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UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

JEFF D., et al., By and Through Their Next Friend Howard A. Belodoff, Plaintiffs, vs. BRAD LITTLE, et al., Defendants.	Case No. 4:80-CV-04091-BLW PLANTIFFS' RESPONSE TO DEFENDANTS' ANNUAL REPORT DKT. 775

Class Counsel's Annual Report Response

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I. Introduction

Procedural Background

This lawsuit was filed "in August 1980 on behalf of Idaho children suffering from severe emotional disturbances against the Governor of Idaho and other state officials, alleging that Defendants were failing to provide adequate and appropriate treatment…" *Jeff D.* Settlement Agreement, at 2, Docket 741, *filed* June 18, 2015 ("2015 Settlement"). "[I]n April 1983, the parties entered into a settlement agreement, approved and entered by this Court as a consent decree, that offered the injunctive relief the class members sought in their complaint." *Id.* Two additional Consent Decrees were entered in December 1990 and December 1998 "to provide community-based mental health services to class members." *Id.*

Almost ten years later, "in November 2007, this Court granted Defendants' Motion to Vacate the consent decrees and dismissed the case." *Id.* On May 25, 2011, the Ninth Circuit issued an opinion reversing this Court's vacatur of the consent decrees and remanded to this Court for further proceedings. *Id.* "[T]his Court ordered Plaintiffs' counsel to meet and confer with Defendants… [who] agreed to use an alternative dispute resolution process designed to help resolve the outstanding compliance issues in this action." *Id.* After 18 months of negotiations, the parties Stipulated to the 2015 Settlement, Ordered on June 29, 2015.

> The purpose of [the 2015 Settlement] is to direct and govern the development and implementation of a sustainable, accessible, comprehensive, and coordinated service delivery system for publicly-funded community-based mental health services to children and youth with serious emotional disturbances ("SED") in Idaho. The specific objective of this Agreement is the development and successful implementation of a service array and practice model that are consistently and sustainably provided to Class Members statewide, in the manner prescribed herein. As a result of this Agreement, Class Members will receive individualized, medically necessary services in their own communities, to the extent possible, and in the least restrictive environment appropriate to their needs.
>
> Class Members are Idaho residents with a Serious Emotional Disturbance who are eligible under this Agreement for services and supports provided or arranged by Defendants and:
> a. Are under the age of eighteen (18);
> b. Have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosable mental health condition or would have a diagnosable mental health condition if evaluated by a practitioner of the healing arts operating within the scope of his/her practice as defined by Idaho state law; and
> c. Have a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified clinician or would have been measured and documented had an assessment been conducted.

2015 Settlement, at 2 (footnotes omitted).

The 2015 Settlement requires Defendants to provide "all of the services set forth in the Services and Supports document, defined in Appendix C, that are necessary to meet their individualized mental health strengths and needs as recommended by a practitioner of the healing arts." 2015 Settlement ¶¶ 18 (footnote omitted), 71.c.

The expanded array of YES home and community-based services and supports includes:[1]

1. Respite
2. Child and Adolescent Needs and Strengths (CANS) Assessment Tool
3. Crisis Response
4. Targeted Care Coordination (TCC)
5. Therapeutic After School and Summer Program (TASSP)
6. Family Support
7. Youth Support
8. Partial Hospitalization
9. Individualized Skills Building Treatment Planning
10. Child and Family Team (CFT) Interdisciplinary Team Meeting
11. Family Psychoeducation
12. Behavior Modification and Consultation (BMC)
13. Intensive Home and Community Based Services (IHCBS)
14. Behavioral Health Day Treatment
15. Skills Training and Development (Partial Care)

The expanded services, added to pre-existing outpatient services, including Assessment, Psychotherapy, Neuropsychological Testing, Case Management, Medication Management, Crisis Services, Substance Use Treatment, Wraparound, Parenting with Love and Limits (PLL), and Skills Building (CBRS), plus Residential Care, constitute the full YES service array.[2]

Defendants are obligated to timely provide Class Members the foregoing services and supports that "are appropriate in scope, intensity and duration to meet to their individual strengths and needs…." 2015 Settlement ¶ 71.d.

The 2015 Settlement required Defendants to develop an Implementation Plan that was filed with this Court on April 29, 2016. Idaho Implementation Plan, Docket 752-1 ("Implementation Plan"). "The [Implementation] Plan is a consensus plan and all the Parties are stipulating for the Plan's adoption and approval by the Court." *Id.* at 4.

"The purpose of this [Implementation] Plan is to implement the Agreement and therefore, the Plan shall be interpreted in compliance with the commitments, outcomes and exit criteria listed in the Agreement. The Plan shall not lessen or broaden any obligations or duties listed in the Agreement." *Id.* at 2. The Implementation Plan was developed by "an implementation work group (IWG) comprised of Plaintiffs' counsel, Defendants' counsel, and children's mental health stakeholders with knowledge relevant to system beneficiaries, services and processes. The IWG is intended to help facilitate successful implementation planning. . . ." 2015 Settlement ¶ 59.

[1] *Annual QMIA Report: Issue 12—December*, at 7, 8.

[2] Descriptions of the YES services are provided in Appendix 1.

"The implementation will occur in a phased approach over four years with the start of new and enhanced services, processes, and products being rolled out beginning in 2016 and continuing until the system of care is fully operational as described in the Plan." *Id.* at 3. "The [Implementation] Plan provides for a continuum of care with new and enhanced services/supports provided in sufficient intensity and scope to meet the needs of Class Members and their families and that are designed to facilitate a home and community-based approach to service delivery." *Id.* at 6.

The Implementation Plan set out the timeframe for performance of Defendants' obligations under the 2015 Settlement.

> In the first year the state will be defining a new and improved continuum of care and a detailed schedule of implementation of services/supports. In 2017 the state will implement the Principles of Care and Practice Model, the Workforce Development plan and the Communication plan. By 2018 the state will have the full continuum of care implemented. Also in 2018 the state will implement the Access Model and will be using the CANS statewide to help in the identification of Class Members and will operate a federally compliant due process and complaint system. By 2019 the state intends to have substantially implemented the objectives in the Implementation Plan and will be measuring adherence to the various new requirements in the [System of Care].

Id. at 4-5

By 2020 Defendants had not "substantially implemented the objectives in the Implementation Plan" as intended. As a result, the parties negotiated an Implementation Assurance Plan in 2021 that was filed with this Court on January 11, 2022. Idaho Implementation Assurance Plan, Docket 770-1. ("IAP").

> The parties developed the IAP because 1) some elements of the Implementation Plan (IP) have been completed even as key deadlines have been missed; 2) the State has initiated the process of seeking bids for the statewide Idaho Behavioral Health Plan (IBHP) contract to maximize the Medicaid program and other funding sources to implement mental health services for the Jeff D class members; 3) the ongoing COVID crisis has impeded collaboration, diverted resources, impacted service delivery, and delayed compliance with the Settlement Agreement (SA) and IP; 4) the IAP will better align focus and action with current challenges and opportunities; and 5) increased oversight or accountability will be needed to achieve full implementation of the SA agreed to by the parties and approved by the Court.
>
> As with the IP, this IAP is intended to be the roadmap for completing implementation of the Settlement Agreement, and therefore, it shall be interpreted in compliance with the commitments, outcomes and exit criteria listed in the Agreement. The goal remains to comply with the Agreement and to satisfy the intent of the Consent Decrees by developing and fully implementing a sustainable, accessible, comprehensive, and coordinated service delivery of

> publicly funded community based mental health services to children and youth with serious emotional disturbances in Idaho.

IAP, at 1.

Notwithstanding the Court's admonition that "Defendants shall timely comply with the Implementation Assurance Plan",[3] a number of deadlines have passed without satisfactory performance. Defendants' Annual Report[4] ("Annual Report") and Plaintiffs' Response ("Response") details the status of these obligations and progress on implementation of the 2015 Settlement, Implementation Plan, and the IAP.

Annual Report Procedures and Submission

Plaintiffs' Response to the Annual Report is filed with this Court in accordance with paragraph 68 of the 2015 Settlement. The 2015 Settlement specifically requires that Annual Report "will account for accomplishments made to date and identify potential or actual compliance issues that need attention, including a summary of proposed or actual remedial efforts made to address these compliance issues." 2015 Settlement ¶ 67. The Annual Report will use whenever possible data and information developed by the Quality Management, Improvement, and Accountability (QMIA") provisions of the 2015 Settlement. *Id.*

The 2015 Settlement provides for the Defendants to first draft the Annual Report and allows Class Counsel an opportunity to provide "feedback." *Id.* Class Counsel made extensive comments on Defendants' first draft. Annual Report, at 2 ¶ 3. After further communications, on April 24, 2023, the parties agreed to continue working on a joint report anticipating it would be filed by mid-2023. Court Report Update, Docket 772, at 2. On May 26, 2023, without consultation or prior notice, Defendants filed their Annual Report. Defendants' counsel simultaneously resigned their positions with the Idaho Office of the Attorney General. Annual Report, at 3.

Class Counsel determined it was necessary to file a Response to the Annual Report because Defendants' filing did not meet the requirements of paragraph 67 and did not provide the Court with an objective status of implementation that included the accomplishments, potential or actual compliance issues, and proposed or actual remedial efforts necessary to address compliance with the 2015 Settlement.

Additionally, Defendants' Annual Report substitutes vague and overly-optimistic descriptions of "accomplishments" offering few specific "proposed or actual remedial efforts," and fewer that include the identification of the timelines, resources, and staffing necessary to ensure successful implementation.

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[3] Order Accepting Joint Motion and Stipulation for Approval of Implementation Assurance Plan, Docket 771, January 24, 2023.

[4] Notice of Filing Annual Report, App. A, Fifth Youth Empowerment Services Implementation Progress Report, Docket 775, May 26, 2023.

Defendants' Annual Report focuses primarily on procedure and planning, and overstates their compliance with these obligations. Of particular concern is Defendants' claim to be in full compliance with IAP deadlines. Plaintiffs do not agree that Defendants are fully compliant with the IAP.

Finally, the Annual Report does not incorporate and properly analyze the available QMIA system data[5] which indicate that the number of children served and the average units of service per youth for key services has declined over the last two years. Service Provider participation has also declined during this period. Defendants' own reports and analysis indicate the YES System of Care Implementation is moving in reverse overall.

Class Counsel's Response

Class Counsel's Response begins with Section II by presenting "data and information developed pursuant to the QMIA provisions of [the] Agreement," as required under paragraph 67 of the 2015 Settlement. Defendants' QMIA data and reports provide the best available information on access to services and supports by Class Members. Section II presents information on number of youths served, types of services provided, intensity of treatment, geographic reach or "statewideness" of services and supports, provider participation and capacity, and quality of care, including trends over time.

