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

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

**PLAINTIFFS' TWENTY-SEVENTH STATUS REPORT**

## I. Introduction

On March 9, 2015, the parties met with the Court to review the status of disengagement activities set forth in the Joint Disengagement Summary filed on June 21, 2013(Doc. 623-2), and further described in defendants' Interim Report on Implementation, dated September 26, 2014 (Doc. 664). At the Court's request, and in response to persistent delays in the completion of those activities, defendants also presented a table which detailed outstanding items in several substantive disengagement areas (Completion Dates for Parties' Activities, Feb. 20, 2015, Doc. 681-1). These items included: (1) rates of community-based mobile crisis intervention; (2) outpatient as a hub service; (3) access to ICC; (4) CANS outcome data; (5) practice guidelines; and (6) behavior health screening. This table described agreed-to actions, meetings and proposed timeframes in which further discussions between the parties would occur.

Over the past two months, the parties (with the assistance of the Court Monitor) have made substantial progress towards the completion of several of the actions identified

in the table of activities, exchanging reports and data and discussing potential responses to the information presented. In certain areas, such as CANS outcome data, the parties have agreed upon a process for collecting and reporting class member outcomes, as well as a timeframe in which the results of that data collection and analysis will become available. In other areas, where further remedial actions are needed, such as those proposed in response to the 2014 SOCPR, additional time will be required to implement and evaluate the preliminary impact of those actions on identified systemic deficiencies.[1] Finally, to the extent the parties disagree about the data collected, or the nature and scope of required remedial actions, as may be the case with outpatient services and the role of outpatient therapists as care coordinators, judicial involvement could be required to reach a final resolution.

In all of these instances, the Court Monitor's expertise, knowledge and facilitation skills remain critical to the disengagement process. In fact, her unique role in evaluating compliance and her responsibility to make further recommendations to the Court, make her indispensable as the parties, and the Court, seek to measure the impact of disengagement efforts in the context of compliance with the Judgment.

## II. Status of Disengagement Activities

In light of defendants' most recent Interim Report on Implementation (Doc. 694, hereafter, defendants' Interim Report) and its update on various tasks undertaken by the

[1] In discussing the need for continued monitoring by Ms. Snyder at the March 9, 2015 hearing, the Court observed: "[P]art of me also has in mind that there is a third variant ... which is we get to the point where both sides acknowledge that the data is not showing what they hoped it would show, and both sides acknowledge what the appropriate approach should be to deal with that disappointing news, and both sides acknowledge that it's going to take a certain amount of time to do that. That could happen, and I would want to leave room for that." (*Rosie D.* transcript, March 9, 2015, 15:13-22).

parties, plaintiffs focus the remainder of this status report on areas of particular concern or disagreement in the ongoing disengagement process.

**A. The Client Review Process**

In response to defendants' plans to cancel the FY 2015 client review and to devote those resources to other quality improvement initiatives (Defs.' Report on Implementation, Dec. 12, 2014, Doc. 673 at 11), the Court directed the parties to file supplemental reports on this key component of overall compliance monitoring – the System of Care Practice Review (SOCPR). Defendants filed their supplemental report on January 5, 2015 (Doc. 678), followed by plaintiffs' submission on January 20, 2015 (Doc. 680).

In response to these filings, and in the context of the March 9, 2015 status conference, the Court made clear the importance it attaches to the client review process as a method for evaluating the remedial service system – both generally and in the context of specific disengagement items concerning the quality of ICC and IHT services. It emphasized the need for advanced notice and communication regarding any proposed changes to this compliance measure.[2] At this time, plaintiffs understand that the defendants will provide them and the Court with notice of any future proposed changes to the client review process, and that this notice will afford sufficient time to comment on proposed changes, and to have any outstanding objections heard by the Court prior to their implementation.

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[2] "...[I]n my opinion, the decision to transfer the resources in such a way that it was not possible to continue with the SOCPR process for 2015 was a decision that reached that level of magnitude where I hope in the future it will be conveyed to me and to the plaintiffs so they'll have an opportunity to have input, and the monitor, before the decision is made." *Rosie D.* Transcript March 9, 2015, 18:21-19:3.

