

**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**

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 on Implementation covers the period since May 30, 2012, when the Defendants filed a comprehensive Report on Implementation. This Report contains the most recent data on access, utilization and other key performance indicators, with a focus on those areas currently under discussion between the parties. Except where indicated, it should be read as a supplement and update to the May 30 report.

A. Utilization of Remedy Services by MassHealth Members under 21

In the first three quarters of State Fiscal Year (“SFY”) 2012 (July, 2011 through March, 2012)¹:

- 7,963 youth received Intensive Care Coordination (“ICC”) services.

¹ These data come from the CBHI Service Utilization Report for the period July 1, 2011 through March 31, 2012, attached as Exhibit 1.

- 6,687 received Family Support and Training (“FS&T”).
- 12,624 received In Home Therapy (“IHT”).
- 1,202 received In Home Behavioral Services (“IHBS”).
- 8,430 received Therapeutic Mentoring (“TM”).
- 8,867 received Mobile Crisis Intervention services (“MCI”).
- The total, unduplicated count of children and youth receiving REMEDY services during the first three quarters of SFY12 was 25,499.
- This count does not include youth receiving other behavioral health services. Typically, approximately 50,000 youth receive outpatient therapy each year. The number of children and youth enrolled during this period was approximately 565,000.

Of the youth receiving ICC during this period, 76% also received FS&T, 61% received outpatient therapy, 36% received TM, 31% received IHT and 16% received IHBS.

B. Timely Access to Services

The most recent CSA Monthly Report, attached as Exhibit 2, reports that in October, 2012, of the 428 members enrolled during the month, 414, or 96%, were enrolled within 14 days and fully 327 (76%) were enrolled within three days. At the end of the month, there were only 16 youth waiting longer than 14 days.

Data on the responsiveness of Mobile Crisis teams, contained in the report attached as Exhibit 3, show a continued trend toward shorter response times. Response time averaged 33 minutes across the state this August, down from 37 minutes in August 2011.

For In-Home Therapy, at the end of October, 2012, 7,186 youth were receiving the service and 72 were waiting, 69% for less than two weeks, 29% for two to four weeks and 2% for eight to twelve weeks.

For In-Home Behavioral Services, at the end of October, 2012, 827 youth were receiving services and 27 were waiting, 33% for less than two weeks, 41% for two to four weeks, 11% for four to eight weeks, 11% for eight to twelve weeks and 4% for over twelve weeks. 22 out of 27 youth waiting were from the Boston-Metro or Central regions.

For Therapeutic Mentoring, at the end of October, 2012, 5,503 youth were receiving services and 37 were waiting, 65% for less than two weeks, 16% for two to four weeks, 14% for four to eight weeks and 5% for eight to twelve weeks. 32 of the 37 youth waiting were from the Central or Western regions.

C. Service Intensity

The most recent CBHI Service Utilization Report, covering the period of July 1, 2011 through March 31, 2012, attached as Exhibit 1, shows that the hours of service delivered each month per enrollee, on average, through each of the remedy services, is remaining steady or increasing slightly. Larger increases are found in Therapeutic Mentoring and Mobile Crisis Intervention².

The Managed Care Entities' ("MCEs") approval of service authorization requests by providers remains over 99%.

² These data cover the period prior to the May 2011 expansion of MCI from three to seven days. It is interesting to note a 12% increase from February to March 2012 for youth twelve and under,

D. Expansion of the Mobile Crisis Intervention service from three to seven days

MCI providers have responded enthusiastically to this program change. They report that it gives them the time necessary to help families connect to appropriate services, especially those who are new to behavioral health services or are reluctant to engage in services. They report being able to use their time effectively between MCI calls to follow up with youth and caregivers and to support implementation of “next steps” for the youth and family. MCI programs report that many families are visibly relieved when told the MCI team can support them through the next seven days, although only a small number actually require help throughout the seven days.

Attached as Exhibit 6 is an internal report from the Massachusetts Behavioral Health Partnership (“MBHP”) tracking the number and length of MCI encounters for the MBHP – managed programs for the period January 2012 through October 2012. The report shows that prior to the expansion of MCI from three to seven days, providers were delivering, and MBHP was paying for, services beyond three days for approximately 30% of the encounters. Over the ten-month period, there is a slight increase in encounters lasting over five days, but a reduction in encounters over four days. Paradoxically, providers report that, as they explain more carefully families’ options for services over seven days, many families, seeming to the providers to be empowered by this information, are clearer about NOT needing or wanting MCI services beyond the initial encounter. The providers report that the seven-day timeframe does help support the small number of families who do want and need a deeper engagement with MCI. Finally, the variation in volume seen in this report is the characteristic seasonal variation for MCI – lower in the summer, higher in the fall and spring.

E. Changes to the CSA Provider Network

In November the Massachusetts Society for the Prevention of Children (“MSPCC”), operator of the CSA in Lowell and one of the five CSAs in Boston, informed the MCEs that it would be closing its CSAs by the end of January. The MCEs are working closely with MSPCC on transition plans for each of the 90 youth currently-enrolled across both sites. On November 30 the MCEs issued an Application for Network Affiliation (“ANA”) to solicit applications to operate these two CSAs from existing providers. The applications are due on December 14, with a planned award date of December 26. The MCEs have also made arrangements with nearby CSAs to take referrals from these catchment areas until the new CSA providers are ready to receive referrals. The neighboring CSAs have agreed to travel out of their own catchment area to serve families and youth in the neighboring catchment areas. The MCEs, with MassHealth oversight, are closely managing this transition to ensure continuity of care for youth and families currently receiving services through these CSAs and to guarantee continued access to ICC in these communities.

