CBHI Service System Assessment
Post-Termination of *Rosie D. v. Baker*

I. The Length and Duration of Waiting Lists Across CBHI Services Has Increased Exponentially Since Termination of the Judgment and Is Depriving Children and Youth of Timely Access to Treatment

Waiting lists have dramatically worsened since the Court evaluated the Commonwealth's compliance with the *Rosie D*. Judgment in 2020 and early 2021. Over the last two years, significantly fewer children and youth are enrolled in both Intensive Care Coordination (ICC) and In Home Therapy (IHT) services. Yet despite reduced enrollment, youth are waiting longer for these and other CBHI services.

For instance, from July 2019 – December 2022, ICC and Family Support and Training (FS&T) providers served 25% fewer families.[1] Monthly enrollment in 2022 remained in the range of 2,400 youth or less – meaning approximately 1,000 fewer youth and families were being served when compared to the years preceding the public health emergency. Despite lower enrollment, average wait times in 2022 (measured by those offered an initial appointment each month) increased from over 20 days in February to more than 31 days in July and 26.9 days in December. As a result, during the first half of FY23, 46% of youth were not offered an initial appointment within the 14-day ceiling established by MassHealth as its Medicaid access standard for ICC.[2]

CSA reports for 2022 also showed that hundreds of youth are waiting for ICC services each month. For the vast majority, wait times were far in excess of the 14-day standard. At the end of July, 240 youth were waiting for a first appointment with ICC, with 173 youth having waited more than 20 days.[3] In December of 2022, 262 youth were waiting for ICC, 194 of whom had waited more than 20 days.[4]

Waiting lists for IHT also have grown exponentially since *Rosie D*. termination proceedings.[5] Between October 2020 – October 2021, the IHT waitlist increased by 177% (from 186 children

[1] ABH letter to Emily Bailey, Chief of Behavioral Health, MassHealth Office of Behavioral Health, and Steven Freedman Director, Health Services Pricing, Center for Information and Analysis, re: Follow-up to Provider Listening Sessions on 101 CMR 352.00: Rates of Payment for Certain Children's Behavioral Health Services, p. 2 (March 6, 2023).
[2] CSA Monthly Report (December 2022), Table 4a.
[3] CSA Monthly Report (July 2022), Table 6.
[4] CSA Monthly Report (December 2022), Table 6.
[5] In December of 2019, one-third of all children received their first In Home Therapy appointment within 14 days. Another third waited up to 4 weeks. Plaintiff's Statement of Material Facts, Doc. 956 at 12. In comparison, in July 2022, three-quarters of youth (75%) had been waiting *more* than 4 weeks for an initial appointment.

waiting to 515 children waiting).[6] During this same year, wait times for families seeking IHT services increased from an average of 2 weeks to more than 4 weeks.[7]

Data from 2022 shows this trend worsening significantly, with more than 800 youth waiting for the first available appointment in February 2022.[8] In July of 2022, 827 youth were waiting for the first available provider. Of these children and families, 75% had waited more than 4 weeks for an initial appointment.[9] In later 2022 and into January of 2023, the number of youth waiting for the first available appointment continued to exceed 700, with the majority of youth waiting more than 30 days, and available provider capacity hovering between 1 and 3% statewide.[10]

During this same period, a similar pattern was emerging for youth seeking In Home Behavior Services (IHBS). Both the size of statewide waiting lists, and overall wait times grew in 2022.[11] In February, 248 youth were waiting for the first available provider of IHBS, 47% of whom had waited more than 30 days. An additional 112 youth were waiting for a provider of their choice. By July of 2022, the number of youth waiting for the first available provider had risen to 310, 67% of whom had waited more than 30 days.[12] In January of 2023, 293 youth were waiting for the first available provider, with less than 1% of statewide provider capacity available to serve new families.[13]

These trends can be seen for Therapeutic Mentoring (TM) as well, with hundreds of children and youth waiting for the service each month, and for increasingly longer periods of time. In February 2022, 51% of youth had been waiting more than 30 days for the first available TM provider. In July of 2022 this number had risen to 66% and remained at 65% in December 2022.[14]

The impact of these waitlists cannot be overstated, especially when youth and families are in crisis and facing significant worsening of their mental health conditions.[15] Just as the

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[6] ABH letter at 2.

