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

INTERIM REPORT ON IMPLEMENTATION

The Defendants hereby submit this Interim Report on Implementation ("Report") as requested by the Court at the July 28, 2009 hearing in preparation for the hearing scheduled for September 28, 2009.

The Defendants hereby report as follows:

PROJECT 3: DEVELOPMENT OF THE SERVICE DELIVERY NETWORK

1. ***Status of Amendments to the Medicaid State Plan Submitted to the Centers for Medicare and Medicaid Services (CMS)***

As previously described in the Report on Implementation submitted to the Court on July 17, 2009, the Defendants, at CMS' request, submitted a new proposed State Plan Amendment for Crisis Stabilization. CMS has since issued a Request for Additional Information (RAI), on August 3, 2009, which the Commonwealth must respond to by

October 30, 2009. As part of the RAI, CMS asked the Defendants to submit a rate method for this service that establishes rates for each type of individual practitioner who may deliver the service at the Crisis Stabilization Services facility, as opposed to the rate method the Defendants first submitted, which established a Crisis Stabilization facility per diem rate. The Commonwealth's Division of Health Care Finance and Policy (DHCFP) has developed this methodology and new rates. DHCFP will provide public notice of the proposed rates and announce a datefor a public hearing shortly . Once DHCFP's public notice of the proposed rates is published, MassHealth will be able to submit its RAI response to CMS. Although the Defendants continue to hope that CMS will approve the Crisis Stabilization State Plan amendment with the proposed change in rate methodology, it remains uncertain whether approval will be forthcoming. The outstanding issue is the assertion by CMS that FFP (Federal Financial Participation; federal matching funds) is not available for costs related to room and board for services other than, as relevant here, services provided by hospitals and psychiatric residential treatment facilities. Crisis Stabilization is designed to be delivered in a non-hospital-level, 24-hour facility located in the community.

2. ***Behavioral Health Services for Children Previously Not Enrolled In Managed Care***

As of July 1, 2009, MassHealth-enrolled children and youth up to age 21 with insurance coverage in addition to MassHealth are enrolled in the Massachusetts Behavioral Health Partnership for their behavioral health care. These members or their parents or guardians have been notified of their enrollment in MBHP and receive information about the services available through MBHP, including coverage of the remedy services.

3. ***Enrollment and Caseloads in Intensive Care Coordination***

MassHealth's contracted managed care entities (MCEs) report that as of September 21, 2009, there were 1,586 children and youth being served by Community Service Agencies (CSAs) across the state. Referrals have been steady at approximately 200 per week.

The 32 CSAs have hired a total of 32 Program Directors, 31 Senior Care Coordinators, 156 Care Coordinators, 31 FTE Senior Family Partners and 90 FTE Family Partners.

As mentioned previously, the MCEs track caseloads on a weekly basis and report to the state weekly. Currently, the average caseload ratio of Care Coordinators to children and youth is 1:8.6. MCEs also count and report to the state the number of instances of any individual care coordinator at any CSA working with more than 18 youth at a time, and the reason the agency has decided to assign more than 18. This last week there was one Care Coordinator with more than 18 cases. The CSA for which this Care Coordinator works is in the process of hiring additional staff and expects this Care Coordinator's caseload to lessen this week or next week. The other instances of a Care Coordinator carrying a caseload of 18 or more children were during the month of August, in which there were two Care Coordinators with caseloads of 18. By the following week these caseloads had dropped below 18. Again, the reported reasons were that new staff were starting imminently, but had not yet begun work. The Defendants monitor the MCEs closely to make sure that the MCEs assure that children and youth who receive ICC services are provided with the services they need.

4. Caseload Dispute

At the July 28, 2009 status conference, the Court asked the Defendants to report at the September 28, 2009 meeting on: a) our progress toward defining the term "intensive" as it applies to the level of need for ICC services; and b) whether we think it is necessary to add more definitive, limiting language on caseloads in the ICC Operations Manual.

Regarding defining the concept of "intensive," we propose developing, in consultation with the Court Monitor and the Plaintiffs, a methodology for performing case reviews designed to identify the characteristics of children and youth with "intensive" needs for ICC services. In performing the case reviews, we would also consult with the ICC providers serving these children and youth. We expect this work to take six to nine months to complete.

