UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

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

PLAINTIFFS' STATEMENT OF MATERIAL FACTS

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I. Prior Proceedings Relevant to the Motion to Terminate

A. The Court's Findings on Violations of the EPSDT and Reasonable Promptness Provisions of the Medicaid Act Concerning Care Coordination.

1. In its initial liability decision, the District Court concluded that the Commonwealth was violating both the EPSDT and reasonable promptness requirements of the Medicaid Act.[1] Among the Court's key findings was that youth with Serious Emotional Disturbance (SED) did not have reasonably prompt access to medically necessary home-based services, including effective service coordination.[2]

2. During a lengthy bench trial, the Court heard evidence of the harms experienced by youth and families who went without effective coordination of medically necessary home-based services, including "expensive, clinically unnecessary and damaging confinement in a long-term residential program or hospital, far from home and family."[3] The Court found it "impossible to overstate the importance of active informed case management" for youth with SED, from identifying appropriate programs and services, to formulating and coordinating implementation of the child's treatment plan.[4] Although some children, in three pilot programs, had access to this kind of wraparound care coordination, the Court concluded that it was not available with reasonable promptness to all youth for whom the service was medically necessary.[5]

B. The Court's Judgment.

3. The Court's January 26, 2006 liability decision directed the parties to negotiate a joint remedial order.[6] After failing to reach agreement, the parties each submitted proposed remedial plans.[7] The Court chose to enter defendants' plan, with several changes described in Orders dated February 22, 2007[8] and July 16, 2007.[9]

4. A central component of the Judgment and remedial plan was an expanded program to provide care coordination – termed Intensive Care Coordination or ICC. If implemented effectively, and consistent with professional standards, ICC could cure the EPSDT and reasonable promptness violations described in its liability decision.[10]

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[1] *Rosie D. v. Romney (Rosie D. I)*, 410 F. Supp. 2d 18, 23, 53-54 (D. Mass. 2006).
[2] *Id*. at 38, 52-54. "Children with SED are particularly challenging to treat because of the severity of their needs and the number and intensity of services they require. The danger for these children, given their complex problems, is that they will not only receive insufficient services, but that a lack of coordination among the service providers will undermine the effectiveness of the treatment that they do receive." *Id.* at 32.
[3] *Id*. at 53.
[4] *Id*. at 38-39, 52. "[C]entralized, knowledgeable, and painstaking service coordination is essential; without it, a child's life becomes a chaos of ineffective, overlapping plans and goals." *Id*. at 31.
[5] *Id*. at 38-40.
[6] *Id*. at 54.
[7] *Rosie D. v. Patrick (Rosie D. III),* 496 F. Supp. 2d 76, 77 (D. Mass. 2007).
[8] *Rosie D. v. Romney (Rosie D. II)*, 474 F. Supp. 2d 238, 239-241 (D. Mass. 2007).
[9] *Rosie D. III.,* 496 F. Supp. 2d at 78-79.
[10] Judgment, ¶¶ 19-29, 38 (program requirements for ICC).

5. Although few in number, the Court's modifications to defendants' remedial plan were significant. For instance, the Court rejected the following provisions proposed by defendants: (1) discretion to unilaterally modify any provision of the plan; (2) a drop dead date for termination of the Court's authority to enforce or modify the Judgment; and (3) limiting enforcement of the Judgment to only those actions that are explicitly required by the language of the EPSDT or the reasonable promptness provisions of the Medicaid Act.[11]

6. In reaching its decision on remedies, the Court directed that modification may occur only for good cause, by order of the Court, or by agreement of the parties.[12] The Court also declined to end its enforcement and modification authority on a date certain, referencing its obligation to ensure full implementation.[13]

7. The Court rejected language that would limit its ability to enforce all aspects of the Judgment, including "a number of initiatives by Defendants that are not explicitly spelled out in either of the violated provisions."[14] The Court concluded that it had "the responsibility to [e]nsure that Defendants take whatever actions are reasonably necessary to remedy the violations found in its judgment on liability. Obviously, some of these measures may not be spelled out in the EPSDT and 'reasonable promptness' provisions of the Medicaid statute."[15]

8. In adopting the remainder of defendants' remedial plan, which included the appointment of a Court Monitor, the Court noted that "respect for the sovereignty of the Commonwealth and the competence of its officials requires the court to allow the state to demonstrate that its chosen remedial plan will address, promptly and effectively, the Medicaid violations identified by the court."[16] However, it cautioned that, "deference is not infinite; the court will not be obliged to close its eyes to unreasonable delays or inadequate measures.[17] The defendants did not appeal either of the Court's 2007 Orders or the final Judgment, entered on July 16, 2007.