The defendants now plan to initiate the new Massachusetts Practice Review (MPR) in October 2015, but will not complete the statewide review and reporting process until early fall, 2016. The plaintiffs expect this review to reveal the status of implementation with respect to several of the key elements of the Judgment. Therefore, the plaintiffs believe that, given the central role of the MPR and the defendants' proposed schedule, it is not possible to fully assess compliance before the end of 2016.

### B. Ensuring youth in ICC and IHT receive all medically necessary remedial services, including adequate care coordination

Over the last two months, the parties have met to discuss the results and recommendations of the 2014 SOCPR in greater detail. Plaintiffs noted deficiencies in a number of areas including clinical assessments, service planning, use of hub-dependent services and transition planning.[3] Of particular concern were findings that ICC had not been discussed with 54% of families relying on IHT as their hub service, even though 43% of families met the criteria for ICC referral (needing or receiving multiple service providers and needing a care planning team). These findings take on even greater significance given that many of the deficiencies noted above were twice as likely to occur in cases where IHT served as the hub service.[4]

In response to these concerns and the recommendations of the statewide SOCPR report, defendants plan to implement the following activities: training initiatives intended

[3] Statewide, SOCPR reviewers concluded that 30% of youth and families in IHT were not receiving the level of care coordination their situations warranted.

[4] For instance, of those cases where the impact score fell below a 5.0 in the rating scale, 11 were ICC cases and 22 were youth with IHT as their hub service. The Impact domain considers whether youth are improving in response to services and whether those services are appropriate for their needs. Under the SOCPR protocol, Massachusetts considers scores of 5.0-5.9 as needing improvement.

to address concerns around the quality of IHT care coordination and service planning; piloting of a risk assessment tool or "trigger list"; and a stakeholder process for addressing deficiencies in the youths' clinical assessments. Rather than attempt to agree on the nature, scope or adequacy of these proposed responses, the plaintiffs have decided to await the results of the 2016 Massachusetts Practice Review to determine their impact and effectiveness.

### C. Massachusetts Practice Review

Since the last status conference, the parties have discussed specific changes to the client review process made as a result of the new MPR protocol. These changes include a new rating scale, the re-organization and revision of certain SOCPR questions, and a new methodology for conducting statewide reviews involving three large geographic cohorts instead of five regionally-based sample groups.[5] Plaintiffs were assured that the new MPR would continue to include the series of questions created by the parties to measure the adequacy of care coordination for youth in with IHT as their hub service. Plaintiffs also received assurances that the MPR reports would include aggregate scores at both the area and sub-item level. Although the new rating scale will not allow for a direct comparison to prior client review results,[6] this continuity in the presentation of data

[5] Defendants still plan to issue public reports approximately three months after these regional reviews are completed. As a result, the first of three MPR reports is expected in early 2016. A final statewide report will follow sometime in the fall of 2016.

[6] The inability to use 2014 SOCPR scores as a baseline to measure improvements between the 2013-2014 service year and the 2015-2016 service year, as well as the inability to compare regional differences in service access and quality, make it even more important that the Monitor is available to lend her experience and expertise with the client review process to the parties' evaluation of FY16 MPR results.

will make it possible to examine what specific aspects of assessment or service planning may need improvement, as well as how these specific areas add up to the aggregate domain score of "Child-Centered & Family Focused Care."

**D. Adequate Care Coordination for Youth in Outpatient Therapy**

Plaintiffs' concerns with the quality of care coordination and access to medically necessary remedial services for youth with outpatient hubs are described in past filings and have been a regular topic in proceedings before this Court. (*See, e.g.*, Plfs' 25th Status Report, Oct. 6, 2014, Doc. 665 and Plfs' 21st Status Report, Sept. 18, 2013, Doc. 633). In accordance with the Joint Disengagement Summary, outpatient hubs were the subject of a special study released in September of 2013. This study was subsequently re-designed, and a new report was delivered in early 2015.

