions in the community, with an additional two teams at 41%.[20] Twelve providers reported that they saw 50% or more of their youth clients in an emergency room setting. *Id.* The most recent provider specific data reflects only a modest improvement, with twelve providers delivering 40% or more of their MCI encounters in the emergency room.[21] Not surprisingly, both statewide and provider level data demonstrates that crisis interventions in emergency room settings are less likely to result in successful diversion from inpatient or other higher levels of care.[22]

For youth and families, the implications of these findings are profound and go directly to the heart of the Judgment. The importance of fidelity to this aspect of the mobile crisis service model is even more critical now, given the intention to use MCI teams for expanded, in-home crisis stabilization. Unless the percentage of mobile and community-based interventions increases significantly, these plans for increased community stabilization will fail, and youth will continue to face unnecessary hospitalization and out-of-home placement.

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[19] *See*, Mobile Crisis Intervention Key Indicators, Run Date 5/6/12, attached as Exhibit 2.

[20] *See*, Mobile Crisis Intervention Key Indicators: Provider Level, Run Date 1/31/12, redacted, attached as Ex. 3, at 8.

[21] *See*, Mobile Crisis Intervention Key Indicators: Provider Level, Run Date 5/6/12, redacted, attached as Ex. 4 at 8.

[22] While the percentage of inpatient admissions has trended down slightly over time, peaks during the summer months have been found to coincide with a rise in the percentage of encounters occurring in a hospital location. *See* Ex. 3 at 8.

G. Crisis Stabilization Services (Judgment, ¶ 32(b))

The Court is well aware of the defendants' longstanding failure to provide Crisis Stabilization Services to youth in their natural setting "or in a community setting that provides crisis services, usually for 24-72 hours but up to 7 days." Judgment, ¶ 32(b). The defendants maintain that the federal government's failure to approve the program for Federal Financial Participation (FFP) excuses their compliance with these provisions. However, CMS' actions were the direct result of the Commonwealth's insistence that Crisis Stabilization Services include all costs for room and board, despite long standing federal law and CMS practice to the contrary. Thus, in a practical and legal sense, the defendants' own application for CMS approval guaranteed its rejection, and the resulting inability to implement this requirement of the Judgment.

After CMS twice rejected the Commonwealth's attempts to cover the room and board costs of its crisis stabilization program, the parties agreed last winter on a plan to expand MCI from a 3-day to a 7-day service in order to provide the in-home component of crisis stabilization. Since this expanded service capacity only became available statewide on May 31, 2012, there will be no preliminary data regarding the utilization or the impact of this service change until much later this year, and no evidence of the durability of this solution until well into 2013.[23] Similarly, the existing Community-Based Acute Treatment (CBAT) program was proposed by the defendants as a means of providing the out-of-home component of this remedial service. Yet there is no evidence

[23] MCI data, like all claims data, is subject to a time "lag" of several months before information on number of encounters, units of service and other measures of resulting connection to services can be produced. In addition to quantitative data on utilization of expanded MCI services, other qualitative measures, such as record reviews and on-site provider monitoring are needed to determine how the change in service delivery is being implemented and whether it effectively meets youth and families need for stabilization services.

in their Compliance Report that this is occurring or that any specific efforts have been undertaken to date to ensure that it can serve this particular purpose. Compliance Report at 71. As a result, it is obviously too early to determine if this approach is substantially meeting the intent of the Judgment.

H. Service System Monitoring (Judgment, ¶ 34)

The Judgment requires a "defined scheme for monitoring success." Judgment, ¶ 34. Effectively "monitoring success" includes child-specific outcomes, provider-specific outcomes measures, and system-wide practice outcomes measures, yet none of these elements is in place. Nor is there a "scheme" which currently allows the Court to measure compliance with the various program components of the remedial order.

The only child-specific measures (both process and functional outcomes) are from the Monitor's CSRs, and these suggest many youth are not benefiting from remedial services, are not projected to improve over time, and do not have the benefit of system practice that is functioning even at an minimally adequate, never mind a good or optimal level. The CSR process evaluates compliance with specific provisions of the Judgment on care management, care planning and service delivery in the context of individual youth and families served.[24] The CSR data reveals significant problems in the delivery of remedial services. *See* Western Mass. CSR at 49; Preliminary Central Mass. CSR at 56; Southeastern Mass. CSR at 49; Northeastern CSR at 49.

While the Compliance Report notes that the defendants intend to implement a similar child review process later this year using the System of Care Practice Review tool, they have not done so to date. Thus, the parties and the Court have no other monitoring

[24] It has yet to be determined what level or CSR score constitutes substantial compliance.

process in place to assess child outcomes, evaluate provider and system performance, or determine whether the system practice is achieving the goals of the Judgment or the requirements of federal law.

