UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.,	)	
Plaintiffs,	)	
v.	)	
CHARLES BAKER, et al.,	)	C.A. No. 01-30199-MAP
Defendants	)	

PLAINTIFFS' MEMORANDUM TO IMPROVE ACCESS TO REMEDIAL SERVICES

At the April 26, 2018 status conference, the Court requested the plaintiffs to submit a proposed order describing specific actions that the defendants should take to improve access to Intensive Care Coordination (ICC) and In-Home Therapy (IHT), as required by the parties' joint Disengagement Measures. The Proposed Order lists those actions that the defendants should undertake. This Memorandum describes the status, timetable, and reasons supporting each action.

I. Increase the Access Goal for ICC by 7.5% Over the 2016 Baseline Set Forth in the Joint Disengagement Measures.

In December 2016, the Court set the 2017 access measure for ICC at a 7.5% increase over the June 2016 baseline of 63%. Achievement of this measure would translate into 70% of children receiving an initial appointment within 14 days, for nine months of a twelve month period. This represented a compromise between the plaintiffs' request for a 10% increase, and the defendants' proposal of a 5% increase. *See* Defendants' Proposed Outcome Measure for Final Disengagement, December 16, 2016 (Doc. 763-1). As the defendants' acknowledge, they

did not meet either the Court's standard or their own. *See* Defendants' Report on Disengagement at 3, September 13, 2017 (Doc. 813 and 813-1).

The plaintiffs had proposed that the 2018 access goal for ICC increase by an additional 7.5%, which would afford 77% of children an initial appointment within 14 days for nine months of a twelve month period. At the time of approval of the Disengagement Measures, the defendants had proposed two 5% increases, or a total of 73% for 2018. After failing to meet the 2017 goal, the defendants revised their request downward, and just six months ago proposed that the goal for 2018 remain the same as that for 2017 – 70%. *See* Defendants' Report on Access Activities and Targets at 5, November 17, 2017 (Doc. 820). The Court should adopt the defendants' proposed standard for 2018.

Rather than reward the Commonwealth for its noncompliance with the 2017 access measure the Court should, at a minimum, require that the 7.5% improvement in access be above the baseline reflected in the parties' Joint Disengagement Measures. Applying the 7.5% improvement benchmark to defendants' 2017 performance would constitute a *reduction* of 3.8% from the 2017 benchmark, reducing 2018 expectations to 66% compliance with the State's own access standard.[1]

II. Increase the Access Goal for IHT by 7.5% Over the 2016 Baseline Set Forth in the Joint Disengagement Measures.

The same analysis and reasoning applies to the 2018 access measure for IHT. The Court had set the goal as a 7.5% increase over the baseline of 48%, or a goal of 55.5%, which represented a compromise between the plaintiffs' request for a 10% increase and the defendants' proposal for a 5% increase. While the defendants' acknowledge they did not achieve this goal, they noted that they did exceed the IHT measure for two of the first seven months of the 2017

[1] It appears that the average of all twelve months for 2017 was 58.7%, making a 7.5% increase over actual performance 66.2% -- or a *reduction* of 3.8% from the 2017 benchmark.

calendar year, while failing to achieve it for ICC in any month. *See* Doc. 813-1. And as with ICC, the defendants proposed, two months later, that the most reasonable and realistic goal for 2018 for IHT would be the same as for 2017 – 55.5% of youth seeking IHT services will be offered an initial appointment within 14 days, consistent with the Medicaid access standard, for nine months in a twelve month period. For consistency, the Court should adopt the defendants' requested standard, even though this is slightly below the benchmark if there was a 7.5% increase over the actual performance for 2017.[2]

III. Expand Provider Capacity for IHT.

For years, IHT quarterly reports have shown virtually no unused capacity to serve children and families. The most recent report for March 2018 indicates that 126 of 161 IHT providers have 5% or less unused capacity, with the vast percentage – well over 100 – having zero (0%) availability. As a result, over 550 children and youth were waiting for the first available IHT provider in March – and another 580 were waiting for the provider of their choice. *See* In-Home Therapy Availability and Wait List Report (March 2018), attached as Exhibit 1. Over 40% of those waiting for IHT services waited over two months, and another 20% waited over a month. *Id.* This trend of waiting for access to IHT services has persisted for years, and remained an intractable systemic problem, despite increasing focus on IHT in the disengagement process. Training, support, and other MassHealth initiatives have not materially altered this reality, increased IHT capacity, or otherwise reduced waiting lists.