[7] Id. For example, in October 2020, 80% of youth waiting for the first available IHT provider were offered an appointment within 30 days. MABH Access Report (October 2020). In October of 2021, that number had fallen to 51%.

[8] Another 373 youth were reported as 'choosing' to wait because they indicated a preference for a particular provider. See MABH Access Reports (February 2022).

[9] MABH Access Report IHT (February, July 2022).

[10] In January 2023, the last month for which data is available, there were 765 youth waiting for an initial appointment and 316 waiting for the provider of their choice. In the first cohort, 59% of youth waited more than 30 days for an initial appointment; in the second cohort 69% of youth waited more than a month. See MABH Access Report January 2023.

[11] In comparison, in December of 2019 a quarter of children received a timely appointment for In-Home Behavioral Services, while an additional 25% waited up to 4 weeks. Plaintiff's Statement of Material Facts, Doc. 956 at 12.

[12] MABH Access Report IHBS (February, July 2022).

[13] MABH Access Report IHBS (January 2023).

[14] MABH Access Reports TM (February, July, December 2022).

[15] In a recent PPAL survey 70% of caregivers reported increased difficulty finding clinical treatment for a child. Respondents also reported that their children were experiencing increasing acuity and complexity of needs since COVID. See, ACCESSING MENTALHEALTH

Commonwealth actively worked to facilitate timely access to care during the litigation, it must again engage in statewide, solution-focused actions to reduce waiting lists and ensure eligible youth "get the health care they need when they need it–the right care to the right child at the right time in the right setting."[16]

In addition to actively monitoring and collecting monthly data on waiting lists, it is also important for MassHealth better understand what racial, linguistic, and geographic barriers are impacting youth and families' access to medically necessary services. Collecting demographic information about youth in CBHI services, and those with significant behavioral health claims or hospitalizations outside of the CBHI service system, can help to identify inequities in treatment access and barriers to care. This data, when paired with information collected by the new Behavioral Health Helpline, can also inform a range of policy decisions including strategies to address existing health disparities in Massachusetts behavioral health system.[17]

II. Provider Network Capacity is Significantly Diminished Since Termination of the Judgment, Impacting the Commonwealth's Ability to Provide and Arrange for Medically Necessary Care.

Adequate provider networks and available provider capacity are critically important to the Commonwealth's ability to deliver medically necessary services in a timely way, and with the intensity and duration youth and families need. However, since the conclusion of the *Rosie D.* case, demand for CBHI services continues to outstrip available provider capacity. This is particularly true for ICC and IHT.

For the majority of 2022, more than two-thirds of Community Service Agencies (CSAs) (21 of 32) were serving fewer than 75 youth and families. Every month, hundreds of youth were waiting for ICC from their local CSA. More than half of these youth waited in excess of 30 days for an initial ICC appointment – two times longer than the Medicaid access standard.

SERVICES & SUPPORTS: Families' Experiences, PPAL (2023); available at: https://ppal.net/publication/accessing-mental-health-services-supports-families-experiences/

[16] "EPSDT: A Guide for States," Center for Medicaid and Medicare Services, p. 12 (2014). The 2014 CMS manual also states that:

> "Services under the EPSDT benefit, like all Medicaid services, must be provided with "reasonable promptness" [quoting 42 U.S.C. § 1396a(a)(8)]. The state must set standards to ensure that EPSDT services are provided consistent with reasonable standards of medical and dental practice. The state must also ensure that services are initiated within a reasonable period of time. . . [referring to 42 C.F.R. § 441.56(e)]. *Because states have the obligation to "arrang[e] for . . ., corrective treatment" . . ., a lack of providers does not automatically relieve a state of its obligation to ensure that services are provided in a timely manner [quoting 42 U.S.C. § 1396a(a)(43)(C)].*

Id. at 12. (emphasis added).

[17] In a FOIA request in March of 2022, the Center sought "Any demographic data captured in, or reported out from, the MassHealth CANS database, including the race, ethnicity, and primary language of children assessed between January 2021 and the present." MassHealth responded that this type of demographic data did not exist as a single record or segregable portion of a larger record within EOHHS' possession, custody, or control and that to identify, segregate, and produce the information would require the development of a new software program and/or coding that did not currently exist.