The initial outpatient study examined a sample of Medicaid-eligible youth with outpatient hubs and one or more remedial services. Despite this unintended methodological error, the initial report provided some valuable information regarding the adequacy of care coordination for youth with outpatient services, as well as the extent to which youth and families were adequately informed about alternative services, including ICC.[7]

Both the initial study and the second, re-designed report were intended to examine the extent to which SED youth with outpatient hubs receive sufficient care coordination and access to medically necessary remedial services. Although the methodology for the second report was the subject of extended discussions between the parties, neither of the study's two cohorts focus on youth with serious emotional disturbance. Rather, the

[7] For instance, this initial report concluded that 58% of the cases sampled did not demonstrate an appropriate level of overall care coordination.

second outpatient report, discussed in the defendants' Interim Report, examines a group of youth under 21 with uninterrupted MassHealth eligibility and eight or more outpatient visits (uninterrupted by ICC or IHT claims) between 12/1/2012 and 11/30/2013. Because of the nature of this data set, and the potential for inclusion of youth with very minimal mental health needs, plaintiffs disagree with defendants' overarching conclusion that "...youth are appropriately stratified within the behavioral health continuum." (Doc. 694 at 5).

Plaintiffs also dispute the conclusion that limited utilization of hospital and CBAT levels of care among the outpatient sample group means these youth do not need, or would not benefit from, home-based services like IHT or ICC. Eligibility for remedial services, including the most intensive service (ICC), has never depended on a youth's risk of out-of-home placement.

Given the very broad study cohort, and the resultant disputes about its core findings, a number of related observations are also questionable, including the adequacy of collateral contacts by outpatient therapists, communications with CBHI service providers, and referrals for remedial services. For instance, Defendants' Interim Report relates that 68% of therapists in the sample group billed for a collateral contact during the study year.[8] However, plaintiffs are more interested in the adequacy, rather than the mere number, of contacts between outpatient hubs and other service providers/schools/state agencies. Very low levels of collateral contact reported for youth in the study group (12% of members receiving less than 30 minutes/year), and modest rates of case

[8] A collateral contact is defined in the outpatient report as "a face-to-face or telephonic exchange lasting at least 15 minutes between the outpatient behavioral health provider of a member under 21 years of age and an individual or agency representative for the purpose of coordinating and supporting the treatment plan for that member's care."

consultation (42% of members receiving approximately 3 hours/year), strongly suggest a need to improve the amount, nature and quality of communication expected from an outpatient hub when SED youth have (or need) multiple providers/clinicians/state agencies/or hub dependent services, and to ensure that outpatient providers are regularly evaluating a youth and family's need for more intensive care coordination.

In addition, the parties continue to disagree about the extent to which youth with outpatient hubs are accessing medically necessary remedial services. A significant number of therapists in the sample, and an even greater number of family members, expressed a belief that remedial services would be helpful for their children, yet these referrals were not made and services were not provided.[9] And despite the therapists' professed knowledge of the remedial service system, the report concludes that caregivers are "under-informed" about CBHI services, with only 36% of sample participants reporting familiarity with ICC.[10]

Despite these significant disagreements regarding the scope and severity of the problem, the parties have identified several remedial actions which may help to address the needs of class members with outpatient hub providers. However, the substance and proposed implementation of these efforts remain under discussion. For example, and as noted in defendants' Interim Report, the parties continue to discuss the purpose and

[9] Within the 50-person sample group, therapists thought that remedial services would have been helpful for (but were not received by) the following number of youth and families: IHT (14), ICC (5), TM (11), IHBS (9) and FS&T (8).

[10] Significantly, only 52% of caregivers in the sample reported having a discussion with their therapists about the type of assistance or support the therapists could provide, such that they could compare this level of care coordination with what may be available under IHT or ICC. More caregivers and therapists agreed that there had been communication about the therapist's role in helping to access services, but still nearly one quarter (22%) of caregivers indicated that they were not informed or were unsure about being informed with regard to the outpatient provider's role in access services for the youth.

content of the outpatient practice guidelines. In order to satisfy agreed upon disengagement criteria and be reasonably calculated to meet the needs of youth with outpatient hubs, these guidelines must accomplish at least two objectives. First, the guidelines should, at a minimum, address the full range of deficiencies identified in the outpatient report. Second, they should describe in reasonable detail the relevant, professional standards expected from outpatient providers, given the significant role they play in providing access to, and coordinating the delivery of, remedial services.