Despite some general administrative actions to add some IHT providers to regional networks, as described in prior reports to the Court, the defendants consistently have failed to

[2] It appears that the average of all twelve months for 2017 was 49.7%, making a 7.5% increase over actual performance 57.2%. For both standards, the Court noted that incremental progress expected in 2018 was not to be confused with, or equated to, the level of access that would ultimately be required in order to demonstrate compliance with federal law and this Court's Judgment.

reduce waiting lists or increase access for IHT services. In March of 2018, statewide data showed that there was less than 2% of IHT capacity available for the hundreds of youth waiting for services, that no region had more than 2.9% available capacity, and that two regions had less than one percent of their total service capacity available to treat new clients. *See* Ex. 1. When examined on a provider by provider basis, regional differences are significant, with less than 25% of Central Massachusetts providers providing ready access to care, as compared to 60% of Metro-Boston providers having 0 individuals waiting.

Since the number of individuals waiting (556), the number of providers with zero available capacity (51%), the number with less than 5% available capacity (75%), and the actual capacity of IHT providers (7,600) has remained relatively consistent for many months, if not years, specific actions need to be taken to expand capacity. And that expansion must be sufficient to significantly reduce waiting time. To accomplish this, without being overly prescriptive, the Court should order the defendants to increase the capacity of IHT providers to serve an additional 750 children and youth, and that no region have less than 5% IHT available capacity, in order to ensure that medically necessary IHT services can be delivered promptly to the more than 500 children and youth who are waiting every month.

IV. Require Corrective Action Plans for Noncompliant CSAs.

Monthly CSA reports indicate the number of children and youth who are waiting at each CSA. Each month, only one-third of CSAs succeed in offering their clients an initial appointment within the 14 day access standard. Many CSA rarely, if ever, meet the 14 day access standard in a month. Several have waiting lists that exceed 30 days, often repeatedly and for months at a time. These outlier CSAs not only enlarge the statewide average waiting list but,

more importantly, frequently deny children and families in their service areas anything close to timely access to ICC services.

Despite numerous requests by the plaintiffs for intensified administrative oversight and enforcement actions, the defendants' reports mention only more general technical assistance and monitoring efforts by their Managed Care Organizations (MCOs). The Court should order the defendants to require a corrective action plan from any CSA that has an average waiting time in excess of thirty days for two consecutive months, and should further require more significant contract enforcement actions if the corrective action plan does not result in a reduction of waiting time to less than twenty days for at least three consecutive months.

V. Implement the Alternative Payment Methodology for ICC Services Statewide.

Almost two years ago, in response to persistent concerns from CSAs about challenges with providing ICC services based upon billing for 15 minute increments of service, MassHealth developed an Alternative Payment Methodology (APM) that reimbursed CSAs based upon a daily rate of $53/enrolled child This reimbursement methodology was widely heralded by the ten CSAs pilot sites as improving services to individuals, assisting in recruiting and retaining staff, improving access to services, and concomitantly reducing waiting lists. *See* Plaintiffs' Supplemental Report on Access (Doc 822-1). The Commonwealth initially committed to adopting the APM statewide – for all CSAs – by July 1, 2018. *See* Defendants' Report on Access Activities and Targets at 3-4 (Doc. 820). Recently, they have been silent on both the commitment to adopt the APM and the date of implementation. *See* Defendants' Report on Actions Related to Joint Disengagement (Doc. 826). As a result, neither the commitment to adopt the APM statewide, nor the access benefits of doing so, have been realized. Instead, the pilot is scheduled to end on June 30, 2018. Ironically, for at least the 10 pilot CSA sites, this will

result in return to the prior reimbursement system, a likely *decrease* in access to ICC, and an *increase* in waiting times for their ICC services.

Based upon information and belief, it appears that MassHealth is still considering whether and under what conditions it will adopt the APM. If it decides to proceed with the APM, it is likely to do so at a dramatically reduced reimbursement rate of $45/enrolled child, or a 15% rate reduction.[3] For the current pilot sites, this cut would be enormous. For all CSAs, this reduction could well undermine the benefits of the APM and its demonstrated success in enhancing access and reducing waiting lists. Given the positive findings of the pilot, and the Commonwealth's longstanding commitment to implement the pilot statewide in its current form, the Court should order the defendants to adopt the APM, with its current payment rate of $53/enrolled child, effective July 1, 2018.