Regarding guidance to the CSAs on caseload ratios, we remain confident that the Operations Manual states clear expectations of providers regarding caseloads and the scope of activities they are expected to perform as part of the ICC service. Current caseloads are low, which is to be expected during start-up, as all clients are in the initial phase of the Wraparound process, which is the most labor-intensive phase. We will continue to monitor closely the MCEs to ensure that children and youth who receive ICC services are provided with the ICC services they need at all times. We remain committed to reviewing the caseload guidance at some point, working with our health plans and providers to refine or change this guidance, if necessary. We continue to believe that the process of learning about appropriate caseload guidance may continue for the first two years of operation. We know from previous experience, and the experience of similar programs in other states, that the caseload mix at the beginning of a service is rarely the caseload mix after some period of service delivery.

5. ***Service Volume in Mobile Crisis Intervention***

Our most recent year-to-date data record 2,040 mobile crisis interventions for children and youth by the Mobile Crisis Intervention Teams. Forty (40%) percent of these encounters occurred in community settings, whether in the home or in another community-based setting. The providers and MCEs continue to educate and inform referral sources, including families, about the availability of the new service and how to access it. While MCI providers are responsible for providing services in the home or community-settings, parents, caretakers and other referral sources are accustomed to the previous practice of receiving crisis services through hospital emergency departments. The MCI teams are working with their communities to teach families, caretakers, and other referral sources that crisis services in the home and community are available to them, but we believe it will take some amount of time to change this well-established pattern.

6. ***Managed Care Entity (MCE) Support of Provider Implementation***

The MCEs continue to work closely with the Mobile Crisis Intervention (MCI) and Intensive Care Coordination (ICC) providers as they implement these services. They hold monthly state wide meetings of ICC providers and, in the near future, will start to replace some of these statewide meetings with regional meetings that will include both ICC and MCI providers, and eventually other service providers to support regional practice. The MCE management teams (one staff person from MBHP and one from one of the other MCEs) conduct weekly calls with each of the ICC providers, and have on-site meetings with each provider every six weeks. Finally, the MCEs meet weekly with MassHealth, and at least

monthly amongst themselves (separate from MassHealth), on management of their common networks of ICC and MCI providers. MBHP continues to provide technical assistance to Mobile Crisis Intervention providers through a contract with a leading national expert on this service.

The Defendants have received feedback from numerous providers that they find these meetings valuable and appreciate the degree to which the MCEs are working together in a collaborative and coordinated fashion.

7. ***Wraparound Training Contractor – Vroon VanDenBerg***

Vroon VanDenBerg (VVDB) staff have completed orientation meetings with the CSAs and have started the first round of trainings for Care Coordinators and Family Partners. VVDB is beginning to work with each CSA to develop individualized coaching plans. In addition, VVDB staff are holding five meetings around the state to provide stakeholders with an orientation to Wraparound. The Defendants have worked with providers, state agencies and family organizations to publicize the meetings and encourage stakeholders to attend.

8. ***Managed Care Entity Utilization Management (UM) Activities***

The Defendants will distribute a survey to CSAs this week to learn about their experience seeking authorization for Intensive Care Coordination and Family Training and Support. The canvass is being conducted through an anonymous online survey that will be returned directly to MassHealth by mid-October. The results of the survey will inform the work of the

Defendants and the MCEs to ensure that the UM activities support effective team-based care planning.

9. Implementation of the Remaining Remedy Services

On September 9th the MCEs held a day-long conference for providers of In-Home Behavioral Services and Therapeutic Mentoring, which start October 1st, and In-Home Therapy, which starts November 1st. The conference included presentations by MCE staff on the program specifications and medical necessity criteria as well as presentations by clinical leaders with nationally-recognized expertise in each of the three new services. The MCEs are working with all of the providers on a variety of readiness activities to ensure that they are prepared to deliver the new services on the start dates.

