UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

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

INTERIM REPORT ON IMPLEMENTATION

The Defendants hereby submit this Interim Report on Implementation ("Report") as requested by the Court at the June 27, 2014 status conference, in preparation for the hearing scheduled for October 14, 2014.

The Defendants hereby report as follows:

In the three months since the last status conference, the Defendants, the Plaintiffs and the Court Monitor have met (in person or on the phone) five times, on July 7, August 6, August 25, September 8 and September 19. In anticipation of those meetings, the Plaintiffs identified four outstanding areas of concern in the Defendants' implementation of the Judgment. These -- together with several areas of concern which have already been addressed, but for which data are currently being collected to assess the efficacy of the proposed "fix" – comprise the universe of issues the parties have agreed to confront as a prologue to judicial disengagement. The parties' meetings focused exclusively on these four outstanding issues, as will the instant Report.

I. Plaintiffs' Four Areas of Concern

The parties wrote four "goal statements" to capture the essence of the Plaintiffs' concerns and state the parties' shared policy goal. The parties are in agreement with respect to three of the four goal statements, with a small difference of opinion on the goal statement regarding the functioning of outpatient therapy as a clinical hub for remedy services. That difference is noted in a footnote to the "Outpatient as a hub" goal statement below. In addition to the goal statements, the parties have effectively collaborated to develop actions the Defendants have taken or will take to achieve each policy goal.[1] The goals and action steps are listed below. The Defendants have not waited until the parties have reached agreement on all items prior to implementing agreed-upon actions, but have worked promptly to implement a number of changes and improvements as the parties reached consensus on them. Accordingly, this document identifies both what Defendants are willing to agree to, as well as including activities that the Defendants have already implemented or are in the process of implementing.

A. Mobile Crisis Intervention ("MCI")

GOAL: *Decrease the inappropriate and unnecessary use of Emergency Departments ("ED"s) as settings for MCI encounters, whether due to program factors internal to the MCI provider or due to the behavior of external referral sources.*

The Defendants have:

- Changed the MCI encounter form to collect information about referrals to emergency rooms, specifically, whether families self-refer or are referred by others, and, if referred by others, by whom. The form will be used starting November 1, 2014, with the first data available for review on January 15.

[1] Some of the actions listed were in process prior to negotiations, but are listed here to provide context to the overall approach to reaching each goal.

- Revised the quarterly MCI Key Indicators Report to report the data on the location of the encounter and the case disposition by age bands. The report due in December will collect the data for two groups, youth 0-18 and youth 19-20. The report due in March will collect the data for three groups, youth 0-14, 15-18 and 19-20.

The Defendants will agree to:

- Engage Kappy Maddenwald to review the current performance of MCI providers. This will be completed in the first quarter of calendar year 2015.
- Arrange one or more meetings between the parties, the Court Monitor and Ms. Maddenwald to: 1) discuss her review and analysis of the MCI provider system, including its DMH-operated programs; 2) consider potential strategies for achieving higher rates of community encounters; and 3) examine the results of data collection efforts listed above, and their relationship to proposed improvement strategies. This is to be completed within one month of the conclusion of Ms. Maddenwald's review of the MCI provider network.
- Use this information to develop practical policy, administrative and/or program changes, with input from the Plaintiffs, to promote increased referral to and use of community-based MCI.
- Continue to work closely with DMH to improve the performance of their ESP/MCI programs.

B. Outpatient as a Hub

GOAL: For children or youth receiving outpatient therapy but not receiving IHT or ICC services, ensure that the outpatient provider: 1) regularly assesses the child/youth's need for

more intensive care coordination or other remedy services; 2) expeditiously discusses the need for other services with the parent or caregiver; 3) offers to either make a referral to needed services or assist the caregiver to make the referral; and 4) with the caregiver's permission, participates in phone calls and/or meetings with the family and the new provider(s). In particular, if the outpatient provider becomes aware that the youth appears to meet medical necessity criteria for IHT and/or ICC, the outpatient provider must inform the youth's caregiver(s) about these services and offer to help the caregiver access one or both services for the youth. [2]

The Defendants have:

- As of May 2014, denied payment to outpatient providers for clinical assessments unless the CANS is completed. The Defendants have had a longstanding interest in denying payment for non-completion of the CANS. System improvements cleared the way for MassHealth to do so, and it notified providers of the change earlier in the spring. This produced immediate and dramatic improvement in CANS completion rates:

