UNITED STATES DISTRICT COURT DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

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

DEFENDANTS' REPLY TO PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION REGARDING SUBSTANTIAL COMPLIANCE

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INTRODUCTION

In Defendants' Motion to Terminate Monitoring and Court Supervision (the "Motion," Docket No. 848), the Defendants reiterated every affirmative command imposed by the July 16, 2007 judgment and remedial order (the "Judgment") and enumerated , in detail, the numerous actions Defendants have taken, since 2007, to comply with each directive. The Motion was supported by a Statement of Material Facts, attested to by an affidavit from Laura Conrad, the Defendants' acting compliance coordinator.

In stark contrast, the Plaintiffs' Opposition (the "Opposition," Docket No. 857) does not put forth evidence (or, for the most part, even argue) that the Defendants have failed to do any of the things the Judgment ordered them to do. Instead, the Plaintiffs, without attribution to any language in the Judgment itself, suggest that the remedy services are "inadequate" or "insufficient." Plaintiffs reassert that Defendants' compliance should be determined against the Disengagement Measures, not the Judgment. But this argument fails as a matter of law, as explained in the Defendants' opening brief.

The Plaintiffs also imply that the Defendants are committing some new, and unlitigated, violation of the Medicaid Act. That they proffer scant evidence of any of these alleged shortcomings is beside the point.[1] The question for this Court is only whether Defendants have complied with the Judgment. If Medicaid members have new claims that were not litigated in the trial of this case, those must be tried and adjudicated in a new action.

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[1] For example, the Plaintiffs again submit an affidavit from Lisa Lambert in an effort to support several assertions in their Opposition. (*See* Pl. Opp., Exh. 4, Lambert Supp. Aff. *See also* Pl. Opp., pgs 11, 18-19, 23-24. Exh. 4). However, as with the previously filed Lambert Affidavit, the statements in the Lambert Supplemental Affidavit are lacking admissible evidence of the matters Plaintiffs seek to prove, contain multi-level hearsay, and lack specificity. (*Id.*).

As Defendants have explained in their previous filings, the 2007 Judgment reflects the Court's determination of the sum total of as to what the Defendants must do to address the violations of federal law found after trial in this matter. *See* Judgment at 1 ("This Judgment and the remedies ordered herein address the findings and rulings contained in the Court's [Jan. 26, 2006, Mem.] of Decision"); *Bd. of Ed. of OK. City Pub. Sch. v. Dowell*, 498 U.S. 237, 249-260 (1991) (if school district has complied with obligations under desegregation decree, it has cured the adjudicated constitutional violations, and decree should be dismissed). Where, as here, the commands of the Judgment have been satisfied, judicial oversight must end. *Horne v. Flores*, 557 U.S. 433, 450 (2009) ("responsibility for discharging the State's obligations [is] returned promptly to the State and its officials when the circumstances warrant").

The Defendants have already set forth, at length, why the Disengagement Measures are not implicitly "already a part" of the Judgment, and why they should not be added to the Judgment at this late date. *See* Defs.' Opp at 5-12. Therefore, the Disengagement Measures do not and cannot provide a means of evaluating compliance with the Judgment.

Mindful of the page constraints governing this Reply and the volume of briefings already pending before the Court on the present Motion, Defendants have limited the scope of this Reply to the primary arguments raised by the Plaintiffs in their Opposition.

I. Plaintiffs' Arguments Regarding Administration of CANS Do Not Support a Finding that Defendants Have Not Substantially Complied with the Judgment.

The Plaintiffs argue that the Defendants have not substantially complied with the assessment requirements generally, or with the Judgment as a whole, based on a subpart of Paragraph 16 of the Judgment, which requires that the Child and Adolescent Needs and Strengths tool (the "CANS") be used as part of inpatient and community based acute treatment ("CBAT") discharge planning, where appropriate. *See* Judgment, ¶ 16(e). Plaintiffs' argument

misses the mark.

As an initial matter, the assessment requirements of the Judgment are broader than the use of the CANS and certainly broader than the use of CANS for inpatient and CBAT discharge planning. *See* Judgment ¶¶ 13-16, 37. For example, the Judgment requires that the Defendants ensure that appropriately trained clinicians and professionals conduct assessments, typically commencing upon intake to treatment, leading to clinical diagnoses and treatment planning. *See id*.at ¶¶ 14, 16(a)-(c). Further, Paragraph 37 sets forth the specific CANS implementation tasks, requiring Defendants to: develop a Massachusetts-specific CANS tool, train providers to complete and use the CANS tool, and amend their regulations and contracts to conform with the new requirements. *Id.* at ¶ 37(b). The Plaintiffs present no argument that the Defendants failed to carry out any of these broad assessment requirements or specific CANS requirements and, indeed, Defendants have fulfilled all of those obligations. *See* Defendants' Statement of Material Facts at ¶¶ 26-30.[2]

