UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.,	)	
Plaintiffs,	)	
v.	)	
CHARLES BAKER, et al.,	)	C.A. No. 01-30199-MAP
Defendants.	)	

PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION FOR SUBSTANTIAL COMPLIANCE AND TO TERMINATE MONITORING AND COURT SUPERVISION

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I. Introduction

The defendants have now moved to terminate monitoring and the Court's active supervision over the entire Judgment, based upon allegations of substantial compliance with every provision of the Judgment. Defendants' Motion for Substantial Compliance and to Terminate Monitoring and Court Supervision (hereafter "Defs' Mot."), Doc. 848. Their accompanying, revised Memorandum (hereafter, "Defs' Mem.")(Doc.854)[1] forthrightly acknowledges that, at least as of 2007, the Commonwealth was violating the Medicaid Act by failing to provide intensive home-based services as required by the Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) and reasonable promptness provisions of the Act. 42 U.S.C. § 1396a(a)(8) (promptness) and §§ 1396a(a)(10)(A) & (43) (EPSDT); s*ee* Defs' Mem. at 4-7. The Memorandum accurately describes the process for negotiating a remedial plan and the Court's ultimate incorporation of many portions of the defendants' plan, with significant modifications, into its Judgment. Defs' Mem. 7-9; *see Rosie D. v. Patrick,* 497 F. Supp. 2d 76 (D. Mass. 2007) and Judgment (Doc. 368). Finally, the Memorandum recounts significant efforts by the Commonwealth to comply with the Judgment by meeting its informing, education and outreach obligations; providing required screening and referral, creating an infrastructure for the provision of home-based services; and developing an information technology and data collection system. Defs' Mem. at 9-14. Given these improvements, the Court should partially disengage from these provisions of the Judgment.

But the Memorandum fails to address, let alone prove, that the defendants currently provide: (1) assessments, using the Child and Adolescent Needs and Strengths (CANS), from all

[1] The defendants' original Motion, Memorandum, Statement of Material Facts, and supporting affidavits were filed on August 6, 2018. On August 27, 2018, the defendants filed a corrected version of their Memorandum, Statement of Material Facts, and the Affidavit of MaryLou Sudders, revising various dates for data reports as well as the rate increases allowed for various remedial services.

behavioral health providers, as required by the Judgment (¶¶13-16); (2) the core services of Intensive Care Coordination (ICC) and In-Home Therapy consistent with the standards in the Judgment (¶¶19-30, 33, 38) and the Commonwealth's own program specifications for each service; (3) timely access to all remedial services, as required by the Commonwealth's own access standards, their program specifications, the Judgment, and the Medicaid Act; (4) an adequate provider network and capacity to ensure the timely provision of medically necessary home-based services, as required by the Judgment and the EPSDT provisions of the Medicaid Act; and (5) Outpatient Therapy consistent with the Judgment's standards for care coordination.[2] Moreover, the Memorandum fails to demonstrate that the Commonwealth has in place a durable remedy, as reflected in a sustainability plan promised by the Commonwealth in the Disengagement Measures as well as commitments to maintain the infrastructure and remedial services in their current form. *See* Disengagement Measure 7 (Doc. 776-1). Given these outstanding areas of noncompliance with the Judgment and federal law, the Court should not fully disengage from its active supervision of the Judgment nor terminate monitoring over these outstanding provisions and obligations. [3]

[2] While many of the monthly and quarterly reports generated by MassHealth are routinely shared with the Court Monitor and the plaintiffs, there is considerable information that the defendants cite and rely upon to prove compliance with the Judgment that has never been provided to the plaintiffs or the Court Monitor. For instance, the defendants have never shared any information on expenditures for remedial services, aggregate utilization of services over time, or aggregate hospitalization rates, as reflected in ¶¶69-71 of their SMF. In order to evaluate the defendants' claims of substantial compliance with the Judgment, within a week of the filing of the defendants' Motion, the plaintiffs promptly sought, through informal means, all information that was used or considered to support the allegations in ¶¶35, 42, 44, 47, 56, 58, 63, 69-71, 79-81 of the SMF. The defendants recently provided summary data tables, but not the underlying data that was considered in creating the table, as requested. Thus, for many of the assertions in the SMF such as the number of youth receiving each remedial service, SFM, ¶¶56, 69, 70, it is impossible for the plaintiffs to analyze the data or challenge the defendants' conclusion.

[3] On August 6, 2018, the plaintiffs filed their Motion to Approve and Order Disengagement Measures, Actions to Improve Access to Remedial Services, and Provisions on Outpatient Services (Doc. 847). That Motion discusses at some length the need and legal basis for each supplemental order. *See* Docs. 847-1, 847-2, and 847-3. The Motion is incorporated by reference herein, and will not be repeated in detail here. However, if the Court allows the plaintiffs' Motion, and enters any of the proposed orders, that will provide additional requirements which have not yet been satisfied, and which thus form an additional rationale for denying the Defs' Motion.

II. The Applicable Legal Standard

The Supreme Court has made clear that the defendants have the burden of proving substantial compliance with a remedial order entered by a court to correct a federal law violation. *See Freeman v. Pitts,* 503 U.S. 467, 494 (1992) ("The *school district bears the burden of showing* that any current [racial] imbalance is not traceable, in a proximate way, to the prior violation." (emphasis added); *Brown v. Bd. of Educ. of Topeka, Shawnee Cty., Kan.,* 978 F.2d 585, 588 (10th Cir. 1992). The defendants' Motion, Memorandum, Statement of Material Facts (SMF), and supporting affidavits (Docs. 848-852) effectively concedes this point, in the defendants' effort to prove substantial compliance with the Judgment. *See* Defs' Mem. 30-33 ("the Court should now, based on the substantial compliance showing, [terminate monitoring and reporting]"). Thus, there is now no debate that the defendants must prove that they have substantially satisfied their obligations under the Judgment, in order to request that the monitoring, reporting, and active supervision provisions of the Court's order end.[4]

The Supreme Court has also made clear that a federal court may, and should where appropriate, gradually reduce its oversight of remedial orders by partially or "incrementally" disengaging from selected obligations of a remedial order, after determining that the defendants have satisfied specific provisions of that order. *Freeman,* 503 U.S. at 490. The concept of incremental disengagement is designed to respect the role and responsibilities of state officials in managing state service systems when they have complied with some, but not all, of their federal

[4] The defendants do not contend that the five-year projected timeframe for terminating reporting and monitoring, as set forth in ¶52, is a drop-dead date which is divorced from a showing a substantial compliance. Nor could they, since that would be both contrary to the language in the Judgment, as well as Supreme Court precedent. *See* Judgment, ¶52 ("This Judgment constitutes a final order of judgment, *subject to the Court's exercise of ongoing jurisdiction to insure implementation*") (emphasis added). Rather, the five-year monitoring and reporting period was the Court's reasonable and best estimate of the time necessary to complete each of the Implementation Projects described in ¶¶34-38 of the Judgment, and to allow sufficient time to assess the success of these efforts. As the defendants recognize, there were early and ongoing warning signs that this projection was optimistic, and agreement by all parties – reflected in subsequent court orders – that monitoring and reporting, including periodic status conferences and ongoing court oversight, must continue. Defs' Mem. 16-17.

remedial obligations, while ensuring ongoing judicial oversight over the outstanding provisions of the remedial order. Three criteria are relevant to assessing whether partial disengagement is appropriate: (1) whether there has been full and satisfactory compliance with the decree in those aspects of the system where supervision is to be withdrawn; (2) whether retention of judicial control in those aspects of the system is not necessary or practicable to achieve compliance with the decree in other facets of the system; and (3) whether the state defendants have demonstrated their good-faith commitment to the whole of the court's decree and to those provisions of the law and the Constitution that were the predicate for judicial intervention in the first instance. *Freeman,* 503 U.S. at 491; *Wyatt By & Through Rawlins v. Rogers*, 985 F. Supp. 1356, 1385 (M.D. Ala. 1997).

Finally, the Supreme Court has recognized that before a court terminates its supervision of a systemic remedial order, it must be assured that the federal law violations have ended, that the conditions which gave rise to those violations will not resurface when the court terminates its active supervision of its remedial order, and that there is proof that a "durable remedy" has been put in place so as to ensure that systemic improvements will be sustained. *Horne v. Flores,* 557 U.S. 433, 450 (2009); *Bd. of Educ. of Oklahoma City Pub. Sch. v. Dowell*, 498 U.S. 237, 249–50 (1992). A history of good faith compliance is a key factor in concluding that remedial reforms with be sustained. *Freeman,* 503 U.S. at 498.

III. The Defendants Are in Substantial Compliance with the Provisions of the Judgment Concerning Notice, Education, Outreach, Screening, Referral, and Information Technology.

A. Notice, Informing, Education and Outreach (¶¶2-7, 36)

The defendants make a reasonable showing that they have complied with CMS' notice and informing requirements for EPSDT, as well as the corollary provisions of the Judgment.