VI. Implement a 3% Rate Increase for IHT.

Defendants have repeatedly stated that they planned to implement rate increases for at least IHT, if not all remedial services, by July 1, 2018, after soliciting comments on proposed rates in the spring. For the first time in their February 12, 2018 Report (Doc. 826), they omit this commitment. Since there has not been a major rate increase for IHT, or other remedial services, since July 2015, IHT providers have not been able to maintain prior levels of service, let alone expand services or increase salaries to retain experienced clinicians. As a result, other private hospital and state social work salaries have dramatically outpaced what is available to IHT clinicians. The IHT provider network has become more fragile, less experienced, and less accessible. Not surprisingly, compliance with the 14 day appointment standard has continued to

[3] There has never been a suggestion that the statewide implementation of the pilot would be at a dramatically different rate. *See* Doc. 820 (the expectation is that the new APM rate would become effective July 1, 2018).

regress, with only one month over 50% this year (April 2017- February 2018), compared to six months over 50% in the prior year (April 2016- March 2017).

On information and belief, the defendants have completed a rate review for IHT that demonstrates at least a 3% increase in the standard rate is justified, and arguably more. Therefore, the Court should order the defendants to increase the rate for IHT by at least 3%, effective July 1, 2018.

VII. Review of the Adequacy of Rates for All Remedial Services.

Federal law – and specifically the EPSDT provisions of the Medicaid Act – require that provider rates be reasonable and adequate to ensure timely access to treatment services.[4] Rates should be based upon an analysis of costs, generally referred to as rate study, which considers the actual costs of providing the service, consistent with medical necessity criteria, program specifications, contract requirements, and other professional expectations, such as the standards issued by MassHealth for each remedial service during the past several years. MassHealth has never conducted a comprehensive rate study for IHT, despite its dual clinical and care coordination roles, and its status as the most highly utilized remedial service.[5] Nor has there been a comprehensive review of the adequacy of rate structures for the four other remedial services (In-Home Behavior Therapy (IHBT), Therapeutic Mentoring (TM), Family Training and Support (FTS), and Mobile Crisis Intervention (MCI)). At the same time, quarterly reports for IHBT and TM consistently demonstrate that these services are operating close to 100% of capacity, and there are waiting lists for most services in most regions. *See* In-Home Behavior

[4] State law also requires the Medicaid agency to review all Medicaid rates bi-annually and increase them as needed to comply with state and federal law, the Medical Consumer Price Index, and other relevant factors. *See* G.L. 118E, § 13.

[5] As noted above, a comprehensive rate study examines the underlying assumptions behind the established rate, using information and experience with the actual provision of the service. Importantly, when this kind of comprehensive analysis was done for ICC, it resulted in a more than 20% rate increase.

Services Availability and Wait List Report (March 2018), attached as Exhibit 2; Therapeutic Mentoring Availability and Wait List Report (March 2018), attached as Exhibit 3. Thus, the defendants are both failing to comply with federal law, as well as failing to substantially implement the Court's Judgment in this case.

The Court should order the defendants to complete the long overdue rate study for IHT and to conduct similar studies for IHBT, TM, FTS, and MCI. Defendants can then implement an appropriate rate increase for each service, as supported by the rate study.

VIII. Conclusion

Five years ago, the Court adopted the Commonwealth's proposed access standard to comply with the EPSDT provisions and reasonable promptness provisions of the Medicaid Act. The Court has been both patient and forbearing in enforcing the State's own standard for meeting its federal Medicaid responsibilities. Recently, it invited the defendants to propose concrete actions that had a reasonable prospect of achieving compliance with this standard in the near future. Instead, the defendants suggested a rather tepid list of vague administrative actions, most of which had been proposed and tried before. It is now time for the Court to require concrete, specific steps that have a significant likelihood of facilitating compliance with the Court's Judgment and the Medicaid Act. For the reasons set forth above, the Court should enter the Proposed Order on Access.

RESPECTFULLY SUBMITTED,
THE PLAINTIFFS,
BY THEIR ATTORNEYS,

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Dated: May 11, 2018 /s/ Steven J. Schwartz