C. Plaintiffs' 2010 and 2011 Noncompliance Motions.

9. Pursuant to the Judgment, defendants were required to develop a home-based service system, including performance specifications for each remedial service and time frames for the provision of services to class members.[18] Although the Judgment did not prescribe the precise contents of these performance specifications, it did describe the components that must be

[11] *Rosie D. III,* 496 F. Supp. 2d at 77.
[12] *Id*.
[13] *Id.* at 79.
[14] *Id*.
[15] *Id*.
[16] *Rosie D. II*, 474 F. Supp. 2d at 239.
[17] *Id.*
[18] Judgment, ¶ 38. The program specifications were submitted to the Centers for Medicare and Medicaid Services (CMS) as part of its review of the State Plan Amendments for these services, and are subject to federal audit. Thus, they are an essential component of each remedial service and a foundational commitment made to CMS to obtain the Federal Financial Participation (FFP) required by ¶ 49 of the Judgment. The program specifications describe how the new services are delivered, the required qualifications of staff, and the various time frames within which care and treatment must be delivered. All providers are required to comply with these standards by contract. O'Brief Aff., ¶¶ 33-34.

included, it did require that the performance specifications be implemented, and it mandated a deadline for their implementation.[19] The identified components of each performance specification included a service definition and philosophy, structural requirements, staffing requirements, service description, community and collateral linkages, quality management, and process specifications. This last component specifically was intended to, and in fact did, include timelines for providing the first face-to-face appointment, as well as for completing assessments and developing the care plan. For instance, defendants' initial program specifications for ICC specifically required that youth and families be offered an initial appointment within three days of confirming their interest in the service.[20]

10. Home-based services became available to class members in the Fall of 2009, and defendants held their ICC providers accountable to the 3-day timeliness standard set out in the ICC Performance Specifications.[21]

11. By early 2010, reports of lengthy waiting lists and a lack of reasonable promptness in the delivery of ICC were presented to the Court by plaintiffs and the Court Monitor. At the Court's request, in June 2010, plaintiffs filed a Proposed Order on Waiting Lists,[22] followed by a motion for noncompliance alleging failure to provide ICC within the State's own promptness standard.[23] The supporting memorandum presented defendants' data documenting average wait times for an initial ICC appointment at 21.5 days in July 2010, together with numerous affidavits describing the harm to children from lengthy delays in accessing ICC.[24] Ultimately, the Court concluded that more information was required to understand the "magnitude of the problem," so it ordered that the parties collect, analyze, and report additional data on timely access to ICC.[25]

12. On September 12, 2011, plaintiffs filed a Supplemental Motion and Memorandum to ensure reasonably prompt access to ICC, accompanied by a revised, proposed order.[26] On October 8, 2011, the Court stated its intent to issue an order ensuring reasonably prompt access to ICC.[27] However, rather than adopt plaintiffs' proposed timeframe of seven days, or impose its own standard, the Court directed defendants to submit a proposed order and stated "I'd like to see the defendants' proposal for what my order should be, because … you're not just technically out of compliance, you're substantially out of compliance and I have to do something."[28]

13. Subsequent briefing from defendants and plaintiffs laid out undisputed evidence of noncompliance with the 3-day standard, including that 15% of youth waited more than 30 days for an initial appointment with an ICC provider.[29]

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[19] *Id.* at ¶ 38(c) & (d).
[20] *See* Ex. 8 -- ICC Program Specifications, dated October 15, 2008 at 9.
[21] Defs.' Supp. Mem. in Opp. to Pls.' Mot. for Entry of Order Regarding Access to Remedy Services at 5 (Doc. 551).
[22] Doc. 490.
[23] Doc. 507.
[24] Pls.' Mem. to Ensure Timely Access to Remedial Services at 1-10 (Doc. 508).
[25] Tr. of Status Conf., June 2, 2011 at 51-52, 63-64 (Doc. 537).
[26] Docs 542, 543.
[27] Tr. of Status Conf., Oct. 18, 2011 at 28, 48 (Doc. 552).
[28] *Id.* at 52-53.
[29] *See, e.g.,* Docs. 543-1, 544-1, 547-1.

14. On November 29, 2011, the Court issued its Memorandum and Order, granting plaintiffs' motion (in part).[30] In response to defendants' request to modify the 3-day standard for ICC services, the Court directed the parties to meet with the Court Monitor, discuss defendants' proposal for a new reasonable promptness standard, and report back to the Court. Additionally, the Court ordered defendants to "[e]ffectuate management strategies specifically targeting the reduction, and ultimately the elimination, of waiting lists for ICC services, including strategies outlined in their Supplemental Memorandum (Doc. 551)," and "include in their January 13, 2012 report a summary of their progress in this area."[31] The Court intended to use this report to "consider the necessity of setting firm deadlines for bringing these times in better compliance with the court's remedial order."[32]

15. In a January 26, 2012 affidavit, defendants updated the Court on their request to the New England Council of Child and Adolescent Psychiatry (NECCAP) to "advise EOHHS on a standard for reasonably prompt access to Intensive Care Coordination," as required by federal law.[33] Defendants, acknowledge that "[f]ederal law requires a state to set standards for the timely provision of EPSDT services, which must meet reasonable standards of medical practice," and had sought "guidance as to an appropriate outside limit beyond which no member eligible for ICC should wait to obtain ICC -- a time period that you would consider to be reasonably prompt."[34] NECCAP's written recommendation, sent in an email to defendants by its President, Dr. Metz, stated:

