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Oct. 18, 2005

STATE OF MAINE
KENNEBEC, ss.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-89-088

PAUL BATES, et al.,

Plaintiffs

v.

JOHN NICHOLAS, et al.,

Defendants

PROGRESS REPORT PURSUANT TO PARAGRAPH 299

From the time of my appointment as court master on September 6, 2003 until approximately January 1, 2005, the mental health system operated under the terms of this Court's order imposing and suspending receiverships containing their own reporting procedures. With the withdrawal of the receiverships at the beginning of 2005, periodic progress reports are once again called for by the terms of the original consent decree. The following report covers the period from January 1, 2005 through September 30, 2005. In the future, progress reports will issue every six months.

Operation of Riverview Psychiatric Center.

At my request, during the month of January, the Receiver of AMHI, Elizabeth Jones, assembled a representative and multidisciplinary team to conduct a site visit at Riverview Psychiatric Center. The purpose of the visit was to assist in the transition from receivership to full state control, to measure the progress that had been achieved, to offer a plan for sustaining that progress and bringing the hospital into full compliance with the consent decree. The team's report, dated January 31, 2005, is attached hereto as Exhibit

A. The transition from receivership to state control went smoothly and David Proffitt, the Superintendent of the hospital, has succeeded under difficult circumstances in sustaining and advancing the progress achieved during the receivership. The team report was used by DHHS in preparing its own comprehensive plan with respect to the hospital, in response to the remand order of the Supreme Judicial Court. In addition, I relied on the report in considering, amending and approving the plan submitted by DHHS.

During the receivership, the Receiver and I held monthly meeting with clients at the hospital, and similar meetings have continued with the Superintendent. The time spent talking with clients at the hospital has been most important, both as a means of learning about aspects of the operation that require attention but also as a means of monitoring improvements in hospital operations. Currently, the operation of the hospital continues to improve and is monitored through such periodic meetings with clients and Quarterly Performance Improvement Reports, the most recent copy of which is attached hereto as Exhibit B. Although there has been improvement, the most difficult and enduring problem in the operation of the hospital is the inability to discharge clients in a timely manner because of the lack of funding for community services. The overlap in services between hospital and community remains an area in need of strengthening.

As part of the process of closing out the receivership of the hospital, Elizabeth Jones proposed amendments to certain provisions of the Consent Decree relating to the hospital. After consulting with the parties, I will report to the Court concerning those amendments, as well as others suggested by the parties.

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Monitoring Developments Relating to Compliance.

Throughout the first six months of the year, I monitored State budget developments and other legislative proposals that might impact the ability of DHHS to comply with the requirements of the settlement agreement. I maintained informal contact and discussions with DHHS and other administration officials. I reviewed the Mental Health Cost Study prepared by the Governor's Office of Health Policy and Finance, and attended briefings conducted by that office and other interested organizations. I reviewed a report issued by the Muskie School regarding the funding challenges for MaineCare generally and conferred with the author. I participated in legislative hearings before the Joint Standing Committees of Health and Human Services, Appropriations and Criminal Justice. This was a difficult year for those who write the budget, and the proposals with respect to adult mental health services were unusually fluid and changeable. For example, DHHS proposed, and later in the legislative session withdrew, a proposal for a statewide capitated rate structure for specified mental health services. A pilot project for a capitated rate structure was included in the plan approved by this Court on December 8,2004. No useful purpose would be served by tracking the shifting proposals that appeared during the legislative session but the final results have been summarized as follows:

> Reductions in the State's biennial budget for Adult Mental Health Services (AMHS) for state fiscal year (SFY) 2006 and SFY 2007 were essentially passed in three parts: Part 1, Part 2 Amended (referred to in this summary as Part 3.) The reductions were as follows:

