UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS,
WESTERN DIVISION

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

DEFENDANTS' REPORT ON DISENGAGEMENT

Now comes the Commonwealth of Massachusetts, through the Executive Office of Health and Human Services ("EOHHS" or "Defendants"), within its role as the sole State agency responsible for administering the Massachusetts Medicaid Program ("MassHealth"), and hereby files this Report on Disengagement (the "Report"). This Report covers the period since April 6, 2017, the date of the most recent prior status conference.

A. INTRODUCTION

Prior to the last status conference, the Parties jointly agreed upon and separately submitted to the Court certain Disengagement Criteria ("Criteria"). In order to monitor the progress toward the accomplishment of the Criteria, the Parties agreed upon two formal data inquiries, the first completed by the end of December, 2017, and the second by the end of December, 2018. This Report updates the court on Defendants' progress in gathering data related to the inquiries. This Report also summarizes certain activities that Defendants are taking to meet the targets set forth in the Criteria.

Consistent with the Court's instruction, the Parties met on September 5, 2017, to discuss

advancement toward meeting the Criteria, progress toward targets, and the current activities designed to meet the targets. The Court Monitor presided at that meeting.

This Report does not address any pending motions by the Plaintiffs, as Defendants have already responded to those motions, which remain pending before this Court.

The Disengagement Criteria document is a potentially confusing series of references to cross-cutting permutations of services, measures, and domains. To address this concern, this Report is organized to be easily and generally understood, with citations to the Criteria whenever needed.

Thus, this Report will address:

I. Access to Intensive Care Coordination ("ICC") and In-Home Therapy ("IHT")[1] services;

II. Quality of ICC and IHT[2];

III. Care Coordination for class members in Outpatient ("OP") Therapy as a Hub[3]; and

IV. Sustainability Planning.

B. DISENGAGEMENT OUTCOME MEASURES

I. Access to ICC and IHT[4]

Access, under the Disengagement Criteria, is measured by monthly reports for both ICC and IHT, gauging the percentage of members who are offered an appointment not more than 14 days after their initial request. This is not equivalent to the number of members who accept an initial appointment within that time period, as some families, for a variety of reasons, choose not

[1] *See* Disengagement Measure 1.
[2] *See* Disengagement Measures 2, 4, 5 and 6.
[3] *See* Disengagement Measure 3.
[4] *See* Disengagement Measure 1. While Disengagement Measure 2 is associated in the Criteria with Access to Hub-dependent services, it is measured by MPR practice quality in MPR areas 5, 6, and 7, and will be addressed in Section II on Quality.

to accept the earliest appointment offered. The pertinent information is self-reported monthly by ICC and IHT providers to the Massachusetts Behavioral Health Partnership ("MBHP") and then forwarded to MassHealth. The Disengagement Criteria set forth an expectation of an increase in access by 7.5% per calendar year in 2017 and 2018, in nine out of twelve months during each year, using June 2016 levels as a baseline. Although Defendants agreed to this goal as establishing aspirational targets, Defendants continue to believe that the current wait times are due to factors largely outside the Defendants' control.

Monthly reports demonstrating the access percentages for an appointment available within fourteen days of the initial request for the first seven months of calendar 2017 are presented in Exhibit 1. 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. As set forth at length in prior filings, Defendants argue access problems are primarily due to current and pervasive workforce shortages affecting many industries and frequently reported in the press. In an analogous field, drawing from an overlapping staffing pool, the Boston Globe recently reported: "Addiction treatment agencies in Massachusetts are struggling to hire and train enough people to care for their patients."[5] In an environment free of these extreme workforce challenges, Defendants have demonstrated that they can provide access to ICC and IHT services within the Commonwealth's Medicaid standard. For example, the average access for the 2014 calendar year shows 90% of youth seeking ICC were offered an initial appointment within 14 days. The Defendants express considerable uncertainty about their ability to achieve the Access Criteria within the two-year

[5] Freyer, Felice J. "Opioid agencies face dilemmas." *The Boston Globe*, August 29, 2017. Web. 11 Sep. 2017.

time-frame, considering the factors beyond the control of the Commonwealth, including labor market conditions and clinician shortages. The Defendants further state that, regardless of their ability to achieve the target percentages, they continue to strive to provide access to all members within this time standard, and would continue to do so even without Court intervention.

Whether or not the access targets can realistically be met, MassHealth has taken a series of actions to ameliorate waits for CBHI services, including the following:

1. MassHealth's MCEs track provider access data monthly and make access a high priority in reviewing program performance. Any providers with recurring waits for service must work towards improved access as a goal, and submit program performance improvement plans to the MCEs. Examples of program performance improvement plan measures include enhanced recruiting efforts and development of relationships with graduate training programs.

