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") in preparation for the hearing scheduled for February 12, 2010.

The Defendants hereby report as follows:

PROJECT 1: INFORMING AND NOTICING IMPROVEMENTS

1. ***EOHHS Interagency Protocols***

As previously reported, interagency protocols have been completed for the Departments of Child and Family Services (DCFS), Developmental Services (DDS), Mental Health (DMH), and Youth Services (DYS), and, within the Department of Public Health (DPH), the Early Intervention program, the School-Based Health Center Program and the Bureau of Substance Abuse Services. Draft protocols have been written, but not yet reviewed by the Plaintiffs, for the Department of Transitional Assistance (DTA) and the Office of Refugees and Immigrants (ORI). Meetings have been or are being scheduled with the Commission for the Deaf and

Hard of Hearing, the Commission for the Blind, the Department of Early Care and Education and the Massachusetts Rehabilitation Commission (for youth ages 18-20).

2. ***Informational Meetings with Staff of Elementary and Secondary Schools***

The Report on Implementation submitted to the Court on December 7, 2009 (December 2009 Report), described informational meetings being held with school staff around the state. Nine meetings had been held at that point, with over 350 participants. Since that time, well-attended meetings have been held in Hyannis, Orange and Northampton. Additional meetings are being scheduled for Pittsfield, Lawrence or Lowell and a second meeting with Educational Collaborative school districts in Rockland. Increasingly, these meetings include staff who have experience with Mobile Crisis Intervention, Intensive Care Coordination and In Home Therapy. Generally, the feedback has been very good. We have strongly encouraged school staff to give feedback, positive and negative directly to the provider agencies, as well as through the Local System of Care Committees. We have also offered contact information for state staff.

3. ***Member Brochure and Other Outreach Materials***

As reported previously, the Defendants have developed a brochure for parents and youth and a guide for various types of staff (primary care clinicians, school staff, child care staff, staff of various community-based organizations) who help MassHealth families and youth access Behavioral Health services. We anticipate that there will be five regional versions of the brochures, which will be available at the end of February. The brochures will contain the telephone numbers of Mobile Crisis Intervention, In Home Therapy and Intensive Care Coordination providers located regionally (Members may receive services from any provider in their MCE's network).

4. *Updated Screening Data*

The data presented in the December 2009 Report included data through June 30, 2009 from MassHealth's Primary Care Clinician (PCC) Plan, but not for screenings provided to our members enrolled in one of our four Managed Care Organization (MCO) plans. These updated data include claims and encounter data for *all* screens billed for *all* MassHealth's health plans, through September 30, 2009.

Quarter	# of well child visits	# of standardized screens	% of children w/ potential BH need identified
Q1 1/1/09 – 3/31/09	120,972	66,444	9.2%
Q2 4/1/09 – 6/30/09	107,825	64,864	9.4%
Q3 7/1/09 – 9/30/09	116,611	74,351	8.4%

For the period January 1, 2009 through September 30, 2009, the number of behavioral health screens as a percentage of the number of well-child visits and other visits in which screens occurred are as follows:

MassHealth Plans	Q1 1/1/09 – 3/31/09	Q2 4/1/09 – 6/30/09	Q3 7/1/09 – 9/30/09
Fee for Service	39.6%	43.6%	48.2%
Primary Care Clinician	56.2%	62.3%	64.4%
MCO	55.8%	61.6%	66.6%
Total across plans	53.5%	58.6%	62.1%

As has been reported previously, screening rates vary by age:

Age Group	Q1 1/1/09 – 3/31/09	Q2 4/1/09 – 6/30/09	Q3 7/1/09 – 9/30/09
< 6 months	29.5%	30.4%	33%
6 months through 2 years	58.9%	64%	67.8%
3 through 6 years	64.4%	70.5%	73%
7 through 12 years	65.6%	72.2%	73.6%
13 through 17 years	58.5%	65%	69.3%
18 through 20 years	27.2%	26.7%	33.6%

PROJECT 3: DEVELOPMENT OF THE SERVICE DELIVERY NETWORK

5. *Status of Proposed Amendment to Massachusetts' Medicaid State Plan to Authorize the Massachusetts Medicaid Program to pay for Crisis Stabilization Services for youth under 21.*

On January 20, 2010, the Commonwealth received a letter from the Centers for Medicare and Medicaid Services (CMS) denying approval of the proposed State Plan Amendment. A copy of the CMS Letter is attached as Exhibit 1.

In the Letter, CMS also expressed its interest in continuing to work with the Commonwealth to develop an approvable State Plan. The Defendants have communicated to CMS their interest in continuing to discuss the issues CMS raised, to determine whether Federal Financial Participation is available for Crisis Stabilization services as described in the judgment[1].

