UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

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

PLAINTIFFS' TWENTY-NINTH STATUS REPORT

I. Introduction

On September 22, 2015, the parties updated this Court on the status of disengagement efforts, including specific tasks outlined in the Joint Disengagement Summary (most recently revised as Doc. 706-1).[1] The Court's questions, and the parties' presentations, focused on two ongoing concerns: (1) delays in timely access to medically necessary services, including adequate care coordination; and (2) the capacity of outpatient therapy to act as a hub service. Also discussed were timeframes for the 2016 Massachusetts Practice Review (MPR) and its anticipated measurement of overall system performance, including professionally acceptable assessments, treatment planning

[1] This table was created at the Court's urging to track progress towards the accomplishment of specific disengagement activities. Over time, it has been updated to reflect ongoing work in the following substantive areas: (1) community-based mobile crisis intervention; (2) outpatient as a hub service; (3) access to high quality ICC and IHT services; (4) CANS outcome data; (5) practice guidelines; and (6) behavioral health screening. The original summary document was drawn from, and relates back to, the larger Joint Disengagement framework developed with the Defendants in 2013, and submitted to the Court on May 21, 2013 (Doc. 620-2).

and service provision among IHT and ICC providers and the resulting effectiveness of remedial services for youth and families.

With continued assistance from the Court Monitor, the parties have discussed the initial installment of CANS outcome data and the pending DMH chart review; considered the 2014-2015 MPR pilot report; and, most importantly, agreed upon the need for a more in-depth assessment of systemic conditions affecting youth and families' timely access to ICC and IHT. The Court Monitor's expertise, her knowledge of the CBHI provider system, and her recommendations for addressing these issues will be critical as the parties develop more comprehensive solutions to ensure access to medically necessary services.

II. Status of Disengagement Activities

As described in Defendants' Interim Report on Implementation (Doc. 706) (hereafter Defendants' Report), several disengagement activities remain in progress or are not projected to take place until calendar year 2016. Among these are: (1) the completion of the CANS outcome report (analyzing both item and domain level data); (2) the launch of new CANS certification and training programs; (3) the completion of the outpatient hub protocol; (4) the implementation of new outpatient requirements informing caregivers about the availability and benefits of ICC; (5) the dissemination of and training on new IHBS practice guidelines; and (6) the examination of DMH youth's referral to and utilization of remedial services. Regional client reviews, initiated in October of 2015, are scheduled to continue in March and June, with a final, statewide MPR report expected in the fall of 2016.

Defendants' Report appears to dispute the extent to which two additional tasks fall within this rubric of disengagement activities: (1) ensuring the delivery of

professionally acceptable and effective IHT; and (2) ensuring timely access to medically necessary care coordination. As discussed below, plaintiffs view these issues as squarely within the parties' Joint Disengagement Framework. Although the specific strategies needed to accomplish these tasks may not be fully enumerated, they are important requirements for compliance with the Court's Judgment and, in the case of timely access to ICC and IHT, represent ongoing legal obligations for the Commonwealth under EPSDT.

A. Remedial Service Practice Guidelines

The parties have completed practice guidelines for MCI, IHT, TM and IHBS. In keeping with the Court's Judgment, these documents establish clinical standards and provider expectations for the delivery of remedial services. Taken together, they represent an important achievement in the disengagement process. Ultimately, their success will be dependent upon the Commonwealth's ongoing coaching and training initiatives. One indication of their effectiveness will be the overall system performance standards measured by the MPR.

B. CANS Outcome Data

In the spring of 2015 the parties agreed upon the scope and perimeters of a standardized CANS outcome report. Conducted annually, this report will examine changes in CANS item and domain scores for youth in IHT and ICC.[2] The first installment of outcome data, shared with the plaintiffs in October and appended to Defendants' Report (Doc. 706-2), examined items level CANS data collected between January 1, 2013 and December 31, 2014.

[2] Defendants also will produce an additional report every year on a topic of special interest.

Analysis of this data set revealed that clinicians identified new concerns for youth and families at lower than expected rates, a worrying finding given the complexity of the population served and the importance of ongoing clinical assessments in the treatment planning process. Among those concerns that were identified, CANS items for high risk behaviors, such as suicidal ideation or self-mutilation, showed significant levels of resolution. This is both encouraging and indicative of the effectiveness of home-based services. However, more commonly identified emotional and behavioral needs, such as poor judgment and hyperactivity/impulsivity, had significantly lower rates of resolution. Youths' more limited improvement on items in the emotional/behavior domain warrant further review and monitoring in future outcome reports. Similarly, low levels of resolution for items related to trauma underscore both the challenges accompanying adverse life experiences and the opportunities for ICC and IHT to improve youth outcomes with greater access to specialized trauma training and treatment models.