> The Board recommends that an outside limit of 10 business days between the time of request for ICC and the first meeting with ICC staff to establish enrollment be instituted. The current 3 day limit should be adhered to whenever possible, recognizing that there is evidence that engagement in services is most likely to occur if the response to a request can occur as soon as possible after the need is first expressed.[35]

16. The State did not adopt the "outside limit" of its federally-required professional recommendation. Instead, defendants proposed 14 calendar days as the Medicaid standard for the initial ICC appointment.[36] The defendants justified their deviation from the NECCAP professional recommendation saying:

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[30] Doc. 557.
[31] *Id*. at 4-5.
[32] *Id*.
[33] Aff. of Emily Sherwood (Doc. 564).
[34] Doc. 564-3 (emphasis in original). In their request, defendants explained: "The Medicaid access standard will be communicated to families as well as providers, that *families have a right to receive this service within this timeframe. We are planning to add the new access standard to the contracts of the managed care entities, and we will hold them accountable for ensuring that our members have access to ICC within the time of the access standard.* Doc. 564-2 (emphasis added).
[35] Doc. 564-6.
[36] Tr. of Status Conf., Jan. 27, 2012 at 32-33.

> [W]e're really hearing clearly from the providers that the three-calendar days . . . is really, really hard to deal with. So we are suggesting 50 percent by five calendar days, 75 percent by ten calendar days, with the remaining within the two-week period.[37]

They then incorporated this 14-day standard into revised program specifications that are required by Paragraph 38(c)(vii) of the Judgment.[38]

17. On March 20, 2012, the Court expressed concern about maintaining progress on implementation and avoiding backsliding, worried that shifting from a 3-day to a 14-day Medicaid access standard could mean the system was "moving in the wrong direction."[39] At the same time, the Court stated its inclination to "adopt the defendants' proposed standards and then say, okay, this is the standard you've proposed. Comply with it."[40] The Court would require regular reports from the defendants to measure if youth were being offered appointments within the graduated time periods proposed.[41]

18. The defendants assured the Court that "a Medicaid access standard is a standard that a Medicaid program takes seriously and believes that needs to be in substantial compliance with."[42] Significantly, defendants did not object to the idea of a proposed order memorializing the 14-day Medicaid access standard, or additional reporting on compliance with that reasonable promptness standard.[43]

19. Following the status conference, the Court issued a Memorandum and Order Regarding ICC Access Standard:[44]

> [t]he court approved a fourteen-day access standard for Intensive Care Coordination ("ICC") access. This means that no more than fourteen days will elapse between the initial contact with the ICC provider and the first offered date for a face-to-face meeting. The court approved this standard with the understanding that the contractual obligations of the ICC providers as contained in their performance specifications would require that the period be three days for at least 50% of the clients, ten days for 75% of the clients, and no more than fourteen days for 100% of the clients. The court will be monitoring data regarding access carefully to insure that the approval of the more generous standard does not result in longer delays.

20. The defendants never appealed this Order. Over the next six years, they did not challenge or object to the appropriateness of the 14-day standard as a measure of reasonably

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[37] *Id.*
[38] *See* Ex. 9 - Performance Specifications for ICC at 11, dated 10/12; Ex. 10- Performance Specifications for IHT at 5.
[39] Tr. of Status Conf., March 20, 2012 at 4 (Doc. 573).
[40] *Id.* at 4-5.
[41] *Id.* at 6.
[42] *Id.* at 21.
[43] *Id.* at 21-22, 25, 57, 64. Defendants also acknowledged that they had yet to meet that 14-day standard in a year and a half of implementation, but believed they were close to doing so, with "concerted effort." *Id.* at 22.
[44] Mem. and Order Regarding Access Standard (Doc. 571) (March 20, 2012 Order).

prompt access to ICC.[45] Defendants' Memorandum and Statement reported on its level of compliance with the 14-day standard.[46]

D. Defendants' 2012 Submission of Compliance and Position on Monitoring and Reporting.

21. Although the Judgment provided that reporting and monitoring would terminate within five years, the Court's July 16, 2007 Order explicitly reserved the authority and discretion to extend its oversight until the Judgment was fully implemented.[47]

22. In early 2012, the Court expressed skepticism that the defendants would achieve substantial compliance with the Judgment by June 30, 2012, given plaintiffs' recent motions for noncompliance, the absence of crisis stabilization, and documented deficiencies in the delivery of ICC services with reasonable promptness.[48] Nevertheless, the defendants' May 2012 Report on Implementation asserted substantial compliance with most aspects of the Judgment.[49]

23. Defendants conceded that there were still "open items" -- activities in process or incomplete as of the date of filing.[50]

24. Plaintiffs' Eighteenth Status Report challenged defendants' assessment of substantial compliance, incorporating by reference all of their data and arguments on reasonable promptness, and noting deficiencies in "screening, assessment, the delivery of Intensive Care Coordination (ICC), effective mobile crisis and crisis stabilization services, and the monitoring of system practice, provider performance and child outcomes."[51]

25. Because no formal motion to terminate monitoring had been filed, because defendants acknowledged certain tasks remained incomplete, and because plaintiffs consistently contested the status of compliance, the Court proposed that the parties negotiate a plan for disengagement, with the goal of ending Court oversight.[52] The defendants consented to this approach.[53]