Additional Activities Related to In-Home Behavioral Services

As the MCEs worked with the providers they had selected for In-Home Behavioral Services, the MCEs became increasingly concerned that many of these providers were not clear on the intent of the service and the language in the specifications, and intended to use generalist clinical staff, who did not meet the provider qualifications articulated in the approved State Plan Amendment or the Service Specifications, to provide In-Home Behavioral Services. Some providers reported their intention to use the same staff to variously deliver In-Home Therapy, In-Home Behavioral Services and Therapeutic Mentoring, services which require distinct and specific skillsets. The MCEs were concerned that this lack of understanding would result in a diminution of the quality of the service provided. The Defendants agree with these concerns. In-Home Behavioral Services (IHBS)

are intended to treat children and youth with behavioral health conditions that result in particularly difficult and persistent behaviors such as self-injurious, ritualistic, repetitive, aggressive or disruptive behaviors, and it does this through teaching alternative *pro-social* behavior. The most effective behavioral treatment requires providers with training and experience in analyzing behavioral antecedents and reinforcements and in developing effective strategies for changing those triggering or reinforcing conditions. In order to better ensure that higher-quality providers are available to provide IHBS, the MCEs decided, and the Defendants agreed, that providers of In-Home Behavioral Services should be trained and certified in Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is "the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior." (Baer, Wolf & Risley, 1968; Sulzer-Azaroff & Mayer, 1991).

ABA certification was chosen because it is the most commonly-held certification for behavioral therapy and the only approach with a national standard and process for certification.

Based on our experience here in Massachusetts with MHSPY and CFFC, as well as the experience of Wraparound Milwaukee and in the state of Hawaii, we anticipate that relatively few children will present with a need for IHBS and that a sufficient number of the more than 400 clinicians in the Commonwealth with ABA certification will want to contract with the MCEs to provide IHBS services. Indeed, since the MCEs notified providers of the ABA

credentialing requirement, several providers who were not previously willing to contract to provide IHBS services have expressed an interest in doing so.

However, in recognition of the concern expressed by the Plaintiffs that this credentialing requirement could adversely impact access for children and youth who need this service, and with the October 1, 2009 start date for the service nearly upon us, the Defendants have directed the MCEs to add additional clarifications to the credentialing criteria in order to effect a broadening of the pool of qualified providers, while at the same time retaining a focus on necessary provider competencies. These new criteria for hiring are intended to clarify the educational and training requirements for staff providing this service. As *hiring criteria*, they are to be used by the provider agencies in the hiring of staff for this service. Providers will NOT have to apply to the MCEs for "waivers" of the ABA certification.

The new credentialing criteria state that a Behavioral Management Therapist must be EITHER:

1. Certified in Applied Behavioral Analysis (ABA); OR
2. Enrolled in an ABA training program and eligible for certification within nine months; OR
3. A clinical Psychologist with experience performing functional behavioral assessments and implementing and evaluating intervention strategies; OR
4. A Master's-level mental health clinician working under the supervision of an ABA-Certified clinician.

The Defendants will be monitoring the MCEs closely to ensure that there is ready access to medically necessary IHBS.

10. ***EOHHS Interagency Protocols***

The protocols for the Department of Child and Family Services, the Department of Mental Health and the Department of Public Health are complete. The protocols for the Department of Youth Services, having gone through four rounds of comments and discussion with the Plaintiffs, will be done as soon as DYS responds to this fourth and final round of comments. A draft set of protocols for the Department of Developmental Services has been completed and is under internal EOHHS review. Remaining protocols under development are those for the Department of Transitional Assistance, the Commission for the Deaf and Hard of Hearing, the Commission for the Blind, and the Office of Refugees and Immigrants.

11. ***Conflict Resolution Process for ICC Teams***

As reported in the July 17, 2009 *Report on Implementation*, the Defendants have developed a conflict resolution process for ICC Teams. The Defendants' proposed conflict resolution process had, at the time of the report, gone through two cycles of comment and discussion with the Plaintiffs. Since the last report, the parties have completed another round, have consulted with Bruce Kamradt of Wraparound Milwaukee, and are in the process of completing a fourth round.

PROJECT 1: INFORMING AND NOTICING IMPROVEMENTS

1. Informational Meetings with Staff of Elementary and Secondary Schools

The Defendants, after consulting with the Department of Elementary and Secondary Education (DESE), decided to work with the statewide network of Educational Collaboratives to co-sponsor seven half-day meetings for school staff across the state. Educational Collaboratives are regionally-based organizations funded by multiple school districts to deliver certain special education services. They frequently function as conveners of their member school districts for a variety of trainings and meetings.

