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' SUPPLEMENTAL REPORT ON ACCESS

At the Status Conference on October 4, 2017, the parties provided updates on implementation of the Joint Disengagement Criteria (Doc. 786-1), including the status of compliance with 2017 access measures for Intensive Care Coordination (ICC) and In-Home Therapy (IHT). The Court noted the need to establish final disengagement measures on access, and to implement additional strategies for improving compliance with the 14 day Medicaid access standard, instructing the parties to try and reach agreement on these matters in the form of a Joint Report. *See*, Doc. 816 (minute entry).[1]

On October 31, 2017, Plaintiffs and Defendants met to discuss delays in timely access to ICC and IHT, potential strategies for improving access to these services, and the setting of 2018 standards which would trigger disengagement of active court monitoring on these issues. Despite the assistance of the Monitor, the parties were unable to reach agreement regarding either the establishment of 2018 access measures, or additional strategies to achieve those

[1] The parties did reach agreement on two other disputed issues: This agreement is memorialized in Plaintiffs' and Defendants' Joint Report to the Court, also dated November 17, 2017, and filed contemporaneously with this Supplemental Report on Access.

measures. As a result, Plaintiffs submit their own Supplemental Report, seeking further action by the Court in setting final disengagement measures on access to ICC and IHT.

I. Strategies for Improved Access to ICC and IHT

The parties' most recent Status Reports address the limited progress towards achievement of 2017 measures for access to ICC and IHT. (Doc. 813; Doc. 814) The Court urged the parties to consider what additional strategies may be employed to improve timely access to these services. In their subsequent meeting with the Court Monitor, Plaintiffs and Defendants discussed several specific actions which could alleviate wait times, improve workforce hiring and retention, and focus quality improvement efforts. The strategies discussed below have a significant likelihood of improving access, reducing wait times for ICC and IHT, and moving the Commonwealth and its CBHI service system towards greater compliance with its own Medicaid access standards, as well as the Disengagement Measures on access. As a result, Plaintiffs' proposed increase in final disengagement standards is both reasonable and achievable.

A. Expansion of Provider Capacity

ICC referrals are up significantly in 2016 and 2017, with more than 1,000 additional youth and families seeking wraparound treatment planning and care coordination each year as compared to 2015. However, many CSAs continue to serve less than 75 youth and families, and fewer youth are being enrolled in ICC.[2] Despite increased demand for ICC, there has been no corresponding move to expand the network of CSA providers and program sites, even in regions where access issues have been most acute.

[2] Between 2011and 2014, ICC enrollment was as high as 3,700 youth per month. Between 2015 and 2017, youth enrollment ranged from 3,250 to 3,575 youth per month. Although wait times for ICC are often attributed to issues with hiring and retaining workforce, a sampling of ICC staffing levels over this six year period suggests that the range of full time equivalent care coordinator positions has remained a relatively stable factor system-wide.

IHT has been, and continues to be, the remedial service with the highest utilization. Over the last two years, the amount of available IHT service capacity has typically hovered in the range of 1 to 2% statewide - meaning approximately 98% of the available service capacity is filled at any given time. During this same period, demand for IHT services has dramatically outstripped network capacity. Monthly access reports in 2016 and 2017 have shown as many as 1,300 youth waiting for the service, with between 40 and 50% of youth waiting more than 30 days for a first appointment. *See, e.g.,* Doc. 728 at 6-7; Doc. 742 at 4.

Plaintiffs propose that increased referrals to ICC in 2016 and 2017, and persistent unmet demand for IHT, warrant a further expansion of provider capacity. Increasing the number of approved IHT providers, and expanding the current network of 32 CSAs should reduce wait times for services and increase timely access to care, particularly in regions with more chronic access problems. As the single State Medicaid agency, Defendants are charged with maintaining an adequate network of service providers - a task squarely within their influence and control, and routinely managed through contractual oversight of the State's Managed Care Entities (MCEs).

B. Rate Enhancements

Planned rate changes for ICC, overall rate adjustments for ICC and IHT, and additional monies for workforce infrastructure, all should have a positive impact on class members' access to care. However, the Defendants have determined not to implement these actions immediately, but instead to wait for at least eight months. This extended delay is unnecessary and could undermine ongoing efforts to achieve disengagement by December 2018.

First, the Defendants have spent more than two years piloting a 'day rate' (also called an Alternative Payment Method or APM) for selected ICC providers. Defendants had planned to implement this day rate across the entire ICC network, but have delayed the implementation date

until sometime after July 1, 2018. As noted in a memorandum prepared by the Association of Behavioral Health (ABH) for the Court Monitor, attached as Exhibit 1, providers piloting this change from 15 minute billing units to day rates have reported substantially increased access and enrollment, greater job retention and job satisfaction, and less administrative burden on the staff and the agency. The Commonwealth should move quickly to implement this APM methodology, as one strategy to improve timely access to care and to achieve Disengagement Measure (#1) by December 31, 2018.

Second, the Commonwealth is proposing an increase in all current CBHI rates – including IHT – with new, higher rates implemented no later than July 2018. While rates must be published for public comment and otherwise comply with state APA regulatory requirements, this process should be initiated immediately so that the new rates become effective as soon as possible. Otherwise systemic benefits derived from these rate enhancements, including potential expansion of provider capacity, will come too late to impact the 2018 disengagement period.

Finally, funding from the Affordable Care Act's Delivery Service Reinvention Program (DSRP) is expected to provide CSAs with five years of additional funding to support technology improvements, workforce recruitment, and training – all of which should have a positive effect on the identification and retention of ICC staff.