[1] Paragraph 32.b. *Crisis Stabilization* – Services designed to prevent or ameliorate a crisis that may otherwise result in a child being hospitalized or placed outside the home as a result of the acuity of the child's mental health condition. Crisis stabilization staff observe, monitor, and treat the child, as well as teach, support, and assist the parent or caretaker to better understand and manage behavior that has resulted in current or previous crisis situations. Crisis stabilization staff can observe and treat a child in his/her natural setting or in another community setting that provides crisis services, usually for 24-72 hours but up to 7 days. Crisis stabilization staff are qualified licensed clinicians and qualified paraprofessionals supervised by qualified licensed clinicians. Crisis stabilization in a community setting is provided by crisis stabilization staff in a setting other than a hospital or a Psychiatric Residential Treatment Facility (PRTF) and includes room and board costs.

6. ***Intensive Care Coordination (ICC) Implementation***

Enrollment and Staffing:

In the 18 weeks since our last hearing on October 12, 2009:

- The cumulative number of youth enrolled in ICC has risen from 1851 to 2794.
- The number of Care Coordinators has risen from 179 to 258 (all staffing figures are expressed in Full Time Equivalents).
- The number of Senior Care Coordinators has risen from 27 to 37.
- The number of Family Partners has risen from 99 to 156.
- The number of Senior Family Partners has risen from 38 to 43.
- The average caseload has risen gradually from 9.2 to 10.1.
- There have been four weeks in which there was one Care Coordinator with a caseload over 18 and one week in which two Care Coordinators had a caseload over 18. These conditions were transient.

PROJECT 4: INFORMATION TECHNOLOGY SYSTEM DESIGN AND DEVELOPMENT

7. ***Tracking Measures***

The Defendants have developed and reviewed with the Court Monitor and the Plaintiffs standard tracking measures for Intensive Care Coordination, Family Support and Training and Mobile Crisis Intervention. MassHealth staff are developing tracking measures for In Home Therapy, In Home Behavioral Services and Therapeutic Mentoring and will be reviewing these with the Court Monitor and Plaintiffs.

THE COURT MONITOR'S CASE REVIEWS

8. In response to an invitation from the Court Monitor to help assemble a diverse group of people to participate in the development of the case review tool, the Defendants informed staff from the Departments of Children and Families, Mental Health, Public Health and Youth Services, as well as MassHealth's MCEs and members of Massachusetts Children's Behavioral Health Advisory Council of this opportunity. A diverse group, including family members, providers, MCE staff, state agency staff, members of the Advisory Council and one of the Plaintiffs' attorneys met for two days to develop the Massachusetts Case Review tool. Staff from MassHealth's Office of Behavioral Health and CBHI met with the Court Monitor and her staff and consultants for a full day prior to the design team sessions and for a half day after, to develop a calendar and operational plan for the case reviews.

CASELOAD RATIOS

9. In response to the Court Monitor's recommendations regarding the dispute between the parties about caseload ratios, the Court asked the Defendants to develop a methodology to define the term "intensity" as used in the Defendants' "ICC Operations Manual." The Manual includes caseload guidance for youth with greater or lesser "intensity" of need for care coordination.

   Over the past months the Defendants have considered various methods of defining the term "intensity" in order to report to the Court. We sought to develop a definition that would allow providers and MCEs to identify youth with a predictable range of intensity of need. As a result of this exploration, we have renewed our conviction that the term "intensity" as a

guide for ICC providers cannot be meaningfully used, because the needs of children and youth are too dynamic – they can change rapidly over the period of involvement with ICC and under the influence of numerous factors, many external to the child and the ICC provider. To categorize and label some youth as needing "intensive" services seems artificial and arbitrary and risks potentially stigmatizing these youth. In addition, the Defendants are concerned that a definition of "intensity" tied to caseload guidance deprives the ICC Provider of the opportunity to use professional, clinical judgment at the treatment level and would actually harm one of the key goals of the Court's decision in this case and good Wraparound practice, which is ensuring *individualized* services that meet *individual* needs.

Accordingly, Defendants propose the following approach:

Together, with the Court Monitor and the Plaintiffs, we will:

- Continue to report and review data on caseloads
- Review CANS data on the strengths and needs of youth receiving ICC services
- Review quality indicators, such as data measuring fidelity to Wraparound
- Learn together about the quality of ICC case practice through the Court Monitor's Case Review process.

The Defendants will ensure that MCEs continue their current practice of using these data to monitor and manage their network of ICC providers with the goal of assuring that individualized, quality ICC services are provided to children.

RESPECTFULLY SUBMITTED,

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