In keeping with these goals, plaintiffs have suggested a much greater emphasis on best practices for outpatient therapists working in the remedial service system, including the ways in which therapists should: (1) assess youth and families coordination needs; (2) provide meaningful information about the benefits of remedial services; (3) facilitate access to home-based services; and (4) effectively coordinate with other service providers, as either the hub or a member of the Care Planning Team. The parties have agreed to continue refining the outpatient guidelines in light of these comments, and to solicit additional input from provider organizations familiar with the delivery of outpatient service in the context of CBHI.[11]

The parties have not reached agreement on the need to adopt a more directive approach to ICC referrals. Despite numerous outreach and training efforts since 2009, and the repeated dissemination of Provider Alerts and "Tip Sheets," families and youth in outpatient remain poorly informed about remedial services, including options for more intensive care coordination. While supporting the Commonwealth's efforts to improve

[11] Therapists' expressed lower levels of satisfaction with the communication between themselves and other hub providers, while also giving comparably low scores for the sufficiency and helpfulness of communications with FS&T and mobile crisis. These responses suggest that best practices for effective communication with CBHI service providers should be addressed in more detail within the outpatient practice guidelines.

provider performance in this area, plaintiffs believe that a number of additional steps are necessary to ensure: (1) that families are adequately informed about their options, including why and how home-based services can help their children; and (2) that families are connected with medically necessary services. For this reason, plaintiffs continue to believe that the defendants should direct providers to refer families who meet medical necessity criteria to ICC, absent their refusal. This approach allows families to use the ICC intake process and their interaction with the potential provider to make a fully informed decision about the benefits of the wraparound team process. The youth or guardian always retains the option to decline the service, following the intake meeting.

**E. Access to Intensive Care Coordination**

Many of the disengagement actions described above have, at their core, the goal of ensuring that youth with outpatient and IHT hubs receive medically necessary remedial services, including wraparound care coordination. If these actions are to have the desired impact, and the home-based service system is to function as intended in the Court's Opinion and Remedial Order, there must be capacity to deliver ICC to all youth who need it, and to do so with reasonable promptness. Plaintiffs have identified a number of persistent, systemic concerns which suggest further action is needed to ensure access to this core remedial service, including low levels of enrollment among CSA providers and steadily increasing waiting lists.[12] Over the last quarter, and as compared to year-to-date figures, the numbers of youth waiting for their first ICC appointments have increased exponentially, and as the time they wait grows longer, fewer and fewer

[12] In February 2015, seven of 32 CSA's supported less than 74 youth. Nine of 32 CSA's served fewer than 100 youth and families.

youth are starting service each month.[13] While workforce limitations and external hiring pressures may impact this problem, there must be a more concerted systemic solution in place in the event other disengagement efforts are successful and the number of ICC referrals begins to rise.

## III. Conclusion

In the past two months, significant progress has been made in several areas of the Joint Disengagement Summary. However, more work remains if the parties are to reach consensus on the full range of proposed remedial actions. Even where agreement is reached, the Court Monitor will need to assist the parties and the Court in assessing the preliminary impact of these actions, while also interpreting results from the upcoming DMH access study, the 2015 CANS outcome report, and findings from the revised 2016 Massachusetts Practice Review. For these reasons, and given the need for further assessment of, and recommendations regarding, the Commonwealth's compliance in these areas, plaintiffs ask that the Court take up the issue of ongoing monitoring well before its order expires in December of 2015.

RESPECTFULLY SUBMITTED,
THE PLAINTIFFS,
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[13] As of the March 8, 2015 follow-up report, 189 youth were waiting for ICC. The number of youth waiting in February 2015 was up 22% over the year to date figure of 4%. Almost 30% fewer youth started in service during the month of February (33% as compared to 60% YTD) and 33% of youth were waiting beyond the 14-day Medicaid standard.

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Dated: May 8, 2015

/s/ Kathryn Rucker