While these requirements are ongoing, and cannot be limited or proven only by the actions taken in 2007-2010 that are discussed in Defs' Mem. at 20-21, SMF at 3-6, ¶¶9-18, there is evidence that the Commonwealth continues to provide information to Medicaid recipients and their families about its EPSDT program and the remedial services, that Managed Care Entities (MCEs) disseminate information to families about their providers, locations, and eligibility criteria for the remedial services, and that state agencies inform their employees about the new services. The plaintiffs have recognized these efforts for some time, not challenged the defendants' ongoing compliance with these provisions, and not required that additional actions be taken in these areas, as part of any Disengagement Criteria or Disengagement Measures.

B. Screening and Referral (¶¶8-10, 36)

Similarly, the defendants have made an adequate showing that reforms to the Commonwealth's screening program to incorporate behavioral health screening protocols, to provide additional compensation to pediatricians and other professionals who perform behavioral health screens, to require the use of selected screening instruments, to collect and track screening data, and to encourage – although not require – referrals to behavioral health professionals when a child is screened positive for a behavioral health condition are important reforms to the State's EPSDT program. Defs' Mem. 21-22, SMF at 6-8, ¶¶19-25. And similarly, the plaintiffs have recognized these efforts for some time, not challenged the defendants' ongoing compliance with these provisions, and not required that additional actions be taken in these areas, as part of any Disengagement Criteria or Disengagement Measures.

C. Role of EOHHS Agencies (¶11)

The defendants continue to allow youth and families to request remedial services without the need for a referral from a screening entity or a primary care provider. Defs.' Mem. at 22;

SFM at 8, ¶23. Since there is no evidence that remedial services are denied due to a lack of a referral from a primary care provider, it appears that the defendants are in substantial compliance with ¶11 of the Judgment.

D. Information Technology and Data Collection (¶¶39-45)

Finally, in the past six years, the defendants have taken a number of additional actions to improve data collection, reporting, and oversight of their service delivery system. At the Court's direction, they began sharing information on timely access to Community Service Agencies (CSAs) and subsequently, on access for all remedial services, through monthly reports that include provider-specific waiting times, capacity, and utilization. They began generating quarterly, provider-specific reports on Mobile Crisis Intervention (MCI). They started sharing information about CANS utilization by provider and level of care. They assumed responsibility for the annual client review (renamed the Massachusetts Practice Review or MPR) and disseminated very abbreviated reports on their findings for ICC and IHT. After extensive negotiations and significant pressure from the Court, they agreed to generate outcome reports using CANS data. Recently, they began collecting information about Outpatient Therapy providers who serve as service coordinators and the gateway to several remedial services. Unfortunately, and without notice to the Court Monitor or the plaintiffs, they suspended system-wide evaluations of wraparound principles and supervision, using the Wrap-Around Fidelity Index (WIFI) and the Team Observation Measure (TOM). Nevertheless, unlike their 2012 Report to the Court which did not include most of these data initiatives, the defendants now have demonstrated a substantially enhanced commitment to, and production of, data on their EPSDT program and the remedial services required by the Judgment. Defs' Mem. at 28-29; SMF at 18-22, ¶¶72-86.

While there remain significant implementation issues with the defendants' use of this data to ensure that MassHealth requirements on CANS utilization, timely access to remedial services, an adequate array of providers for all remedial services, and the appropriate provision of ICC and IHT are met, basic information is now regularly available on all of these issues. Therefore, the plaintiffs believe that the defendants have now made an adequate showing that they are in compliance with these provisions of the Judgment.

IV. The Defendants Are Not in Substantial Compliance with the Provisions of the Judgment Concerning Assessments, Intensive Care Coordination, In-Home Therapy, the Timely Provision of Home-Based Services, the Service Delivery Network, and Service Coordination.

Although the SMF cites numerous documents, reports, and recently-compiled data to support the assertions of compliance in Defs' Mem. 19-29, it is noteworthy that the defendants make no mention of contradictory data or evidence that undermines these assertions. Specifically, the annual CANS assessment report that identifies the percent of completed CANS by each type of service provider, the findings of the 2017 and 2018 Massachusetts Practice Review (MPR), recent CSA and IHT waiting list reports, regional and provider-specific capacity reports, and MassHealth's 2017 outpatient report are all noticeably absent in the SMF and never discussed in the Memorandum. This information – all of which is routinely shared with the parties and the Court Monitor and frequently cited in periodic status reports to the Court – is compelling evidence of noncompliance with various provisions of the Judgment.

A. The Defendants Are Not in Compliance with the Assessment Requirements of the Judgment.

In its 2006 liability decision, the Court underscored how the absence of a comprehensive, diagnostic assessment can harm youth with SED and their families, finding that "without a clinically appropriate, detailed assessment of an SED child, proper treatment is obviously

impossible." *See, e.g*. *Rosie D. v. Romney*, 410 F.Supp.2d 18, 34 (2006). The Court cited trial evidence showing a number of deficiencies in the State's assessment of youth with SED. It found that there was no way to assure youth received assessments at any particular time or in a consistent form. *Id.* In fact, the evidence made clear that "thousands of SED youth got no comprehensive assessments at all." *Id*. Moreover, many, if not most, of assessments that were conducted lacked the depth, analysis and comprehensiveness needed to form the foundation for long-term treatment. *Id*. To comply with the diagnostic requirements of EPSDT, the Court ordered the adoption of a standardized, comprehensive assessment tool, to be performed at specific times, used to identify medically necessary services, and shared with those responsible for creating an individualized treatment plan with the youth and family. Judgment (¶¶13-16).

Following consultation with the plaintiffs, the Court Monitor and experts, the defendants selected the Child and Adolescent Needs and Strengths (CANS) as their system-wide, standardized comprehensive assessment tool. As its name indicates, the CANS is an instrument that assesses the strengths and needs of a child, as well as of the child's family or caretaker. It examines the child's and family's functioning across multiple domains, including home, community and school. The CANS asks the responder – usually a family member or caretaker – to answer several questions organized under six general categories: problem presentation, risk behaviors, functioning, care intensity, caregiver capacity, and strengths.[5] The individualized clinical information collected through the CANS is used "…to inform treatment planning and ensure that treatment addresses identified needs." Judgment (¶15). The CANS also plays an important role ensuring youth who meet medical necessity criteria for Intensive Care Coordination (ICC) are referred to this core remedial service. These youth include children and

[5] The CANS was developed by Dr. John Lyons to provide a structure and guide for evaluating both the strengths and needs of children with behavioral health conditions. It has been repeatedly tested and validated, and is now being used by several States.

adolescents transitioning from acute treatment settings or residential/inpatient programs operated by the Department of Mental Health (DMH). *Id.*, ¶16(d),(e).

In their pending motion, the defendants recite a litany of contractual and regulatory steps they have taken to require administration of the CANS, but fail to mention their own data showing persistent noncompliance with these requirements across provider and service settings. For instance, the defendants note that "[i]n-patient behavioral health providers and Community-Based Acute Treatment ("CBAT") service providers must complete a discharge planning process inclusive of the CANS assessment, and make referrals for any medically necessary services." SMF at 9, ¶29. However, they are silent on providers' noncompliance with this regulation.

Over a 24-month period – between the 3rd quarter of FY2015 and the 2nd quarter of FY2017, the last period for which data is available – the weighted average of CANS compliance across managed care plans ranged from 36-54% for inpatient settings, and 38-69% for CBAT programs. *See* CANS Compliance Level by Service, data compilation covering January 1, 2015 – December 31, 2016, attached as Exhibit 1. Notably, the higher scores, 54% and 69%, for inpatient and CBAT, respectively, were achieved in 2015 and never repeated. Further, the performance of providers in individual managed care plans often was significantly lower than the weighted average. For instance, in the first quarter of FY2017, four of the six managed care plans reported inpatient compliance scores less than the weighted average of 48%, and three of six plans reported CBAT compliance scores lower than the reported average of 49.73%. *See* CANS Compliance by Service, (July 1, 2016 – September 30, 2016), attached as Exhibit 2.

The defendants have not produced data on CANS compliance since the second quarter of FY17, due at least in part to unresolved technological challenges.[6] Notably, the defendants have produced no data demonstrating compliance with CANS assessments for any DMH facilities or programs, even though DMH is a central provider of children's mental health services and probably the primary provider of intensive, facility-based services.

For youth whose behavioral health needs require inpatient or other 24-hour acute treatment, the absence of a CANS assessment could not come at a worse time. Navigating discharge from these short-term treatment settings is an "extraordinarily difficult and stressful experience" for youth and families. *See* Supplemental Affidavit of Lisa Lambert ¶4, attached as Exhibit 4, (hereafter "Lambert Supp. Aff."). Referrals to home-based services "could mean the difference between a stable and well-planned transition, and a continuing cycle of behavioral health crises, repeated re-admission to higher levels of care, missed school, even criminal justice or child welfare involvement." *Id.*.

