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

DEFENDANTS' OPPOSITION TO PLAINTIFFS' EMERGENCY MOTION TO REQUIRE ADHERENCE TO PUBLISHED SPECIFICATIONS AND CRITERIA FOR IN-HOME BEHAVIORAL SERVICES

The Massachusetts Executive Office for Health and Human Services ("EOHHS"), defendant in the above-captioned matter, hereby opposes the emergency motion ("Motion") of the plaintiffs for an injunction barring EOHHS from implementing any refinement of the credentialing requirements for clinicians delivering In-Home BehavioralSupports ("IHBS") set forth in the defendants' applicable State Plan Amendment.[1] In support of its opposition, EOHHS states as follows:

Background

[1] This opposition does not address the suggestion in the plaintiffs' Motion that EOHHS has unilaterally altered the medical necessity criteria for a member to be eligible for IHBS. As discussed at length at the September 28, 2009 status conference, no such change has been effectuated, nor is one contemplated. To the extent that statements by Managed Care Entities or consultants created a perception that medical necessity criteria had been narrowed, EOHHS has committed to take the necessary steps to cure that misperception.

1. The instant controversy arises in the context of the run-up to the implementation of IHBS, a service which, pursuant to a February, 2009 order of this Court, went into effect on October 1, 2009.

2. In anticipation of implementing IHBS, EOHHS (after extensive consultation with the plaintiffs) submitted a description of the new service to the federal Center for Medicaid and Medicare Services ("CMS") as part of its State Plan Amendment governing the remedy services in this case. CMS approved the State Plan Amendment for IHBS in June, 2009. The language in the State Plan Amendment regarding credentialing requirements for clinicians providing IHBS was, in turn, incorporated into MassHealth's performance specifications for IHBS, which were promulgated in October, 2008.

3. That language, in relevant part, stated only that, in order to serve as an in-home behavior therapist whose services would be Medicaid-compensable, a person must:

a. Be a Master's-level (or higher) clinician.

b. Have a minimum of 20 hours of coursework and training in conducting behavioral assessments and selecting, implementing, and evaluating intervention categories.

c. Have two (2) years of relevant experience providing direct services to youth and families who require behavior management to address mental health needs.

d. Have supervised experience conducting behavioral assessments and designing, implementing, and monitoring behavior analysis programs for individuals.

See October 2008 IHBS Performance specifications, attached to Motion at Exhibit 1, page 3 (emphasis added).

4. Beginning in July, 2009, as the implementation date for IHBS neared, EOHHS started to hear, from the Court Monitor and from individual Managed Care Entities ("MCEs"), that providers that had indicated an intention to provide IHBS had an incomplete understanding of what the service entailed and, more distressingly, an unrealistic plan for delivering the services through clinicians who manifestly lacked the experience and/or training contemplated (but not made explicit) by the performance specifications. A more detailed chronology of these communications is set forth in the Affidavit of Emily Sherwood (the "Sherwood Affidavit"), attached as Exhibit A hereto.

5. After consultation with EOHHS, the MCEs determined that the most effective way to ensure an appropriate level of quality in the incipient IHBS would be to provide more detailed guidance as to the nature of "training in conducting behavioral assessments and selecting, implementing, and evaluating intervention categories" contemplated by the performance specifications. Accordingly, on or about September 4, 2009, the MCEs issued a provider alert to all of their enrolled network providers clarifying that, in order to provider compensable IHBS, a clinician must be trained and certified in Applied Behavioral Analysis ("ABA"). EOHHS approved the provider alert before it was issued.

6. As explained in more detail in the Affidavit of Suzanne Fields (the "Fields Affidavit"), attached hereto as Exhibit B, and in the defendants' September 24, 2009 Status Report, ABA certification was selected because it is the national standard for certification for behavioral therapy (with well over 400 clinicians in Massachusetts currently holding the credential), and best embodies or certifies the therapeutic skill set that an IHBS provider would need.