[2] This is the Defendant's formulation of the appropriate goal for outpatient-as-a-hub. The Plaintiffs' preferred language is: "For children or youth receiving outpatient therapy but not receiving IHT or ICC services, ensure that the outpatient provider regularly assesses the child/youth's need for more intensive care coordination or other remedy services. If the youth meets the medical necessity criteria for IHT or ICC, the outpatient provider must: 1) inform the youth's parent/guardian about these services; 2) <u>make the appropriate referral on their behalf, unless the parent/guardian declines;</u> and 3) with the parent/guardian's permission, participate in phone calls and/or meetings with the family and the new provider(s)." (Emphasis supplied.) As the underscored language makes clear, the parties' lingering dispute turns on whether an outpatient clinician should (a) refer a child/youth to an ICC or IHT provider at the direction of a parent or caregiver who has been briefed on the benefits of those services and for whom the provider has offered to arrange for the referral; or (b) make that referral as a matter of course upon finding that the child/youth meets the medical necessity criteria for the service, unless specifically directed not to do so by the parent or caregiver. The parties continue to discuss the implications of each alternative.

Health Plan	April	May	June
Boston Medical Center/HealthNet	60%	64%	85%
Cambridge Health Alliance/Network Health	64% (April: 51%)	62%	65%
MBHP	63%	67%	70%
Neighborhood Health Plan	51%	58%	82%

- Directed outpatient providers to give the CBHI brochure to all families of EPSDT-age youth at the time of the initial visit to ensure that families are not only informed about the availability of remedy services, but have a tangible description to refer to at home.
- Redistributed the In Home Behavioral Services "Hub" waiver policy[3] to all CBHI and Outpatient providers to ensure that clinicians are aware of the option and how to obtain a waiver.
- Directed MassHealth's contracted health plans to re-distribute a billing guide to providers. This was re-distributed in response to outpatient providers' complaints that they were not paid for communicating with a child's school teachers, pediatricians or other providers, when MassHealth actually does pay for such activity when providers bill for it.

[3] The policy is to permit a child to obtain In Home Behavioral Health Services under circumstances in which a child does not need the services of a Clinical Hub (outpatient, In Home Therapy or Intensive Care Coordination). For example, a child with Autism and limited language ability would not be able to benefit from the language-based therapies used in outpatient therapy or IHT. If, in addition, the child did not have a need for ICC, the waiver would allow the child to receive IHBS services independent of a Clinical Hub service.

- Directed MBHP to investigate the current state of outpatient practice through a study of a sample of children and youth receiving outpatient therapy as their only "hub" service. The study will also include an analysis of outpatient claims data to identify the extent to which outpatient providers are billing for collateral contacts and case consultations. The Outpatient Study Report will be available in December, 2014.[i4]

The Defendants will agree to:

- Conduct meetings of the parties and the Court Monitor to review the Outpatient Study Report soon after its release.
- Use this information to devise feasible and practical policy, administrative and/or program changes as necessary, with input from the Plaintiffs, to promote appropriate referral by outpatient providers to other medically necessary behavioral health services, including appropriate levels of care coordination.
- Develop and disseminate written guidance for outpatient providers regarding their obligation to provide regular assessment of a youth's need for other behavioral health services, including higher levels of care coordination. MassHealth will develop the guidance document by the end of November and revise it, if necessary, based on the results of the Outpatient Study due in December. It will be disseminated to outpatient providers in January 2015.
- Redesign the CANS training curriculum and certification test to support providers' effective performance of hub roles. The revised training will include information on

[4] As Defendants noted in their last Status Report, this Outpatient Study Report is a re-boot of a prior attempt to canvass the same landscape, the flawed methodology of which yielded data that were largely unresponsive to the questions posed.

all of the remedy services, the role of referral and care coordination in each of the hubs and the role of the CANS in service planning and clinical collaboration. This is due to be implemented in the summer of 2015.

- Disseminate written guidance, including the redesign of the CANS training curriculum, described above, and develop and provide training for providers.
- Add questions and prompts to the CANS to 1) trigger the provider to re-assess the youth's need for care coordination and other remedy services every 90 days; 2) prompt the provider to both help families access the needed services and to collaborate with the new provider(s) and 3) document the provider's discussion of new services with the family and whether the family accepted or rejected the recommendations. These changes require significant programming changes to the CANS application. MassHealth is in the process of developing a budget and timetable, but at this point the completion date is to be determined.
- Develop and share a report displaying data collected on the new CANS questions referenced above. Production date and frequency have not yet been determined.
- Implement the Defendant's improved CANS consent form (developed this Spring) to facilitate sharing of CANS assessments among clinicians working with a member, including outpatient providers, whether or not they are functioning as the hub. The new form will be available through the CANS application in January 2015.
- Revise the CBHI Protocols with the child-serving agencies during State Fiscal Year 2015. The revisions are intended to encourage state agency staff to provide information about ICC and/or IHT to families of youth who appear to meet medically

necessary criteria for one or both of these services. Revisions will be completed by June 30, 2015.

C. Intensive Care Coordination

GOAL: Ensure access to ICC for children and youth who meet medical necessity criteria for the service and ensure that ICC providers deliver high-quality ICC services.