After a lengthy out-of-home placement, youth often need significant supports and services, including a wraparound team and coordination of care across home, community and school settings. Lambert Supp. Aff., ¶5 A timely CANS assessment performed during the discharge planning process "allows the youth and family to engage home and community-based service providers *prior* to discharge, to involve them in transition planning, and to ensure a comprehensive treatment plan is in place on the day the youth leaves the facility." *Id.* Indeed, the availability of the home-based services often avoids prolonged out-of-home placement, by offering a way to facilitate timely discharge. *Id.* When CANS assessments are not completed,

[6] *See* Exhibit 3, Email from Margot Tracy to the parties, dated July 9, 2018: "CANS Compliance Level of Care—this report has been unavailable for several months now; it is based on the individual MCE BH-24 report, which has been suspended due to a CANS database issue which IT is working to resolve."

consistent with the Judgment and the State's own regulatory and contractual requirements, youth and families can experience delays in access to care, poorly planned discharges, heightened risks in their homes and communities, and serious set-backs in their long term recovery. *Id.* at ¶¶4-5.

Moreover, as the defendants' own data shows, even youth directly engaged with remedial service providers do not receive a CANS assessment as required. Between July 1, 2016 and September 30, 2016, IHT providers only complied with the CANS requirement 75% on average, and ICC providers 87.5% of the time. *See* Ex.2.

Defendants cannot demonstrate substantial compliance with Section B of the Judgment if they fail to enforce the very requirements established to remedy deficiencies in the assessment and diagnosis of class members. Nor can they demonstrate that they have established a sustainable and durable plan of correction in this area, when 50% youth in inpatient and CBAT levels of care are still not receiving a CANS assessment, more than 10 years into the implementation process. Therefore, the Court should continue its monitoring and judicial oversight of paragraphs 13-16 of the Judgment.

B. The Defendants Are Not in Compliance with the Requirements of the Judgment Concerning Intensive Care Coordination and In-Home Therapy.

In support of their Motion to Terminate, the defendants recite steps taken in 2008 and 2009 to develop and launch the four remedial services, including the two key services, Intensive Care Coordination (ICC) and In-Home Therapy (IHT).[7] More recently, as promised in the Disengagement Criteria, the defendants developed practice guidelines for IHT, IHBT, TM and

[7] These steps included: (1) amending the Medicaid State Plan to include new remedial services; (2) creating Medical Necessity Criteria that establish service eligibility, continuing care, and discharge planning requirements; and (3) drafting Program Specifications that describe how the services are to be provided and by whom. Memo at 24-27; SMF at 13. *See* defendants' Exhibit E, Doc. 850-5 or www.mass.gov/lists/performance-specifications (accessed September 7, 2018).

MCI.[8] Yet the defendants' filing is silent as to how remedial services are being provided to class members today – saying nothing about their quality, effectiveness, or fidelity to the specifications and service standards set out above.[9]

By initiating the required remedial services and funding those services over the past eight years, the defendants suggest that they have fully discharged their obligations under the Judgment. *See, e.g.*, SMF at 13-17. They make no effort to demonstrate that youth are actually receiving remedial services consistent with the Judgment, with the program specifications that govern each service, and with standards that they created to ensure adequate service implementation. As with the CANS assessment process, they deliberately sidestep any discussion of data concerning the adequacy of ICC and IHT, and the findings of their own system reviews which demonstrate that those services are not being provided consistent with the Commonwealth's own standards.

Over the years, both the Court Monitor and the defendants have employed various evaluation tools to assess the home-based service system. In 2016, the defendants assumed full responsibility for this system review process, and designed the Massachusetts Practice Review (MPR) to serve as the State's primary mechanism for evaluating the adequacy, quality, and

[8] For example, IHT performance standards – required by paragraph 38(c)(viii) of the Judgment – and titled "CBHI IHT Practice Guidelines" can be found at https://www.mass.gov/files/documents/2016/07/qf/practice-guidelines-iht.pdf. This document sets out expectations for critical elements of service provision, including intake, assessment, treatment planning, care coordination, supervision and transition planning. The equivalent document for ICC is titled "Program Description and Operations Manual" and can be found at https://www.masspartnership.com/pdf/ICCOPsManualDec2011FINALclean.pdf..

[9] For instance, while the amended program specifications for MCI allow crisis services to be provided for up to seven days, rather than the original 72 hour-limit set forth in the original MCI specification, there is no information about the adequacy, appropriateness, or necessity of extended treatment by MCI providers. This is particularly important given the Commonwealth's abandonment of the Crisis Stabilization model described in the Judgment, which was designed to address ongoing crisis situations. In fact, the only information available at all on this critical performance question is that virtually all MCI encounters last *less* than 72 hours, suggesting that MCI does not offer extended crisis support and that the absence of performance standards on this issue has immense consequences to children, youth, and families. *See* Average Length of MCI Encounters, attached as Exhibit 5.

effectiveness of these services.[10] The MPR focuses on ICC and IHT because of their central roles in the service system, and their responsibility to coordinate delivery of other remedial services.[11] *See* FY2017 MPR Report, attached as Exhibit 6.

The MPR examines required standards of practice through the lens of individual service delivery, giving it a unique and important perspective on implementation of the remedy. A random sample of youth and families is drawn from across the state, based on their participation in either ICC or IHT. Once consent is obtained, trained reviewers examine relevant medical records and conduct interviews with multiple informants, including the youth, the caregiver and the IHT or ICC provider. The MPR examines service system performance across multiple domains, including youth and family progress. Reviewers rate the adequacy of provider practice using a scale from 1 to 5, with 1 being adverse and 5 being exemplary. Individual scores are then aggregated to determine the percentage of clinical practice experienced by youth and families as adverse, poor, fair, good or exemplary. Since the review is based upon a statistically random sample of all children and youth receiving ICC and IHT, the findings from the MPR are generalizable to all class members in these programs.

The MPR provides significant evidence of the status of compliance with the *Rosie D.* Judgment, including whether ICC and IHT are delivered consistent with the requirements of the Judgment, established service specifications, and practice standards. The defendants acknowledge the significance of the MPR, describing the tool as "a means of analyzing quality

[10] The defendants contract with the Boston-based Technical Assistance Collaborative (TAC) to complete these annual reviews.

[11] *See* Ex. 6, MPR Report at 1 ("The MPR is a qualitative case review tool that is implemented by trained reviewers who examine the clinical record and interview multiple stakeholders, including the CBHI service provider, the caregiver, the youth (if over 12), and other formal providers who work with the youth and family. MPR reviews are specifically focused on In-Home Therapy (IHT) and Intensive Care Coordination (ICC) services because of the critical role these services play as the "hub" of care coordination for the youth and families served. Quantitative ratings combined with qualitative observations allow for examination of trends in IHT and ICC service delivery practice and youth and family progress since their enrollment in these services, and ultimately provides an understanding of the current state of practice – by service, by agency/provider, and for the system overall").

of care and overall outcomes," *see* Defs' Mem. at 28, and to inform the improvement of services and programming. SMF at 20 (¶78).

Several specific compliance requirements in the parties' Joint Disengagement Measures are based on the MPR, including the adequacy of care coordination, clinical assessments, service delivery, treatment planning, team formation and team participation. In order to satisfy the Joint Disengagement Measures, there must be a 10% annual increase in the number of services considered "good or better" by the MPR. This formula for incremental change uses baseline data from ICC and IHT system performance gathered in 2016. Additionally, the Joint Disengagement Measures required that no youth should experience "adverse practice" (a rating of 1 on the MPR scale) except in rare circumstances. *See* Doc. 776-1 at 2-3.

The most recent annual MPR report was issued in January 2018. It included data from 60 ICC recipients and 61 IHT clients collected between July 1, 2016 and June 30, 2017. *See* Ex. 6. The findings, as discussed below, demonstrate that the Commonwealth is not in compliance with the Judgment's provisions on ICC and other remedial services.

1. FY2017 MPR for ICC

The FY17 ICC report raised significant concerns about the quality of ICC services, and specifically, providers' ability to deliver the service consistent with the requirements of the Judgment and MassHealth's performance specifications and practice guidelines. More than two-thirds of youth received assessments and service planning that fell short of the "good" or accepted practice rating. *Id.* at 15. Similarly, the formation of youths' treatment teams failed to meet the standards for good practice in 64% of cases. *Id.* at 16.

Even more troubling were the number of youth whose ICC practice was rated poor or adverse, meaning youth are receiving services that "did not meet minimal established standards of practice," or where practice was "absent, wrong, possibly harmful or implemented in ways that were inappropriate, harmful or contraindicated." *Id.* at 11. For instance, in the area of assessments, 28% of the cases were rated "poor." *Id.* at 15. An additional 3% of assessments were categorized as adverse to the youth and family. *Id.* The remaining 38% of ICC assessments were rated as fair – meaning they did not consistently meet required standards for even an adequate assessment. *Id.*

As noted in Section IV.A, *infra*, inadequate or incomplete assessments can have cascading negative effects for youth's treatment planning and access to medically necessary services. When nearly one-third of all clinical assessments reflect poor or adverse practice, it suggests remedial providers are failing to consider family strengths and needs, cultural views, or natural supports. *Id.* at 10. They may also be overlooking critical diagnostic information or failing to identify significant behavioral risks that can jeopardize the child's health, safety and welfare.