7. As described in the Sherwood Affidavit, the plaintiffs, upon learning of the provider alert, expressed strong reservations that requiring clinicians to hold ABA certification would tend to limit the number of clinicians able and willing to provide IHBS during its start-up phase, and would consequently threaten to suppress access to the service for MassHealth clients, particularly in the state's les populous regions. While EOHHS did not necessarily agree with that proposition, it did engage in intensive discussions with the plaintiffs and the Monitor, in an effort to address that concern. See Sherwood Affidavit at ¶¶ 4-5. Ultimately, EOHHS proposed the issuance of an amended provider alert, stating that IHBS providers could apply to the MCEs for a waiver of the ABA certification requirement on behalf of clinicians who met one of three additional criteria:

a. The clinician was enrolled in an ABA training program;

OR

b, The clinician was a clinical psychologist with experience performing functional behavioral assessments and implementing and evaluating intervention strategies;

OR

c. The clinician held a Master's-level degree and was working under the supervision of an ABA-certified clinician.

8. The plaintiffs ultimately rejected the proposed waiver criteria as insufficient, in their view, to ensure a minimally acceptable level of access to IHBS upon its implementation. The plaintiffs accordingly filed the Motion on September 23, 2009, seeking an injunction that would bar EOHHS from giving effect to the MCEs' provider alert and making any clinician who met the general criteria set forth in the performance

specifications eligible to provide IHBS, at least until such time as the parties could agree upon additional criteria, if any, that should be required.

9. On September 24, 2009, the MCEs, at EOHHS's direction, issued an amended provider alert, informing providers that any clinician who was ABA-certified or who met any of the other three criteria that had initially been proposed as grounds for a waiver request, could provide compensable IHBS.[2]

Grounds for Opposition to Request for Injunction

10. As with any request for equitable relief, this Court should grant the plaintiffs' Motion only if it finds that (a) the plaintiffs are likely to succeed on the merits of their request; (b) the plaintiffs would suffer more irreparable harm if the Motion is denied than EOHHS would suffer if it were granted; and (c) issuance of the Motion serves the public interest. See, e.g., Narragansett Indian Tribe v. Guilbert, 934 F.2d 4, 5 (1st Cir. 1991). Because the plaintiffs satisfy none of these three prongs, their Motion should be denied.

Balance of the Harms

11. In support of their request for injunctive relief, the plaintiffs argue, in essence, that access to IHBS will be unduly restricted, particularly in the state's more rural and less populous regions, if eligibility to provide such services is limited to those who meet one of the four credentialing criteria set forth above. In support of that contention, the plaintiffs rely upon preliminary responses to an e-mail survey MCEs sent to providers, inquiring into the providers' intention to provide IHBS in light of the (then-

[2] To be clear: Tthe September 24, 2009 provider alert made clinicians who met any of the three new criteria eligible to provide IHBS, not merely eligible to apply for a waiver of the ABA-certification requirement, as had been initially proposed.

extant) requirement that eligible clinicians be ABA-certified. See Exhibit 5 to Motion. The plaintiffs also cite communications they received directly from providers and stakeholders, suggesting that too few clinicians (particularly in Western Massachusetts) held ABA certification to allow for an acceptable level of access to IHBS if the new credentialing requirement remained in place. Id.

12. To date, the empirical data available to EOHHS do not confirm this assertion. As set forth in detail in the Fields Affidavit, 18 providers statewide have begun providing IHBS services, and seven more have to date confirmed to EOHHS that they intend to begin offering IHBS at some point during October, and currently have one or more clinician in their employ who meets one or more of the new credentialing requirements. See Fields Affidavit at ¶ 6. Of that number, three provider agencies are located in Western Massachusetts, not counting the Massachusetts Behavioral Health Partnership ("MBHP"), which has contracted with an additional provider organization in Western Massachusetts and in several other regions. Id. at ¶ 6.. Moreover, as detailed in the Fields Affidavit, this level of access compares favorably in many respects to that of the Family Stabilization Teams ("FSTs"), an established service that EOHHS has operated for almost 15 years. Id. at ¶ 6. It is the considered opinion of EOHHS that this level of access will be sufficient to satisfy even optimistic estimates of demand for IHBS during its earliest phase. Id. at ¶¶ 6-8.

13. It is well-settled that, in weighing a request for injunctive relief in the context of ongoing litigation, a court should consider only allegations of irreparable harm that are actual and readily apparent from the record. See, e.g., State of New York v. Nuclear Regulatory Commission, 550 F.2d 745, 755 (2nd Cir. 1977) ("injunctive relief

can and should be predicated only on the basis of a showing that the alleged threats of irreparable harm are not remote or speculative but are actual and imminent"). Where there is, at the very least, substantial doubt about the extent to which access will be limited by the credentialing requirements set forth in the September 23, 2009 provider alert, the plaintiffs cannot demonstrate that the balance of harms favors granting the requested injunction.