C. Quality Assurance / Program Improvement

Intensifying MCE oversight of underperforming CSAs should increase the Commonwealth's overall compliance with the statewide Medicaid access standard of 14 days.[3] Specifically, Plaintiffs recommend enhanced use of corrective actions for those providers not

[3] Addressing outliers within the CSA network would have a significant impact on access measures statewide. For instance, in September 2017, the most recent month for which data is available, 7 CSA locations had average wait times in excess of 40 days, and two in excess of 60 days. This same monthly access report shows 12 CSA locations serving fewer than 75 youth and families.

achieving access standards or other work plan targets on hiring and waiting list management. The MCEs should immediately identify both CSAs and IHT providers with a pattern of noncompliance with the Medicaid access standard, require a plan of correction within 30 days, and establish performance improvement targets to take effect in early 2018.

The Defendants' January 2018 Report to the Court should confirm their willingness to immediately implement the strategies above, by expanding provider network capacity, expediting planned rate changes, and developing, monitoring, and reporting on outcomes from provider-specific corrective action plans. These changes can and must occur in time to meaningfully impact compliance with the 2018 Access Criteria.

II. Access Standards for Disengagement in 2018

Ultimately, the efficacy of any access improvement strategy will need to be measured against an established disengagement standard for 2018. The Plaintiffs recognize that any 2018 access measure must balance two considerations: (1) the reality of the 2017 performance gap; and (2) the percentage of improvement required to demonstrate substantial compliance with both the Judgment and the Commonwealth's 14 day Medicaid access standard.

After hearing arguments from Plaintiffs and Defendants, this Court set the 2017 disengagement measure at 7.5 % improvement over the June 2016 baseline of 63 % compliance for ICC and 55% compliance for IHT. The Court left the 2018 measure to be determined, understanding attainment of this final measure would trigger the disengagement of active court monitoring on the Access Criteria. Given the parties' continuing inability to reach agreement, the Joint Disengagement Access Measure for 2018 will have to be established by the Court as well.

Taking into account the available performance improvement strategies above, the importance of class members' timely access to medically necessary services, and the number of youth who are harmed by these continuing delays, Plaintiffs urge the Court to again adopt a compromise standard for 2018, requiring 7.5% improvement over 2017 access measures. Taken together, these measures would total 15% improvement in access to ICC and IHT over the two year disengagement period, using baseline data from June 2016 as the starting point for change.

In other words, disengagement on the Access Criteria would occur if the Commonwealth complied with the 14 day access standard 78% of the time for ICC and 70% of the time for IHT. Importantly, these measures would only need to be met in 9 out of 12 calendar months – an expectation which the remedial service system has historically achieved, and even exceeded.[4] Although First Circuit standards for substantial compliance would demand much more from Defendants in the way of demonstrating timely access to remedial services, the proposed compromise standard would represent a significant improvement over the 2016 baseline.[5]

IV. Conclusion

Timely access to medically necessary services is central to the Early, Periodic Screening, Diagnosis and Treatment provisions of the Medicaid Act, and a key feature of this Court's liability decision and Judgment. The parties' Joint Disengagement Criteria highlights the

[4] Between 2011 and 2015, the average time between a request for ICC and the offer of a first appointment was within the 14 day access standard in 8 out of 12 months. In 2013 and 2014, this standard was achieved in 12 out of 12 months.

[5] *See, e.g., Fortin v. Commissioner of Massachusetts Dept. of Public Welfare*, 692 F.2d 790, 795-96 (C.A.1 (Mass.) 1982) (affirming the lower court's determination that defendants were not in substantial compliance with consent decree enjoining delays in welfare eligibility determinations and corresponding standards, weighing factors including the seriousness of the harm, the nature of the interest at stake, and the degree to which noncompliance affects that interest); *Ricci v. Okin*, 537 F. Supp. 817, 830 (D. Mass. 1982) (finding defendants' planned staff reduction failed to comply with required personnel standards in state schools for individuals with I/DD, was not based on the needs of the residents, and posed a threat to the constitutional and statutory rights to treatment protected under the Consent Decrees.)

importance of this issue by establishing agreed-upon Access Criteria for both ICC and IHT, including an approach to measuring access over time. To complete this existing framework, all this Court need do is establish the 2018 access standard which, once achieved, will demonstrate a level of compliance sufficient to ensure the sustainability and the durability of its remedial Order. Plaintiffs contend that 70-78% compliance with the Commonwealth's own Medicaid access standard is both a reasonable and an achievable standard for disengagement on Access.

RESPECTFULLY SUBMITTED,

THE PLAINTIFFS,
BY THEIR ATTORNEYS,

/s/ Kathryn Rucker
Steven J. Schwartz (BBO#448440)
Cathy E. Costanzo (BBO#553813)
Kathryn Rucker (BBO#644697)
Center for Public Representation
22 Green Street
Northampton, MA 01060
(413) 586-6024

Daniel W. Halston (BBO # 548692)
Wilmer Hale, LLP
60 State Street
Boston, MA 02109
(617) 526-6000

Frank Laski (BBO#287560)
154 Oliver Road
Newton, MA 02468
(617) 630-0922

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was filed electronically through the Electronic Case Filing (ECF) system. Notice of this filing will be sent by e-mail to all registered participants by operation of the court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic as a non-registered participant. Parties may access this filing through the court's CM/ECF System.

Dated: November 17, 2017 /s/ Kathryn Rucker