Over time, continued analysis of CANS item and domain data should assist the parties in better understanding class members' presenting and emergent service needs, as well as the extent to which their conditions are improved and resolved by the delivery of remedial services.

C. Outpatient as a Hub

The designation of outpatient clinicians as clinical hub service providers has been a matter of debate between the parties since the inception of the remedial service system.

Plaintiffs still contend that this office-based service model, as it currently exists, does not lend itself to the delivery of effective care coordination for youth with SED.[3]

MBHP's special outpatient study in September of 2013, and the subsequently re-designed outpatient report (delivered in early 2015), provided important insights into the experience of youth in outpatient therapy. These reports highlighted the modest utilization of remedial services, low levels of collateral contracts, and limited knowledge of alternative care coordination options among youth in outpatient. Although the parties are nearing completion of several disengagement tasks related to outpatient hubs (*e.g.*, drafting outpatient practice guidelines; developing a process for holding outpatient providers accountable for evaluating youths' and families' need for, and interest in, ICC), considerable doubts remain as to whether outpatient therapy can provide the requisite foundation for assessing youths' care coordination needs, making referrals when medically necessary, and adequately overseeing the delivery of remedial services.

These doubts are re-enforced by recent feedback from outpatient provider organizations, many of whom also deliver home-based services. Limited reimbursement for collateral contacts, lack of reimbursement for time spent connecting youth and families with services, productivity requirements, and the constraints of hourly treatment sessions all discourage outpatient providers from performing these care coordination responsibilities.[4] Without additional funding, most outpatient clinics lack the resources to systemically review the needs of youth and families on their caseload, meet with them

[3] 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.*, Docs. 633; 665; 695; 703).

[4] Providers report that outpatient collateral contact rates are approximately half of what other CBHI service providers receive for performing this function, and that other activities, such as time spent identifying potential service referrals, are not reimbursed all at.

to discuss home-based service options, and actively assist them in connecting and communicating with remedial service providers. Even outpatient programs operated by CBHI provider organizations report the need for additional resources or new positions to perform these critical functions.

While it remains possible that the introduction of an outpatient protocol, the ICC Evaluation of Need Form, and the revised CANS certification and training requirements will positively impact access to medically necessary remedial services for youth in outpatient, these approaches are not designed to bolster the underlying foundation of the outpatient service. Nor will these approaches provide additional supports or resources to perform critical referral and coordination tasks.

Because of inherent limitations in the outpatient service, there are compelling reasons to consider additional strategies, while working with outpatient providers to identify and address remaining structural and systemic barriers which impede class members' access to adequate care coordination and other medically necessary remedial services. Absent some significant enhancement of this model, it is becoming increasingly clear that the service coordination expectations of outpatient therapists when they serve as a clinical hub for youth with SED will never be realized.

D. Ensuring Youth in ICC and IHT Receive All Medically Necessary Remedial Services, Including Adequate Care Coordination

Over the next 12 months, the Massachusetts Practice Review (MPR) will play a critical role in helping the parties, the Monitor and the Court evaluate ongoing disengagement efforts, measure class member outcomes, and assess overall system performance. Rather than negotiate, or attempt to evaluate, each new initiative designed to improve ICC or IHT service performance, the parties have agreed that MPR findings

will serve as the primary basis for evaluating IHT and ICC providers' delivery of professionally acceptable remedial services including assessments, treatment planning, and service coordination.[5] Although it will not be possible to fully assess these efforts or the systems' overall compliance with the Judgment until the fall of 2016, periodic data on IHT utilization, length of stay, and support of other hub-dependent services provide a window into the experience of youth and families with this important and highly-utilized service.

Pursuant to the parties' Joint Disengagement Framework, defendants recently shared an IHT key indicators report for April 2015. According to this data, the average length of stay in IHT is now approximately 7.6 months, although more than a quarter of providers still reported an average length of stay of less than 6 months. A third of providers had, on average, more than 38% of their members dis-enrolled in two months or less – while a startling 26% of all youth in IHT were discharged within this timeframe. By comparison, a quarter of IHT providers had average lengths of stay between 9.2 and 13 months, suggesting a significant divergence in provider practice. The potential negative impact of shorter lengths of stay is illustrated by recent CANS outcome data correlating length of treatment with greater improvements in youth functioning and related clinical conditions. Greater reductions in the severity of CANS ratings, and increased resolution of identified problems, occurred when youth remained in IHT for 9 months.