I. Provider Performance Standards (Judgment, ¶ 38)

Recognizing the importance of measuring provider performance and adherence to the specifications of Court-ordered remedial services, the Judgment sets out a series of tasks to be undertaken in the early stages of implementation. These tasks include the creation of "detailed performance standards for contractors and providers." Judgment ¶ 38(c). Notably, performance standards are different from program specifications for each remedial service, as demonstrated by their different descriptions in different paragraphs of the Judgment. Despite the development of program specifications and provider contracts, the Commonwealth has never specifically set out the standards by which it will measure provider performance. Nor has it formally measured the provider system against even the basic expectations laid out in program specifications for each remedial service.

In the absence of these standards, and a process to measure against them, the Court has little objective or qualitative information upon which to determine the Commonwealth's level of compliance with the delivery of remedial services or the sustainability and quality of these efforts. After much insistence by the plaintiffs, there now is data on statewide access to, and the total capacity of, remedial service providers. However, once a youth is referred to a service, there is no information regarding the extent to which providers are actually delivering remedial services, as required by the Judgment, whether service delivery is consistent with the tasks and timeframes required by program specifications and EPSDT, and whether care is provided with the level of

consistency and competency required to meet the needs of youth and families. Until provider performance standards exist, and data regarding adherence to these standards is available, it will be challenging if not impossible to measure the quality of individual or system-wide provider performance or to know the existing degree of compliance with the Court's Judgment.

J. Data Collection (Judgment, ¶¶ 44- 46)

Adequate data collection provides the necessary foundation to assess defendants' response to the statutory violations and the performance of their obligations under the Judgment. Most important, timely and reliable data collection provides the parties, the Monitor, and the Court with the information to determine if class members are receiving the benefits of the Judgment and that the remedy is securely in place.

The Judgment sets forth the available methods for data collection and describes in detail the content and types of data to be collected in order to track, monitor and evaluate the behavioral health care provided to children. Data collection must be sufficient to monitor implementation on at least 3 levels: (1) individual child outcomes; (2) provider performance; and (3) system outcomes. The Judgment recognized that neither existing data systems, such as MassHealth claims data nor the MCE's utilization data, were sufficient to address the requirements of the Judgment. Judgment, ¶¶ 40-43. Paragraph 44 therefore required that the defendants construct a new data system to report on various provisions of the Judgment. As the Compliance Report makes clear, this simply has not happened. Compliance Report at 78-79. Instead, the Report claims that the creation of the CANS data system satisfies this obligation, despite its establishment as a separate and unrelated requirement of the Judgment and despite current limitations in the use and application of the

information it produces. *Id.* at 81.

Pursuant to the Judgment, the defendants are required to design a multi-level data collection strategy and put in place tracking measures to monitor EPSDT screening, clinical assessments, ICC and IHT, home-based treatment services and systems outcomes. To date, the defendants have reported on pieces of quantitative data collected on screening and CANS, and have introduced instruments such the Wraparound Fidelity Index and the Treatment Observation Measure to look at certain aspects of provider practice. However, defendants have yet to present, and are far from adopting, any credible systematic approach to monitoring and evaluating other essential components of implementation such as the impact of positive screens, the use of CANS findings, and the appropriate provision of home-based service.

Glaringly absent, at this late date, is data useful to monitoring and evaluating provider performance and child outcomes. Nor is there any information, as required by the Judgment, to determine if youth actually receive the services set forth in the ICP, with the intensity and duration required to meet their needs. Instead, the Compliance Report concedes that this information simply does not exist. Compliance Report at 83(d). [25]

In early status reports, the defendants suggested that the design and development of

[25] The rate of authorization denials provides a poor proxy for the kind of member level utilization data contemplated by the Judgment, since it offers no information regarding the appropriateness of the plan or the frequency, duration or intensity of the services contained within it. Nor does it reveal whether those services were available to be delivered in a timely way or consistent with the goals and objectives articulated by the ICP. Finally, it cannot reflect the impact of periodic and ongoing clinical reviews, through which MCEs often signal their intentions not to reauthorize services, leading providers not to request additional or continuing units. See Preliminary Central Mass. CSR at 64: "Agencies struggle with securing the amount of authorized units to address youth needs…[t]hey also experience lack of uniformity in authorization practices across MCOs and spend a lot of administrative time justifying needs of youth for the service." See also, Western Mass. CSR at 55: "Families expressed a feeling that services for their children were sometimes reduced too quickly and that staff are pressured into doing less."

the CANS, together with existing claims and encounter data, would provide sufficient data collection and management capacity to meet the requirements of the Judgment. More recently, the defendants themselves have questioned the feasibility of using CANS data and seem to have abandoned that approach without presenting other acceptable monitoring and evaluation strategies.

