UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 01-30199-MAP
DEVAL PATRICK, et al.,	)	
Defendants.	)	

PLAINTIFFS' TENTH STATUS REPORT

I. Introduction

Since the last status conference on June 1, 2009, there have been significant accomplishments in implementing the Court's Judgment, a number of remaining challenges that have been identified, and several disputes that are in process. Despite the multiple implementation tasks and short timelines, the parties have worked collaboratively during this period to design the final elements of the new children's behavior health system. The Defendants' July 17, 2009 Implementation Report (hereafter Defs' Report) describes in detail many of the key implementation activities and all of the recent accomplishments. The Plaintiffs Tenth Status Report highlights the key accomplishments and describes the most important pending activities and outstanding disputes for the Court's consideration.[1]

[1] Given the length and detail of the Defendants' Implementation Report, the plaintiffs' Report will confine itself to the most important accomplishments and upcoming activities, or specific topics where additional information is important for the Court to understand the status of implementation of its Judgment.

II. Major Implementation Accomplishments

A. CMS Approval of Remedial Services

After more than a year of review, negotiation, and modifications, on June 4, 2009 CMS approved MassHealth's State Plan Amendment (SPA) for EPSDT Services. The SPA will allow the Commonwealth to receive federal funding for Mobile Crisis Intervention Services, In-Home Therapy Services, In-Home Behavioral Services, Therapeutic Mentoring Services, and Family Support Services. A previously-approved SPA authorized federal funding for Intensive Care Coordination Services. A separate SPA for Crisis Stabilization Services is still pending.

This long awaited decision is the critical hurdle for initiating the remedial services mandated by the Court. It represents another significant milestone in the implementation process and reflects considerable efforts from MassHealth officials and substantial assistance from the Court Monitor and her consultants.

B. Initiation of Intensive Care Coordination, Family Partners, and Mobile Crisis Intervention

On June 30, 2009, children and families throughout the Commonwealth began receiving the first three remedial services – Intensive Care Coordination (ICC), Family Support and Training (Family Partners), and Mobile Crisis Intervention. ICC and Family Partners are provided by the thirty-two new Community Service Agencies (CSAs). All but one of the CSAs were certified as "ready" on June 30, and that one was subsequently certified as ready on July 20, having satisfied over ninety specifications for service initiation. Program standards and performance measures still have to be developed for each service. In addition, the service approval process for these ICC and Family Partners remains in dispute. *See* section IV(B).

Mobile Crisis is provided by a network of Emergency Services Providers, most of which have been offering crisis services for several years. Unfortunately, four of the five MCEs have not signed new contracts with all of the ESP providers, and two MCEs had not signed contracts with even half of the ESP providers. Since Mobile Crisis services are distinctly different from – and far more comprehensive than – the earlier program offered by these providers, it appears that this service, as defined in the Judgment and as approved by CMS, has not begun on time. As the Defendants' Report acknowledges, these ESP providers only are offering the same services as previously provided by "honoring existing contracts."

Nevertheless, the initiation of the core remedial services is a major milestone in the implementation of the *Rosie D.* Judgment. It also is one of the most significant events for families and children in the past decade.

C. Training and Coaching

After months of delay, MassHealth finally selected a nationally-recognized leader in wraparound services to provide training to new ICC staff (care coordinators and family partners) and in-home therapy staff, and mentoring and coaching to newly formed Individual Care Teams. A contract with Vroon VanDenBerg Associates was signed on June 30, 2009 and will begin immediately. John VanDenBerg, the director of VanDenBerg Associates, is one of the leading national trainers on the wraparound planning process and trained many of the team leaders in Arizona's new children' mental health system.

D. Education and Outreach

The defendants' Report catalogues a number of important educational activities and events to inform families, providers, professionals, and concerned community organizations about implementation issues, and specifically about the initiation of remedial services. *See* Defs' Report at 2-17. While the plaintiffs were offered the opportunity to review and comment on the recent notice sent to MassHealth members, *id.* at 5, they were not provided drafts of any revisions to the several member handbooks, *id.* at 5-7, the revised MassHealth regulations, the revised menu of screening instruments, *id.* at 8, the revised provider handbook, *id.* at 9, the outreach fact sheets, *id.* at 14, and the two brochures for parents and providers, *id.* at 14.[2]

As is evident from the Defs' Report, all of the information provided to families has been in the form of written notices. Families have expressed considerable dismay that at the end of June 2009, the only information they have received about the new remedial services was a plain envelope from MassHealth with a form notice. Many inadvertently discarded the envelope. No other method of disseminating this important information has been attempted, such as public service announcements, media presentations, family forums, or other communication strategies that are suggested by CMS and that have been proven to be effective by public health agencies.