F. Behavioral Health Screening and Follow-up to Screening

The most recent Behavioral Health Screening Report, attached as Exhibit 4, shows that screening rates have rebounded after their slight decline in the last three quarters. That decline was associated with a tightening of billing requirements.. Beginning July 1, 2011, MassHealth and the MCEs started denying payment for Behavioral Health Screening claims if the provider failed to indicate the outcome of the screening; that is, whether or not the child had a potential behavioral health need. Following implementation of this change, billing for BH screens dropped by approximately two percent for the three subsequent quarters. In the most recent quarter for which data have become available, April 1, 2012 through June 30, 2012, the overall screening rate returned to the previous rate of 67% overall. As a result of this change in policy,

the percentage of claims lacking a modifier (i.e., claims lacking information about the result of the screening) has dropped from 16% to less than 1%.

Screening rates for children and youth from six months of age to 17 were over 70% in this quarter: 73% for children six months to two years old, 76% for children three to six years old, 77% for children seven to twelve years old and 71% for youth 13 to 17. Screening rates for infants are much lower (42%) due to a lack of consensus among providers regarding the utility of screening infants this young with the currently available screening tools, and screening rates for young adults 19 to 20 are similarly low (39%).

The rate of follow-up visits or behavioral health services after a positive screen for Members in MassHealth's Primary Care Clinician Plan continue to hover around 53-54%. MassHealth expects to learn more about PCCs' follow-up practices upon completion of the Behavioral Health Screening chart review study, which is currently in the process of being implemented.³

G. Collection and Analysis of Outcome Data

1. WFI and TOM Data

Data from the 2012 Wraparound Fidelity Index ("WFI") phone survey of 600 caregivers of youth enrolled in ICC, combined with data from providers using the Team Observation Measure ("TOM"), continue to show strong fidelity to the Wraparound model. The average fidelity score for Massachusetts' providers on the WFI was 79%, up 2% from last year. Massachusetts' providers scored higher than the national average in the categories of Team Based Practice, Collaboration and Individualized Care. Massachusetts' providers made statistically significant improvements in Family Voice and Choice, Team Based Practice and

³ A Request for Responses was issued and prospective vendors have submitted proposals, which are being reviewed by the project team at Commonwealth Medicine, University of Massachusetts Medical School.

Persistence. EOHHS has shared WFI and TOM data with the CSAs and discussed them with the CSAs in the MCE technical assistance meetings and calls to ensure that each CSA is aware of and actively addressing any areas that need improvement. This activity is part of EOHHS' ongoing management and quality improvement activities.

2. CANS Data

The Defendants are on schedule to produce a report on the functioning of youth enrolled in ICC and/or IHT, using CANS data, by the end of December, 2012. The analysis will report on aggregate changes in CANS scores on six individual CANS items (School Attendance, School Behavior, School Performance, Functioning in the Family, Functioning in the Community and Caregiver Stress). The analysis will also include the General Assessment of Functioning ("GAF") score, a 100-point scale of functioning that is part of the DSM-IV diagnosis recorded on the CANS. Once available, this information will be shared with the Plaintiffs and the Court.

In addition, to optimize the collection and clinical use of CANS data by providers, the Defendants are collaborating with their CANS contractor, the Shriver Center at the University of Massachusetts Medical School, to develop an application to help providers download and analyze the CANS data for youth they are serving. This initiative is due to be completed by the end of SFY13.

3. Survey Data

The Defendants have implemented the pilot Family Feedback Survey and are currently receiving and tabulating results. The survey questions in English are attached as Exhibit 5.⁴ A random sample of 400 youth currently receiving ICC for at least four months was pulled from the CANS database, with the goal of receiving completed surveys from 200 caregivers. Each

⁴ The survey is also available in Spanish.

Community Service Agency was given a list of sampled youth for their agency, along with a form letter for caregivers and a Dunkin' Donuts gift card (included to incentivize participation). CSA staff are in the process of distributing the letters and gift cards. The letter directs caregivers to a survey website that can be accessed on a computer or smart phone.

Preliminary results indicate that the vast majority of families report that the services have improved the quality of life for children and their families. A report synthesizing the responses of all caregivers who participated in the survey will be ready to share with the parties and the Court by sometime in mid-December.

4. Case Review Data

In order to implement the Community Service Review ("CSR") the Court Monitor needed staff to organize and manage the case review process. To implement the System of Care Practice Review ("SOCPR") the defendants also need to engage staff and manage the process, and are required by state law to do so through an open public procurement process. The Request for Responses ("RFR") for this activity will be released very shortly, with a projected late January start date for the contract. . After the reviewers are trained, they will conduct case reviews focused on youth receiving In-Home Therapy in April, May and June. Additional case reviews will be conducted in SFY14.

Respectfully submitted,

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Date: December 5, 2012

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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