Rather than acknowledge Defendants' compliance with the assessment requirements of the Judgment, Plaintiffs focus on data related to the administration of CANS during inpatient and CBAT discharge planning processes. But these data must be understood in context. As Defendants have previously shown, in state fiscal year 2017, only 20% of children and youth who received remedy services required inpatient or CBAT admission at any time during the year. *See* SMF ¶¶ 71. More broadly, only 0.5% of MassHealth members under the age of 21 had a behavioral-health related inpatient admission that year, while only 0.4% were admitted to

[2] The technological issues related to CANS reporting mentioned by the Plaintiffs were partially resolved in June 2018, and are anticipated to be fully resolved on October 21, 2018. *See* Conrad Aff. ¶ 8.

a CBAT facility. *See* Affidavit of Laura Conrad, attached as Exhibit A. Of this narrow percentage of members, (generalizing from the three months of data Plaintiffs have presented), approximately 50% of these members *are* having CANS administered as part of their discharge planning. *See* Pls' Opp. at Ex. 2. Plaintiffs' narrow focus – on the use of a particular assessment *tool*, in a single, limited clinical context – fails to address the Defendants' substantial compliance with the Judgment's assessment requirements in total.[3]

II. Arguments Relating to the Performance of the ICC and IHT Service Delivery System Do Not Show that Defendants Have Not Substantially Complied with the Judgment.

As the Defendants have explained, full attainment of the Disengagement Measures is not the measure of compliance with the Judgment, and any allegation of new, untried violations of the Medicaid Act cannot be used to evaluate compliance with the 2007 Judgment. While these contentions by Plaintiffs are misplaced, Defendants will briefly respond to the Plaintiffs' primary arguments below.[4]

A. Access to ICC and IHT.

The Plaintiffs suggest that the Defendants are not in substantial compliance with the Judgment because there are active waitlists for both ICC and IHT services. Pl. Opp. at 18-28.

[3] The data presented by the Plaintiffs also support the fact that the vast majority of members engaged with Intensive Care Coordination ("ICC") and In-Home Therapy ("IHT") services (three-quarters or more) are receiving assessments inclusive of the CANS. *See* Pl. Opp. at Ex. 2.

[4] Notwithstanding some references to the duration of MCI encounters, the Plaintiffs have made no argument that Defendants have failed to comply with the Judgment with respect to any remedy services other than ICC and IHT. Further, Plaintiffs themselves assert that the Court should terminate monitoring and active supervision of the MCI service, under Paragraph 32 of the Judgment. (*See* Pl. Opp. at 41).

As a starting point, the Judgment – written in 2007, before the remedy services were created – is entirely silent as to temporal requirements for the delivery of remedy services. The Medicaid Act itself provides only that eligible individuals must receive services with "reasonable promptness," *see* 42 U.S.C. § 1396a(a)(8), and federal regulations require state Medicaid agencies to set "reasonable standards" for timely delivery of services, upon consultation with relevant medical experts, generally not to exceed six months. 42 C.F.R. § 441.56(e). Courts construe that requirement as barring "delay caused by *the agency's* administrative procedures," including "mismanagement of allocated funding." *Guggenberger v. Minn.*, 198 F.Supp.3d 973, 1012 (D. Minn. 2016) (internal quotation omitted) (emphasis added). *See also, Boulet v. Cellucci*, 107 F.Supp.2d 61, 80 (D. Mass. 2000) (defendants held to violate reasonable promptness requirement, but only to the extent that the state itself maintained multi-year waitlists when available placements existed). Notably, the Plaintiffs do not claim that the Defendants have erected any systemic or administrative barriers to the receipt of ICC or IHT services or even that the Defendants have failed to promptly allocate *available* ICC or IHT capacity. On the contrary, the Plaintiffs acknowledge that ICC and IHT providers are operating at full or near-full capacity across the state. Their argument is focused entirely on their assertion that Defendants must alleviate clinician shortages, and thereby increase system capacity, and that Defendants' efforts to date have failed to cure these shortages in the labor market. These allegations, even if true and even if properly before the Court, do not rise to the level of a reasonable promptness violation and cannot be a measure of determining Defendants' compliance with the Judgment.