2. The Office of Behavioral Health ("OBH") and the Children's Behavioral Health Knowledge Center ("CBHKC") at the Department of Mental Health ("DMH") have initiated multiple efforts to enhance both the quality and the flow of qualified staff into IHT and ICC programming. Very rarely can these efforts provide a quick payoff; most represent long-term investments in workforce development. Examples include:

- Attracting graduate students to CBHI internships and strengthening the internship experiences so more interns join the CBHI workforce. In order to accomplish this, MassHealth has developed an Integrative Seminar for IHT social work interns in the Boston area. To date, fourteen interns have been admitted to this program for the upcoming academic year (2017-2018). These interns will meet as a group five times during the course of their internship, and engage in a curriculum focused on practical skills that lead to success in IHT.
- Encouraging graduate programs to inform and attract students to CBHI-relevant courses

and to CBHI internships. CBHI has engaged numerous social work schools in this discussion state-wide, and plans to expand that engagement to counseling programs. As an example of the success of this outreach, Smith College School for Social Work offered a course designed and taught by MassHealth staff on IHT policy and practice, enrolling nineteen MSW students in the summer of 2017.

- Providing financial support for license-eligible clinicians to become licensed at the independent practice level. Financial support may include: transcription and validation of credentials from another country, provision of exam preparation courses or materials, and dispensation of examination and licensing fees. As of this writing, forty-two individuals have been approved for support under this effort. Of those forty-two individuals, four will work in ICC, twenty-eight in IHT, and ten in Mobile Crisis Intervention.

While the initiatives described above focus primarily on IHT, the Community Service Agencies ("CSAs") that provide ICC are eligible for infrastructure and workforce investments through Delivery System Reform Incentive Payment ("DSRIP") under the Federal Affordable Care Act. Although these payment contracts are still in procurement, Defendants anticipate that most CSAs will be funded for a variety of activities in 2018 and subsequent years. Defendants expect that DSRIP funding will likely be used, in part, for activities such as recruitment and training to enhance the CSA workforce and support improved access to ICC.

Defendants also expect that investments in quality measures, as outlined below, will produce the side-effect of staff retention, which will, in turn, lead to access improvement. Defendants posit that increasing efficacy of treatment and clinician effectiveness will lead to increased clinician job satisfaction and retention. Therefore, MassHealth sees the quality improvement initiatives as described in this Report as integral to – rather than distinct from -- the

accomplishment of access targets.

II. Quality in ICC and IHT[6]

Quality, under the Disengagement Criteria, is measured by the Massachusetts Practice Review ("MPR") for ICC and IHT. MPR scores ICC and IHT in the following areas: Assessment (Area 1), Service Planning (Area 2), Service Delivery (Area 3), Team Formation (Area 5), Team Participation (Area 6), and Care Coordination (Area 7). Each MPR area is rated on a 5-point scale: 1 = Adverse, 2 = Poor, 3 = Fair, 4 = Good, and 5 = Exemplary. The Criteria focus on the percent of reviewed cases that are scored in the "Good" or "Exemplary" Levels of practice (a score of 4 or 5, respectively). The Criteria establish a 10% improvement expectation in quality over the course of two years, and further stipulate that, except in rare circumstances, no child should be treated within an Adverse Level of practice (a score of 1). The MPR is conducted annually, collecting data on approximately sixty ICC cases in the fall, and approximately sixty IHT cases in the spring. The baseline year for IHT is 2016, and Defendants are permitted to choose either 2016 or 2017 MPR results as a baseline year for ICC, to reconcile the data production discrepancy. Defendants choose to use the 2017 calendar year as the baseline year for ICC, and, as a result, the first change scores for ICC will not be available until early in the 2018 calendar year.

MPR IHT reviews for the 2017 calendar year were completed and scoring results appear in

[6] In the Disengagement Criteria, MPR practice quality measures are variously associated with issues of Access (Disengagement Measure 2), Utilization (Measures 4 and 5) and Effectiveness (Measure 6). Quality measures, per the Criteria, are further discussed under the heading of Quality in ICC and IHT. In order to provide a further area of data, Defendants include the child progress area of the MPR, but underscore that no targets were established under the Criteria.

Exhibit 2. To summarize the results, changes over the 2016 baseline for areas 1, 2, 3, 5, 6, and 7 are as follows:

- 1 (Assessment) 7%
- 2 (Service Planning) 0%
- 3 (Service Delivery) 5%
- 5 (Team Formation) 14%
- 6 (Team Participation) 19%
- 7 (Care Coordination) 14%

The 10% target was achieved in three of six areas, and the mean change over six areas was 9.8%. Defendants contend that these findings are encouraging, and that the numerous initiatives they have adopted to enhance IHT quality are showing positive results, despite the workforce shortage and staff retention challenges. However, Defendants are cautious to rely on these data, as progress is unlikely to follow a linear path. Defendants' initiatives, many of which may be familiar to the Court from previous reports, include the following:

- Training Direct Service staff members. Training includes approaches such as ARC/GROW,[7] a trauma-informed approach to family treatment based on the Attachment/Self-Regulation/Competency model developed by the Trauma Center at Justice Resource Institute.
- Strengthening supervision for all service providers. Defendants are accomplishing this through two initiatives: Reflective Supervision and the Yale Supervision initiative.