Section III addresses Defendants' program and procedural accomplishments, building on what is reported in the Annual Report. The discussion provides this Court with relevant information and context not shared in the Annual Report. In particular, the Response details Defendants' failure to comply with nearly all of the procedural obligations set forth in the IAP, contrary to claims made in the Annual Report.

Section IV of the Response presents compliance issues and proposed or actual remedial efforts made by Defendants, as required by paragraph 67 of the 2015 Settlement. The Response adds to the Annual Report's short list of compliance issues and addresses the following problems that Class Counsel have identified as requiring remediation:

- Availability of Services
- Workforce Deficiencies
- Delay in IBHP Contracting
- Mental Health Early and Periodic Screening, Diagnostic, and Treatment (MH EPSDT) Review
- IAP Compliance Measures and Exit Criteria; Collaboration Issues
- Due Process

Class Counsel's Response concludes with a brief summary of the status of Implementation and a recommendation for greater accountability and improved performance by Defendants so that

[5] The QMIA system includes the quarterly QMIA reports as well as other quality and performance-related committees' and work groups' analyses and reports, Quality Reviews, consultant reports, performance improvement plans, managed care encounter data, and more.

Class Members with SED and their families can receive the mental health services and supports promised by Defendants many years ago.

II. Relevant Information Drawn from Quality Management, Improvement, and Accountability (QMIA) System

In order to understand Defendants' progress on Implementation of the 2015 Settlement, it is useful to review the data that Defendants' have developed to measure system performance "pursuant to the QMIA provisions of [the] Agreement." 2015 Settlement ¶ 67. These data provide considerable information about Idaho's children's mental health system, including the number of youths served for most YES services, the scope and intensity of services provided, the distribution of care, key characteristics of the provider community, and quality of care. Class Counsel presents these data below in order to accurately inform the Court on the status of implementation.

A. Number of Youths Served

The number of youth served is the most common metric associated with mental health services. It is typically reported as "unduplicated," meaning that each recipient is counted once, regardless of how many or how much services they receive. Because the metric "Number Served" only reflects whether a child received *any* service—yes or no—it does not measure the intensity of services. Number served is an important measure of whether the system is reaching all or most of the youths who are *Jeff D* Class Members.

i. Medicaid Recipients

Defendants report that "In the fourth quarter of SFY 2022, 14,029 Medicaid members between the ages of 0-17 accessed mental health services. Of that total, 2,092 of the members accessing services were enrolled in the Medicaid YES program." Annual Report, at 38. In fact, Defendants misread the QMIA Report as the 2,092 youths in the Medicaid YES program were served *in addition to* the 14,029 regular Medicaid members for a total of 16,121 youths served. Figure 1 below shows the QMIA data for the number of Medicaid Members assessing services from SFY 2019-Q1 to SFY 2023-Q2.[6] The Annual Report overlooks the fact that the total number of youths served has declined to 15,347 for SFY 2023, a reduction of nearly 3,000 served per quarter since participation peaked at 18,105 in the fourth Quarter of SFY 2019.[7] *Id*. Notably, the number of Medicaid members under age 18 has been increasing every quarter since 2020. QMIA # 24, at 58. The result is declining utilization or "penetration rates"[8] by Class Members for

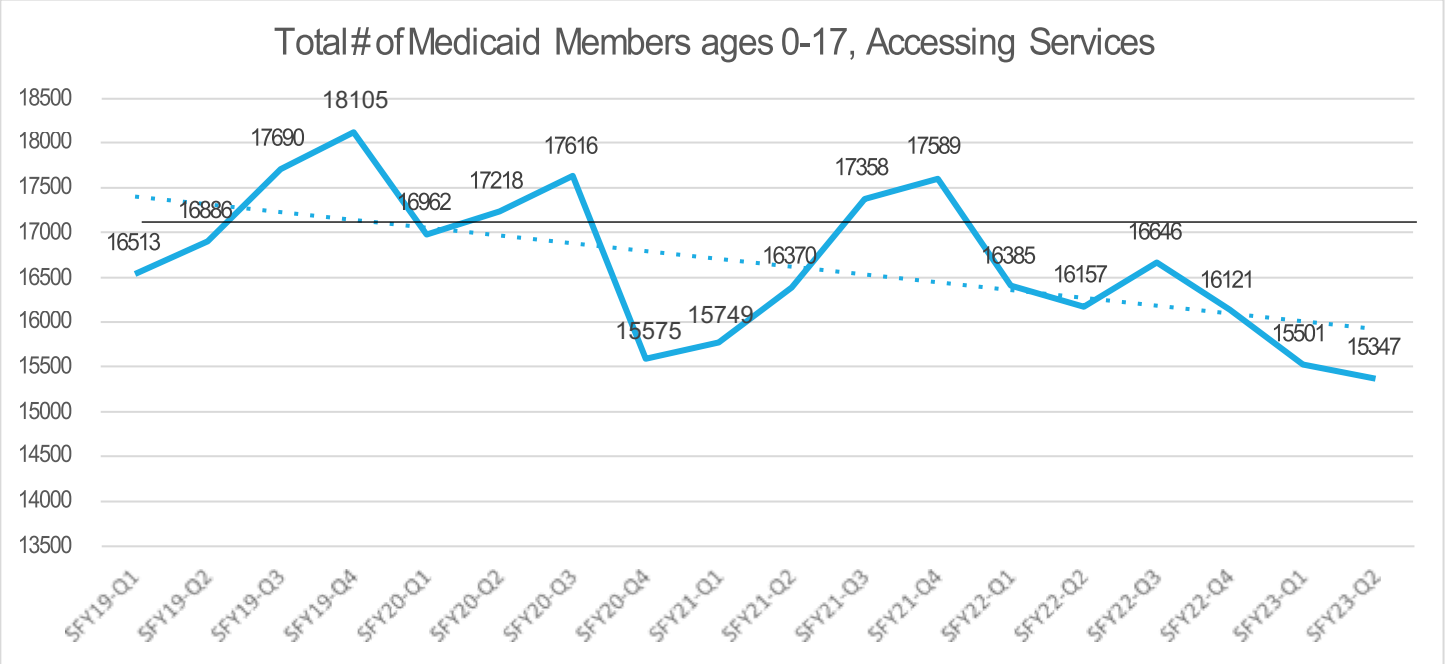
[6] *Youth Empowerment Services QMIA Quarterly Report: Q2, SFY 2023*, at 6. (Hereinafter, QMIA #24.)

[7] Medicaid members who receive behavioral health services are not the same as Class Members who get treatment because not every Medicaid covered behavioral health service requires a SED diagnosis. The number of youths provided psychotherapy, for instance, includes individuals who are not SED and, therefore, not Class Members. As such, reported data on Medicaid members served is greater than the number of Class Members served. More intensive services, (e.g., Intensive Care Coordination, Child and Family Teams, Day Treatment, Partial Hospitalization, Residential Care and more) treat youths with higher needs, so more recipients of these services will be Class Members, and the data more accurately reflect Class Member information.

[8] The YES "penetration rate" is the percentage of all Medicaid members under age 18 that receive one or more units of YES services over the course of a year. Penetration rate does not account for quantity or quality of YES

YES services. *Id.* In other words, the number of Class Members is rising as the number served is falling.

Figure 1



ii. Department of Behavioral Health (DBH) YES Outpatient Care Number Served

QMIA data shows the number of youths provided community-based care by DBH has also declined since peaking in SFY2020. Wraparound services declined from 335 in SFY 2020 to 180 in SFY 2022; Parenting with Love and Limits (PLL) is down from 137 to 70, and Court Ordered services dropped from 373 youths served to 311.[9] DBH did not track vouchered respite prior to SFY 2021;[10] but, the trend is down in the reported data, with 603 vouchers issued in SFY 2021,[11] and 345 issued in SFY 2022.[12]

iii. Institutional Services by Medicaid or DBH

Limited psychiatric hospitalization and residential care provided by DBH or Medicaid are reported in the Quarterly QMIA reports. The only hospitalization data available is for State Hospital West's adolescent unit, formerly State Hospital South.[13] The unduplicated number of

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services provided to recipients—it simply counts the unduplicated number of youths who "touch" the YES system. For example, if ten children are Medicaid members, and one child gets at least one YES service, the penetration rate would be 10 percent.

[9] *Youth Empowerment Services QMIA Quarterly Report: Q1, SFY 2023*, at 29.

[10] *Youth Empowerment Services QMIA Quarterly Report: September 2020*, at 19, footnote 6.

[11] *Youth Empowerment Services QMIA Quarterly Report, Sept 2021: State Fiscal Year 2021, 4th Q 2021* at 55.

[12] *Youth Empowerment Services QMIA Quarterly Report: Q4, SFY 2022*, at 52. (Hereinafter, QMIA #22.)

[13] More complete Inpatient Admissions data (includes more than just State Hospital West) have only recently been added to the QMIA reports and trend data from SFY 2020 is not available. What the data does show is a downward trend beginning in March 2022 through December 2022. QMIA #24 at 31.

youth served has declined from 101 served in SFY 2020 to 60 served in SFY 2022. QMIA #24, at 32.

Conversely, residential services, which may include out-of-state Psychiatric Residential Treatment Facilities (PRTF) or in-state Residential Treatment Centers (RTC), is the only broad category of YES services to have increased capacity since SFY 2020, from 18 to 37 in SFY 2022.

B. Scope and Intensity of Medicaid Care

Scope (what is the array of available services) and intensity[14] (how much of each service is provided in a specified period) of services is important because the 2015 Settlement requires that youths receive services *in appropriate scope, intensity and duration.*[15] 2015 Settlement, at ¶71.d. Children with more intensive needs require a range of services, provided frequently enough and long enough to manage their acute illnesses.[16] For example, a SED treatment plan may require weekly individual psychotherapy sessions, bi-monthly family counseling, behavior and/or skills training sessions two-to-three times per week, peer support calls or meetings several times during the month, a monthly child and family team meeting and regular case management to coordinate their care. All combined, these services may add up to as many as twenty, thirty, or more hours per month. This intensive treatment regimen may be needed for several months or more. Providing intensive home and community-based services can reduce the use of more expensive and restrictive institutional care.

QMIA data and additional information from Optum Idaho[17] provide insight into the scope and intensity of YES services provided to Medicaid-eligible Class Members. Reviewing changes in access to services from SFY 2020 to SFY 2022 offers insight into Defendants' implementation progress.