E. Defendants' Actions to Comply with the Judgment (2013-2017).

26. The defendants worked with plaintiffs and the Court Monitor to develop a set of concrete actions designed to achieve compliance with the Judgment and the termination of

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[45] *See, e.g.,* Defs.' Rept. on Disengagement at 2-3 (Doc. 813); ICC Data Rept. Doc. 813-1; Joint Disengagement Measures (Doc. 776-1).
[46] Mem. at 18; Defs.' SMF, ¶ 52.
[47] *Rosie D. III,* 497 F. Supp. 2d at 79.
[48] Tr. of Status Conf., Jan. 27, 2012 at 16-17; Tr. of Status Conf., March 20, 2012 at 1-8 (Doc. 573) ("I have a very hard time seeing that you will be able to say that you've substantially implemented the remedial order by July of 2012").
[49] Doc. 577.
[50] *Id.* at 111.
[51] Doc. 578.
[52] Tr. of Status Conf., June 25, 2012 at 7-8 (Doc. 579).
[53] *Id.* at 18-19.

monitoring and reporting.[54] On June 21, 2013, the parties filed their Joint Disengagement Criteria, laying out the four main areas in which further data collection, analysis, and implementation efforts would be focused: timely access, utilization, effectiveness, and quality standards/practice guidelines.[55]

27. During 2015, the Court encouraged the parties to move the disengagement process forward, grapple with remaining issues of alleged noncompliance, and provide a clear pathway for achieving an effective remedy, including a means to achieve the reasonably prompt provision of ICC services.[56]

28. In late 2015, defendants acknowledged a "pervasive and lasting problem with access to services, particularly ICC and IHT" (In-Home Therapy).[57] As a result of this failure to achieve the qualitative Disengagement Criteria, and continuing disagreement regarding overall compliance with the Judgment, the parties negotiated and filed specific Joint Disengagement Measures, including quantitative benchmarks for assessing improvement over a two-year period.[58]

29. Disengagement Measure One set standards for gradually increasing the percentage of class members who received an initial appointment for ICC and IHT within the court-ordered 14-day reasonable promptness standard.[59] While the parties could not agree on the exact percentage of annual improvement for Measure One, there was no disagreement with 14 days as the appropriate standard against which to measure reasonably prompt access to ICC and IHT services.

30. The Court declined to formally order the new Disengagement Measures, believing it unnecessary to ensure defendants' continued efforts toward implementation.[60] However, it noted that:

> The Joint Disengagement Measures give practical form to the substantive terms of the Remedial Order in the context of the final phase of implementation. The court manifestly possesses the power to enforce these measures to the extent necessary to ensure compliance with the Remedial Order. The fact that these measures have been agreed to voluntarily – as an expression of good faith on the part of both parties – does not in any way undercut the court's responsibility to ensure that the Remedial Order is fully complied with through the implementation of the disengagement measures.[61]

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[54] *Rosie D. v. Baker (Rosie D. IV),* 362 F. Supp.3d 46, 54-56 (D. Mass. 2019) (Doc. 848 at 20-28).
[55] Doc. 623-2.
[56] Tr. of Status Conf., December 10, 2015 at 17, 24 (Doc. 724).
[57] Defs.' Interim Rept. on Implementation at 14 (Doc. 706).
[58] *Rosie D. IV,* 362 F. Supp.3d at 55-56.
[59] Doc. 776-1. Defendants' system performance in June of 2016 became the baseline for measuring progress over time. *Id*. At that time, only 63% of class members seeking ICC services were being offered initial appointments within 14 days. *Rosie D. IV,* 362 F. Supp.3d at 56.
[60] Order re: Plaintiffs' Mot. to Approve Joint Disengagement Measures (Doc. 815). The Court observed: "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." Tr. of Status Conf., April 6, 2017 at 19-20 (Doc. 802).
[61] *Id.* at 3.

31. Although continuing to characterize the Disengagement Measures as voluntary, defendants acknowledged that they defined "what disengagement looks like" and, if achieved, would result in the end of active monitoring and reporting to the Court.[62]

32. Unfortunately, the incremental annual progress anticipated by the Disengagement Measures did not occur.[63] Instead, data collected from late 2016 to early 2018 evidenced deterioration in the prompt provision of ICC and increasing waiting lists for both ICC and IHT services.[64] By the fall of 2017, defendants acknowledged that the progress measure for reasonably prompt access to ICC and IHT would not be met:

> To summarize the findings of the reports, ICC did not meet the access target in any of the first seven months, and IHT met the access target for two of the first seven months. As a result of this preliminary data, Defendants will not hit the disengagement target in 9 of 12 months in calendar year 2017.[65]

33. Defendants' compliance with their 14-day Medicaid access standard actually decreased during the first half of 2017, going from 61.64% to 50.3%.[66] Throughout FY2017-18, an average of 220 youth were waiting for an initial appointment at the end of each month. During the last quarter of FY2018, 97 youth waited more than a month in April; 101 in May; and 71 in June.[67]