The Defendants have:

- Counted the number of children and youth who have received[5] ICC in the period from June 30, 2009 through June 30, 2014. The unduplicated number of children who have received ICC is **24,704.**
- Directed the MCEs to identify CSAs with an enrollment of fewer than 75 Members in any of the past three months, reporting the results to the Office of Behavioral Health ("OBH") by August 20. The Defendants further directed the MCEs to meet with each of these CSAs by September 30 to review possible reasons for low enrollment and potential ways to increase enrollment, and to report back on general themes to OBH by October 15th.
- Directed the MCEs to identify CSAs with Care Coordinator caseloads of 16 or higher in any of the past three months, reporting the results to OBH by August 20. The Defendants further directed the MCEs to meet with each of these CSAs by September 30 to review their case practice, and report back on general themes to OBH by October 15th.

[5] This is a count of all Members under 21 with at least one claim for ICC.

- Clarified expectations for IHT providers regarding assessment of need for care coordination and referral to needed services, as part of the IHT Practice Guideline's coaching and training curriculum.
- Reviewed ICC enrollment as a percentage of DCF enrollment in each DCF area/ICC catchment area.

The Defendants will agree to:

- As noted above, add questions and prompts to the CANS to trigger 1) a review by an outpatient or IHT clinician of a youth's need for care coordination or other remedy services every 90 days; and 2) steps to help families access IHT or ICC if needed.
- As noted above, revise the CBHI Protocols with the child-serving agencies to encourage State Agency staff to provide information about ICC and/or IHT to families of youth who appear to meet medically necessary criteria for one or both of these services.
- Hold a meeting with the plaintiffs and the Court Monitor to discuss: 1) ICC data collection referenced above; 2) strategies to increase CSA utilization and enrollment while maintaining appropriate caseloads; and 3) the written summaries of the Fall 2013 – Spring 2014 SOCPR findings and recommendations regarding the provision of high quality assessments, treatment planning and care coordination by ICC providers.

D. Clinical Outcomes

GOAL: Implement a regular cycle of analysis of CANS data to monitor the demographic and clinical characteristics of children and youth using CBHI services and the clinical impact of those services.

The Defendants have:

- Designed and are in the process of implementing multiple measures to improve the quality of clinicians' CANS ratings. These include: 1) use of an improved consent form to allow clinicians to share CANS assessments with other clinicians working with the same youth, expected in January 2015; 2) a complete revision of the CANS training and certification materials, expected in Summer 2015; 3) adding an outcomes report-generating capacity to the CANS application for CANS providers, expected date to be decided.

The Defendants will agree to:

- Design semi-annual CANS data reports that will allow the Defendants to monitor the demographic and clinical characteristics of the class members using CBHI services and the clinical impact of those services. To monitor clinical impact, the reports will include data on changes in the first three CANS domains (functioning, symptoms and risk factor) on the item and domain levels, and also report data using the Reliable Change Index methodology for change at the domain level. Expected date of completion of the report design: 12/31/14
- Produce the first report by March 31, 2015.
- Continue to analyze these data to explore pertinent issues that come to MassHealth's attention through MCE network management activities, case reviews, other data reports and anecdotal reports.

The Defendants will not only agree to monitor the characteristics of children and youth using CBHI services and the clinical impact of those services, but will make these reports public by posting them, with explanatory narrative, on the CBHI website.

II. Additional reports or other deliverables in addition to the activity in Section I:

- Practice Guidelines – the MCI and IHT Practice Guidelines are in final form after review by the Plaintiffs and will be published in October. The Practice Guidelines for In Home Behavioral Services and Therapeutic Mentoring have been revised and are being reviewed by stakeholders. They will be ready for Plaintiff review in mid-to-late October. Expected publication date: 12/31/14.
- The Southeast, Western and Statewide SOCPR reports are undergoing final edits and are anticipated to be available in November 2014.
- Updated utilization data on IHT, TM and IHBS, expected to be available by 12/31/14.
- The 2013 Clinical Topic Review conducted by Commonwealth Medicine on Behavioral Health Screening Among MassHealth Children and Adolescents. The Defendants have received a draft version of the report; the final version is expected by early November 2014.
- The Outpatient Study, expected in December 2014.

Respectfully Submitted,

MARTHA COAKLEY
ATTORNEY GENERAL

/s/ Daniel J. Hammond
Daniel J. Hammond, BBO #559475
Assistant Attorney General
Government Bureau
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-2200, Ext. 2078

Date: September 26, 2014

I hereby certify that a true copy of this document was served electronically upon counsel of record through the Court's electronic filing system on today's date.

/s/ Daniel J. Hammond
Daniel J. Hammond
Assistant Attorney General