Table 1, below compares the scope and intensity of the Medicaid Services provided in State fiscal years (FY) 2020 and 2022. The first three columns reflect QMIA data for the Total Number of Youths Served in SFY 2020 and 2022, and the percent change over time. The next three columns show Optum data relating the number of Total Service Units Provided by service and Fiscal Year, and the change in percent provided over time. Total Number of Service Units per

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[14] Service intensity is often not reported when describing system performance. In part that is because service units are not uniform. Hospital stays, for example, include multiple services and are reported in days, typically. In contrast, Psych Therapy may be reported in 45 minute, 60 minute, or other minute units. Notwithstanding, understanding how many service units are provided is essential to understanding system performance and capacity.

[15] Duration of services is not reported except for some institutional care. Calculating average duration from the data is beyond the scope of this Response.

[16] "…evidence-based treatments for youth with intensive mental health challenges consistently require multiple hours of treatment contact per week." *Final Report of the Youth Empowerment Services (YES) Quality Review, 2021-2022* Union Point Group at 17. (Hereinafter, "2022 QR").

[17] Optum Idaho is the current managed care organization contractor for outpatient mental health services under Idaho's Behavioral Health Plan (IBHP). Optum manages the outpatient service provider network that serves YES Class members and collects and compiles data used by Medicaid to manage and report on its children's mental health benefit.

year reflects the YES system statewide service capacity. Dividing system capacity (Total Service Units Provided) by the Total Number Served results in the Average Service Intensity per youth served, which data are presented in the last three columns in the table. Average Service

Table 1	Statewide Scope and Intensity of Care FY 2020 to 2022								
	Total Number Served			Total Service Units Provided			Average Service Intensity (Units per User)		
YES Service	FY 2020	FY 2022	Change in Nbr. Svd	FY 2020	FY 2022	Change in Units provided	FY 2020	FY 2022	Change in Avg. Units Per User
Psych Therapy	19,847	18,919	(928)	408,411	290,766	(117,645)	21	15	-25%
Medication Management	4,709	4,657	(52)	21,991	17,667	(4,324)	4.7	3.8	-19%
Psych Testing	2,686	2,529	(157)	38,578	33,111	(5,467)	14	13	-9%
Case Management	2,809	2,729	(80)	79,939	120,033	40,094	28	44	55%
Skills Building	1,975	2,739	764	399,149	542,050	142,901	202	198	-2%
SUDS	740	800	60	79,788	75,288	(4,500)	108	94	-13%
Crisis Services	717	885	168	3,757	2,836	(921)	5.2	3.2	-39%
CANS	13,775	13,045	(730)	138,179	119,133	(19,046)	10.0	9.1	-9%
TCC	1,121	1,285	164	114,748	62,363	(52,385)	102.4	48.5	-53%
Respite	868	716	(152)	295,128	169,967	(125,161)	340.0	237.4	-30%
Behavior Mod & Consult	33	146	113	19,009	180,492	161,483	576.0	1236.2	115%
BMCA	44	159	115	1,484	7,153	5,669	33.7	45.0	33%
CFT	312	409	97	2,373	2,541	168	7.6	6.2	-18%
Day Treatment	41	74	33	4,196	12,056	7,860	102.3	162.9	59%
Fam Psych Ed	197	212	15	2,512	3,536	1,024	12.8	16.7	31%
Fam Support	768	434	(334)	63,747	30,646	(33,101)	83.0	70.6	-15%
IHBS All	2	60	58	183	16,354	16,171	91.5	272.6	198%
PHP Partial Hosp	51	305	254	1,124	5,718	4,594	22.0	18.7	-15%
Skills Train And Develop	31	259	228	808	62,930	62,122	26.1	243.0	832%
TASSP	19	47	28	-	2,002	2,002	-	42.6	
Youth Support	329	575	246	32,058	77,516	45,458	97.4	134.8	38%

Intensity best reflects how children and families experience the YES system of care because it is measured in units provided per child.[18]

Psychotherapy, the predominant YES treatment with 19,847 youths served in SFY 2020, declined to 18,919 youth served in SFY 2022. The Total Number Served also declined for Medication Management, Neuropsychological Testing, and Case Management. The less available services, Skills Building, Substance Use Disorder Treatment, and Crisis Services increased in Total Number Served. Skills Building showed a significant increase in number of

[18] Table 1 data sources: Optum Idaho Reporting Team, Idaho Behavioral Health Plan Ad Hoc Report: Total Units by Service Code run 09/02/2020; Optum Behavioral Health Plan: Other-02 QMIA Quarterly Report: 2022-Q3 (07/01/2022 – 09/30/2022); and Optum Report, YES WR3871 Total Units By Service Code (06/15/2023). Optum data for Class Members was provided to Class counsel on a confidential basis. Due to privacy restrictions these data cannot be included here.

youths served from 1,975 in SFY 2020 to 2,739 in SFY 2022. For expanded YES services, it is evident that the availability of three of the four services most in demand, i.e., CANS, Respite and Family Support, have declined in terms of number served. TCC registered a modest increase. The number of youths provided Youth Support increased significantly, as did BMC, Skills Training and Development (STAD) and IHCBS All, although the overall numbers of children receiving these services remained relatively low. The total net number of youths provided new YES services decreased from SFY 2020 to SFY 2022 by 262 children statewide.

Turning to Total Service Units Provided, the data show that Psychotherapy and Skills Building were the bulk of services youths received, with more than 800,000 units of the two services delivered in SFY 2020. Total Service Units Provided significantly declined for Psychotherapy, and substantially increased for Case Management[19] and Skills Building (CBRS) by FY2022. Medication Management, Neuropsychological Testing, Substance Use Disorder and Crisis Services units provided all declined between SFY 2020 and SFY 2022.

For expanded YES services, Total Service Units Provided also declined, with very substantial contractions in CANS (down 19,046 units), TCC (down 52,385 units), Respite (down 125,161 units) and Family Support (down 33,101 units) services. Large unit increases in other services including Youth Support (up 45,458 units), Day Treatment (up 7,860 units), BMC (up 161,483 units),[20] STAD (up 62,122 units), and IHCBS (up 16,771 units) is a positive sign, although the very low numbers of youths receiving these essential services means the increases had minimal impact on Class Members' access to care overall.

While Total Service Units Provided offers good insight into changes in a particular service over time, the measure is not directly comparable across services because "units" are not a consistent unique measure. For instance, therapy units vary from 45 to 60 minutes per unit, whereas Skills Building units are all 15 minutes.[21] As such, adding total service "units" of different services together does not provide a meaningful measure of system performance. Thus, the loss of 117,645 therapy units (45-60 minutes) from 2020 to 2022 far outweighs the gain of 142,901 skills building units (15 minutes) in terms of the clinical time spent with youths. Accordingly, the appearance that system capacity grew in the tradeoff between reduced psychotherapy units and increased Skills Building units isn't accurate. In fact, the opposite is true. Future reporting using more standardized units would facilitate assessment of system capacity and Implementation compliance.

Dividing Total Service Units Provided by Total Number Served reveals Average Service Intensity per youth, which declined over time in every service except Case Management. *This is how the service system is experienced by the average youth and family*. For example, the 25 percent

[19] The significant increase in Case Management services was largely offset by the significant decrease in TCC. See Table 2. Below.

[20] On information and belief this item is incorrectly overstated. Correcting errors in reported data, however, is beyond the scope of this Response.

[21] *Optum Idaho Provider Manual*, January 2023. Payment methodology, Individual Psychotherapy, p. 60; Skills Building, p. 96.

reduction in average Psychotherapy units provided per youth, shown in the last column of the top row of the table, would translate into an average of 6 fewer units or sessions, or 15 down from 21 for the year.

Judging from Table 1, several critical services are in limited supply, and some are not reported at all. Most notably, Intensive Care Coordination (ICC) is not included in Defendants' reports. ICC is defined as "a case management service that provides a single point of accountability for ensuring that medically necessary services are accessed, coordinated, and delivered consistent with the Principles of Care and Practice Model. 2015 Settlement, at 44 (Appendix B). ICC includes both assessment of service needs and service planning utilizing a facilitated Child and Family Teams (CFT) process. It includes assessing, reassessing, monitoring, facilitating, linking, and advocating for needed services for Class Members and their families." 2015 Settlement, at 52. ICC is a required service for thousands of YES members.[22] ICC is critical because it assists the family in assessing varied services from multiple agencies in complex cases.

Defendants have determined that Wraparound with Intensive Services (WInS) and Targeted Care Coordination (TCC) constitute ICC under the 2015 Settlement. The available data show that WInS was provided to 335 youths in SFY 2020 and 188 in SFY 2022, *supra* at § II.A.ii. Table 1 shows TCC was provided to 1221 and 1285 youths respectively. Assuming there is no duplication in Class Members served for these two services, ICC provided to Class Members (combined total) declined from 1,556 in SFY 2020 to 1,473 in SFY 2022. Service intensity, however, was down dramatically for TCC, from 114,748 units in SFY 2020 to 62,363 units in SFY 2022. As a result, Class Members receiving TCC were provided half the units of service, on average, in SFY 2022 compared to SFY 2020. *See* Table 1. Service intensity for WInS is not available.

Another service of particular concern is Child and Family Teams ("CFT"). Class Members with more serious needs who are entitled to ICC must also be provided a formal CFT.[23] "The CFT approach is a teaming process that brings together the family and individuals that the Class Member and his or her family believe can help them develop and implement a care plan that will assist them in realizing their treatment goals." 2015 Settlement, at 48. Defendants created a service and Medicaid billing code called Child and Family Interdisciplinary Team ("CFIT") that corresponds to the CFT service required under the 2015 Settlement. Judging from Table 1, access to CFITs in SFY 2022 was clearly inadequate: Less than one-third (409) of the 1,285 Class Members who received TCC (Defendants' ICC) received the CFIT service. *See* n.20, *supra,* at 11.

[22] The Settlement requires "that Class Members with more intensive needs shall be provided Intensive Care Coordination (ICC) as defined in the Services and Supports document." 2015 Settlement, at ¶19.

[23] "Class Members who are provided ICC shall be afforded a formal Child and Family Team (CFT) in accordance with the Practice Model, attached hereto as Appendix B." 2015 Settlement ¶ 20. "Class Members who are provided ICC shall continue receiving ICC until the CFT determines that the ICC Class Member no longer meets medical necessity for ICC and has the CFT has approved a transition plan." *Id.* ¶ 21.