34. In response to these reports, the Court pressed for "concrete steps" to remedy "excessively long" wait times for ICC, emphasizing the importance of service coordination in remedying the federal law violations found in its 2006 liability decision and its central role in the remedial home-based service system created by the Judgment:

> This is the front door to 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. It's important. . . . . These services have to be provided, and they have to be provided promptly, reasonable promptness. So that's my responsibility.[68]

35. At its April 2018 status conference, and again in June 2018, the Court expressed no confidence that such a plan was forthcoming.[69]

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[62] Tr. of Status Conf., April 6, 2017 at 26 (Doc. 802).
[63] *Rosie D. IV,* 362 F. Supp.3d at 56.
[64] *Id.*
[65] Defs.' Rept. on Disengagement at 3 (Doc. 813).
[66] Doc. 813-1.
[67] Pls.' Opp. to Defs.' Motion for Compliance, Exs. 9-10 (Docs. 857-9, 857-10).
[68] Tr. of Status Conf., Jan. 16, 2018 at 3, 6 (Doc. 824).
[69] Order of June 14, 2018 at 3 ("Defendants were unable to identify any practical measures that would give the court reasonable assurance that these critical access problems will be promptly and effectively addressed").

F. Defendants' 2018 Motion to Terminate Monitoring and Court Supervision.

36. On August 6, 2018, defendants filed their Motion Regarding Substantial Compliance and to Terminate Monitoring and Court Supervision.[70] Despite its caption, the motion only sought to end monitoring and reporting, based upon a showing of substantial compliance, and did not move to terminate any of defendants' other obligations under the Judgment, the Court's authority to enforce the Judgment, or the Judgment itself under Rule 60(b)(5).[71] It made no claim that the case should be dismissed, that the Judgment should be vacated, or even that any provision of the Judgment other than in Section I.E.3 (¶¶ 47-49) should be terminated. In fact, defendants' Memorandum explicitly disavowed filing their motion under Rule 60(b)(5) – the common procedural vehicle for ending a state's obligations under a systemic injunction.[72]

37. Plaintiffs' Opposition recounted the history of waiting lists for ICC and IHT, resulting in problems ensuring reasonably prompt access to service coordination, and a host of other deficiencies in implementing the Judgment.[73] The attached exhibits relied primarily on defendants' own data, documenting the amount of time youth and families waited for an initial ICC or IHT appointment.

G. February 7, 2019 Memorandum and Order.

38. On February 7, 2019, after extensive briefing and oral argument, the Court denied defendants' Motion, refusing to terminate active court oversight and monitoring of the home-based service system.[74] The Court's decision provides a detailed history of the litigation, the initial liability decision finding violations of the EPSDT and reasonable promptness provisions of the Medicaid Act, the parties' efforts to implement the 2007 Judgment, and the specific factual and legal arguments supporting its ruling.

39. The Court found a continuing violation of federal Medicaid law, evidenced by a long history of problems with reasonably prompt access to service coordination and resulting waiting lists for ICC and IHT.[75] It held that "[d]efendants have so far failed to provide these clinical services to a large portion of the Plaintiff class with anything approaching "reasonable promptness,"[76] later noting that "[d]efendants' failure to comply with the judgment and remedial order itself, without reference to the parties' agreed upon disengagement measures, is glaring."[77]

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[70] Doc. 848.
[71] *Id.*
[72] Doc. 849 at 35 & n. 26.
[73] Doc. 857 at 18-24.
[74] *Rosie D. IV,* 362 F. Supp.3d at 61.
[75] *Id.* at 48, 50. The Court observed that "placement [in] inappropriate clinical settings, such as emergency rooms or longer-term in-patient facilities due to the absence of responsive home-based services, can be extremely damaging to these fragile children and was a primary shortcoming of the pre-2006 system that the remedial order aimed to rectify." *Id.* at 52.
[76] *Id.* at 48.
[77] *Id.* at 57.

40. The Court rejected defendants' argument that the Judgment did not require them to deliver remedial services with "reasonable promptness," since this theory "flies in the face of the explicit liability finding, the manifest import of the remedial order, and, most importantly, the clear language of the Medicaid statute itself and the law's regulations."[78] Rather, the Court concluded that, "[f]ederal law and Section I(C) of the judgment require Defendants to provide care coordination services for the class members 'with reasonable promptness.'"[79]

41. In addition to a lack of timely access to ICC and IHT, the Court found that "serious concerns exist, with substantial objective verification, regarding the quality of some of the care coordination being provided," including the extent to which youth in IHT or outpatient therapy are receiving care coordination consistent with the Judgment.[80] However, the Court expressly reserved any decision on other portions of Judgment, and the need for continued court monitoring, anticipating the issuance of a further order in response to plaintiffs' pending motions.[81]

H. The First Circuit's Decision

42. The First Circuit's decision to reverse and remand for further proceedings hinged on a perceived failure to properly modify the Judgment to reflect this Court's 2012 Order approving a 14 day Medicaid access standard.[82]

43. The question of defendants' substantial compliance with the Judgment itself was not addressed by the First Circuit's decision. Rather, the Court of Appeals clearly anticipated returning this issue to the District Court.[83]

II. Timely Access to Remedial Services

44. A survey of states with home-based programs that are longstanding, stable, and effective, most require the first face-to-face appointment within seven days.[84]

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[78] *Id.* at 51, n.7. *See also* Tr. of Hearing of Sept. 27, 2018 at 21-22 (Doc. 867) ("[W]hen the judgment is anchored on a finding of the reasonable promptness -- failure to comply with the reasonable promptness requirements and that you are off the hook on that because I didn't use the phrase -- or the draft judgment that was submitted to me didn't use the phrase 'reasonable promptness,' that seems to me to be a pretty tortured argument.").