[2] In fact, the Defs' Report is the first time the plaintiffs learned about any of these materials, and particularly the changes to the screening instruments that are listed in the Judgment and that were the subject of extensive negotiations and prior discussion between the parties.

III. Ongoing Activities and Upcoming Challenges

A. Screening

While MassHealth has implemented a new screening program for primary care clinicians and now collects data on the number and findings of behavioral health screens completed by primary care clinicians, Defs' Report at 19, there is no information on the actions taken by primary care clinicians to provide or refer for behavioral health services when needed. MassHealth regulations specifically mandate that such referrals be made, tracked, and reported by primary care clinicians. *See* 130 C.M.R. § 144(D). Similarly, the Judgment requires tracking and monitoring of behavioral health "services provided by pediatricians or other medical providers or behavioral health providers following a screen…." Judgment, ¶10. This is no indication this is occurring. Monitoring the results of screenings and their impact of the quality of behavioral health treatment provided to children is an important challenge for the next year.

B. Identification of Children Who Need Behavioral Health Services

The Judgment notes that children can access Medicaid-funded behavioral health services even if they do not have a screening by a primary care clinician. Judgment, ¶ 11. However, state agency staff, school personnel, health care providers such as community health centers and hospitals, child care and early intervention providers, and other community organizations such as Head Start have not been trained or provided the necessary information to identify and refer children for mental health assessments and home-based services, as required by ¶¶ 12, 16 of the Judgment. Most, if not all information about identification has been targeted to MassHealth medical providers. Defs' Report at 22. Integrating these entities into the new children's mental health system, and tracking and

monitoring their identification of children with behavioral health needs will be a key task for this year.

C. Assessments

The defendants have developed a new CANS instrument, trained an impressive array of clinicians, developed a web-based application of the instrument to facilitate its use across providers, and created a data collection and tracking system to generate information on children's functioning. Defs' Report at 20-24. Although the CANS Project was completed in April 2009, no information has been provided to the plaintiffs about the number and findings of CANS assessments, and particularly about the number and percentage of children determined to have SED. According to the Defs' Report, this information has been available since December 2008.

C. Community Service Agencies

During the past three months, CSAs were selected, contracts were signed, initial staff was hired, and preliminary training was offered. Although CSA were permitted to hire as many care coordinators and family partners as needed to appropriately serve the number of enrolled youth, they must have at least three care coordinators and one family partner hired by July 1, 2009. MassHealth established this floor and many providers plan to do no more than satisfy this minimal requirement. If there is a surge of requests for ICC services, as many families and providers expect will happen, particularly for children involved with DCF and DMH, this minimal staffing pattern will present enormous backlogs, and either result in long waiting lists for services or huge caseload for care managers. This is an even greater concern given some providers' plan to only hire one new care manager every four months.

An Operations Manual for Community Services Agencies (CSAs) was completed in June, as required by ¶ 27 of the Judgment. Because the Manual failed to contain caseload limits for care coordinators which are critical to ensuring effective services, the plaintiffs filed a dispute with the Court Monitor. *See* section IV(A), *infra.* The Monitor's recommendation requires that a definition of "intensity" be established in the fall, and that firm caseload limits be established within the next year.

The Manual also incorporates the protocols developed by EOHHS for each of its child-serving agencies that are required by ¶ 30 of the Judgment. Each protocol includes a description of the agency's role in and commitment to the new Children's Behavioral Health Initiative, service descriptions for each remedial service, the referral process for accessing services, participation by state agency workers in the care planning process and Care Planning Team, coordination between state agency personnel and the CSAs as well as other remedial service providers, a dispute resolution process for addressing disagreements between state agencies responsible for the youth, and involvement of each agency on the Local System of Care Committee.

To date, only protocols for DCF and DMH have been finalized. EOHHS still must finalize protocols for DYS, DPH, DDS (formerly DMR), and several other smaller agencies. These protocols are essential to guide agency staff in referring children to ICC, in participating in the Individual Care Planning process, and, perhaps most importantly, in ensuring consistency between the Individual Care Plan and any agency-specific plans, so that the care provided to children is guided by a single treatment team and a single treatment plan. In addition, the standard conflict resolution process applicable to all EOHHS agencies remains outstanding.

There is no firm timetable for even an initial draft of protocols from the Office of Probation or other child-serving agencies outside of EOHHS. All parties now agree that such protocols are necessary to ensure the full and constructive participation of state human service agencies. However it appears there will be no equivalent process to formally articulate protocols for the participation and engagement of state educational agencies with the new Medicaid service system, nor any agreement on the training of state or local educators.