Other services of concern with no reported data:
Therapeutic Behavioral Services (TBS)—an important type of Intensive Home and Community Based Services intended to reduce the need for institutional care, is "available" but not provided, Annual Report, at 27, and is not reported; and
Therapeutic Foster Care (TFC)—another key alternative to institutional care, is not reported, likely because it is not being provided. Annual Report, at 27.

C. Statewideness—Regional Distribution of Services

Compliance with the Agreement requires YES services and supports to be adequately provided in each of Idaho's seven Health and Human Services regions.[24] The forgoing tables depict statewide aggregate access to services. QMIA data also report the distribution of services and supports for all seven IDHW Regions for most services provided.

The data available from the QMIA system provides two measures to evaluate regional availability of services: number of youth served, *see e.g.,* QMIA #24, at 16, and penetration rate, *see e.g., Id.* at 17.[25] Table 2 below details SFY 2020 and 2022 QMIA data for YES services by number of youths served by service and Region, and whether access increased or decreased over time.[26]

[24] "The specific objective of this Agreement is the development and successful implementation of a service array and practice model that are consistently and sustainably provided to Class Members statewide,[1] in the manner prescribed herein." 2015 Settlement, at ¶1.
"For the purposes of this Agreement, "statewide" means sufficient in quantity, scope, duration, and geographic distribution to meet the needs of Class Members." *Id.* at n.1.

[25] Units of service by service and region are not reported by Defendants and compiling and calculating that amount of Optum data is beyond the scope of this Report. In the future, Defendants should add this information to the QMIA reports in order accurately describe the YES service delivery system.

[26] Source of Table 2 data is QMIA #22. SFY 2022 figures are from the table on page 5; FY 2020 figures were compiled from the 18 individual services tables found on pages 16-51. Miscellaneous and out-of-state members are not shown on these tables. That, and rounding, may cause the sum of the regions not to add up to the Statewide total.

Table 2 YES Outpatient Treatment Number Served by Service Type and Region FY 2020 - 2022

Region	FY	1	2	3	4	5	6	7	Total
Assessments									
CANS- Billed to Medicaid	2020	1,421	423	3,169	3,591	1,406	856	3,018	13,775
	2022	1244	324	2,746	3,381	1,412	774	2,959	12,754
Percent Change		-12%	-23%	-13%	-6%	0%	-10%	-2%	-7%
Psych and Neuropsych Testing	2020	330	57	404	529	254	347	760	2,686
	2022	238	77	361	470	173	294	723	2339
Percent Change		-28%	35%	-11%	-11%	-32%	-15%	-5%	-13%
Behavior Assessment	2020	23	0	4	9	1	0	7	44
	2022	70	1	20	68	0	0	0	157
Percent Change		204%		400%	656%	-100%	0%	-100%	257%
Outpatient Treatment Services									
Psychotherapy	2020	2,053	708	4,441	5,115	2,024	1,433	4,357	19,857
	2022	1,981	669	4,020	4,831	2,136	1,262	4,055	18,742
Percent Change		-4%	-6%	-9%	-6%	6%	-12%	-7%	-6%
Med Management	2020	246	174	1,235	1,436	331	416	939	4,709
	2022	207	210	1,164	1,453	378	435	807	4,598
Percent Change		-16%	21%	-6%	1%	14%	5%	-14%	-2%
Skills Building (CBRS)	2020	115	63	369	484	62	125	778	1,975
	2022	132	128	418	680	96	178	1,109	2,711
Percent Change		15%	103%	13%	40%	55%	42%	43%	37%
Targeted Care Coordination (TCC)	2020	56	28	113	219	54	78	582	1,126
	2022	27	51	138	265	87	134	591	1,283
Percent Change		-52%	82%	22%	21%	61%	72%	2%	14%
Substance Use Services	2020	57	28	162	155	131	53	167	753
	2022	57	12	105	96	168	57	279	771
Percent Change		0%	-57%	-35%	-38%	28%	8%	67%	2%
Crisis Intervention	2020	75	43	45	95	61	29	255	601
	2022	44	26	38	36	27	21	239	432
Percent Change		-41%	-40%	-16%	-62%	-56%	-28%	-6%	-28%
Child and Family Team (CFIT)	2020	59	19	30	41	33	17	113	312
	2022	33	26	36	82	70	40	118	402
Percent Change		-44%	37%	20%	100%	112%	135%	4%	29%
Skills Training and Development (STAD)	2020	0	10	0	0	10	2	9	31
	2022	0	30	2	3	135	4	107	281
Percent Change		0%	200%			1250%	100%	1089%	806%
Behavior Modification and Consultation	2020	25	0	4	4	0	0	0	33
	2022	73	1	18	54	0	0	0	144
Percent Change		192%		350%	1250%	0%	0%	0%	336%
Intensive Outpatient Treatment Services									
Partial Hospitalization (PHP)	2020	4	0	20	27	0	0	0	51
	2022	0	1	11	155	8	5	22	301
Percent Change		-100%		-45%	474%				490%
Day Treatment	2020	1	0	2	7	8	2	21	41
	2022	0	0	2	5	31	4	31	73
Percent Change		-100%	0%	0%	-29%	288%	100%	48%	78%
Intensive Home and Community Based Services (IHCBS)	2020	1	0	0	1	0	0	0	2
	2022	0	0	5	17	0	28	10	60
Percent Change		-100%	0%		1600%	0%			2900%
Support Services									
Medicaid Respite	2020	54	50	116	187	63	40	358	868
	2022	6	64	103	195	40	67	238	705
Percent Change		-89%	28%	-11%	4%	-37%	68%	-34%	-19%
Youth Support Services	2020	9	20	29	126	26	39	81	329
	2022	4	22	65	219	96	45	125	572
Percent Change		-56%	10%	124%	74%	269%	15%	54%	74%
Family Psychoeducation	2020	73	2	1	24	72	0	24	197
	2022	29	0	11	27	122	2	18	209
Percent Change		-60%	-100%	1000%	13%	69%		-25%	6%

Table 3. Penetration Rate of Medicaid Members Accessing YES Outpatient Services by Region								
SFY 2023, Q1	Penetration Rate by Region							
	1	2	3	4	5	6	7	Total
Assessments								
CANS- Billed to Medicaid	2.1%	1.8%	2.8%	3.8%	1.7%	2.10%	3.6%	2.8%
Psych and Neuropsych Testing	0%	0.1%	0.2%	0.2%	0.1%	0.5%	0.6%	0.3%
Behavior Assessment	0.1%	0%	0%	0.1%	0%	0%	0%	0%
Outpatient Treatment Services								
Psychotherapy	4.0%	4.4%	5.0%	6.4%	3.4%	5.0%	6.5%	5.1%
Case Management	0.1%	0.2%	0.3%	0.7%	0.5%	0.5%	1.4%	0.6%
Med Management	0.3%	1.4%	1.4%	2.0%	0.7%	1.7%	0.9%	1.2%
Skills Building (CBRS)	0.2%	0.8%	0.5%	0.9%	0.2%	0.7%	1.6%	0.7%
Targeted Care Coordination (TCC)	0%	0.2%	0.2%	0.4%	0.1%	0.5%	0.9%	0.4%
Substance Use Services	0%	0%	0.1%	0.1%	0.2%	0.1%	0.3%	0.2%
Child and Family Interdisciplinary	0%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%
Skills Training and Development	0%	0%	0%	0%	0.2%	0%	0.1%	0%
Behavior Modification and	0.2%	0%	0.1%	0.1%	0%	0%	0%	0.1%
Crisis								
Crisis Intervention	0%	0.1%	0%	0%	0%	0.1%	0.1%	0%
Crisis Psychotherapy	0.1%	0.1%	0.0%	0.1%	0%	0%	0.1%	0.1%
Crisis Response	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.3%	0.1%
Crisis Services	0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.2%	0.1%
Intensive Outpatient Treatment Services								
TASSP	0%	0%	0%	0%	0%	0%	0.5%	0%
Partial Hospitalization (PHP)	0%	0%	0.1%	0.1%	0%	0%	0%	0.1%
Day Treatment	0%	0%	0%	0%	0%	0%	0%	0%
IHCBS	0%	0%	0%	0%	0%	0.1%	0%	0%
Support services								
Respite	0%	0.5%	0.1%	0.2%	0.1%	0.3%	0.3%	0.2%
Youth Support Services	0%	0.1%	0.1%	0.2%	0.1%	0.1%	0.2%	0.1%
Family Support	0%	0%	0.1%	0%	0%	0%	0.4%	0.1%
Family Psychoeducation	0%	0%	0%	0%	0.1%	0%	0%	0%
	Number Served < 1 %			Number Served < 0.1%				

Table 3 compares penetration rates—the number of youths served divided by the number of youths who may be eligible for care, reported as Medicaid members—by Region and YES service.[27] Penetration rates allow an apples-to-apples comparison among regions of varying size, and is reported here as a percent. Thus, a five percent YES penetration rate means that

[27] The data in Table 3 reflect quarterly information, rather than annual data as in Tables 1 and 2. This is due to inconsistent QMIA reporting that does not include annual totals in recent reports. Quarterly data cannot be combined from the tables because many children receive services for more than one quarter and the combined numbers would no longer be "unduplicated." Additionally, recent QMIA reports include more services than

five Class Members out of each 100 Medicaid members received the service in question. For comparison, Defendants estimate that the *Jeff D* class is approximately 20,000 youths. Dividing this number by the Medicaid members under 18 of about 200,000 youths means a penetration rate of 10 percent may be expected in order to provide a particular service to every Class Member.

The key "take-aways" relating to the statewide distribution of YES evident from the two QMIA data Tables above are:

- There is considerable variability in access to services among regions. For instance, reading the penetration rates from Table 3, it is apparent that psychotherapy was provided to an average of 6.5 youths per 100 Medicaid members in Region 7, whereas 3.4 per hundred children were served in Region 5. The differences in other services were greater: Region 4 provided CANS assessments to 3.8 percent of Medicaid youths, more than double the number in Region 5 of 1.7 percent. Case Management services in Region 7 were provided to 14 times as many youth as were provided in Region 1, and seven times as many as in Region 2.
- Many services are mostly unavailable statewide. Table 2 shows only Regions 3 and 4 provided all of the YES services—but the numbers of youth served were nominal in Behavioral Assessments, Day Treatment, Intensive Home and Community Based Services, and Family Psychoeducation Services. Table 3 shows that nominal access to care (penetration rate of 0.1 or less—one in one thousand or fewer youths severed) occurred in three quarters of all of the cells in the table. Only four services, CANS, Psychotherapy, Medication Management, and Skills Building, are provided to more than 5 youth per thousand (0.5 %) statewide, (with a few exceptions for Region 1 and 5). Setting aside Region 7, Crisis Services, Intensive Outpatient Treatment Services, and Support Services other than Respite, are virtually unavailable statewide. Region 1 provides virtually no treatment for 15 services; Region 2 doesn't provide 10 services.
- There are bright spots in the data in that the least-available YES services are increasing in numbers served. But, the large percentage increases in these services are applied to a very small base. For instance, a 1600% increase from one child served resulted in just 17 children served provided IHCBS in Region 4. As such, the systemic impact was minimal from SFY 2020 to SFY 2022. Moreover, statewide average improvements in number served or penetration rates are not mirrored in every Region. In the ten services with significant increases statewide, Region 1's numbers served declined for nine services. *See* Table 2, *supra*. Day Treatment increased statewide by 78%, from 41 to 73 served, but the number served declined in regions 1 and 4, and Regions 2, 3 and 6 combined served just six Class Members. *Id*.