[79] *Id.*. at 61.

[80] *Id.* at 59.

[81] Doc. 869. The Court focused on continued federal law violations, as evidenced by the Commonwealth's failure to provide timely access to Intensive Care Coordination. Doc. 877 at 6. Judge Ponsor anticipated that remaining areas of alleged noncompliance could be addressed by the Court as needed, following his retirement. *Id*. at 6, n.5 (noting that the "[a]bsence of discussion of Plaintiffs' additional arguments, particularly deficiencies in the quality of services, should not be taken to imply either acceptance or rejection of them").

[82] *Rosie D. v. Baker (Rosie D. V)*, 958 F.3d 51, 57 (1st Cir. 2020) ("We agree that it was error for the district court to conclude, at least without proper analysis, that the fourteen-day standard was required by federal law and that the Judgment set forth an obligation by the Commonwealth to see that its contractors provided services within fourteen days.").

[83] *Id*. at 59 (enumerating the range of potential issues to be addressed on remand, including compliance with, and further modification of, the 2007 Judgment).

[84] Ex. 4 - O'Brien Aff.,¶ 25 and Att. 1 (first appointment required in 7 days in Georgia, 2 days in Indiana, 3-5 days in New Jersey, 3 days in Oklahoma, 7 days in Texas).

45. The national standard for providing the first service appointment for care coordination services is ten days. This standard was developed by the federally-funded national technical assistance network and is used by most wraparound programs like ICC.[85]

46. The monthly summary reports from Community Service Agencies (CSAs) include several measures that quantify this noncompliance for ICC. Since the Court last reviewed this data in August 2018, the percentage of youth who waited longer than 14 days just for an "offer" of an initial appointment equal or exceeded 25% for 22 of the past 29 months.[86] On average, more than half waited more than 20 days, more than a quarter waited for 40 days, and many waited for 60 days.[87]

47. In 2019, only about one-third of the CSAs offer appointments in 14 days, more than one-third offer appointment between 15-30 days, and a quarter of all CSAs do not offer appointment until more than 30 days.[88] The percentage of ICC providers with average wait times over 14 days was even higher in December of 2020, with 44% waiting 15-30 days and 25% waiting more than 30 days on average, despite decreased enrollment during the pandemic.[89]

48. For In-Home Therapy, only one-third of all children received a first appointment on time. Another third waited up to 4 weeks, almost 20% waited up to 8 weeks, 10% waited up to 12 weeks, and 7% waited longer than 12 weeks.[90]

49. For In-Home Behavioral Services, only a quarter of children received a timely appointment, while 25% waited up to 4 weeks, 20% waited up to 8 weeks, 20% waited up to 12 weeks, and 13% waited longer than 12 weeks.[91]

50. For Therapeutic Mentoring it was even worse. Only 15% of children received a timely appointment, while 20% waited up to 4 weeks, 30% waited up to 8 weeks, 20% waited up to 12 weeks, and 13% waited longer than 12 weeks.[92]

II. Network Capacity to Provide Timely Remedial Services

51. As detailed in defendants' own reports, more than 65% of ICC providers have average wait times far in excess of the 14 day requirement, with 25% posting averages wait times of 30 days or more.[93]

52. In December 2019, 72% of IHT providers, 80% of IBHT providers, and 57% of TM providers reported zero capacity to accept new clients. In December 2020, 51% of IHT

[85] Ex. 11 - Wraparound Implementation and Practice Qualify Standards at 16.
[86] Ex. 12 - Summary of CSA Reports: August 2018 – December 2020, Report 4.
[87] *Id.,* Report 6.
[88] Ex. 13 - Summary of CSA Providers Wait Times for Services at 1.
[89] *Id.*
[90] Ex. 14 - IHT/IHBS/TM Waiting List Reports at 1 (Dec. 2019).
[91] *Id.* at 3.
[92] *Id.* at 5.
[93] Ex. 13 at 1.

providers, 69% of IHBS providers, and 39% of TM providers reported that their programs were full and unable to serve new clients.[94]

53. In December 2019, only 2 of 10 reporting IHBS providers in the Central region had any capacity to accept new clients.[95] In December 2020, only 4 of 11 reporting IBHS providers were able to accept new clients in this region.[96]

54. In December 2020, four of the five regions had IHBS utilization rates of 94% or higher, with a statewide average of 92.9%.[97] In other words, only 7% of the total network capacity for IHBS was available in December of 2020. As a result, 111 youth were waiting for the first available IHBS provider, and 67 were waiting for a provider of their choice. In the first cohort, only 29% waited less than 14 days for this remedial service.[98]