Moreover, Plaintiffs use the wrong data purportedly to support their argument that Defendants are not in compliance with the Judgment. The Plaintiffs focus solely on children *waiting* for services and how long they have been waiting. Should the Court wish to rely on

data to evaluate compliance in this area, the more relevant inquiry is: of all children who need and want ICC or IHT, how many are *actively engaged in treatment*. These numbers tell a vastly different story. For example, at the end of March 2018, of the 8,777 children requiring (and desiring) IHT, 87% (7,641) were receiving the service, while only 13% were waiting for services to begin. Similarly, of the 3,582 children requiring (and desiring) ICC at the end of March 2018, approximately 93% (3,343) were actively engaged in treatment.[5] *See* Affidavit of Laura Conrad, attached as Exhibit A, at paras. 4, 5.[6]

Thus, the Defendants have not erected any administrative barrier to the prompt delivery of ICC and IHT services, and therefore have not violated "reasonable promptness" provisions of the Medicaid Act. And, significantly, the overwhelming majority of children who want and need the services are, at any given moment, already receiving them.[7]

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[5] The actual number of children waiting for IHT may actually be lower than these figures suggest because children could be counted twice because they are listed on multiple providers' wait lists or could have already begun treatment with one provider but remain on the waitlist of another. The wait list data also include children waiting by choice for a specific provider, and children waiting for *any* duration, including for fewer than 14 days.

[6] These numbers are indicative of the range seen over the past nine months (November 2017 – July 2018). Within that timeframe, the percentage of members actively engaged in IHT has ranged from approximately 85 to 90% each month. Similarly, the percentage of members engaged in ICC ranged from 92 to 96% each month. *See* Conrad Aff. at ¶¶ 4, 5.

[7] As stewards of the program, the Defendants take the existence of any waitlists seriously, but believe the current waitlists to be indicative of capacity issues in the private labor workforce. Nevertheless, the Defendants are taking many active steps geared toward enhancing the capabilities and longevity of the current workforce and feeding the pipeline for new providers, including proposing a new payment methodology to help ICC providers retain clinicians, and working with graduate schools to help improve the training and recruitment of newly-graduated clinicians. While Defendants remain hopeful that these efforts will have long-term impacts on reducing wait times for members, eradication of wait lists is not a standard by which the Court can or should measure compliance with the Judgment.

B. Quality Reviews.

The Plaintiffs would also have this Court assess Defendants' compliance with the Judgment based on the arbitrary numeric targets on the Massachusetts Practice Review ("MPR") set forth in the Disengagement Measures. The Plaintiffs argue that the MPR is the appropriate vehicle for measuring system-wide quality for ICC and IHT, and that the level of quality reflected by the MPR is "inadequate." Once again, the Plaintiffs' argument is inapposite. The Disengagement Measures are not the measure for compliance with the Judgment and the Judgment does not require Defendants to conduct system-wide assessments of the quality of ICC or IHT services or to establish that the service delivery system for ICC and IHT is performing to any particular level on that theoretical measurement.

Even if system-wide quality assessment were an obligation under the Judgment – which it is not – the Plaintiffs have not shown that the MPR clinical case review tool itself is an appropriate way to measure it.[8] The MPR is an in-depth clinical case review process, not a tool to measure system-wide performance. (*See* SMF ¶77).[9] The Judgment itself recognizes that MPR-type clinical case reviews are only "appropriate in very limited circumstances and [are] time-intensive and costly." Judgment, ¶ 43. The MPR is used, as the Judgment contemplates,

[8] For example, Plaintiffs fail to support their assertion that MPR findings are "generalizable to all class members." *See* Pl. Opp. at 13. The MPR sample size equates to approximately .8% of IHT cases and .4% of ICC cases each year. *See* Conrad Aff. at ¶¶ 9-10. Additionally, as the Court and parties have seen in the past two years alone, MPR scores can vary based on the small sampling selected for a given review cycle.

[9] The Defendants have implemented, and continue to administer, a number of quality review tools. These tools include the Wraparound Fidelity Inventory ("WFI") and the Team Observation Measure ("TOM"). Contrary to Plaintiffs' incorrect assertions, the WFI and TOM continue to be used and have not been "suspended." *See* Pl. Opp. at 6. *See also* Wraparound Fidelity Summaries, available online: https://www.mass.gov/service-details/cbhi-data-reports (accessed September 13, 2018).

for the limited purpose of identifying areas for targeted and general provider improvement efforts. (*See* Judgment, ¶ 43. *See also* Pl. Opp., Ex. 6).

Even if the MPR were the appropriate tool to perform a system-wide quality assessment, Plaintiffs have also failed to explain how the targets in the Disengagement Measures, if achieved, would amount to substantial compliance with the Judgment.[10] Plaintiffs cannot rest on the MPR's results to "prove" that Defendants have not substantially complied with the Judgment.

III. There are No Requirements in the Judgment Concerning Service Coordination When Provided by Outpatient Therapists.

Plaintiffs also argue that the Judgment contains (or, alternatively, *should* contain) requirements governing care coordination provided outside of ICC. Asserting, once again without reference to a provision of the Judgment, that care coordination delivered outside of ICC is within the ambit of the Judgment, Plaintiffs argue that care coordination delivered by outpatient therapists is not sufficiently robust, and that therefore Defendants are not in compliance with the Judgment. The assumption underlying Plaintiffs' argument is incorrect.