D. Other Agency Data

Family and Community Services (FACS), the State Department of Education (SDOE) and the Idaho Department of Juvenile Corrections (IDJC) are essential partners in the YES system of

previously. Additional services reported include case management, four types of Crisis Services, Family Support, and TASSP.

care. Each of these agencies are part of Idaho's child-serving system of care and each independently involves thousands of Class Members. Coordinating services and supports efforts is essential if YES is to be successfully implemented. The state of data collection for FACS, DOE, and IDJC is far behind the accomplishments of DBH and Medicaid, and contributes little added value in monitoring implementation of the 2015 Settlement.

First, very little information is actually made available. FACS data in the most recent report has one chart that shows the number of children and youth in foster care by quarter for 18 months. *See*, QMIA #24, at 38. No data are presented regarding how many of these youths may be SED or received mental health services from DBH or Medicaid. No data is presented on children involved in the child welfare system, but not in custody. Understanding this population is especially crucial as providing home and community-based services for youths with SED can prevent foster care placement along with the trauma and expense that entails. Having no data about the children served by both mental health and child welfare is a serious omission from the QMIA data.

Information on children in the custody of the IDJC is of better quality and value. *See* QMIA #24, at 38-40. However, the data involves very few youth who are involved with the juvenile justice system in Idaho. According to Erica Marshall, director of the Idaho Justice Project, "At any given time, there's roughly 180 children in the care or custody of the State Idaho Department of Juvenile Corrections. But much of the juvenile justice system is actually administered at the county level. For instance, in 2021, there were 5,612 that had juvenile fees assessed against them."[28] The QMIA reports need to get a handle on the thousands of youths involved with juvenile justice to determine how many are Class Members and how collaboration with County Juvenile Corrections, in addition to IDJC, can provide better access to appropriate mental health care to help avoid delinquency and detention.

SDOE information provided in the QMIA reports offers very modest information about the cross-over population of likely Class Members by reporting on the percentage of children served in various disability categories and the number of youths receiving special education services. *See* QMIA #24, at 40. Combining this information could lead to actionable information about Class Members with an IEP. Better still, examining information about youths with SED that do not have an IEP would provide important opportunities to improve access to mental health treatment for students that would help to improve educational attainment, avoid school drop-outs, increase graduation rates, and assist teachers in making the school environment more educational for every student.

[28] "As thousands of Idaho juvenile offenders remain 'in the system,' families are shackled to 'cost of care' and collection fees," Boise Public Radio, February 15, 2022. https://www.boisestatepublicradio.org/news/2022-02-15/idaho-juvenile-detention-correction-cost-of-care-center-fiscal-policy-juvenile-justice-legislature#

E. Access Barriers and Quality of Care

The *2015* Settlement required the parties to jointly develop an annual Quality Review process. 2015 Settlement ¶¶ 56-58. Defendants are required to "identify 'lessons' learned" with recommendations "to improve clinical and program quality." *Id.* ¶ 56.

The Quality Review provides essential information about how the YES system works and whether it is delivering appropriate services and supports to Class Members at the clinical level. The Quality Review findings seek to verify and explain the aggregate data presented in the quarterly QMIA reports in order to facilitate system reform and generate corrective action. Accordingly, Quality Review results provide essential insight into the status of *Jeff D* Implementation.

Defendants have completed two annual Quality Reviews. The initial Quality Review, completed in 2021 ("2021 QR"), focused on high-needs youth because "QR sampling data indicate that 40% of youth completing an Initial CANS may have intensive treatment needs." 2022 QR, at 29, *supra* n.15. The 2021 QR "found that youth with intensive treatment needs experienced:

- Delays in the initial access to care;
- Infrequent treatment sessions;
- Care coordination that did not successfully engage partners at school or in the community; [and]
- Disparities in both care and outcomes for persons who identified as culturally diverse."

2021 QR, at 4.

Building on these findings, the second annual Quality Review ("2022 QR") completed in January 2023 closely examined[29] access barriers for youths and their caregivers to intensive community-based treatment services; challenges for agencies and practitioners in providing these services; and quality issues relating to or resulting from these challenges.

Barriers to Care for Accessing Intensive Services

"Navigating access to services, particularly specialized services, is a vexing challenge for families of youth in YES. . ." 2022 QR, at 26. Defendant's findings that were relevant to the status of implementation and the access and availability of services and providers to *Jeff D* youths and their families presented in the 2022 QR included:

[29] The 2022 QR sought to identify actions likely to result in more youth having better experiences and outcomes of care. The 2022 QR focused on understanding the initial process of accessing appropriate care for twelve youth designated as needing Level 2 or Level 3 intensive community services, per the CANS assessment. 2022 QR, at 6. Twelve (12) caregivers and 7 youth were interviewed and asked about the care received and also conducted two youth focus groups, with 4 participants. *Id.* The QR Team surveyed 158 agency representatives and individual practitioners regarding the continuum of care they currently provide, and expansion intentions within the next six months. *Id.* at 7. They were asked about what supports are important to expand the services they offer, and how well IDHW supports efforts to expand care. *Id.*

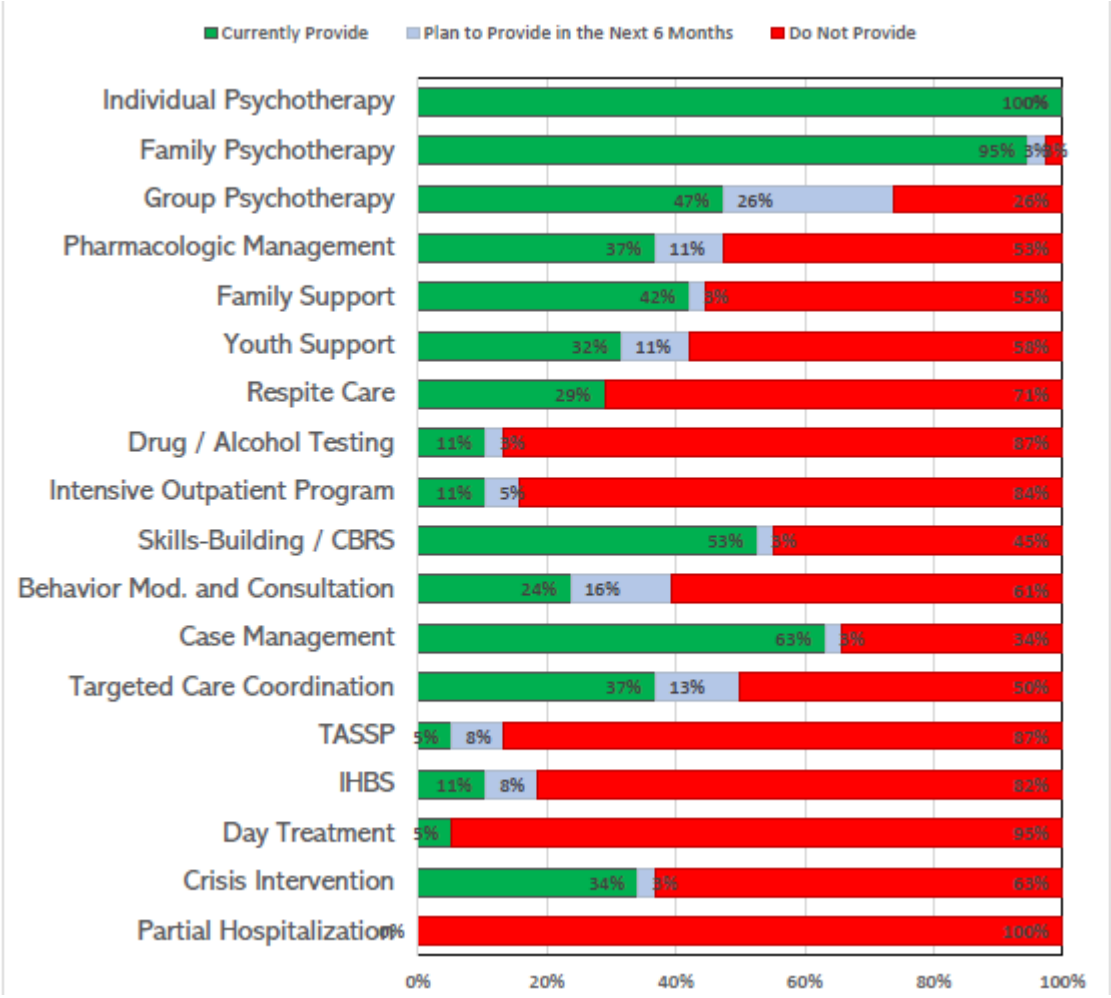
- Caregivers noted difficulty in finding a provider who accepted Medicaid and had the training and skills to address the youth's specific needs and strengths. 2022 QR, at 9.
- Caregivers described a series of challenges in trying to get the appropriate dose of treatment for their child. These included high turnover among treatment professionals, lack of fit with the counselor, and difficulty managing transportation." 2022 QR, at 17.
- "Reported wait times for an appointment ranged from 'a couple of weeks' to 'six months.'" 2022 QR, at 9.
- Parents stated the process was stressful, frustrating and overwhelming and noted that providers might not continue with Medicaid or might not consistently show up for appointments. 2022 QR, at 9. Almost all caregivers described the process of being able to choose the appropriate care for a youth as an unsatisfying. 2022 QR, at 11.
- They were never informed of the range of eligible services their child could receive. They were only offered a therapist to talk with for a couple of months. 2022 QR, at 11.
- Families were deeply concerned about accessing appropriate services needed to address the complex challenges experienced by their child. 2022 QR, at 11.
- Difficulty accessing care coordinators to help locate and connect to needed services. 2022 QR, at 11.
- None of the youth files reviewed had a Child and Family Team meeting in the first 90 days of care. 2022 QR, at 11.
- Youth or families are not routinely introduced to a potential care coordinator, or had the benefits of this service are presented to them. 2022 QR, at 12.