2. FY2017 MPR for IHT

The FY2017 IHT practice review (the agreed-upon measure for IHT compliance in calendar year 2017) also failed to meet disengagement benchmarks for assessment and service planning. *See* Ex. 6 at 15-17. Despite incremental improvements over FY2016 scores, 64% of clinical assessments and 58% of care coordination still failed to meet the good practice standard. *Id.* at 15. Service planning scores remain unchanged from 2016, with 64% of practice rated as less than good. *Id.* MPR progress ratings showed *only 36%* of youth were making good or better progress as a result of remedial services. *Id.* at 17.

There were findings of poor and adverse practice across multiple IHT service domains, including assessment, service delivery, team participation, care coordination and transition planning. Strikingly, 11% of the assessments conducted for youth in IHT in FY17 involved adverse practices that were potentially harmful to the child; 23% fell into the "poor practice" category and 30% represented fair practice. *Id.* at 15. As with the ICC results, about two-thirds (64%) of IHT assessments failed to meet the "good practice" standard. *Id.* A full 36% of care coordination and 26% of service planning was rated as adverse or poor, along with 22% of service delivery, 24% of team participation, and 38% of transition planning. *Id.* As noted above, these findings suggest that 20% - 33% of youth are receiving remedial services that "did not meet minimal established standards of practice," or, even worse, where practice was "absent, wrong, possibly harmful or implemented in ways that were inappropriate, harmful or contraindicated." *Id.* at 11.

3. FY2018 MPR for ICC

In the fall of 2017, the defendants conducted a new set of MPR reviews for ICC.[12] The findings of these reviews were previously designated as the baseline for assessing compliance with the 2017 Disengagement Measures. However, as evidenced by the most recent findings, the defendants failed to meet established benchmarks in three of five areas: clinical assessments, service planning, and care coordination. *See* FY18 ICC MPR Domain Results, attached as Exhibit 7. Nearly two-thirds of ICC clinical assessments failed to meet the good (accepted) practice standard. Not surprisingly, other aspects of service delivery suffered as a result. *Id.* Reviewers found that 55% of youth's service planning and 50% of team formation was inconsistent with good practice. *Id.* An additional 56% of youth were denied good transition

[12] These late 2017 reviews will eventually be incorporated in the FY2018 annual MPR report, along with IHT reviews conducted during the Spring of 2018.

planning, and 45% of youth had care coordination that fell below good practice standards. *Id.* Overall, *only 27%* of the youth reviewed experienced good or better progress as a result of these remedial services. *Id.*

As in FY2017, a significant percentage of ICC practice was found to be poor or adverse to youth and families: 22% of assessments; 25% of service planning; 18% of team formation; 11% of team participation; 14% of care coordination; and 25% of transition planning received these designations. *Id.* Thus, between 33% and 61% of youth receive ICC services that fail to meet the clinical standard for good or accepted practice, as defined by the defendants in the context of the Judgment. *Id.*

4. FY2018 MPR for IHT

In late August 2018, defendants released the FY2018 MPR scores for IHT. *See* FY2018 MPR IHT Review Practice Domain Results, attached as Exhibit 8. Remarkably, the percentage of good or better clinical practice *declined* across the board in the areas of assessment, service delivery and planning, team formation and participation, care coordination, and transition planning. *Id.* Even the measure of youth progress decreased from 36% to 31% good or better progress. *Id.* The amount of poor and adverse practice in assessment and service planning decreased by 1% point, and similar modest reductions occurred in transition planning and service delivery. *Id.* Moreover, and of particular concern, the percentage of care that did not meet minimal established standards or was absent or harmful to youth actually *increased* in other areas. *Id.* In FY18 the MPR showed 41% of team formation and 31% of team participation was poor or adverse, up from 19% and 24%, respectively. *Id.* Similarly, poor or adverse care coordination in IHT increased by 10% from 26% to 36%. *Id.*

Although the MPR has demonstrated some progress in selected areas, these scores make clear that continued court oversight is required to ensure ICC and IHT services are delivered as required by the Judgment and the defendants own service specifications and standards. Defendants cannot demonstrate substantial compliance with the standards set out in Section C and paragraph 33(b) of the Judgment when *less than half* of youth sampled are receiving ICC or IHT services that are considered good practice or better, and as much as *a third* are subject to practice that is rated poor or adverse.

When remedial services are so far below what is considered accepted practice, youth and families make little progress, are placed at risk, and may even be harmed. *See* Lambert Supp. Aff. at 3, ¶18. The quality of care they receive should not depend on where they happen to live, or the provider who happens to cover their region. *Id*. Without greater consistency and adherence to practice standards, youth will not have the full benefit of the remedy in this case, and will continue to experience adverse outcomes like unnecessary hospitalization, time out of school, and child welfare or criminal justice involvement. *Id*.

C. The Defendants Are Not in Compliance with the Requirements of the Judgment Concerning the Timely Provision of Home-Based Services.

The Court's liability decision found a violation of both the EPSDT and the reasonable promptness provisions of the Medicaid Act. *Rosie D.,* 410 F. Supp. 2d. at 53. Its Judgment mandated that all remedial services must be provided promptly. *Rosie D. v. Patrick,* 497 F. Supp. 2d 76 (D. Mass. 2007). Promptly means consistent with state timeliness standards that are mandated by federal law, 42 C.F.R. §440.56(e), as well as with MassHealth program specifications that are mandated by ¶38(c)(vii) of the Judgment.

For nearly a decade, during this post-judgment phase of *Rosie D*., the parties, with the oversight and aid of the Court, have contended with and engaged in litigation over the

defendants' continuing violations of their Medicaid obligations under federal EPSDT and reasonable promptness mandates, as well as their own 14-day access standard that was created in response to the plaintiffs' 2011 Supplemental Motion to Ensure Timely Access to Remedial Services (Doc. 542). Yet despite almost eight years of judicial restraint, marked by at most intermittent improvements in the length of illegal waiting lists for EPSDT services, the defendants' recent status reports and their monthly data reports show consistent noncompliance with the timely access standards and their program specifications for remedial services. *See* Defendants' September 13, 2017 Status Report on Implementation (Doc. No. 813) and November 17, 2017 Status Report on Implementation (Doc. 820).

It is beyond dispute that the problem of timely access to ICC and IHT services waiting lists and noncompliance with access requirements has persisted since the inception of the remedial services ordered by the Court. Rather than effectively initiate reforms and improve access to ICC, IHT and other remedial services, the defendants have resisted taking significant new actions or proposing effective improvement plans, as requested by the Court. Instead, in response to the plaintiffs' 2011 Motion to Ensure Timely Access, they simply abandoned the original 3-day access standard that was incorporated into the program specifications for IHT and other remedial services, even though these specifications – and the requirements to prompt appointments – had been negotiated by the parties, presented to and approved by CMS, and submitted to the Court as evidence of compliance with ¶38(c) of the Judgment. The defendants sought to justify their actions based upon: (1) an analysis of the access standards of similar intensive care coordination programs in other states; and (2) a review by an advisory committee of the New England Council of Child and Adolescent Psychiatry (NECCAP). Significantly, neither source supported MassHealth's revised 14-day access standard.

The state comparison, set forth in the Affidavit of Margot Tracy, Doc. 544-8, reviewed ICC programs in Milwaukee, Wisconsin, Indiana, Maryland, and Arizona. They each had mandatory requirements that appointments must be scheduled within 3 days (Indiana and Maryland) or 7 days (Arizona and Wisconsin). *Id.* at 3. The NECCAP – which functions as the advisory group to MassHealth on EPSDT periodicity schedules that are required by the Medicaid Act – recommended an outside limit of 10 days between the time of request for ICC and the first meeting with ICC. *See* Doc. 564-6.

The defendants rejected the findings of both of these reports, and instead adopted a 14-day access standard for ICC and other remedial services. The Court, somewhat reluctantly, deferred to the defendants' proposal, but insisted on periodic, provider-specific data to assess compliance with this extended standard. Unfortunately, lengthening the access standard to 14 days did little to bring defendants into compliance. Over the last eight years, waiting lists for ICC and IHT services have persisted and grown over time. This record of noncompliance has occurred, despite this Court's November 29, 2011 Order to Ensure Timely Access to Remedial Services directing defendants to "effectuate management strategies specifically targeting the reduction, and *ultimately the elimination, of waiting lists* for ICC services…." *See* Doc. 557, ¶5 (emphasis supplied).

A graphic depiction of this historical noncompliance illustrates how long children and families wait for core services like ICC and IHT, and, strikingly, how many CSA providers have waiting lists that vastly exceed the Medicaid access standard. *See* Youth Waiting for ICC, FY17-18, attached as Exhibit 9; ICC Access Data, FY17-18, attached as Exhibit 10; and IHT Data, FY17-18, attached as Exhibit 11. As the State's own data reports demonstrate, for the better part of the remedial phase of this case, the defendants consistently have failed to meet –

and not even come close to meeting – their Medicaid access standard that requires an appointment with an ICC or IHT clinician within 14 days of a request.