[7] Attachment Regulation Competency ("ARC") works in tandem with the GROW Curriculum as a framework of intervention for youth and families who have experienced traumatic stress. The GROW Curriculum is based on an approach consisting of four modules: 1) "Grit to Great" – Self-Knowledge exercises; 2) "Rise, Rewire, Resilience" – Systemic Thinking exercises; 3) "Outsmart the Crowd" – Leadership Skills exercises; and 4) "Willpower the World" – Change Management Skills exercises.

Reflective Supervision is implemented through a training program for supervisors. The Yale Supervision Initiative provides organizational consultation on supervisory policies and procedures, as well as supervision training for program managers and clinical supervisors.

- Implementation of the IHT Practice Profile ("IHT PP"). The IHT PP is based on a model developed by the National Implementation Research Network at UNC Chapel Hill. This is a multi-year project during which:
    - Over the course of a year, IHT supervisors and other experts developed a highly detailed consensus description of IHT best practices. This was accomplished primarily during the 2016 calendar year;
    - IHT programs piloted three strategies for implementing the IHT PP, ending in October 2017;
    - To expand implementation within their organizations, IHT sites will spread best strategies to other IHT sites within their parent organizations, beginning in the fall and winter of 2017.
    - IHT pilot programs' best strategies will be expanded state-wide, beginning in the summer of 2018.

Initiatives such as building, testing and implementing the IHT PP, and influencing the curriculum and flow of students in clinical training programs, are long-term investments in quality.

III. Care Coordination in OP as a Hub

Disengagement Measure 3, items (2) and (3) state:

> (2) By December 31, 2017, the Defendants will conduct the initial targeted client record review designed to assess the quality of outpatient practice in areas similar to MPR Areas 5, 6, and 7 (Team Formation, Team Participation, Care Coordination) delivered by outpatient providers to a sample of MassHealth Members under the age of 21. This record review will determine a baseline measure of outpatient practice in these areas.

> (3) By December 31, 2018, the targeted client record review will demonstrate a 10% improvement over 2017 baseline scores in these areas.

The Parties have agreed that the Disengagement Criteria for 2017 will be the creation and implementation of a measurement tool for OP. Defendants have devised and piloted the client record review tool. Further, MassHealth staff, along with MassHealth's MCEs, will have collected baseline data on over one hundred outpatient charts by September 15, 2017. A copy of the chart review tool is filed as Exhibit 3 to this Report. Defendants will share with Plaintiffs and the Court Monitor a summary of baseline data, and any measurement issues arising in use of this tool, by October 31, 2017. The baseline will be used to establish the 10% improvement target for the period ending December 31, 2018, per the Disengagement Criteria. Defendants are on track to have fully implemented the agreement of the Parties related to improvements in OP.

IV. Sustainability Plan

The Criteria specify that:

> [B]y December 31, 2018, the Defendants will submit to the Court a sustainability plan concerning access to and the quality of remedy services described in the Judgment. The Defendants will develop the plan in consultation with the Court Monitor and will provide the Plaintiffs with an opportunity to review the plan at least 60 days prior to submission to the Court.[8]

Sustainability is a priority, and Defendants expect to satisfy this target by December 31, 2018.

C. CONCLUSION

It bears reiterating that, in 2012, Defendants made a *prima facie* showing of substantial compliance with the Judgment in this case, and since that time have continued to maintain that they are in full compliance with the Judgment. Nonetheless, at the Court's direction,

[8] *See* Disengagement Measure 7.

Defendants have worked with the plaintiffs and the Court Monitor, first to articulate areas of concern surrounding the Court's disengagement from this litigation, and then to identify specific ways of measuring the efficacy of the Defendants' quality-improvement efforts in those areas. The goal, both then and now, has been to demonstrate to the Court that the services created pursuant to the Judgment are now mature Medicaid services, which the Defendants are capable of managing as such, without continued Court intervention or oversight.

The Defendants submit this Report to provide a snapshot of their efforts in connection with each of the Disengagement Criteria. They do this even though, as noted, some measures may not prove to be realistically within the scope of the Defendants' control, and that progress in certain areas will not likely be linear in nature. Defendants ask that the Court consider these factors while determining the Defendants' progress toward the accomplishment of the Disengagement Criteria.

Respectfully Submitted,

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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.

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