Provider Challenges to Providing Intensive Services

For agency respondents and individual providers, the QR provider survey results indicate a net reduction in the continuum of services being offered to YES recipients. "*Twenty-seven percent* of agency respondents indicated that they had stopped providing at least one service in the past year. *Sixteen percent* of individual practitioners indicated that they had stopped providing at least one service in the past year." 2022 QR, at 31 (emphasis added).

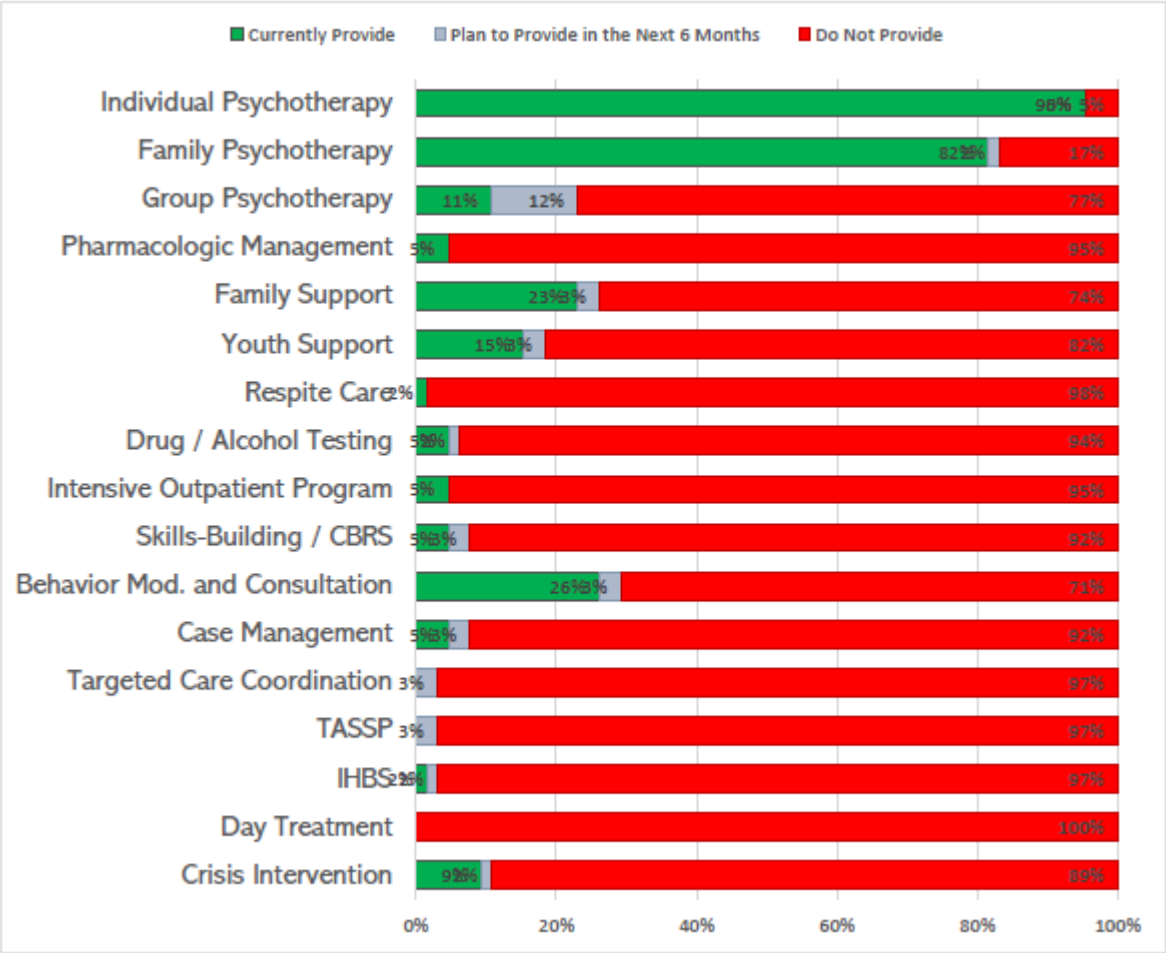
2022 QR, Chart 1 (below) identifies agencies' self-reported service array. Response percentages are based on survey responses from 38 child-serving agencies who participated in the Summer 2022 survey. 2022 QR, at 27.

Chart1. AgencyRespondents'CurrentandPlannedServices



C2022 QR, Chart 2 (below) identifies individual practitioners' self-reported service array. "Response percentages are based on survey responses from 65 child-serving practitioners who participated in the Summer 2022 survey." 2022 QR, at 28.

Chart 2. Individual Practitioners' Current and Planned Services

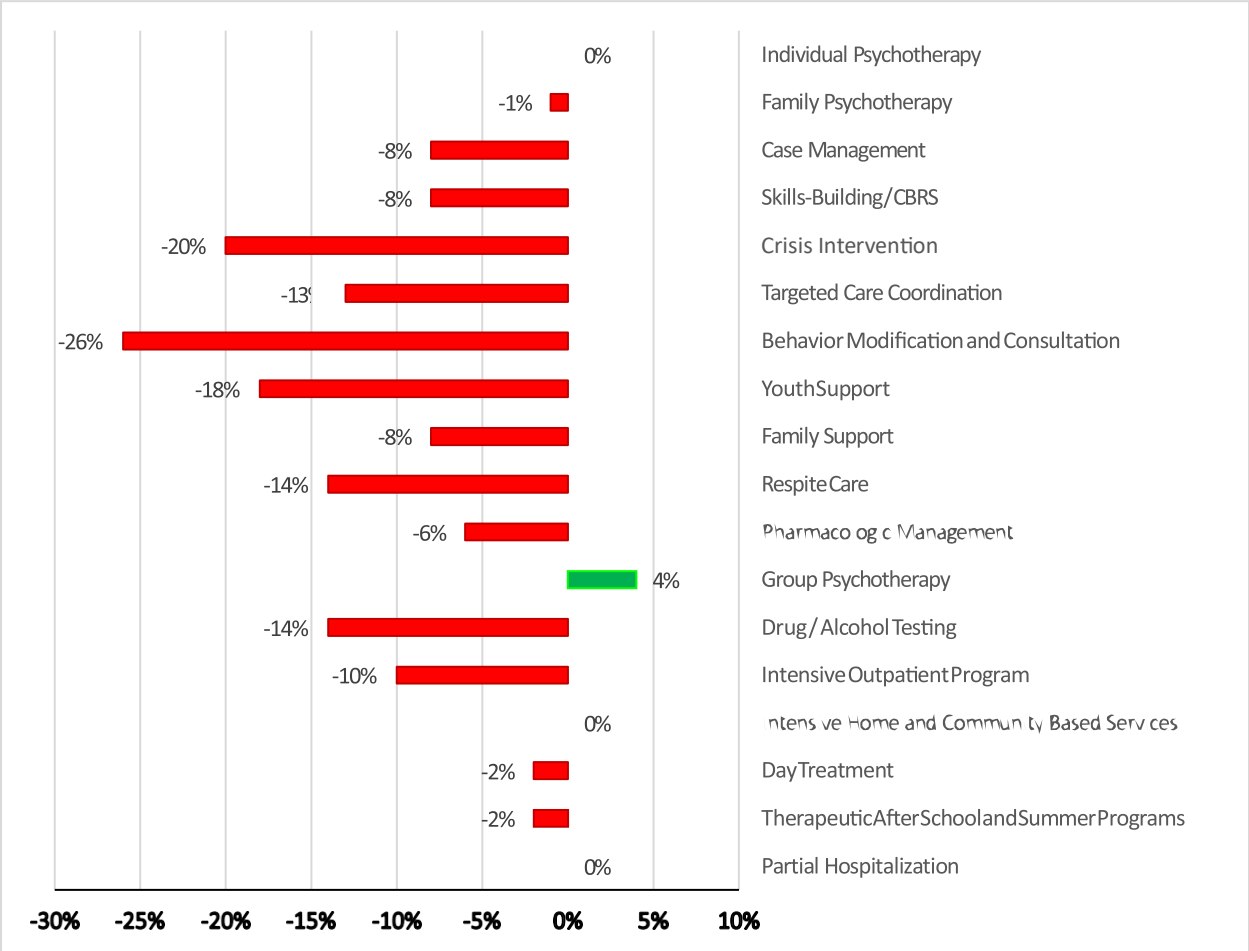


Both annual QRs asked provider respondents about their intentions to add a new service type in the next six months. The survey found that:

> Across services, about 9% of providers indicated that they planned to add a specific service in the next 6 months. However, when this year's respondents were asked about services they currently provide, they were 8% less likely than last year's respondents to currently be providing a given service (Chart 3).

2022 QR, at 30.

Chart 3. Net Change in Care Types that Agencies Currently Provide (2021-2022)



> For both agency respondents and individual practitioners, the results indicate a net reduction in the continuum of services being offered to YES recipients. These within and cross-year results indicate that it is more likely that the public behavioral health continuum of care in Idaho is contracting than that it is expanding.

2022 QR, at 31.

What is more, the service arrays in QR Charts 1 and 2 are disproportionately focused on services which are appropriate for youth with mild to moderate behavioral health concerns. "Only about 10% of agencies indicate that they provide Intensive Outpatient Programs, Intensive Home and Community-Based Services, or Drug and Alcohol Testing. Only about 5% indicate that they provide Day Treatment or Therapeutic After School and Summer Programs." 2022 QR, at 29. "Only about 5% of individual practitioners provide services targeted towards youth with severe or complex behavioral health needs." *Id*.

The QR investigation of the reasons for service expansions and reductions revealed that agencies and individual providers identified a series of barriers to expanding the continuum of care they offered. These included:

- A lack of clear procedures for service initiation;
- Reimbursement rates which did not keep up with the costs of doing business;
- Difficulty recruiting therapists willing to work in the public sector;
- Dearth of affordable, high-quality training needed to provide effective services;
- Confusing and mis-aligned assessment and service authorization procedures;
- Onerous and duplicative assessment processes.

2022 QR, at 31.

The inadequate and shrinking base of providers and practitioners, and the mismatch between services offered and services needed, has adversely affected the quality of care for YES Class Members and their families, according to the 2022 QR.