D. In-Home Therapy, In-Home Behavior, and Therapeutic Monitoring Services

For each of the remaining new remedial services – In-Home Therapy, In-Home Behavior, and Therapeutic Monitoring Services – medical necessity criteria have been agreed to, program specifications have been finalized, a provider network has been selected, and service authorization parameters have been developed. Program standards and performance measures still have to be developed, as required by ¶ 38(c)(vi), (vii) and (xii) of the Judgment. In addition, the service approval process for these services remains in dispute. *See* section IV(B).

E. Monitoring and Evaluation

The Monitor must play a central role in the data collection, review, and evaluation of each component of the remedy. As provided by the Judgment, she has access to all relevant information concerning required activities, such as screening, assessment, SED determination, service planning, service delivery, service referrals, service utilization, and client outcomes. The Monitor must have the resources to review and evaluate this information, to advise the parties of her findings, and to assist in efforts to facilitate compliance. The Monitor is currently reviewing various evaluation programs and

instruments used in other States and should develop an evaluation program in the next several months.

The parties met separately with the Court Monitor and her consultants to discuss ideas for the Monitor's future data collection, monitoring, and evaluation activities. The plaintiffs shared their views with the Monitor concerning the information they believe is needed to assess the implementation process during the next several years, the monitoring activities they believe are appropriate, and a timetable for undertaking these activities. The plaintiffs made clear that they do not believe that the data from the CANS assessment process, as described in the Defs' Report at 49-50, 53, is sufficient to evaluate the effectiveness of the new remedial services.[3] The Monitor's primary focus during the next year be assessing the strengths and weaknesses of the new children's mental health system and overseeing the development of its quality improvement program, before shifting her attention to assessing compliance with specific provisions of the Judgment.

F. Expansion Populations

The parties have not had an opportunity to further discuss the process for transferring children in expansion populations to CommonHealth. Based upon further factual and legal research, the plaintiffs now believe there is strong support for implementing a system that automatically transfers to CommonHealth all children in expansion populations who are determined to have SED, subject to verification procedures or the submission of additional documentation in specific cases.

It appears from the defendants' Report at 2-4 that most of the notices, information,

[3] To the extent that the defendants' assert that they have completed Project 4, Defs' Report, at 48-57, the plaintiffs have previously indicated their disagreement with this assertion. *See* Pls' Ninth Status Report at 11 (Doc. # 453). Reliance on Medicaid claims data and CANS information is not sufficient to monitor and evaluate implementation with the Judgment.

and customer service assistance are limited to children enrolled in MassHealth Standard or CommonHealth. There is no indication that focused information is being provided to families of children who are enrolled in any of the other MassHealth categories or expansion populations about their eligibility for services if they transfer to CommonHealth, the critical importance of transferring to CommonHealth, and how to accomplish this transfer.[4]

IV. Pending Disputes

A. Care Coordinator Caseload Limits

The CSA Operations Manual describes the role, responsibilities, and services provided by care coordinators as part of the core service, Intensive Care Coordination (ICC). Although wraparound and home-based programs throughout the country, as well as the model programs in Massachusetts (MHSPY and CFFC), commonly set caseload limits for care managers of 1:8 [one care manager for eight children and families], MassHealth was unwilling to mandate this limit for ICC care managers that serve youth with intensive needs. Similarly, despite national data and research demonstrating that service effectiveness diminishes dramatically if there are not firm caps on case manager caseloads, MassHealth was unwilling to establish firm caseload limits on care managers serving children with less intensive needs. Instead, MassHealth planned to issue general guidance to CSAs on "suggested" caseload ratios based on an undefined standard of

[4] Thus far, the defendants have considered, but rejected, procedures that would automatically transfer children who are determined to have SED and who are in other MassHealth eligibility categories to CommonHealth. Similarly, they have declined to adopt a process which would result in an automatic application for CommonHealth by all children in other benefit categories who, pursuant to the new preliminary assessment process, are determined to have SED. Instead, the defendants have decided to require children and families in expansion groups to request a redetermination of eligibility and to complete new forms and documentation requesting CommonHealth. The defendants have offered to provide new information to families about the advantages of reapplication, and to encourage providers to support families in this process.

"intensity." As a result, the plaintiffs submitted a dispute to the Court Monitor.

On May 28, 2009, the Monitor issued her recommendations. She required that parties develop a definition of intensity by July 31, 2009, and that MassHealth promptly identify and begin to collect data on care manager caseloads. She determined that MassHealth's suggested caseload guidelines are acceptable on an interim basis, provided that firm caseload limits are established in a reasonable time based upon the new data. On June 8, 2009 she issued an addendum to those recommendations, in which she required that the CSA Operations Manual establish a firm upper caseload limit of 1:18, effective immediately.