The consensus of the education stakeholders was to schedule the meetings for October and November, as schools were overwhelmed in September with back-to-school activities and H1N1 flu preparation. The first meeting will be held October 8th at the South Shore Collaborative and the remaining meetings on selected dates throughout October and into early November. The Massachusetts Organization of Educational Collaboratives is working with its members to select the locations for the various dates. The Defendants will work with DESE and the Collaboratives to publicize the meetings and encourage appropriate staff to attend.

Appropriate staff include principals, special education directors and staff, school nurses, school psychologists and guidance and adjustment counselors. Participants will receive information on the CBHI initiative, including descriptions of the new services and how staff can help students access these new services as well as other MassHealth Behavioral Health services. In addition, we'll discuss how schools can refer to and collaborate with providers of the remedy services. We will also discuss the similarities and differences between the ICC care planning process and the process for developing an Individualized Education Plan (IEP).

2. Work with Juvenile Court Stakeholders: Court Clinics, Juvenile Court Judges, Magistrates and Probation

The Defendants have worked together with staff of the Department of Mental Health's Forensic Mental Health Services to develop written "Questions and Answers" for Court Clinic staff, answering key questions about when and how the Court Clinics can help children and youth access MassHealth Behavioral Health services.

The Defendants, DMH, and the Office of the Chief Justice of the Juvenile Court are also developing plans for regional meetings for Juvenile Court staff, as well as other methods and venues for communicating with stakeholders about the case, the remedy, and how children and youth who are clients of MassHealth can access the services. In addition, EOHHS staff are working with staff of the Office of the Commissioner of Probation on educational means and methods for informing Juvenile Probation Officers about the availability of the new services and how to access them.

3. Member Brochure and Other Outreach Materials

As reported previously, the Defendants have been working on a brochure for parents and youth and a brochure for clinical and non-clinical professionals and staff who might be helping families access the remedy services for their children. After some work with a consultant, we decided to produce printed brochures for parents and youth, but make a "down-loadable" booklet or pamphlet available electronically to teachers, primary care clinicians, child care center staff, outpatient therapists and others. The electronic booklet will contain more detailed information like that found in the MassHealth section of the interagency protocols.

The Defendants are currently working on a final draft of the new brochure for families and youth. The booklet for professionals is in an earlier stage of development. The Defendants will share both documents with the Plaintiffs for comment. We expect to notify an extensive list of relevant professionals that the family brochure is available and the process for ordering them for further distribution.

PROJECT 1: SCREENING

The Defendants will have updated screening data for the November Report on Implementation. We are working closely with the Court Monitor to support a series of fourteen visits by Christina Crowe, a clinical consultant working with the Court Monitor, to primary care practices across the state. During these visits Christina will be speaking with clinicians and office staff to learn about their experience implementing standardized behavioral health screening in their office. The Defendants look forward to receiving the reports of these visits and to working with the Monitor to identify best practices to share and barriers to address. The Defendants will share this information with our MCEs to incorporate into their screening quality improvement activities.

PROJECT 2: CANS ASSESSMENT

As of September 21, 2009 there were 15,643 CANS records entered into the CANS IT system. Most importantly, the number of organizations entering CANS records has steadily risen, from 169 at the end of June to 207 today. The number of trained and certified assessors has topped 8,000 and continues to grow, although much more slowly. The Defendants will have updated CANS claims data in time for the November Report on Implementation.

Through the Defendants' contract with the Center for Adoption Services Research at the University of Massachusetts, we are able to provide ongoing technical assistance and implementation support to CANS assessors. UMass now has an email list of over 9,000 clinicians who have registered through the UMass CANS training website. UMass has revamped and revised its online training curriculum, updating it with what they have learned delivering the in-person training over the past two years. Responding to the results of a survey of CANS utilizers, EOHHS and UMass have just launched a year-long series of meetings and conference calls on the topic "Using CANS Effectively in Clinical Practice." EOHHS and UMass staff will meet with small groups of CANS users interested in topics such as using the CANS in treatment planning, in supervision, and with parents. The learning and best practices gathered from these small meetings will be documented by UMass and disseminated through email, the UMass and CBHI websites, and conference calls.

RESPECTFULLY SUBMITTED,

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Date: September 24, 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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Assistant Attorney General