Quality Concerns related in the 2022 QR

In a nutshell, "Youth generally experienced care that did not meet quality standards." 2022 QR, at 26. Further, "the care youth received was often delayed, not well matched to the intensity of their needs, and somewhat collaborative." 2022 QR, at 13. Other findings include:

- "Waitlists and delays in initial appointments" 2022 QR, at 9.
- "Difficulty accessing care coordinators to help locate and connect to needed services" *Id*.
- "The lack of providers able to provide a full array of services is creating particularly acute care shortages for youth with the greatest community treatment needs." *Id*. at 29.
- File reviews, using fourteen indicators of high quality, found that: "The practice standards were met only about one-third of the time." [30] *Id.* at 13.
- File review found the Timeliness Practices Standards were met only in 58% of the initial functional assessments (the CANS), 58% of the treatment plans, and 50% of the psychiatric consultations. *Id*. at 16.
- The review of the files showed "only one third of youth had an initial CANS completed before the Treatment Plan was signed." *Id.* This is important because the CANS is intended to provide the basis for drafting the Treatment Plan.
- "File review data indicate that in the first 90 days of care, youth experienced an average of 20 minutes of treatment per week and less than two (1.7) treatment sessions per month. This translates to one 45-minute treatment session every other week. These dose levels are even lower than those found in last year's QR (which averaged 30 minutes of treatment per week). No youth in this year's sample averaged more than half an hour of treatment per week. These levels are grossly inadequate for youth with serious, impairing mental health concerns." 2022 QR, at 17.

[30] The file evaluations of the care provided was based on fourteen indicators of care quality. 2022 QR, at 14, Table 1. Practice Indicators and Definitions by Care Process.

F. Conclusion

In summary, the QMIA system data reviewed above demonstrate that clinically appropriate services, provided in sufficient scope, intensity and duration needed by Class Members and their families, remains a distant goal. Mandated Service and Supports are less accessible, provided to fewer children, and in declining intensity on average. Many key services for youths with the highest acuity or service needs are unavailable in most communities in all Regions. What is more, a shrinking workforce is providing inadequate care to many children, frustrating Class Members and their parents who seek treatment services. Overall, the data indicate that progress on Implementation appears to have gone backwards since the parties last reported on Implementation status to the Court.

III. Accomplishments Made to Date

Defendants' Annual Report has two sections on Implementation progress and achievements. Section II, 'Achievements and Continuing Work,' includes efforts outside of the Implementation Assurance Plan "that will ultimately help the state fulfill the Settlement Agreement commitments, outcomes, and exit criteria." Annual Report, at 9. Annual Report Section III, 'Progress and Continuing Work on Implementation,' addresses Defendants' progress and continuing work on the IAP specifically, *see* Annual Report, at 19-43.

In Sections II and III, the Annual Report combines information relating to what is required under the 2015 Settlement with what has been accomplished in meeting these requirements and with what is "continuing work," or more to the point, what has not been done and what remains to be achieved for compliance with the 2015 Settlement and the Implementation Plans.

In Section III. A., below, Class Counsel briefly addresses the accomplishments included in the Annual Report, Section II. The review of Defendants' accomplishments relating to the IAP follows in Section III.B, below.

A. Program and Procedural Accomplishments

Defendants highlight ten efforts outside of their Implementation Assurance Plan efforts "that will ultimately help the state fulfill the settlement agreement commitments, outcomes, and exit criteria." Annual Report, at 9. Class Counsel agree that several of these accomplishments will advance implementation and provide services to Class Members. These include:

- New Psychiatric Residential Treatment Facilities (PRTF) in Idaho, *Id*. at 10.
- 988 Hotline Project and Mobile Crisis Response Team, *Id*. at 11.
- Youth Behavioral Health Community Crisis Centers, *Id*. at 12.
- Youth Assessment Centers, *Id.* at 14.

The Legislature's commitment of substantial resources for these services is an important step forward. There is concern, however, that these efforts are far from complete, and will provide uncertain and limited services to YES Class Members.

For instance, new PRTFs and the Crisis and Assessment Centers are a work in progress with much more needing to be done. It remains to be seen how these facilities will be operationalized and when, and how many YES Class Members will ultimately be served. Additionally, expansion of intake services such as Youth Assessment Centers and 988 Hotline Project referrals will add to demand for treatment services that may not be available for all of the reasons identified in the QMIA and QR reports.

As regards the managerial accomplishments recounted in the Annual Report,[31] progress is more uncertain. For instance, "IDHW has begun creating an IBHP Collaborative Governance Bureau…[whose] Chief will report to both the Division of Behavioral Health Deputy Administrator and the Division of Medicaid Deputy Administrator for Benefits." Annual Report, at 10. The operative words here are "has begun creating." The new Bureau is not yet functioning and its director has yet to substantively engage with Class Counsel or the Implementation Work Group (IWG), *supra*, at 3, or the Interagency Governance Team (IGT).[32] Also, "In April 2022, IDHW hired a YES Enterprise Project Manager to plan, implement, and manage enterprise-level system design projects necessary for the completion of the YES System of Care (SoC)." Annual Report, at 10. "[T]he new Project Manager has been a tremendous boon to the Department's YES team, and is helping the DBH and Medicaid teams engage collaboratively across divisions, and stay on task as they move towards full implementation of the YES SoC." *Id*. Yet, even with the added YES Enterprise Project Manager, Defendants concluded in November 2022 that DBH, Medicaid and FACS did not have a "shared vision" of YES implementation of the 2015 Settlement,[33] and IDHW has since missed deadline after deadline for completing IAP required planning and implementation documents, including the Service and Supports Crosswalk, Access Pathways Maps, QMIA Plan update, compliance measures, and more.

Another claim, that "development of the QRT [Quick Reaction Team] has greatly improved cross-divisional collaboration within IDHW," is questionable. Annual Report, at 10. House Bill 233[34] required IDHW to implement an interagency agreement to establish a clinical team to

[31] Defendants include aspects of negotiating and awarding a new IBHP contract in several parts of their Report. Class Counsel address IBHP accomplishments in Section III.B., and problems and remedies in Section IV below.
[32] "The purpose of the Interagency Governance Team (IGT) is to collaboratively coordinate and oversee the implementation of the court approved Agreement in the Jeff D. class action lawsuit. The (IGT) shall advise the parties to the Agreement on implementation and serve as a vehicle for communication among parties, to identify and remove barriers to implementation, and monitor implementation of the Agreement." 2015 Settlement, App. D, at D-1.
[33] "In late 2022, IDHW approached Class Counsel, the IGT, and the IWG with a proposal to take a break in regularly scheduled monthly meetings so that IDHW's Divisions of Behavioral Health, Medicaid, and Family and Community Services could focus on developing a shared vision and action plans for continuing development of YES."
IAP, at 17.
[34] 16-2426A. SERIOUS BEHAVIORAL HEALTH CONDITIONS — PREVENTION OF REMOVAL FROM CUSTODY. (1) The department shall not make a substantiated disposition that a child has been abused, neglected, or abandoned by a parent or guardian under the child protective act, Chapter 16, title 16, Idaho Code, because of a request for inpatient hospital treatment or an out-of-home placement for the child, if the child's recent mental health condition demonstrates that the child is likely to cause harm to himself or to suffer substantial mental or physical deterioration, and/or is likely to cause harm to others, and if the risk cannot be eliminated before returning the

review cases of children in hospitals or other facilities "to connect the child and his family with the appropriate services, treatment, and support in order to stabilize the child's serious emotional disturbance and to prevent removal by the department." Idaho Code § 16-2426A(2). "The IDHW Divisions of Medicaid, Behavioral Health, and Family and Community Services (FACS) entered into an Intra-Agency Agreement establishing a Quick Reaction Team (QRT) to comply with that provision." Annual Report, at 15. Defendants acknowledge, however, that

> "[t]here is not currently a system in place to evaluate or measure effectiveness of the QRT. Class Counsel for the plaintiff class have reported that implementation of the QRT has been slow but is improving. Although the QRT and IDHW's work with hospitals has improved collaboration, access to services for children with intense needs continues to be a challenge.

Annual Report, at 16.

Moreover, implementation of the Medicaid, Behavioral Health, and FACS collaboration depends on providing new guidance to child welfare workers on changes brought about by HB 233. The Annual Report states, "IDHW's Child Welfare Program within FACS adopted and refined an Administrative Directive providing guidance to Child Welfare workers about changes to Idaho Code Section 16-2426A." Annual Report, at 17. The Annual Report acknowledges that the FACS Administrator "engaged with Class Counsel and families to address the language of the administrative directive." *Id.* But Defendants did not disclose that IWG stakeholders and Class Counsel do not agree that the Administrative Directive adequately implements HB 233 and that discussions with the FACS Administrator about revisions are ongoing.

The Annual Report also touts the development of its new project planning process Defendants call "Agile Sprints." Rather than presenting accomplishments achieved using this approach, however, Defendants' Agile Sprints discussion promises future performance and seeks to excuse delay:

> IDHW *intends* to bring several recommendations from the Agile Sprints to the IGT so that the stakeholders can provide guidance about which efforts should be prioritized. *Once prioritized, detailed work plans will be developed* to ensure timely implementation. As noted, this is a time of great transition for IDHW, with the redesign of DBH, the creation of a new IBHP Joint Bureau and the procurement of a new, much more expansive, IBHP Contract.

Annual Report, at 19 (emphasis added).

In all of 2023, the sum total outcome of the Agile Sprints process shared with Class Counsel has been four 30-minute presentations by the Department describing possible action items and priorities to be considered rather than a specific plan and timeline to implement the outcomes.

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child to the child's family.

B. IAP Accomplishments

The IAP was intended to aid Defendants in completing the Implementation Plan by focusing their efforts and setting timetables to complete important design and operational tasks. Much of the IAP is directed at documentation requirements that include a Service and Supports Crosswalk document (Objective A), an updated Practice Manual (Objective B), an Access Pathways Map (Objective C), a Workforce Development Plan (Objective D), a Due Process Protocol (Objective E), and an updated QMIA plan (Objective G). IAP *passim*. These Objectives mirror and are derived from corresponding 2015 Settlement Section V. Commitments A. through E. and G. 2015 Settlement, ¶¶ 16-58.