The defendants' representation that 78% of youth began ICC treatment within 14 days (SMF, ¶47) is, at best, misleading. Their supporting documentation is a compilation of seven years and 11 months of data. But a monthly breakdown of their data, especially for the three most recent fiscal years as set forth below, demonstrates the fallacy of that representation and underscores the unsustainability of their claim. In fact, over the 36-month period from July 2015 through June 2018, the defendants only achieved 78% compliance three times: November 2015, December 2015 and October 2016. They ended fiscal year 2017 at a low of 49%; they started fiscal year 2018 at 50% and ended it at 53%.[13]

Figure 1: ICC 14-DAY ACCESS RATES FY 2018, FY 2017, FY 2016

FY 2018	0-14 days	FY 2017	0-14 days	FY 2016	0-14 days
June 2018	53%	June 2017	49%	June 2016	63%
May 2018	58%	May 2017	59%	May 2016	66%
April 2018	59%	April 2017	62%	April 2016	60%
March 2018	65%	March 2017	64%	March 2016	61%
Feb. 2018	64%	Feb. 2017	64%	Feb. 2016	56%
January 2018	67%	January 2017	62%	January 2016	54%
Dec. 2017	67%	Dec. 2016	69%	Dec. 2015	79%
Nov. 2017	71%	Nov. 2016	72%	Nov. 2015	78%
October 2017	71%	October 2016	78%	October 2015	76%
Sept. 2017	68%	Sept. 2016	77%	Sept. 2015	71%
August 2017	51%	August 2016	75%	August 2015	65%
July 2017	50%	July 2016	68%	July 2015	56%

At the end of 2017, the defendants were dramatically noncompliant with the 14-day access standard for ICC and IHT. According to MassHealth's own data that it presented to the Court, only 58.7% of youth and families received an initial appointment with ICC within 14

[13] See CSA Monthly Reports, FY16-FY18, Report 4: Distribution of Time from Request to Date Offered for Initial Appointment.

days; and only 49.7% of youth and families were offered an initial appointment with IHT within 14 days. *See* Defs' Status Report, Doc. 813-1. Remarkably, eight years earlier, in 2011, the defendants reported that 45% of youth received an initial appointment within *three* days. *See* Affidavit of Emily Sherwood at 2, Doc. 544-3. Thus, despite extending the access standard by more than 300%, the compliance rate with the substantially longer access standard only increased by a modest 13%.

This persistent pattern of noncompliance continues to this date, at the same time defendants seek to terminate active judicial oversight. Analysis of defendants' monthly reports for the last two years shows that for *every* month, *hundreds* of children and youth are waiting for ICC services. On average, 220 youth were waiting at the end of each month throughout FY2017 and 2018. *See* Ex. 9. Most were waiting up to twenty days, but a significant number waited longer than a month. For example, during the last quarter of FY2018 – the most recent data available – 97 youth waited more than a month for ICC in April; 101 waited longer than a month in May; and 71 waited more than a month in June. *Id.* Since the data presented in these exhibits is drawn directly from the defendants' own monthly reports which were developed at the direction of the Court in response to the plaintiffs' initial 2010 motion, and which are shared with the parties and the Court Monitor on a regular basis, the factual basis for noncompliance is undisputed.

This pattern of noncompliance with MassHealth's own 14-day standard to offer youth an initial appointment for ICC services is deep and widespread. More than half of the 32 CSAs failed to meet the 14-day standard in nine of the twenty-four months during the past two fiscal years (July 2016 through June 2018). *See* Ex. 10. In addition, between a quarter to a third of the CSAs have extensive waitlists that exceed 30 days. *Id.* Significantly, the defendants are not

demonstrating improvement: In each of the last two months of FY2018, 17 [53%] of the 32 CSAs failed to meet the 14-day standard. Ten providers had waitlists that ranged between 32 and 98 days in May, and 11 waitlisted youth from 31 to 112 days in June.

And this pattern of noncompliance is not confined to a single program – ICC. The defendants also have failed to address longstanding waiting lists for IHT. Equally troubling, the numbers of youth waiting for this core service continue to rise. In two of the last three months of FY2018, more than 600 youth were waiting for a first available appointment. *See* Ex.11.

This Court knows well the tragic consequences of long delays and access to necessary remedial services, particularly for those families in crisis or with needs for urgent care, calling it "shattering" to read that youth are continuing to face lengthy emergency room stays and unnecessary inpatient admissions. *Rosie D*. Tr. 5:1-17 (January 16, 2018). Because of lack of progress in resolving lengthy waiting lists, the Court repeatedly pushed defendants to act to remedy "excessively long times."[14] Waiting lists result in not only delay, but denial of medically necessary services. While waiting, children can experience behavioral health crises, school suspensions, emergency room care, inpatient admissions, and out-of-home placements. *See* Lambert First Affidavit, ¶5, Doc. 847-4. Frequent trips to the emergency room and over-reliance on out-of-home placements are exactly the harmful consequences remedial services are designed to prevent and ameliorate. Chronic waiting lists of any duration for children with complex care coordination needs deprive those children and their families the benefits of this court's judgment. Those benefits include the possibility for children to remain with their families, in their local communities and schools with the support of in-home services. *Id., ¶*22. Yet the negative impact of chronic waiting lists reaches beyond individual family hardship. As

[14] *See*, *Rosie D*. Tr. 3:3-14 (January 16, 2018) ("This is the front door of the system where people are often in crisis and children are in need, and the question of allowing children to get to the services promptly is pressing.").

the director of the Massachusetts Parent/Professional Advisory League (PPAL) states, "When waiting lists become the norm for youth and families across the state, the entire system loses credibility and families lose hope that services will be there when they need it most." *Id., ¶*12.

The defendants' Motion and Statement of Facts rely on counting the number of individuals served though the CBHI program and the amount of Medicaid dollars expended over the years since the Judgment was entered to bolster their argument for termination. *See* SMF, ¶¶46, 47, 63. These statistics cannot alone overcome the undisputed factual record of their failure to reduce and eliminate long waiting lists. There is no question that the failure to insure timely access to ICC and IHT remains a substantial barrier to many class members receiving care coordination and medically necessary remedial services. As this Court correctly observed in its liability decision: "[t]he fact that the defendants provide some services does not relieve them of the duty to provide all *necessary* services with reasonable promptness." *Rosie D.,* 410 F. Supp. 2d at 53.

D. The Defendants Are Not in Compliance with the Requirements of the Judgment Concerning the Service Delivery Network and the Capacity of Service Providers to Deliver Medically Necessary Home-Based Services.

1. Provider Network Capacity

Pursuant to ¶38(c) of the Judgment, the defendants are required to develop and maintain a service delivery system adequate to deliver the remedial services described in the Judgment. That system must include "approaches that maximize access to services…." and that is a based upon planning that reflects "anticipated need and provider availability." *Id.* ¶38(c)(i), (iii). The defendants' Motion claims compliance with their obligations under ¶38 of the Judgment through the creation of a statewide network of Community Service Agencies (CSAs) responsible for coordinating, providing and arranging for medically necessary home-based services, as well as

the development and implementation of each of the required remedial services. Defs' Mem. at 23-26; SMF at 10-13. However, defendants ignore their obligations to maintain and sustain an adequate service delivery network that can deliver the required remedial services when and where children and youth need them.

First, they overlook their duty to maintain a service provider network with sufficient capacity to provide necessary remedial services to all class members promptly. The parties and the Court are acutely aware of the direct connection between the adequacy of the capacity of provider networks and timely access to remedial services. *Rosie D.* Tr. 31:19-32:3; 33:15-21; 36:22-37:10; 39:5-10. (October 4, 2017). The defendants have argued, as a rationale for not ensuring timely access, that increasing capacity is not within their control, even though their own Managed Care Organizations (MCOs) determine the number and qualifications of providers in their networks and MassHealth's contract with these MCOs, as well as federal law, require that there be a sufficient array of providers to ensure medically necessary services are provided promptly. *See* Doc. 850-2; 42 C.F.R. 440.61. However, there is little dispute, and unrebutted evidence, that a growing waiting list and insufficient provider capacity are directly related, if not causally connected. Here, both deficiencies constitute noncompliance with the Judgment and violation of the federal EPSDT and reasonable promptness mandates of the Medicaid Act.

As previously noted in Plaintiffs' Memorandum to Improve Access to Remedial services, (Doc. 836), the defendants' March 2018 service report indicates that 126 of 161 IHT providers have 5% or less unused capacity, with a vast percentage, well over 100, having zero availability. As a result, over 550 children and youth were waiting for first available IHT provider in March 2018, and another 580 were waiting for the provider of their choice. *Id.* at 3. Over 40% of those waiting for IHT services waited over two months, and another 20% waited over a month. *Id.*

Near zero capacity is the norm for IHT, and has been ongoing problem in several parts of the state, including the central and western regions. In fiscal years 2017 and 2018, IHT capacity dropped below 1% seven times in Western Massachusetts and three times in Central Massachusetts. Significantly, capacity bottomed out at zero (0%) in the central region as recently as May 2018. Ex. 11 shows that both statewide and regionally, service capacity remains woefully insufficient to meet class members' needs, with existing network providers unable to ensure timely access to remedial services such as IHT. As discussed *supra* and as detailed in Ex. 10, few CSA providers regularly meet the 14-day access standard for ICC, reflecting inadequate capacity.