Given that IHT is far and away the most highly utilized remedial service and a primary source of care coordination for thousands of youth and families, it is concerning

[5] Although reviewing a relatively small sample of youth, the October 2015 MPR Pilot confirmed the need for continued quality improvement activities in IHT as mean scores were below the minimum standards for acceptable practice.

to see the infrequency with which class members and their families receive IHT-supported, hub-dependent services. In April 2015, just under half of IHT enrollees received TT&S (IHT's accompanying paraprofessional service), but levels of utilization for FS&T, TM and IHBS remain surprisingly low. On average, 18% of IHT providers used family partners, 30% used therapeutic mentors, and only 6% included IHBS providers in the youth and families' treatment plan. As with length of stay, there were variations in provider practice, but all within a relatively low range of utilization. While some percentage of youth and families may be adequately served with only IHT, these key indicators continue to re-enforce the importance of ensuring that youth who need one or more hub-dependent services are considered for, and appropriately referred to, ICC.

E. Timely Access to Remedial Services

The parties' disengagement efforts have, at their core, the goal of ensuring that youth and families have reasonable access to medically necessary remedial services, including the level of intensive care coordination available through ICC and wraparound treatment planning. If 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 and other home-based services to all youth who need them, and to do so with reasonable promptness.

During FY2015, waiting lists for ICC became an entrenched feature of the service system, and a significant barrier for hundreds of youth and families.[6] The numbers of

[6] Plaintiffs highlighted persistent, system-wide access problems during this past fiscal year, including low levels of enrollment among CSA providers and steadily increasing waiting lists for ICC and IHT. (*See, e.g.,* Docs. 622, 633, 657, 674, 695 and 703) Dramatic increases in wait time persisted throughout 2015 despite declines in the levels of ICC enrollment. At the start of FY2016, youth were waiting more than 24 days for an initial ICC appointment to be offered, with over 44% of those youth waiting in excess of the Medicaid access standard.

youth waiting for IHT appointments also increased over the 12-month period, while available capacity within the system remained less than 3% statewide.[7] Although IHT waiting lists remain high, recent CSA reports show improvement, including reductions in the length of time youth are waiting. However, it is premature to conclude that this change will continue, since the economic, financial and structural issues contributing to longstanding delays in access have yet to be fully analyzed or resolved.

Understanding and addressing issues which affect ICC and IHT providers' ability to hire and retain qualified staff are important next steps in achieving compliance with the Court Judgment and corresponding Medicaid access standards. Factors reported to date include: (1) the demands of delivering home-based services, given levels of productivity required by the rate structure; (2) the inability of providers to offer salaries and benefits competitive with other state agencies and hospital-based behavioral health services, even with prospective rate increases; and (3) the myriad of administrative demands associated with the managed care system. Like the parties and the Court, remedial service providers are invested in addressing these systemic problems, and in continuing to deliver needed remedial services. They should be included in the design of any system-wide solutions.

Additional factors relevant to ICC access include local and regional variations in CSA capacity, caseloads, waiting lists and length of stay. A more informed understanding of these data points and their interrelationship may reveal additional

[7] In July 2014, 130 youth were waiting for their first available IHT appointment and 258 were waiting for a specific IHT provider. In contrast, in July of 2015, 228 youth were waiting for an appointment with the first available IHT provider, while 355 youth were reported as waiting for a specific provider.

strategies for reducing waiting lists and growing system capacity without compromising the intensity and duration of medically necessary care coordination.

Although defendants characterize these efforts, and their ongoing outreach to graduate training programs as "beyond the scope of the disengagement activities," timely access to all remedial services, including ICC and IHT, is integral to achieving the goals of the Judgment and to ensuring ongoing compliance with federal law. This is not the first, nor will it be the last time the home-based service system faces workforce shortages or economic downturn. In order to be a sustainable and durable solution for youth and families, this system must have solid and financially viable service models, a collaborative mechanism for analyzing access issues when they do occur, and a demonstrated ability to proactively intervene and resolve these problems at the local, regional and state-wide levels to ensure the provision of medically necessary services.

III. Conclusion

As the 2015 calendar year comes to a close, the number of outstanding disengagement tasks continues to grow smaller. However, serious concerns persist regarding access to, and delivery of, professionally acceptable care coordination across all three hub services. The full measure of effort required to resolve these problems, and to prevent their re-occurrence, remains unclear. In the coming months, previously agreed upon strategies for supporting outpatient hubs will be in place, the DMH chart review will be completed, and initial results from the MPR will become available. This information should allow the parties to begin taking stock of remaining disputed issues, while enabling the Court Monitor to focus on those areas of the Joint Disengagement

Framework where additional recommendations and actions may be necessary in order to achieve compliance with the Judgment.

RESPECTFULLY SUBMITTED,
THE PLAINTIFFS,
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Dated: December 7, 2015 /s/ Kathryn Rucker