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Initiatives		SFY 2006 Reductions	SFY 2007 Reductions
1.	Reduce MaineCare funding by system redesign	$450,489 (Part 2)	$900,977 (Part 1)
2.	Eliminate grant funds for housing coordinator positions (3)	$194,731 (Part 3)	$194,731 (Part 3)
3.	Reduce MaineCare funding for Medication Management	$369,036 (Part 1) $340,482 (Part 2)	$1,419,036 (Part 1)
4.	Reduce MaineCare funding for Outpatient Therapy	$515,992 (Part 2)	$515,992 (Part 1) $515,992 (Part 2)
5.	Reduce grant funding for technology, training, and transportation	0 (Part 1)	$208,879 (Part 1)
6.	Eliminate funding for the Receiver	$131,681 (Part 1)	$131,681 (Part 1)
7.	Parity: Evidence-based practices and crisis coverage (shifting costs of current services to private insurers)	$1,500,000 (Part 1)	$1,500,000 (Part 1)
8.	Managed behavioral health care savings in MaineCare	0	$10,431,749

The most significant development in the budget finally enacted at the end of the last session is the legislative mandate for DHHS to create a managed health care system for behavioral services and achieve more than $10.4 million in budgeted savings for fiscal year 2006-07. The budget language, a copy of which is attached as Exhibit C, provides little detail or direction concerning the eventual contours of the managed care system. The design, planning and implementation of such an abrupt and fundamental change in the method of funding and delivering mental health services will require

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careful consideration and monitoring during the remainder of fiscal year 2005-06. Thirty four states have adopted managed health care systems for behavioral services but there is little evidence that managed care alone is a proven remedy for the service deficiencies that stand in the way of achieving compliance with the consent decree.

Other legislative and administrative developments of interest that were monitored include the following:

<u>MaineCare cuts for "non-categorical" adults.</u> Since 2002, the MaineCare program has included a non-categorical waiver that extended MaineCare eligibility to non-disabled childless adults, aged 21 to 64, living below the federal poverty level. Under this program, Maine receives roughly $2 of federal matching funds for each state dollar it expends, up to the federal spending cap of approximately $120 million specified in the waiver. During the spring it became clear that Maine was going to exceed the spending cap and would be solely responsible for any additional growth in the program. Administratively, Maine chose to "freeze" new enrollment in this group, put on hold the expansion of income eligibility from 100% to 125% of the federal poverty level and cut the services for those who were already enrolled. Of particular importance to the consent decree is the fact that the service cuts eliminate community support services and residential services for those with mental illness. This has been an important program for people with mental illness, and in the preceding legislative session in 2003 the existence of the program was used to justify significant reductions in so called "grant funding," or unmatched state funding, for adult mental health services. It is likely that class members included in the non-categorical program will continue to receive services from grant

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funding. Non-class members may or may not be entitled to grant funding by virtue of ADA discrimination provisions. In any event, grant funding was budgeted for other mental health services. Although it is difficult to determine who will bear the burden of reduced services, it is clear that the general fund appropriation for clients who are not eligible for Medicaid and services that are not covered by Medicaid has been reduced.

Proposal for Outpatient Commitment. A significant amount of effort and controversy was generated by the introduction and passage of L.D.151, the outpatient commitment bill. Although eventually enacted by both houses, it is tabled on the Appropriations table for lack of funding. Presumably, it will be considered again when the legislature reconvenes.

Legislative Directives for DHHS Planning Process. L.D. 1515, enacted as Resolve 2005, chapter 85, attached as Exhibit D, requires DHHS to ensure that the plan presented to the court to achieve compliance be consumer-directed, community-based and comprehensive. The resolve provides a layer of values, standards, measures and parameters, in addition to those set forth in the consent decree, that are to guide the transformation of the mental health system. DHHS is required to provide a report and recommendations to the Joint Standing Committee of Health and Human Services no later than January 15, 2006. This resolve became effective on September 17, 2005, and did not affect the preparation of the plan that was submitted by DHHS on June 29, 2005. Since the DHHS plan was approved only in part, the preparation of future submissions, other than in the process of dispute resolution, may be subject to the directives set forth in the Resolve.

Information Concerning the Consent Decree Process and The Operation of The Hospital. From time to time I have been called on to provide information to legislative committees or individual legislators concerning the progress and procedure of the consent decree process, the operation of the hospital and the procedures that apply to forensic clients.