55. For TM providers, 4 of 5 regions had more than 89% utilization in December 2020, with an 89.8% statewide average. As a result, 26 youth were waiting for the first available provider, and 46 youth were reported waiting for the provider of their choice. Of the 26 youth, only 1/3 waited less than 14 days.[99]

56. For IHT, all five regions had utilization rates over 93% in December 2020 and the statewide average was 93.8%. As a result, 226 youth were waiting for the first available IHT provider, and 171 were reported as waiting for their provider of choice. Of the first group, only 35% had their offer of a first appointment within 14 days. In the second group, that number dropped to 23%.[100]

57. In December 2019, 176 youth were waiting for the first available TM provider,[101] 335 youth were waiting for the first available IHT provider,[102] and 196 youth were waiting for the first available IHBS provider.[103] The number of youth waiting more than 14 days for the first available appointment in December 2019 was the same or worse than in 2020 for all three services.[104]

III. Provision of ICC and Remedial Services to Eligible SED Children

58. Defendants track statewide referrals to ICC in on monthly basis, with yearly aggregate referrals calculated at the end of each fiscal year.[105]

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[94] Ex. 15 - Summary of IHT/IHBS/TM Providers' Capacity: 2019 and 2020 at 1.
[95] *Id.* at 12-13.
[96] *Id.* at 14-15.
[97] Ex. 14 at 4.
[98] *Id*.
[99] *Id*. at 6.
[100] *Id*. at 2.
[101] *Id*. at 5.
[102] *Id*. at 1.
[103] *Id*. at 3.
[104] *Id*. at 1, 3, 5.
[105] Ex. 16 - CSA Monthly Report: June 2019.

59. Of a total of 8,549 referrals to ICC from all sources during fiscal year 2019, only 4 came from DYS, and only 49 from Probation. That is less than 1% of referrals for ICC from juvenile justice agencies. In contrast, youth from the child welfare agency were 13% of all new referrals to ICC.[106]

60. MassHealth's FY2017 Report on Outpatient as a Hub was 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.[107]

61. Part II of the Outpatient Report examined the adequacy of care coordination with entities like medical professionals, state agencies, crisis teams, and other remedial service providers. Overall, care coordination was found to be adequate only 48% of the time. 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.[108]

62. More than 50% of charts sampled did not include an ICC Evaluation of Need within the past six months.[109]

63. The Court Monitor also conducted a study in 2018, which validated a number of concerns regarding outpatient providers' ability and preparedness to delivery adequate care coordination.

IV. Provision of ICC and IHT Consistent with the Requirements of the Judgment

64. The MPR evaluates of these requirements by assessing individual service delivery, giving it a unique and important class member-based 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.

65. "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."[110]

66. Reviewers rate the adequacy of provider practice using a scale from 1 to 5, with 1 being adverse and 5 representing best practice. The MPR Practice Rating Scale and Indicators has remained consistent since 2016.[111]

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[106] Ex. 5 - Kamradt Aff., ¶ 33.
[107] Ex. 17 – MassHealth Report on FY2017 Outpatient as a Hub: February 2018.
[108] *Id.* at 14, 34-35.
[109] Ex. 18 – MassHealth Report on FY2017 Outpatient Consultation Chart Audit at 2.
[110] FY2017 MPR at 4, available at https://www.mass.gov/doc/mpr-year-end-summary-fy-2017-0/download.
[111] FY2019 MPR at 5, available at https://www.mass.gov/doc/mpr-year-end-summary-report-fy-2019-0/download.

67. Individual scores are then aggregated to determine the percentage of youth and families in each category.

68. In fiscal year 2019, the last year for which data is available, 23% of youth in IHT had assessments that were poor or adverse, and an additional 48% had assessments that were scored as fair.[112] Only 29% of youth reviewed had assessments that were considered good or better. In the category of service planning, 25% of youth experienced poor or adverse practice, and another 39% of cases did not consistently meet established standards.[113] When evaluating care coordination, 27% of practice was scored as poor or adverse, and only 44% of youth experienced coordination that was considered good or better.[114] With only two exceptions, every category in Domain One revealed that less than half of youth were receiving good practice, consistent with established standards.[115]

69. The 2020 ICC report documented poor or adverse care for 29% of assessments; 29% of service planning; 32% of service delivery; 13% of youth and family engagement; 27% of team formation; 21% of team participation; and 29% of care coordination and transition planning.[116]

70. The four MCEs conduct chart reviews for children with SED using a standardized series of questions or probes organized under six categories of service delivery: record keeping, assessments, treatment planning, ongoing care, care coordination, and transition.[117] A summary of the 2019-2020 findings of chart reviews conducted by the two largest MCEs – Beacon Health and MBHP – focuses on the 12 questions that correlate with requirements of the Judgment.[118]

71. Beacon's ICC chart reviews for 2019 and 2020 included over one hundred randomly selected ICC case files, with at least one from each of the 32 Community Service Agencies (CSAs). Between 15-35% of comprehensive assessments and 20- 28% of treatment plans were not completed in a timely way. In 45-50% of charts reviewed, there was no evidence that the ICC assessments were shared with the parent /caregiver, and regular discussions regarding the engagement of natural supports were absent in 43-49% of cases. The level of care coordination was not appropriate for the level of need in 20-22% of cases, and between 39-40% of team members were unaware of transition and discharge criteria.[119]