Plaintiffs' Motion and Memorandum for Further Orders reiterate several concrete actions which defendants can take to improve access to medically necessary services, and to reduce the harms experienced by youth and families when these services are not available when needed. Doc. 847. These actions include expanding provider capacity, implementing ICC rate reform, a planned rate increase for IHT, and comprehensive rate studies to assess whether IHT and other remedial service providers have the resources required to comply with the Judgment and defendants' own program standards and service specifications. *See, e.g.,* Doc. 847; Doc. 847-5 (DiGravio Aff. at ¶¶9-10).

While defendants' corrected Statement of Material Facts references the overall percentage of rate increases paid to IHT and other home-based service providers over the last nine years,[15] SMF at 11, ¶35, it makes no assertions about the sufficiency of these rates, the extent to which they have kept pace with inflation or service demand, or their adequacy to incentivize needed growth in provider capacity. Moreover, according to the State's own data,

[15] The revised SMF recognizes that the rate increase for most remedial services is actually 10% over nine years, rather than the 20% originally asserted in the original SMF.

the actual expenditures for the two services that did receive a significant rate increase over the past nine years – ICC and Family Support – *decreased* by approximately 30% between 2014 and 2017.

Service rates for *Rosie D*. remedial services were initially set in January 2009. *See* 114.3 CMR 52.00, Rates of Payment for Certain Children's Behavioral Health Services, attached as Exhibit 12. Since that time, In-Home Therapy providers have received periodic rate increases, the last being a 1.1% increase in 2016. Today, a Masters-level IHT clinician is reimbursed at $20.40 per 15 minute unit of service, as compared to $18.40 per 15 minute unit in January of 2009. The result is a $2.00 increase in unit rate over a nine-year period. *See* 101 CMR 352.03, Rates of Payment for Certain Behavioral Health Services, attached as Exhibit 13. Therapeutic Training and Support services (a paraprofessional who sometimes works with the in-home therapist) had a 10% rate increase over the same nine year period, from $12.02 in 2009 to $13.18 in 2016. The result was a $1.16 increase per unit of service. *Id*.

Similar cost of living rate increases have occurred for providers of Therapeutic Mentoring, Family Support and Training, In-Home Behavior Therapists, and MCI over the last nine years. For example, Therapeutic Mentoring providers were reimbursed at $12.98 per 15-minute unit of service in 2009. Since 2016, they receive $14.23 per unit of service, a total increase of $1.25 or approximately 10%. Masters-level Behavior Therapists received $24.81 per 15-minute unit in 2009. Since January of 2016, these providers earn $27.21 per unit of service, a total increase of $2.40 or approximately 10%.

When the undisputed evidence shows MPR findings of absent or inconsistent adherence to service standards and practice expectations, hundreds of youth waiting for remedial services every month, and insufficient remedial service capacity to meet their needs, the defendants

cannot demonstrate substantial compliance with the Judgment or with their continuing obligations under EPSDT. To the contrary, these facts strongly support the need for further remedial action to secure compliance with those obligations.

E. The Defendants Are Not in Compliance with the Requirements of the Judgment Concerning Service Coordination When Provided by Outpatient Therapists.

In its liability decision, the Court concluded that Outpatient Therapy alone was insufficient to meet the plaintiffs' need for care coordination, *see Rosie D.* 410 F. Supp. 2d at 38-39, 52-53, writing at length about the importance this service for youth with Serious Emotional Disturbance (SED) and its central role in remedying identified EPSDT violations. *Id*. at 23, 31-32. The plaintiffs' proposed remedial plan, submitted in response to that decision, envisioned that all service coordination for home-based services would be provided through Intensive Care Coordination, with In-Home Therapy and Outpatient Therapy providing clinical treatment interventions. Doc. 338 (August 28, 2006). So too did the Remedial Plan ultimately approved by the Court. *Rosie D. v. Patrick,* 497 F. Supp. 2d 76 (D. Mass. 2007). However, the defendants subsequently decided that IHT and traditional outpatient therapists would also perform this function, if the child was not enrolled in ICC.

Outpatient Therapists serve close to 40,000 MassHealth members under the age of 21, the vast majority of whom have SED. *See* Doc. 723 at 8 n. 6. Although some youth in Outpatient Therapy do not receive, and may not need, remedial services, studies conducted by the Commonwealth, as well as utilization data, suggest there are thousands who rely on this traditional, office-based therapy for referrals to, and coordination of, remedial services. *Id*. at 5-6, 8 n. 6.

While the parties debated the limitations of outpatient therapy over the past several years, the Court repeatedly reiterated its view that care coordination is a central element of the

remedy,[16] and that the Judgment's standards for the delivery of care coordination should be applicable to whatever providers defendants designate to carry out this critical function, including outpatient therapists:

> If the defendants say, Okay, we're going to do intensive care coordination, but we're not going to do it with the same acronym. We're going to do intensive care coordination with an OP acronym rather than an ICC acronym. They still have to do extensive care coordination. If they fail to do that, then they're in violation of the remedial order. And so, I'm wondering why you need to amend the judgment to address outpatient treatment when outpatient treatment is substantively doing what the remedial order requires the defendants to do and if they fail to do it, they're out of compliance with the order and who cares whether it's OP or ICC.

Rosie D. Tr. 50:4-16 (April 6, 2017).[17]

It adopted this view in a subsequent order, denying without prejudice the plaintiffs' Motion to Incorporate Provisions on Outpatient Therapy. *See* September 27, 2017 Order at 4 (Doc. 815). The evidence is undeniable that neither the service coordination responsibilities imposed by the defendants on outpatient therapists nor the referral to and provision of other remedial services needed by children and youth receiving Outpatient Therapy conforms to the requirements of the Judgment.[18]

Although the defendants expect Outpatient Therapy to provide all medically necessary service coordination activities for children and youth who are not otherwise receiving ICC or IHT, the evidence continues to demonstrate that it does not. *See* FY2017 Outpatient Report at 3,

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[16] *See, e.g., Rosie D*. Tr. 36:16-18 (April 6, 2017) "I'm very sensitive to the fact that care coordination is -- it is, and always has been, a key component to the system of care."

[17] *See also*, *Rosie D.* Tr. 9:8-13 (March 4, 2016) "If we're going to use outpatient as a coordination tool, to come up with something that is substantively, whether it gets a brand-new acronym or not, is substantively the sort of care coordination services that need to be delivered to ensure that the coordination, in fact, takes place."

[18] The defendants have persisted in arguing: 1) that their decision to utilize outpatient therapists as a provider of care coordination does not implicate the Judgment; and 2) that they are not required to take any steps to ensure youth who depend on outpatient therapists for access to remedial services are receiving the coordination they need. *See, e.g,* Ex.14 at 3; Doc. 786 at 3 ("Defendants decided – outside of the requirements of the Judgment – to use the IHT and outpatient hubs as a means to provide care coordination to MassHealth members").

As a result, it is not surprising that Defendants' Memorandum and Statement of Facts fails to mention outpatient therapy, or to offer any evidence demonstrating that adequate care coordination is available to youth and families who rely on outpatient providers to perform this function.

attached as Exhibit 14*; see also, e.g.,* Docs. 723 at 5-6; 695 at 6-8 (outpatient study finds few service coordination activities and few referrals to other remedial services). Rather, several reviews have shown reliance on outpatient therapists to deliver this key remedial service has meant less effective and even inadequate service coordination for thousands of class members with SED.[19]

Despite this long standing dispute, and in an effort to address the evidence of noncompliance with the Judgment, the parties agreed upon a series of reforms designed to enhance Outpatient Therapy so that it can provide improved care coordination for SED youth who rely upon this service for approving, authorizing, coordinating, and monitoring the provision of remedial services. Specific changes limited to outpatient billing categories and service authorization parameters have been implemented recently by the defendants, along with the dissemination of Outpatient Therapy practice guidelines and web-based training for therapists. *See, e.g*., Doc. 777 at 5.

Defendants agreed to measure the impact of these changes as part of the Joint Disengagement Measures (Doc. 776-1), and conducted outpatient chart reviews during calendar years 2017 and 2018. Done primarily by managed care staff, and using a tool developed by Defendants, the reviews were designed to measure "whether youth with SED who have outpatient therapy as their hub receive all medically necessary remedial services including care coordination," and whether the frequency and intensity of care coordination was sufficient to meet their needs. *See* Ex. 14.

[19] These reviews include various outpatient reports conducted over the past five years, the court filings that discuss them, as well as the Court Monitor's 2018 outpatient provider study, which validated a number of concerns regarding outpatient providers ability and preparedness to delivery adequate care coordination.

On February 9, 2018, Defendants shared a final version of the 2017 Outpatient Report, including aggregate findings on 73 members' chart reviews pulled from 19 provider agencies.[20] *Id.* at 5. Part I of the Outpatient Report analyzed reviewer scores on the adequacy of outpatient provider assessments and resulting treatment plans using a four point scale of agreement. Resulting scores ranged from a low of 2.95 to a high of 3.45. *Id*. at 8. Although the majority of outpatient charts contained evidence that clinicians understood the presenting problem, and gathered sufficient assessment data, only 32% of reviewers found that these preliminary steps led to a fully developed and articulated formulation, or analysis of the child's needs. This, in turn, affected the clarity and appropriateness of the treatment plan and the rationale for potential treatment interventions, with 57% of cases falling outside of the best practice range. *Id*. at 10. Finally, reviewers found deficiencies in provider oversight and modification of treatment plans as youth's needs changed. Only 34% of reviewers were in complete agreement with the statement: "As treatment has continued, the clinician has confirmed or altered the formulation through considering new information," resulting in an average score of 2.95. *Id*. at 11.