In February 2022, the percent of available IHT program capacity statewide was less than 1% with 99.3 % utilization. In July of 2022, available statewide capacity was 97.9%.[18] Meanwhile, total monthly waiting lists for IHT have grown into the thousands with more than half of those youth waiting 30 days or more.

These two services are responsible for child and family team formation, as well as securing, coordinating, and monitoring service delivery over time. As a result, limitations on ICC and IHT provider capacity have cascading negative effects on children and youths' ability to receive other medically necessary services they need to remain at home and in their communities.

In fact, provider capacity is limited across all five CBHI services and has become increasingly more so since termination of the Judgment. In the period between September 2021 and December of 2021, the percentage of providers reporting zero availability to accept new clients climbed from 58% to 65%. In the first half of 2022, between 71-79% of providers reporting said they had zero availability to accept new clients.[19]

Since the termination of the Judgment in 2021, there also are significantly fewer full-time employees (FTEs) delivering CBHI services. Between July 2019 and December 2022, CSAs lost 33% of Family Partner FTEs; 37% of BA-level Care Coordinator FTEs; and 41% of MA-level Care Coordinator FTEs.[20] The CSA monthly report for December 2022 confirms that more than 22 full time care coordination positions were lost in the second half of the calendar year 2022 alone.

As noted by the Association for Behavioral Health in a recent letter to the Commonwealth:

> The departure of critical clinical staff has resulted in providers' inability to offer timely access to services for children and families who seek immediate assistance with challenging behavioral health needs. Limited staffing has substantially increased the wait times for families; it is now commonplace for a child to wait a month or longer for services.[21]

For the last two years, CBHI providers have raised alarms about the increasing fragility of the home-based service system, their inability to hire and retain qualified staff, and a related diminishment in service quality. IHT providers seem to be at the greatest risk given higher salaries and more competitive rate methodologies for clinical services delivered by the new Community Behavioral Health Centers (CBHCs). CPR is aware that at least two IHT programs have closed due to insufficient staffing, and that more are at risk of closing as a result of the inability to compete with newly established market rates for clinician roles under the Roadmap.

IHT programs also face increasing demands as a result of Medicaid's new hospital diversion program. Although reportedly beneficial to youth in crisis, these new diversionary programs

[18] MABH Access Reports IHT (February, July 2022).
[19] See CBHI Provider Detail and Waiting List reports (September 2021 – June 2022).
[20] ABH letter at 2 (March 6, 2023).
[21] Id.

depend on an already stressed network of IHT clinicians. Participating providers are now being asked to prioritize delivery of intensive, short-term interventions to youth presenting in emergency rooms, further limiting staff availability and access to care for hundreds youth in the community on protracted waiting lists. It remains to be seen if temporary rate increases in January of 2023 will stabilize IHT programs and improve network capacity, particularly for programs operated by non CBHC providers.

Many CBHI providers also deliver outpatient therapy to MassHealth members and have spoken out publicly about the impacts of insufficient provider capacity on youth and families who need outpatient services. A 2022 ABH outpatient survey cites more than 3,200 children and youth waiting for outpatient services statewide, with average wait times for individual therapy exceeding 15 weeks.[22] The inability to access outpatient services also prevents youth from being properly assessed, and referred to, medically necessary CBHI services.

It is critical that the Commonwealth continue to invest in the delivery of home-based services, and in the workforce that makes these highly integrated services available to children and families in the community. Immediate efforts are needed to equalize market rates, update existing rate methodologies, and implement initiatives that stabilize and expand the behavioral health workforce. Absent these efforts, the personal costs to children and families, and the financial costs of higher and more restrictive levels of care, will only worsen over time.

III. Delivery of ICC and IHT Is Increasingly Inconsistent With, Or Adverse To, Established Service Standards

The Commonwealth's Massachusetts Practice Review (MPR) was used during implementation of the *Rosie D.* Judgment to make two critical assessments: 1) whether delivery of ICC and IHT was occurring consistent with established service standards; and 2) whether youth and families were benefiting from these services. Based on an earlier client review instrument utilized by the Court Monitor, the MPR was designed by the Commonwealth, and is administered annually under contract with the Technical Assistance Collaborative.