Partial Approval of Comprehensive Mental Health Plan Following Remand From The Supreme Judicial Court. Following the remand from the Supreme Judicial Court at the beginning of the year, the parties and I reviewed the planning documents that had been prepared under this Court's supervision, and approved in part pursuant to an order of this Court dated December 8, 2004. Although these planning documents were prepared for the purpose of securing an extension of the suspension of the receivership ordered for the community mental health system, the substance of the plan was useful as a starting point for preparing a plan to comply with the requirements of the consent decree and the order of remand. Revisions were necessary, however, as a matter of both substance and form. In addition, I concluded that portions of the earlier plan were no longer viable because the additional funds identified in that plan had not been included in the Governor's budget for DHHS that was submitted to the Legislature.

This Court, on remand from the Supreme Judicial Court, ordered DHHS to submit its final plan by June 29, 2005 and authorized me to establish a more detailed work schedule to accomplish this task. After receiving and considering a series of submissions from DHHS and comments from Plaintiff's counsel, and working directly with the parties, I filed an order dated July 29, 2005, with reference to the plan that:

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a. Approved, with revisions, the plan provisions for measuring and evaluating compliance.

b. Approved, with revisions, several major portions of the plan, including the portion dealing with Riverview Psychiatric Center.

c. Disapproved portions of the plan dealing with continuity of care and cost of plan implementation.

Among the deficiencies that required disapproval were:

a. The plan for crisis services was tentative and incomplete;

b. The team approach and the managed care initiative were undefined and demonstrated no capacity to address the continuity of care and service issues that have been identified.

c. Inadequate residential services and housing resources, primarily rental assistance.

d. Vocational rehabilitation services were inadequate.

e. The plan for consumer involvement was inadequate and totally dependent on an application for a federal grant that, as of the date of this report, has been declined.

Following the entry of my order, and within the time provided in the settlement agreement, both plaintiffs and defendant invoked informal dispute resolution pursuant to paragraphs 293 and 294 of the consent decree. On September 27, 2005, I met with counsel and DHHS officials and identified the following issues that require resolution:

a. Greater definition of managed care and team approach; plan for improved continuity of care.

b. Crisis services (including action steps in response to inventory report and coordination among hospital ED's, crisis providers and community support providers); capacity of warm line; peer support services in emergency departments, and blue papers.

c. Vocational services.

d. Housing resources and residential services.

e. Services for elderly and clients with traumatic brain injury.

f. Performance standards for Riverview.

g. Consumer involvement in monitoring, evaluation and quality assurance.

h. Cost of plan implementation.

i. Riverview Psychiatric Center operations as reflected in various specified paragraphs of the consent decree from 134 through 204.

j. Enforcement of regulations under paragraph 282.

k. Treatment of nursing home eligible patients at Riverview.

l. Definition of a covered non-class member.

In addition the parties wish to begin the process of developing compliance standards pursuant to paragraph 290. I am currently in the process of scheduling informal dispute resolution sessions during the next month and one-half to address the issues presented.

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While I had the plan under consideration, I conferred extensively with members of the Recovery Committee, an advisory group formed by me that includes those named in Exhibit E. I also conferred with Elizabeth Jones, the former receiver of Riverview, and Joseph Bevilacqua, former commissioner of mental health in three states.

Recommendation.

I am concerned by the fact that, although considerable progress has been achieved, there is still not a complete and approved comprehensive plan as required by the consent decree and the Court's remand. Moreover, the unapproved portion of the plan involves the most difficult and important reform - improvements in continuity of care. The introduction of managed care at this particular point in time could easily delay the formulation of a final plan for at least another nine months, if not longer. The informal dispute resolution sessions with reference to the plan should be concluded by mid-November. I propose to report to the Court not later than December 1, 2005 whether it is likely that a final approved plan can be achieved in a timely manner or whether there are other interim measures that will assure continued progress toward compliance while awaiting the final development of the funding and service delivery changes involved in the implementation of managed care.

DATED: October 18, 2005

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Daniel E. Wathen
Court Master

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