On June 30, 2009, the defendants informed the Monitor, for the first time, that they did not consider this matter within the scope of the dispute resolution process described in the Judgment and claimed thatthe recommendations exceeded her authority. The defendants refused to accept the compromises reflected in her decision. They characterized the entire issue as a "diversion" and requested that the Monitor withdraw substantial portions of her recommendations. On July 6, 2009, the Monitor rejected the defendants' suggestions and affirmed her recommendations with minor modifications as to certain time lines.

On July 20, 2009, the defendants' filed an Objection to the Monitor's Recommendations with the Court. The plaintiffs hope to submit their response by July 24, 2009.

B. Prior Approval and Utilization Review

Although there is increasing uniformity in the proposed managed care service authorization process, significant and substantive variations remain which threaten the

integrity of wrap-around teams and the treatment professional's role in clinical decision-making.

Each MCE will use the same service authorization parameters and each has agreed to review the entire Individual Care Plan rather than discrete service requests. However, the MCEs have decided to use markedly different approval procedures. This means that providers must seek authorization to offer each service in a different way, depending on which managed care entity is responsible for the youth's behavioral health services. Even more troubling, four of the five MCEs require that the provider, including the CSA, obtain *prior* approval from the MCE before they can offer any service. Traditionally, prior approval both slows and limits access to services. MBHP, held out at trial as the most experienced and sophisticated of the Medicaid contractors, is the only managed care company that is not imposing this prior approval requirement. This irrational distinction between MCEs is neither helpful to families nor easily manageable by providers. It is strongly opposed by a range of stakeholders, including family groups, national experts, organizations assisting children, and local providers. This opposition is also shared by the Monitor and her consultants.

This prior approval process inevitably will delay services and, perhaps more importantly, will undermine the authority and integrity of the team. Under this prior approval regime, the treatment professional and team does not decide what the child needs and receives – they merely recommend a service and a distant managed care entity determines whether or not it is medically necessary

In order to avert a potentially chaotic situation early in the implementation process, the Monitor met with the Secretary of EOHHS and the director of MassHealth

to express her deep concern with the irrational and problematic distinction between the registration process adopted by MBHP and the prior approval and clinical review process adopted by the other MCEs. It is unclear whether the Secretary will require any modification to the proposed procedures, but the Defs' Report suggests that she has not, at least as of July 17, 2009. *See* Defs' Report at 36-37

C. Right to Appeal Eligibility Denials and Adverse Service Determinations

Under federal and state regulations, any Medicaid recipient can appeal unfavorable eligibility and service decisions made by MassHealth or one of its managed care entities. However, MassHealth takes the position that eligibility or service decisions made by a service provider are not appealable, even when that provider has been effectively delegated gate keeping authority for a larger service system. As a result, if a youth is deemed ineligible for or terminated from ICC by a CSA, or if a team refuses to approve a particular service, those decisions cannot be appealed by the family. This leaves the family with no voice, no due process, and little or no recourse, other than to seek services from a CSA in another region of the state, even though there is only one CSA, and one ICC program, for each geographical area.

The plaintiffs previously raised the issue of due process protections for children determined not to have a Serious Emotional Disturbance. Although the Court indicated a reluctance to impose procedural protections for adverse clinical decisions concerning diagnosis, the defendants have now applied that rationale to all decisions concerning the eligibility for, or receipt, modification and termination of remedial services. This approach is in stark contrast to the Individual Service Plan (ISP) regulations of the Department of Mental Health and the Department of Mental Retardation, both of which afford clients the

right to appeal from adverse clinical and service decisions.[5] Similarly, it stands in stark contrast to the Medicaid regulations that allow nursing facility residents with psychiatric or cognitive disabilities to challenge the clinical determinations of PASARR reviewers, both with respect to the need for and type of mental health or habilitative services that an individual needs, even though these determinations may be made by private providers working under contract with state agencies.

Given the broad scope and far-reaching implications of the defendants' refusal to provide families with a meaningful opportunity to challenge adverse service determinations, the plaintiffs intend to seek court resolution of this dispute once it is clear how the lack of a meaningful appeal process impacts families and children.

V Conclusion

The plaintiffs look forward to discussing these issues with the Court at the status conference currently scheduled for July 28, 2009

RESPECTFULLY SUBMITTED
BY THEIR ATTORNEYS,

July 22, 2009

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[5] These regulations were key features of the development of DMH's and DMR's community service systems as a result of various consent decrees in western Massachusetts and throughout the Commonwealth.

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Date: July 22, 2009 /s/ Steven J. Schwartz