As part of a 2022 FOIA request, the Commonwealth produced the first MRP data since the FY2019 ICC and IHT reviews referenced in *Rosie D.* termination proceedings. This modified MPR was done in FY 2022 with a reduced sample size - 48 ICC recipients and 42 IHT recipients.[23] The results reflected a significant and troubling deterioration in service performance and youth outcomes.

Perhaps most shockingly, the FY2022 MPR showed that between 20 and 40% of sampled youth were receiving care described as "poor" or "adverse" to them – more than at any other time in

[22] See Outpatient mental health access and workforce crisis: Issue Brief. Association of Behavioral Health, Outpatient survey issue brief, pp. 6-7 (February 2022); available at https://www.abhmass.org/images/resources/ABH_OutpatientMHAccessWorkforce/Outpatient_survey_issue_brief_FINAL.pdf.

[23] *FY22 Massachusetts Practice Review: Practice Summary Report*, Technical Assistance Collaborative, p. 5.

the history of the MPR.[24] For the combined sample, service delivery was determined to be poor or adverse in the following key practice areas: 38% of assessments; 29% of service planning; 20% of service delivery; 29% of team formation; 25% of team participation; 39% of care coordination, and 42% of transition plans.[25]

Under youth progress, 33% of children in the sample were declining or found to be making no progress towards their treatment goals.[26]

Also significant were the failures of IHT providers to deliver appropriate care coordination for youth not in ICC. Supplemental IHT questions revealed that in FY22 47% of youth were not receiving the right level of care coordination. Reviewers also felt that many IHT providers were not making sufficient contact with other providers, schools, or State agencies when needed to coordinate care for their clients. Despite this, 52% of in-home therapists said neither they nor the team ever discussed ICC as an option with their clients. [27]

These results make clear that far too many youth are receiving insufficient, ineffective, and potentially harmful care coordination from CBHI providers. In response, the Commonwealth must reinvigorate its corrective action process and engage in targeted oversight and quality-improvement efforts with its ICC and IHT provider networks.

IV. Reduced Community Encounters and Increasing Response Times Are Significantly Diminishing Confidence in Mobile Crisis Teams and Their Ability to Prevent Unnecessary Emergency Room Boarding and Acute In-Patient Admissions.

Poor performance by MCI providers in key aspects of the service specifications (encounter location and response time) has undercut perceptions of the service as a reliable and effective alternative to calling 911 or presenting at a hospital emergency room. The resulting harm to children and families is evident in the continued worsening of the ER boarding crisis, as well as reports of youth with suicidality and high acuity needs being discharged without access to appropriate home-based services.[28]

In 2021 and 2022, monthly MCI reports illustrate continued, uneven compliance with both the 60 minute maximum response time, and the service's emphasis on providing crisis response in the community. For instance, in February of 2022 only 13 of 21 reporting teams had better than

[24] The MPR describes these terms as follows: Adverse: "Practice is either absent or wrong, and possibly harmful - or - practices used may be inappropriate, contraindicated, or performed inappropriately or harmfully." Poor: "Does not meet minimal established standards of practice." Id. at 4.
[25] Id. at 7-8.
[26] Id. at 10.
[27] Id. at 10-11.
[28] Massachusetts Hospital Association data indicated that there can be hundreds of children in a given week boarding in hospital emergency departments, awaiting transfer to inpatient or other settings. On March 13, 2023, there were 127 pediatric patients boarding in hospital emergency departments. See, https://www.mhalink.org/MHA/IssuesAdvocacy/State/Behavioral_Health_Boarding/MHA/IssuesAndAdvocacy/Capturing_a_Crisis_MHAs_Weekly_Behavioral_Health_Boarding_Reports.aspx?hkey=40f7493a-e25b-4a28-9cda-d7de41e622d2.

75% compliance with required response times, and only 13 teams had more than 50% of their crisis encounters in the community. In July of 2022, there had been little change. Only 14 of 21 regional mobile crisis teams reported 75% or better response time compliance, and only 12 of 21 providers reported having 50% or more of their crisis encounters in the community.[29]

As far back as November of 2021, families surveyed on the PPAL website overwhelmingly reported that their experiences with MCI were not helpful. Almost half of respondents who experienced a behavioral health crisis in 2021 reported that they called 911 instead of MCI.

