MMPI Massachusetts Medicaid Policy Institute

Implementing the Rosie D. Remedy

The Opportunities and Challenges of Restructuring a System of Care for Children's Mental Health in Massachusetts

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Rosie D. Case: Background

- *Rosie D. v. Romney*: Class action lawsuit filed against state on behalf of children with serious emotional disturbances
- Landmark decision in July 2007
  - State failed to meet EPSDT requirements:
    - Insufficient screenings, assessments, and treatment service coordination for children in Massachusetts with SED
    - Insufficient home-based behavioral support services for children with SED

Main Components of Court's Decision

- Defined "serious emotional disturbance"; established plaintiff class at ~15,000 children
- State must provide home-based services to Medicaid-eligible children who request and need them
- Aggressive implementation timelines
- Remedy is legally enforceable; state is bound by terms of judgment

The Remedy

- Entitles Medicaid-eligible children with SED to home and community-based services
- Goal is to create a unified System of Care, using the wraparound approach
- Calls for creation of new mental health infrastructure

Summary of Remedial Plan

- Notification of EPSDT Services
  - Outreach to children, families and MassHealth mental health providers
- Behavioral Health Screening/Identification
  - PCPs / pediatricians perform screens using standardized screening tools
- Assessment and Diagnosis
  - CANS survey
- Intensive Care Coordination (ICC) and Treatment Planning
- Intensive Home and Community-Based Services

Home and Community-Based Services

- Existing Services
  - Mobile crisis intervention
  - Crisis stabilization services

- New Services
  - In-home behavioral services
  - In-home therapy services
  - Mentor services

Service Delivery Network

- MassHealth-lead agency, working with DMH
- Community Service Agencies (CSAs)-statewide service delivery network
  - 15-30 geographic areas across state
  - Coordinate, provide, arrange care
- MassHealth's behavioral health contractor (MBHP) select CSAs, assist in service delivery coordination
  - MassHealth/DMH establish qualifications, standards, performance measures for each CSA
  - Providers in MassHealth's managed care or FFS network contract with CSAs

Other Plan Components

- Data collection
  - web-based information technology system
  - mental health tracking component
    - number of EPSDT screens & assessments, number of referrals, utilization data
- Direction and oversight
  - Karen Snyder-court monitor
  - Emily Sherwood-Compliance coordinator

Implementation Opportunities/Benefits

- Improved EPSDT screening and treatment
  - Early identification---early intervention
- Improved Service Delivery
  - Streamlined across multiple child-serving agencies
  - Treatment plans tailored toward child/family
  - More clearly defined services; consistent provider rates

Implementation Opportunities/Benefits (2)

- Shift from Institutionalized/Residential Care to Community-Based Care
  - Care in more familiar settings (homes, schools, child care centers)
  - Relatively portable services
  - Least restrictive settings allows integration

Implementation Opportunities/Benefits (3)

- Improved Outcomes Measurement
  - New data collections system-improved quality of care
  - Improved tracking of children

Implementation Challenges

- Workforce Shortages
  - Shortage of "child trained" providers
- Provider Capacity Issues
  - Outpatient providers doing collateral work
  - Uneven distribution of providers/inadequate number of multicultural providers
  - Licensure issues
  - Change in existing provider model to wraparound approach

Implementation Challenges (2)

- Lack of Detail in Remedy
  - Structure of delivery system unclear
    - Provider contract negotiation, billing rates, utilization standards, provider qualification/training, performance measures
    - Which entities will serve as CSAs/how they will be selected
    - EOHHS has discretion to "fill in details"

Implementation Challenges (3)

- State and Federal Approval
  - CMS approval required for new services for federal financial participation (FFP)
  - Legislative funding required for new services

Programmatic and Administrative Costs

- Administrative Costs
  - initial setup, program design
  - provider training
- Annual Program/Operating Costs
  - screening/assessments
  - service coordination, new services, program maintenance

Cost Estimates

- Plaintiffs: $200-400 million
- EOHHS: $149-612 million
- Court: $459 million
- $202 million-MassHealth's behavioral health expenditures for children under 21 in FY 2005
- Certain expenditures already accounted for (existing therapy, home-based services)
- Estimates depend on number of children served

Funding Sources

- MassHealth-provides majority of funding
  - Appropriations, savings offsets, cost avoidance
  - Streamlining service coordination/in-home support services
  - Mobile services less costly than acute inpatient care
  - Cost offsets within EOHHS, not necessarily Office of Medicaid
  - Utilization management techniques (prior authorization, payment reviews, etc.)

Potential Implications for Involved Parties

- Impact on MassHealth
  - Budget Neutrality requirement of 1115 waiver
    - State must work with CMS to modify budget neutrality limit to integrate *Rosie D*. provisions
  - Relationship with Chapter 58-HealthCare Reform Law
    - Challenge is to implement remedy without compromising core components of other programs

Potential Implications for Involved Parties (2)

- Impact on Other EOHHS Organizations
  - Interagency collaboration-critical component of implementation
  - DMH,DSS,DYS,DMR-key players
  - DMH working closely with Office of Medicaid
  - Challenge to integrate overlapping delivery systems
  - Challenge to maintain funding for children with SED not Medicaid-eligible

Potential Implications for Involved Parties (3)

- Impact on Other EOHHS Organizations
  - Challenge to avoid creating separate system of care with separate lead agencies
    - CSAs should contract with providers affiliated with MBHP or MCOs
    - Input of existing child-serving agencies—critical
    - Avoid creating two distinct systems-*Rosie D.* system & system for non-*Rosie D.* children

Potential Implications for Involved Parties (4)

- Impact on Existing Delivery System
  - Workforce, training, capacity issues
  - Danger of building new system at expense of existing outpatient programs
  - Concern that single "gate" in each region (CSAs) could create bottleneck

Potential Implications for Involved Parties (5)

- Impact on Children with SED and their Families
  - Community-based shift is positive change
  - New system may seem intrusive
  - Input from families/parents is critical
  - Continuity of care for *all* children must be maintained

Current Models

- Coordinated Family Focused Care (CFFC)
- Mental Health Services Program for Youth (MHSPY)
- Worcester Communities of Care (WCC)
  - Each effective in own niche
  - Certain elements can be replicated
  - Too costly to duplicate on larger scale

Conclusion

- *Rosie D.* remedy has potential to transform children's mental health infrastructure
- Creates unified System of Care, using wraparound approach
- Significant challenges and opportunities
- Current climate is amenable to successful implementation
- Success will hinge on monitoring, strategizing, and evaluating progress as implementation moves forward