Part II of the Outpatient Report examined the adequacy of care coordination. It presented a single, aggregate score averaged across identified opportunities for coordination with entities like medical professionals, state agencies, crisis teams, and other remedial service providers. Overall, care coordination in outpatient treatment was found to be adequate 48% of the time, partially adequate 17% of the time, and inadequate 34% of the time. *Id.* at 14. Among those youth with insufficient care coordination, reviewers pointed most often to limited contacts with schools, remedial service providers (MCI, TM, and IHBS), and doctors and nurses. *Id*. at 34-35.

[20] An additional 41 member records were excluded from the final review because of disputed sampling criteria, duplication, incompleteness, or other errors.

Despite these findings, the Report offered no substantive recommendations, strategies or action steps designed to achieve the 10% baseline increase memorialized in the Joint Disengagement Measures, and no concrete plans to ensure care coordination for youth in outpatient therapy is delivered consistent with the standards set out in Judgment.

The Court's 2007 Judgment devoted an entire section to care coordination and service planning. *Rosie D. v. Patrick,* 497 F. Supp. 2d 76 (D. Mass. 2007), defining the role and responsibility of the care manager, the values and principles that will inform the treatment planning process, and the ways in which the care planning teams will develop and carry out individual service plans. Doc. 367-2 (¶¶19-29). The defendants cannot demonstrate substantial compliance with these sections of the Judgment when thousands of youth with SED rely on outpatient care coordination, when that coordination has repeatedly fallen short of required service standards and responsibilities set out by the Court, and when youth are denied access to medically necessary services as a result.

V. The Defendants Have Not Established a Durable Remedy.

A consistent history of compliance with the Court's Judgment and remedial requirements, coupled with a good faith commitment to sustain the systemic improvements that contributed to the history of compliance, can be evidence of a durable remedy. Despite a passing reference to this concept, *see* Defs.' Mem. at 33, the defendants have not presented evidence or a plan to demonstrate that they have a durable remedy in place. To the contrary, the failure to submit a sustainability plan, as required by Disengagement Measure 7, and the absence of any firm commitment to maintain the infrastructure, rules, screening, assessment, service delivery, training, technical assistance, evaluation, and data collection methods, including the medical necessity criteria, program specifications, practice guidelines, and data reports for each remedial

service, strongly suggests that the termination of judicial supervision may result in substantial modifications to the current children's mental health system.[21]

A. Waiting Lists for Remedial Services Persist.

In 2011, the plaintiffs filed their first motion challenging the failure of the defendants to provide ICC services promptly. *See* Plaintiffs' Memorandum in Support of Motion to Ensure Timely Access to Remedial Services at 12-18 (Doc. 508). Despite court-directed actions to expand reporting on waiting lists, and some resultant decrease in the length of these waiting lists for ICC services, the same deficiencies in timely access to ICC and then IHT became the new standards for disengagement, as reflected in the 2013 Disengagement Criteria and then the 2016 Disengagement Measures. *See* Plaintiffs' Reply to Defendants' Opposition to Approval of Joint Disengagement Measures at 2-5 (Doc. 783). It is noteworthy that the problem of timely access to ICC and IHT services, waiting lists, and noncompliance with various access requirements has persisted since the inception of the remedial services ordered by the Court, despite a series of motions, data requests, hearings, unkempt promises, and unfilled reforms. And they continue to this day. As the Court noted earlier this year, there is no evidence that defendants have a plan to remedy these deficiencies:

> I still lack confidence that there is a real plan that the defendants feel will be effective to tackle the access issue, and it is especially troubling in the area of in-home therapy, where so many of the community service agencies are basically at peak, and, nevertheless, hundreds of needy children are waiting for excessive periods of time to get access to their in-home therapy services, which sometimes can make a difference between a relatively stable situation and a catastrophe.

Rosie D. Tr. at 6:7-15 (April 26, 2018).

[21] In fact, the defendants have already hinted that they are considering modifying the 14-day access standard for EPSDT services.

B. There Continues To Be a Lack of Engagement with Other Entities that Serve Children with SED.

A key provision of the Judgment (¶12), and a central strategy for ensuring its ongoing sustainability, is the requirement that the defendants educate, coordinate, and enhance the capacity of the entities that serve children with SED – including all EOHHS agencies, schools, community health centers, hospitals, and community mental health providers – to access remedial services. EOHHS issued protocols for several EOHHS human service agencies concerning their role in the provision of home-based services. Defs' Mem. at 22; SMF at 8, ¶24. There has been no evaluation of the agencies' implementation of the protocols, no evidence of their participation in service planning or delivery, and no proof that state agency staff, school personnel, and other entities connect children with SED to remedial services. *Id.* Moreover, there is considerable evidence to the contrary in the monthly CSA reports, which demonstrate that there a few referrals to CSAs from the Departments of Mental Health, Developmental Disabilities, or Youth Services. *See* June 2018 CSA Report, attached as Exhibit 15. Efforts by the parties several years ago to analyze the cause and consequences of this lack of referrals proved fruitless. Most importantly, the lack of referrals from DMH and DYS suggests that one of the Judgment's core purposes – to enhance access to remedial services for children in the care of various state agencies – has been frustrated. The defendants fail to address these issues, and to prove that they are in compliance with ¶12 of the Judgment.

C. The Defendants' Failure to Develop a Sustainability Plan

At the Court's urging, the agreed-to Disengagement Measures included a provision requiring the development of a sustainability plan. Specifically, the defendants agreed to Disengagement Measure 7, which requires that:

(1) By December 31, 2018, the Defendants will submit to the Court a sustainability plan concerning access to and the quality of remedy services described in the Judgment. The

> Defendants will develop the plan in consultation with the Court Monitor and will provide the Plaintiffs with an opportunity to review the plan at least 60 days prior to submission to the Court.

The concept of a sustainability plan was developed by the Court. At various status conferences, it noted the Supreme Court's requirement of a durable remedy, pressed the defendants for evidence that such remedy existed, and strongly urged the parties to ensure that there would be a written plan, developed in conjunction with the Court Monitor, which described the actions that the defendants would continue to take to ensure that the benefits of the Judgment were continued after the Court terminated its active supervision of the case. Such a plan is particularly important given the recent, massive restructuring of the Commonwealth's Medicaid system. In March 2018, the Commonwealth eliminated the five former MCEs and replaced them with 13 new Accountable Care Partnership Plans; 3 new Primary Care Accountable Care Organizations (ACOs); 2 Managed Care Organizations (MCOs); and MassHealth's Primary Care Clinician (PCC).[22] This change affected approximately 1.2 million MassHealth managed-care members. *Id*. It is also essential to ensure that the gains of the past decade are not diluted over time, that the services and structures created as a result of the Judgment are maintained, and that the benefits to class members from the Judgment are not compromised.

No sustainability plan has ever been submitted, developed, drafted, or discussed by the parties. There is no evidence in the defendants' detailed filings that any plan is even envisioned. Thus, the key document which the Court requested, and that the defendants promised would demonstrate that its systemic improvements will be sustained and that a durable remedy has been created, is simply absent. Moreover, the scant reference to a durable remedy lists only a single

[22] *See* Office of Medicaid letter to Interested Parties on Continuity of Care through transition to new managed care arrangements (Feb. 21, 2018), available at https://www.mass.gov/files/documents/2018/04/04/ContinuityofCare-02-21-18.pdf. It is obviously too early to tell what effect this major system delivery and payment system will have on the defendants' implementation of the Judgment, its provision of remedial services, and, most importantly, the utilization of these services by class members.

activity: the allocation of a small portion of new federal funds that were made available to the Commonwealth for administrative improvements, which will be shared with CSAs for information technology and with IHT providers for training. The glaring absence of any maintenance of effort promises or commitments to maintain the screening, assessment, service delivery, and data requirements of the Judgment speaks volumes and should cause the Court to pause before accepting the defendants' global assertion that it will sustain the current system.

In many ways, the parties have arrived at precisely the point predicted by the Court in April of 2017 – the defendants have been unable to achieve the Joint Disengagement Measures, yet ask the Court to terminate its oversight of the litigation:

> It's just an agreement between the parties about disengagement criteria and we get a year down the road or year and a half down the road and the measures have not been -- have not been complied with. They haven't gotten up to fulfilling those measures and, yet, they want the Court to stop its oversight. Well, they're going to be in a pretty awkward position when you come in and say, You haven't complied with the Court's remedial order which already exists, because this agreement was intended -- and I don't think defendants can escape the implication that this agreement, whether it's a Court order or not, is intended to embody this final phase of compliance with the Court's original remedial order.

Rosie D. Tr. 19:16-24-20:1-5 (April 6, 2017).