In 2022, families calling the PPAL support line continued to report problems with MCI responsiveness, delays in community encounters, lack of empathy and compassion, and judgmental interactions with providers. Law enforcement officers collaborating with PPAL in CIT trainings also reported difficulties accessing and turning over calls to MCI staff as an alternative to arrest. These reports are especially troubling given the shifting landscape for mobile crisis services in Massachusetts, including re-procurement of the MCI provider network as part of the Roadmap's CBHC network,[30] and the Commonwealth's decision to require hospitals to provide or contract for their own ER crisis evaluation services.[31]

As part of the Commonwealth's current focus on expanding and enhancing community-based crisis response systems for children and adults, it is critical that reported deficiencies in MCI service delivery be addressed through additional provider training, expert technical assistance, enhanced contract oversight, and a return to more rigorous data analysis and reporting requirements.

V. Interagency Agreements Created Under the Judgment Are No Longer Facilitating Intended Collaboration for MassHealth Youth.

In 2022, CPR partnered with legal services attorneys representing children and youth in special education, child welfare, and juvenile justice matters to better understand how access to CBHI services was impacting these class members. In the special education and child welfare contexts, attorneys reported very few, if any, instances in which the school district provided MassHealth eligible youth with referrals to CBHI services. This was true even in cases where the student was identified as having unmet behavioral health needs and subjected to a Child Requiring Assistance (CRA) petition filed by the local school.

These anecdotal reports are consistent with a February 2022 survey conducted on the PPAL website, showing schools as the most common source of CRA reporting among survey respondents. A recent statewide report also concluded that many youth, including those with connections to the child welfare system, end up in the Juvenile Court's CRA process because of

[29] MCI Monthly Provider Reports (February, July 2022).
[30] See, e.g., https://www.mass.gov/community-behavioral-health-centers.
[31] Pursuant to Section 32 of Chapter 177, beginning January 1, 2023, hospitals are required to provide or arrange for crisis services in their emergency departments and provide access to a behavioral health clinician for evaluation, treatment, and referral. Additionally, MassHealth is requiring that hospitals be responsible for ED-based crisis evaluations and interventions, and disposition determinations. *The Crisis in Children's Behavioral Health*, Massachusetts Association of Health Plans, p. 20 (January 2023).

barriers to accessing services outside the court process.[32] This report cited a common misunderstanding regarding both the potential harms of court involvement and the limited options available to the Juvenile Court to secure needed services.[33] As noted by the authors, if children and youth are unable to access necessary behavioral health services when they need them, their conditions worsen, often leaving the CRA process as a "last resort."[34]

According to a survey of 69 CRA-involved youth done by the Office of the Child Advocate and the Child/Adolescent Family Law division of the Committee for Public Counsel Services, in 93% (n=63) of cases, youth needed mental health, physical health and disability-related services (e.g., in-home therapy, outpatient mental health consultation/therapy and psychiatric consultation/assessments) at the time they were referred to the juvenile court.[35]

When children and youth eligible for and in need of in home services from CBHI are instead referred to the CRA process, and/or placed in the custody of the Department of Children and Families (DCF), it is strong evidence that guidance developed with the Massachusetts Department of Elementary and Secondary Education (DESE),[36] and interagency agreements like those with DCF,[37] are not facilitating medically necessary community-based referrals for youth with unmet behavioral health needs or working to prevent unnecessary out-of-home placements.

[32] *Improving Massachusetts' Child Requiring Assistance System*, The Commonwealth of Massachusetts Juvenile Justice Policy and Data Board, pp.51-52 (December 2022); available at https://www.mass.gov/doc/improving-massachusetts-child-requiring-assistance-system-an-assessment-of-the-current-system-and-recommendations-for-improvement-10-years-post-chins-reform/download.
[33] Id.
[34] Id. at 53.
[35] Id. at 52.
[36] See, e.g, https://www.mass.gov/service-details/cbhi-for-educators.
[37] Children's Behavioral Health Protocols, Process and Procedures for Accessing MassHealth Behavioral Health Services on Behalf of DCF Children and Families, p. 16, et seq. (June 2006); available at https://www.mass.gov/doc/department-of-children-and-families-dcf-0/download.