Failure to move forward to establish and maintain a basic system of data collection to monitor and evaluate essential components of behavioral health services not only deprives the parties and the Court of information necessary to determine compliance but also constitutes an omission of a necessary condition and essential requirement for implementation of the Judgment.

IV. Compliance Standards and Disengagement Criteria

Given the absence of agreement between the parties concerning compliance standards and the need for clear criteria for satisfying the Court's Judgment, it appears prudent for the parties, under the direction of the Monitor, to attempt to negotiate compliance standards, disengagement criteria and outcome measures, at least for those disputed requirements. If this process fails to generate an agreed set of standards, the Court should determine what it considers to be the criteria that must be met to satisfy its Judgment.

In several areas, these standards are evident from the provisions of the Judgment or the Medicaid Act. For instance, pursuant to the EPDST provisions of the Act and the Judgment, *all* children must receive a periodic screen that includes a behavioral health evaluation. MassHealth reports that approximately 70% of Medicaid-eligible children are screened with one of the approved behavioral health instruments. While this is a

considerable improvement over the pre-Judgment rate, it is also far less than the federal statutory requirement. Clearly, 100% compliance is neither realistic nor possible. Whether a 70% screening rate is or is not sufficient – and what percent should be determined adequate compliance – must be established. Similarly, MassHealth regulations require that *all* positive screens generate treatment responses, including referrals for specialized treatment and follow-up by the primary care clinician to determine if the member was provided care by the referral clinician. The standard for compliance with the broad scope of this regulation, and the corollary provision in the Judgment, *see* ¶ 10 (requiring referrals for follow-up assessment and treatment) remains to be determined.

In other areas, the parties have agreed, or the Court has established, a *process* to measure compliance but no compliance standards. For instance, the provisions on care management, care planning, and service delivery (Judgment, ¶¶ 19-37) are currently being evaluated by the CSR, which the Monitor is implementing on a regional and statewide basis. Yet there remains the important task of the parties agreeing upon, or, in the alternative, the Monitor determining, the specific level or scores on the CSR that constitute substantial compliance.

Finally, in a number of other areas, there appears to be considerable confusion and even debate with respect to the Judgment's requirements. The Judgment requires access and quality standards for each of the remedial services (Judgment, ¶ 38). There have been different interpretations by the parties and even contradictory interpretations by the defendants of these provisions. In these areas, compliance standards are needed.

Compliance standards, or disengagement criteria, are frequently established by the parties in systemic reform injunctive cases, such as this one. For example, in both the

mental health case involving persons with mental illness in western Massachusetts, as well as the consolidated cases involving persons with intellectual disabilities at five state developmental centers, the plaintiffs and state officials negotiated disengagement criteria which, when satisfied, provided the basis for the court to disengage from long-standing consent decrees. *See Brewster v. Dukakis,* 3 F.3d 488 (1st Cir. 1993); *Ricci v. Okin,* 823 F. Supp. 984 (D. Mass. 1993). Alternatively, courts can develop compliance standards or identify criteria for assessing compliance with its judgment. Either way, the result is clear and measurable standards for determining when the defendants have fulfilled their obligations under existing court orders, and thus when the court can relinquish its supervision over the litigation.

V. Next Steps to Address Compliance Disputes

Rather than wait until the defendants formally claim compliance with the Judgment and the Medicaid Act by moving to terminate this litigation, or until after an evidentiary hearing on compliance with little clarity on the standards for assessing compliance, the plaintiffs believe the better course is for the parties to seek to agree on compliance standards. The process could be chaired by the Monitor, involve her expert consultants when appropriate, and result in a list of remaining actions necessary to satisfy the disengagement criteria or compliance standards. The process should begin with the compliance issues noted above, and specifically focus on outcomes.

In the absence of such a process, the Court could solicit recommendations from the parties and the Monitor on compliance standards, and establish disengagement criteria on its own. This would be preferable to waiting until a compliance motion is filed, or an evidentiary hearing held, where there parties would have little common understanding of

exactly what was required to demonstrate that the Judgment has been satisfied, that EPSDT mandate is being fulfilled, that a durable remedy has been implemented, and that there is no realistic possibility of a return to the violations that gave rise to the Judgment.

V. Conclusion

The plaintiffs look forward to discussing these issues with the Court at the June 25, 2012 status conference.

RESPECTFULLY SUBMITTED
BY THEIR ATTORNEYS,

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by e-mail to all parties by operation of the court's electronic filing system.

June 14, 2012 /s/ Steven J. Schwartz