Public Interest

14. As described in more detail in the Fields Affidavit, enjoining the effect of the more specific credentialing requirements risks giving rise to the very problem that the provider alert was designed to prevent: the provision of In-Home Behavioral Supports by clinicians who lack the training and experience to do the job well. Both the MCEs and, to some extent, the Monitor acknowledged that the benefits of IHBS would be undermined if providers used existing personnel, many of whom lacked rigorous training in behavioral assessment and intervention, to provide the service. See Sherwood Affidavit at ¶ P 2-3. Yet, according to feedback received by the Monitor and MCEs, this is precisely what some providers were intending to do, based upon their (presumably) good-faith reading of the credentialing requirements set forth in the performance specifications, before the MCEs intervened by issuing their more detailed provider alerts. See Sherwood Affidavit at ¶¶ 2-3; Fields Affidavit at ¶¶ 3-4. The public interest would not be served by reinstituting this state of affairs.

15. Moreover, as described in the Fields Affidavit, it would be exceedingly difficult, as a functional matter, to tighten credentialing requirements after IHBS has been implemented, as plaintiffs suggest the parties could agree to do if, after the injunction

were granted, it became apparent that EOHHS's quality concerns were well-founded. It is relatively foreseeable that, in reliance upon the (minimalistic) credentialing requirements set forth in the performance specifications, providers would make hiring decisions and formulate business plans based upon their assumption that specific certifications would not be necessary for IHBS clinicians – decisions that would be exceedingly difficult to modify if credentialing criteria were subsequently made more rigorous. See Fields Affidavit at ¶ 9. Accordingly, as a functional matter, clinicians who began providing IHBS in conformance with the more general performance-specification language would almost have to be "grandfathered in" as compensable providers, thereby perpetuating what could turn out to be a substandard level of care. Id.. This, too, would subvert the public interest in a robust and effective IHBS.

Likelihood of Success on the Merits

16. At bottom, EOHHS approved the MCEs' provider alert clarifying the credentialing criteria for clinicians providing IHBS because it was persuaded that such clarification was necessary to safeguard the quality of such services once they started being delivered. As discussed at the September 28, 2009 status conference, EOHHS did not then perceive (and does not now concede) that such clarification could be effected only at the expense of decreased access to the program services.[3] In order to prevail on the merits of their injunction request, the plaintiffs must demonstrate, on the existing record, (a) that such an implicit trade-off between quality and access actually exists; and (b) that EOHHS's balancing of these two objectives (if that is indeed what it did) was unreasonable. On the sparse factual record that presently exists, they cannot do so.

[3] Indeed,its inability to foresee that the proposed change would be interpreted in this way led to the delay in including the plaintiffs in this discussion – an omission that, in hindsight, EOHHS regrets.

17. As discussed above, EOHHS was confronted, virtually on the eve of the IHBS implementation date, with credible indications of an incipient problem: i.e., that IHBS was likely to be delivered by providers using clinicians who – while arguably satisfying the bare-bones training and experience criteria set forth in the performance specifications – nonetheless lacked proficiency in key aspects of behavioral therapy. EOHHS ultimately addressed the problem by working with the MCEs to require specific credentials for IHBS clinicians, as a means of ensuring the quality of the services actually delivered. The plaintiffs argue that the more rigorous credentialing requirements will likely restrict access to IHBS on the part of children and families needing that service. To date, however, the empirical data available do not support that contention. See Fields Affidavit at ¶ 6.

18. Of course, in the unlikely event that future data tend to show that such access problems are indeed real, and that they are in fact a byproduct of the more rigorous credentialing requirement, a timely motion filed at such time might fare differently. However, such a motion would likely not even be necessary, given that, if access truly proved to be threatened, it would be in all parties' interest for the plaintiffs, the Monitor, and EOHHS to revisit the credentialing criteria and to make any changes necessary to ensure adequate access.[4] On the existing record, however, that bridge need not be crossed.

WHEREFORE, EOHHS respectfully requests that this Court enter an order denying the Motion, without prejudice.

[4] Indeed, EOHHS has already indicated to the parties its willingness to engage in such discussions. See Fields Affidavit at ¶¶ 10-11.

Respectfully submitted,

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Date: October 5, 2009

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

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