VI. The Court Should Terminate Monitoring and Its Active Supervision Over Certain Provisions of the Judgment But Continue Monitoring and Supervision of Others.

Consistent with the Supreme Court's opinion in *Freeman,* and based upon a showing of substantial compliance with certain provisions of the Judgment, the Court should terminate monitoring and reporting, and relinquish active supervision over paragraphs 2-11, 36, and 39-45 of the Judgment.

Conversely, given the defendants' failure to comply with the provisions of the Judgment on assessments and CANS, service coordination and service planning, timely access to remedial services, provider capacity and network adequacy, the Court should continue monitoring,

reporting, and active supervision of all other sections of the Judgment, including ¶¶1, 12-31, 32-35, 37, 38, and 46-52.[23]

The five key deficiencies described in detail in Sections IV.A-E, *supra*, not only violate the Judgment but also implicate federal law.[24] The failure to provide necessary assessments, required by the "Diagnosis" component of EPSDT; the failure to provide ICC and IHT services consistent with CMS approved program specifications, Defs' Mem. at 24; SMF at 11, ¶¶36-37 and accepted standards of professional practice; the failure to provide timely access to remedial services, consistent with Medicaid's access standard and the timelines set forth for ICC and IHT in MassHealth's program specifications for each service; the failure to ensure an adequate array of providers and an efficient provider network; and the failure to ensure that outpatient therapists provide adequate service coordination all implicate, if not contravene, federal Medicaid requirements.

A. EPSDT

Congress enacted the Early and Periodic Screening, Diagnosis, and Treatment provisions (EPSDT) of the Medicaid Act, 42 U.S.C. §§ 1396a(43), 1396d(a)(4)(B), 1396(r), in order to ensure that children receive regular, preventive medical care so that conditions are detected "early" and treated promptly, before they become serious, debilitating, and/or chronic. Courts have held that Congress' intent would be thwarted, and the statute violated, unless services were

[23] In light of the well-publicized problem of children waiting in emergency rooms for days just to receive urgent mental health care, *see Rosie D.* Tr. 5:1-17 (January 18, 2018), it is difficult to conclude that the defendants have met their burden of demonstrating that their crisis intervention programs required by ¶32 are adequate. Moreover, as noted in ¶33 of the SMF, CMS declined to approve the Crisis Stabilization service. The defendants fail to explain that the reason for the federal government's decision was because the Commonwealth refused to omit prohibited activities and residential costs from its State Plan Amendment (SPA). In effect, the Commonwealth's service specifications for Crisis Stabilization that were submitted to CMS ensured a rejection of the SPA and doomed the program.

[24] The Court's liability decision found violations of both the EPSDT and the reasonable promptness provisions of the Medicaid Act. *Rosie D. v. Patrick,* 410 F. Supp. 2d. at 53. Its Judgment mandated that all remedial services must be provided promptly. *Rosie D. v. Patrick,* 497 F. Supp. 2d 76 (D. Mass. 2007). As noted above, promptly means consistent with state timeliness standards set forth in program specifications and the Commonwealth's own EPSDT access standard.

provided as soon as a need was detected and medically necessary services were identified. *Clark v. Richman*, 339 F. Supp. 2d 631, 640 (M.D. Pa. 2004) ("The Commonwealth's [Medical Assistance] program must also provide for the actual provision of EPSDT services *in a timely fashion*.") (emphasis added); *Memisovski v. Maram*, 2004 U.S. Dist. LEXIS 16772, at * 149-151 (N.D. Ill. 2004) (holding that state's failure to establish a health and well-being program that ensured provision of services to Medicaid-enrolled children on a timely basis violated the EPSDT requirements of the Medicaid Act). The EPSDT regulations make this mandate specific. 42 C.F.R. § 441.56(e) (1984) requires that the State Medicaid Agency "must set standards for the timely provision of EPSDT services, which meet reasonable standards for medical and dental practice...and must employ processes to ensure timely initiation of treatment…." See *also Clark v. Richman*, 339 F.Supp.2d 631, 647 (M.D. Pa. 2004) (upholding a claim for "failure to employ processes to assure the timely provision of EPSDT dental services in violation of the Medicaid Act and 42 C.F.R. 441.56(e), in particular").[25]

After extensive briefings, hearings, and delays, the Commonwealth established a 14-day standard for the provisions of remedial services. *See* Sec. IV.C *supra.* The Court has relied upon this federally-mandated standard, and the Commonwealth's commitment to implement it, for eight years. The Commonwealth's failure to meet this standard, as described in Section IV(C), *supra,* violates the EPSDT provisions of the Medicaid Act.

EPSDT also requires that each state provide or arrange for the provision of covered services. 42 C.F.R. § 441.61. States must have an adequate array of providers and a sufficient

[25] In fact, the program specifications for each remedial service usually provides a far shorter timeframe for the mandatory provision of that service. For instance, the program specifications for In-Home Therapy Services require that providers must respond telephonically to all referrals within one business day and offer a face-to-face meeting within 24 hours. The Medicaid Act mandates that States set reasonable standards. 42 U.S.C. § 1396a(17). Courts have applied the statutory standards provision to require that services comply with the state's timeliness provisions, as set forth in program specifications. *See Kirk T. v. Houston,* No. 99-3253, 2000 WL 830731 at *3-4 (E.D. Pa. 2000)

number of providers to ensure that medically necessary services are actually delivered, and delivered on a timely and adequate basis. Serious deficiencies or gaps in provider networks, or simply an insufficient supply of providers, violates the Medicaid Act. *O.B. v. Norwood,* 170 F. Supp. 3d 1186, 1192-93 (N.D. Ill. 2016; *Health Care for All v. Romney,* 2005 WL 1660677 *15 (D. Mass., July 14, 2005). The defendants' failure to ensure an adequate supply of providers to deliver remedial services when and where needed constitutes a violation of EPSDT.

Finally, as the Court determined in its initial liability decision, a failure to provide medically necessary services, include needed assessments, adequate home-based therapy, and essential service coordination – whether through a new program model like ICC or an old one like Outpatient Therapy – violates EPSDT. *Rosie D.,* 410 F. Supp. 2d at 32.

2. Reasonable Promptness

The Medicaid Act also mandates that requested medical assistance "shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930(a)-(b) (1996). Courts have interpreted this requirement strictly, applied it vigorously, s*ee Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998), and relied upon it to invalidate waiting lists for medically necessary services. *See Boulet v. Cellucci*, 107 F.Supp.2d 61, 79 (D. Mass. 2000) ("[T]he waiting list violates the 'reasonable promptness' requirement if settings are available for the services plaintiffs request"). In addition to contravening EPSDT mandates, persistent waiting lists for ICC, IHT, IHBS, and TM also violate the reasonable promptness provisions of the Medicaid Act.

VII. Future Procedural Steps

The Court's June 14, 2018 Scheduling Order (Doc. 844) directed the defendants to state their position on whether the Court "needs to take evidence and make specific factual findings in support of any ruling that they have not substantially complied with the court's remedial order…." Order at 3. If the defendants believed this was necessary, then the Court ordered the defendants to identify "precisely what factual issues need to be addressed and what witnesses or other evidence should be presented at any such hearing." *Id.* at 4. The defendants' Motion and Memorandum declined to do so, but reserved the right to respond to the Court's directives in any reply. Defs' Mot. at 2.

Since the defendants did not answer the questions posed by the Court, the plaintiffs obviously cannot respond to a non-existent position. Therefore, and reluctantly, the plaintiffs will need an opportunity to file a sur-reply on these questions, once the defendants respond to the Court's directives.

But from the framing of the issues thus far, and subject to a review of the defendants' reply, it appears that the Court can consider the documents, affidavits, and other evidence submitted by the parties and decide the defendants' Motion without an evidentiary hearing. This is particularly appropriate where the defendants' own data, in the form of CANS reports, current waiting list reports, CSA reports, provider capacity reports, and the MPR facially demonstrate that the defendants have not achieved substantial compliance with the Judgment. Moreover, a decision to approve the further orders submitted by the plaintiffs in conjunction with their recent Motion, Doc. 847, would plainly resolve the matter without the need for further litigation, since there is no dispute that the defendants are not in compliance with the Disengagement Measures, the Actions to Improve Access to Remedial Services, or the Provisions on Outpatient Therapy.

To the extent the Court identifies any important factual issues that are in dispute and that materially affect its decision, it can and should direct the Court Monitor to conduct a focused evaluation of those issues, and issue a report setting forth her professional opinions on compliance, as set forth in ¶48(a)(3) of the Judgment (Monitor's authority to independently evaluate compliance). Any such evaluation and report should be completed promptly and filed with the Court within sixty days.

VIII. Conclusion

For the reasons set forth above, the Court should terminate monitoring and active supervision over the notice, education, outreach, screening, referral, and information technology provisions of the Judgment, and specifically ¶¶ 2-11, 32, 36, 39-45, but continue monitoring and active supervision over all other provisions of the Judgment.

RESPECTFULLY SUBMITTED,
THE PLAINTIFFS,
BY THEIR ATTORNEYS,

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was filed electronically through the Electronic Case Filing (ECF) system to all counsel of record.

Dated: September 10, 2018 /s/ Steven J. Schwartz