72. Between 23-24% of Beacon's IHT assessments and 20-30% of treatment plans were not completed in a timely way. In 37-53% of cases, there was no evidence the assessment was shared with the parent/caregiver, and regular discussions of natural supports were absent in 67-68% of cases. The level of care coordination was not appropriate in 35-53% of cases reviewed, and between 60-64% of teams were unaware of transition and discharge criteria.[120]

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[112] Ex. 19 - Summary of ICC and IHT MPR Scores: FY2017-2020 at 3.
[113] *Id*. at 3.
[114] *Id*. at 4.
[115] *Id*. at 3-4.
[116] *Id.* at 1-2.
[117] Ex. 26 - Affidavit of Karen Detmers, ¶¶ 23-29.
[118] Ex. 20 - Summary of MCE Chart Review Scores for Beacon Health and MBHP: 2019-2020.
[119] *Id.* at 1.
[120] *Id*. at 2.

73. Between 46-51% of MBHP's assessments and 50-63% of treatment plans were not completed in a timely way by ICC providers. In 49-56% of cases, there was no evidence the comprehensive assessment was shared with the parent/caregiver, and discussions on the engagement of natural supports were absent in 50-51% of cases. Inappropriate care coordination showed the level of need did not match the level of coordination delivered in 13-17% of cases reviewed. There was no evidence that teams were aware of transition criteria in 30-36% of cases.[121]

74. Between 24-46% of MBHP's IHT assessments and 46-47% of treatment plans were not completed on time. In 54-73% of charts, there was no evidence the assessment was shared with the parent or caregivers, and between 68-78% of cases showed no evidence of regular discussions on the engagement of natural supports. The level of care coordination was found to be inappropriate for the level of need in 22-23% of cases reviewed, and 40-50% of charts showed no evidence teams were aware of transition criteria.[122]

V. Required Assessments

75. 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 30-54% for inpatient settings, and 38-69% for CBAT programs. 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.[123]

76. Defendants have provided no current data, or even data more recent than 2017, concerning CANS compliance by provider. In fact, as noted in their response to plaintiffs' document request, "the technological issues identified in 2018 relating to the CANS data were resolved in 2019. However, MassHealth continues to work to determine the extent to which ongoing data reliability is impacted. The CANS quarterly report has been suspended while this work is ongoing."[124]

77. Notably, defendants have produced no data demonstrating compliance with CANS assessments for any DMH facilities or programs, even though DMH is a central provider of intensive, facility-based services.

VI. Mobile Crisis Services

78. MBHP generates quarterly reports on MCI utilization which identifies the number of MCI "encounters" by location – either in the community or in a hospital setting. These reports include historical encounter data by location dating back to 2010.[125]

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[121] *Id*. at 3.
[122] *Id*. at 4.
[123] Ex. 21 - Summary of CANS Assessments by Level by Program Type: FY15-17.
[124] Ex. 1 - Plaintiffs' Document Request Emails at 4.
[125] Ex. 22 - MBHP Report on MCI Encounters by Location: 2010-2019 at 15.

79. "Mobile Crisis Intervention provides mobile, community-based crisis intervention services, which are intended to reduce the volume of emergency behavioral health services provided in hospital emergency departments (EDs) and ESP offices, to reduce the likelihood of psychiatric hospitalization, and to promote resolution of crisis in the least restrictive setting and in the least intensive manner."[126]

80. "An answering machine or answering service is not permitted, including those directing callers to call 911 or to go to a hospital emergency department (ED). Mobile Crisis Intervention arrives within one (1) hour of receiving a telephone request 24 hours a day, 365 days a year. For remote geographical areas, Mobile Crisis Intervention arrives within the usual transport time to reach the destination."[127]

81. Seventeen percent (17%) of children are hospitalized as their first service after MCI, while another 23% receive emergency treatment as their first service after MCI. An additional 13% of youth receive no services in the 45 days after MCI.[128]

82. The Commonwealth, through its Executive Office of Health and Human Services (EOHHS), has proposed, funded and begun to implement several systemic reforms which include "Establishing **Community Crisis Stabilization (CCS) for youth** to provide short-term, intensive 24-hour treatment, expanding a service currently only available for adults."[129] This is essentially the same service as required by the Judgment, ¶ 32(b).

RESPECTFULLY SUBMITTED,
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[126] Ex. 23 - MCI Performance Specifications at 2.
[127] *Id.* at 7.
[128] Ex. 24 - EOHHS Report on MCI Follow-up Services: 2019-2020 at 3.
[129] Ex. 25 - Roadmap for Behavioral Health Reform at 10.

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CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2021, I electronically filed the foregoing document using the CM/ECF system. I certify that the counsel of record are registered as ECF filers and that they will be served by the cm/ecf system to: Daniel J. Hammond, Daniel.Hammond@mass.gov and Douglas Martland, Douglas.Martland@mass.gov

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