The Judgment directs that: "[t]he Defendants will provide Intensive Care Coordination to children who choose to receive Intensive Care Coordination, including a Care Manager, who facilitates an individualized, child-centered, family-focused care planning team . . ." *Id.* at ¶19. This section of the Judgment obligated the Defendants to create the ICC service and to meet all the specifications for that service enumerated by the Judgment. It did not require the

[10] Contrary to the assertions in Plaintiffs' Opposition, a score on the MPR of "Fair" does not connote substandard care, lack of treatment, or even member dissatisfaction with the services. As Defendants have previously explained to the Court, "Fair" ICC and IHT services are helping children and families, even as MassHealth strives to further improve them. (*See* Docket No. 749, Interim Report on Implementation, September 13, 2016, at 9).

Defendants to offer care coordination in any other context. Any argument that care coordination provided by outpatient therapists somehow fails to comply with the Judgment is a non-starter, as the Judgment imposes no obligations in this area at all.[11]

IV. A Sustainability Plan is Not Required by the Judgment, and, in Any Event, Defendants Have Established a Durable Remedy.

Relying, once again, on the Disengagement Measures, the Plaintiffs contend that the Defendants have not demonstrated that the steps they have taken to comply with the Judgment constitute a "sustainable" remedy to the Medicaid Act violations found by the Court. The Defendants are, of course, committed to a high-quality, sustainable delivery of services to children with SEDs. But the Judgment imposes no obligation to produce a "sustainability plan" or meet any other particularized requirement regarding sustainability. Nevertheless, the Defendants *have* implemented a durable remedy, and take great exception to the Plaintiffs' suggestion that the remedy has been implemented with anything other than a good-faith commitment to creating a robust and sustainable system of remedy services.

The Defendants' Statement of Material Facts, together with their numerous periodic status reports, have apprised the Court over these past eleven years of the countless tasks they have undertaken – not only to comply with the Judgment itself, but also to improve the quality and durability of the resulting system of care separate and apart from any obligations imposed by the Judgment. Marylou Sudders, the Secretary of the Commonwealth's Executive Office of Health and Human Services, submitted an affidavit attesting to the Commonwealth's commitment to ensuring that the legacy of *Rosie D.* endures. Sudders Aff. ¶ 16. Furthermore,

[11] To the extent that the Plaintiffs have asked the Court to modify the Judgment, retroactively to *add* new requirements relating to outpatient therapists' delivery of care coordination services, the Defendants continue to oppose that request, for the reasons set forth in their opposition to the Plaintiff's Motion to Modify the Judgment. *See* Docket No. 858.

behavioral-health advocates have called the Commonwealth's system a "point of pride" and referred to it as a "successful" model. *Id.* ¶¶ 14-15, Exs. 1-2. Indeed, these same advocates are now supporting efforts by the Division of Insurance to clarify that *private* insurers are required to make similar home- and community-based services available to their policyholders. *See* Docket No. 856, generally. Clearly, the remedy services have become a model to be emulated.

Plaintiffs are wrong to suggest that the remedy will disappear without the presence of active court monitoring. The end of monitoring is specifically contemplated by the Judgment, and it is a requirement of federal law once the Defendants have demonstrated with the Court's decree. To suggest otherwise not only casts unwarranted aspersions on the Commonwealth's demonstrated commitment to the remedy but undermines the authority of this Court's permanent injunction. Nothing in this record suggests, let alone demonstrates, that concern over the durability of the remedy is warranted.

V. Other Issues.

As a final matter, the Plaintiffs are wrong to suggest that, as a next step, the Court should direct the Court Monitor to file a report evaluating various aspects of the Defendants' compliance with the Judgment. The Defendants have demonstrated that they have substantially carried out each of the Judgment's commands, and there are no material factual disputes to be adjudicated. The Plaintiffs, nonetheless, assert that compliance should be measured, not with respect to the Judgment, but with respect to other, external measures. This position is without merit and, at most, raises a question of law for the Court to decide; it does not require a report from the Court Monitor.

CONCLUSION

For these reasons, and for the reasons set forth in the Defendants' Memorandum in support of their Motion, the Court should find that the Defendants have substantially complied

with the 2007 Judgment, and should accordingly terminate active judicial oversight in this case, including all monitoring and reporting requirements.

Respectfully submitted,

MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

By its attorney,

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Date: September 24, 2018

CERTIFICATE OF SERVICE

I, Daniel J. Hammond, Assistant Attorney General, hereby certify that the foregoing document, which was filed through the ECF system, will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on September 24, 2018.

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