These program documents are the design and operational blueprints for the 2015 Settlement. The Services and Supports Crosswalk comprehensively describes the services and supports that must be provided to Class Members under the 2015 Settlement. The Access Pathways Map schematically shows how a child accesses services and supports starting with being identified as needing assistance and ending by completing treatment. The QMIA plan describes how data will be gathered and reported to provide information and measurements to manage the service system and assess whether 2015 Settlement Commitments and Outcomes have been met. The Due Process Protocol seeks to assure that youths are fairly treated, errors are corrected, and access to treatment is legally sufficient. The Workforce Development Plan is intended to organize and coordinate efforts to increase service system capacity of providers in order to fulfill Defendants' obligation to adequately serve all Class Members. Finally, the Practice Manual pulls together all of the operational documents into a single plain language, public-facing, operations guide for Class Members, their families, practitioners, providers, agency staff, decision-makers and others.

The deadlines for completing the authoritative documents detailed in the IAP are critical, in part to stem implementation delays that had become endemic, and in part because interdependencies were causing delays on one task to delay the entire enterprise. Because Defendants' intended to use a new contractor and new IBHP to implement much of the 2015 Settlement, the IAP assured that "Each YES Authoritative Document will be incorporated into the IBHP Contract as an amendment, as if set forth in full, on the date the IDHW Director approves the document." IAP OBJECTIVE H ¶ 5. In order to meet this obligation and assure that the IBHP contract complies with the YES system design and blueprints, the authoritative documents—in particular the Services and Supports Crosswalk and the Access Pathways Map—needed to be completed prior to executing the new IBHP contract. The deadlines for these deliverables were set accordingly in the IAP.[35] *See* IAP OBJECTIVE A ¶ 1.a. (Services and Supports Crosswalk), and OBJECTIVE C ¶ 1.a. (Access Pathways Map). The Court recognized the immediacy of the IAP deadlines, emphasizing in its Order of January 24, 2022, that "Defendants shall timely comply with the Implementation Assurance Plan."[36]

[35] The drafting process for authoritative documents was intended to provide flexibility for Defendants to negotiate with their agencies, agents, and contractors on the Final Documents, having reached agreement with the parties and the IWG on Final Drafts.

[36] Docket 771.

Defendants begin Section III of the Annual Report asserting, "The IAP established a number of deadlines that IDHW, the IWG, and the Parties must meet. IDHW can report that it has substantially met all of the IAP deadlines or has obtained agreement with Class Counsel and the IWG to extend the IAP deadlines."[37]

While it is true that Class Counsel and the IWG have found it necessary to extend deadlines for Defendants, it is not the case, as of the filing of Class Counsels' Response, that IDHW is in substantial compliance with all of the IAP deadlines. To the contrary, at present, all but one key system design deliverable—the Due Process Protocol—remains outstanding and incomplete, as is detailed below, seven years into an implementation period that IDHW promised would be completed in four.

Objective A: Services & Supports Accomplishments

The Crosswalk is the authoritative description of the services and supports Defendants must provide to Class Members pursuant to Appendix C of the 2015 Settlement. *See* 2015 Settlement, at 50-57. The IAP describes Defendants' obligation to "complete a Services and Supports Crosswalk that provides authoritative guidance on services and supports and Appendix C to all YES Providers and stakeholders." IAP, at 5. A final Draft of the Crosswalk was due by the execution of the IBHP Contract. IAP OBJECTIVE A ¶ 1.a. This should have been a straightforward deliverable as much of the work had already been completed before the IAP was filed.

Based on the Idaho Department of Administration's December 2020 notice of intention to contract, the parties had expected execution of the contract in February or March of 2023. Anticipating the imminent deadline, Defendants submitted a template for its Services and Supports Crosswalk to the IWG for review on December 19, 2022. Class Counsel reviewed the documents and responded on January 19, 2023. Defendants submitted a full draft on February 29, 2023, which Class Counsel responded to on March 16, 2023, observing that the document had not progressed much from the draft version completed by the parties in 2020:

> In a nutshell, the draft Crosswalk presented to us needs considerable revision to satisfy the need for an unambiguous and authoritative description of the service and supports required by the [2015 Settlement] to be included in the Jeff D System Of Care. In its present form the Crosswalk neither clearly and accurately describes what are the services and supports required under the [2015 Settlement], nor reconciles various customary practices, programs and services guidelines, policies, rules, regulations and statutory authorities that govern and determine access to care.

Email from Class Counsel to Deputy Attorney General KayT Garrett dated 3/16/23.

[37] Defendants include a table in the Annual Report listing a number of IAP deliverables, their Due Dates, and Progress notes. Annual Report, at 21. For the reasons set forth, Class Counsel disagrees with every progress note included for deliverables with due dates save one: the QR process was timely and quite capably completed.

Defendants executed a new IBHP contract on June 16, 2023, after Defendants filed their Annual Report. Two weeks after the deadline to complete the final draft of the Services and Supports Crosswalk, on June 30, 2023, Defendants emailed a new draft to IWG members, and subsequently requested comments by July 31, 2023. After reviewing the latest draft, Class Counsel advised Defendants of their "serious concerns about the latest draft. . . ." This included edits that "are fundamentally at odds with the purpose of the Services and Supports Crosswalk." Class Counsel concluded stating that "the IWG will likely have no alternative but to conclude at its next Meeting, 'that timelines for the YES authoritative documents will not, or have not, been substantially met…' per the provisions in IAP OBJECTIVE B, paragraph 3.e.iii." Email from Class Counsel to Deputy Attorney General Alan Foutz dated 7/31/23.

Objective B: Practice Model and Services Roll-out Accomplishments

The Annual Report claims to have met Objective B obligations involving: (1) the Center of Excellence (CoE), IAP Objective B.1; (2) Practice Manual, IAP Objective B.2; and (3) Services Roll-out, IAP Objective B.3. Additional information on each of these items helps to put these claims into perspective.

(1) Regarding the COE, Defendants seek credit for having presented one PowerPoint in February 2023 to the IWG, and for beginning "implementation, hiring, and onboarding staff" for the Center of Excellence. Annual Report, at 26. What is not stated is that shifting DBH resources away from direct services has resulted in a decrease in the number of YES Class Members served. *See* DBH service data, § 2.a., *supra*, at 7-9.

(2) The Practice Manual, as described above, is the information resource that is intended to bring together all of the other authoritative documents into one accessible guidebook for families accessing YES services and supports and others. An initial Practice Manual was completed in January 2020. Because the initial Practice Manual was completed before other authoritative documents, the IAP required a review and update "ninety days following the completion of the Access Pathways Map." IAP OBJECTIVE B ¶ 2.a.i. The Annual Report states that "IDHW has begun updating the Practice Manual consistent with the completed Authoritative Due Process Protocol." Annual Report, at 26. The Annual Report fails to note that the Access Pathways Map is more than seven months overdue, and thus, the Practice Manual Update is more than four months late. Defendants nevertheless take credit for starting work on one section of the Practice Manual.

(3) Defendants have little to say about substantive accomplishments providing Class Members with required treatment. Instead, the Annual Report mostly describes administrative activities involving research, planning, preparation, training, contracting, and aspirations for the future. What it does not do—with the exception of program accomplishments addressed in Section III.A. above—is provide evidence of how many children were served as a result of Defendants' roll-out efforts. What speaks loudly about the status of the roll-out of services and supports is the data reported in the QMIA quarterly reports, the Quality Reports, and Optum's data.

Objective C: Access to Services Accomplishments

The Access Pathways Map is a fundamental system design and accountability tool that describes how YES Class Members and their families are identified, assessed, referred to treatment, provided appropriate care, and transitioned out of care in Defendants' multi-agency System of Care. To be useful, an access map or maps must clearly and accurately describe how a beneficiary moves through the complex systems of screens, assessments, eligibility and clinical decisions, referrals, treatment, and transitions so that thousands of clients, practitioners, supervisors, managers, administrators, and facilities understand how to access or deliver care. The 2015 Settlement and Implementation Plans required Defendants to complete the Final Draft Access Pathways Map on December 31, 2022.

Defendants failed to meet this deadline. The IWG agreed to postpone the deadline based on representations that the work would be completed by the end of February 2023. That deadline was not met. Defendants and the IWG continued to work on the documents through the end of April when Defendants requested a formal deadline extension, among other things. Defendants also produced an updated series of Access Pathways Maps on May 5, 2023. The IWG agreed to a formal extension to June 30th, which was subsequently amended after the parties and the IWG met on May 17, 2023.

Counsel for Defendants memorialized the extension in her letter to the IWG dated May 21, 2023:

> The membership of the Implementation Work Group (IWG) engaged in a collaborative, problem-solving process and agreed on the following timeline for finalizing the Access Pathways Maps at the IWG meeting held on May 17, 2023.
>
> - June 30, 2023: by this date, the Department will provide the IWG with drafts of "new" access maps that describe the YES system as outlined in Appendix A.
> - July – August 2023: IWG Membership will review the maps and collaborate on revisions as needed.
> - September 2023: The Department will have the month of September to incorporate suggestions and revise the maps.
> - October 2, 2023: by this date, the Department will deliver final Access Pathways Maps to the IWG.

Email from Deputy Attorney General KayT Garrett to IWG dated 5/21/2023.

Defendants did not provide the IWG drafts of the Access Pathways Maps on June 30, 2023, as promised. During the parties' face-to-face meeting on August 10, 2023, Defendants committed to share a portion of the Access Pathways Maps within two weeks, which were delivered to Class Counsel on August 18th.

Objective D: Sustainable Workforce and Community Stakeholder Development Accomplishments

A sustainable quality workforce is the self-evident lynchpin to a successful behavioral health service system. Accordingly, focusing on training and developing the behavioral health workforce is a critical priority. The 2015 Settlement required Defendants to "develop and implement a workforce development plan…" 2015 Settlement ¶ 39. The Implementation Plan added details to this requirement, providing for a Workforce Development Workgroup to complete a Workforce Development plan by February 28, 2017, and implement that plan beginning May 1, 2017. Implementation Plan, at 22-23.

The IAP Objective D also requires IDHW to:

> 3. [D]evelop a Workforce Development Plan that fully incorporates requirements of the Agreement, including plans to:
>
> > a. Assess, develop and strengthen the workforce to deliver services to Class Members.
> >
> > b. Identify and address gaps in the workforce capacity necessary to meet the needs of Class Members
> >
> > c. Develop sustainable regional and statewide education, training, coaching, mentoring, and technical assistance to providers that serve Class Members
>
> 4. IDHW will consult with the IWG, subject to procurement restrictions, as IDHW develops the Workplace Development Plan and, with the IWG, will incorporate timelines and interim deadlines for action items."

IAP OBJECTIVE D ¶¶ 3, 4.

The Annual Report presents four pages of discussion on workforce challenges, administrative activities, and potential solutions. *See* Annual Report, at 32-34. It fails to acknowledge that Defendants have not drafted the Workforce Development Plan as required.

Objective E: Due Process Accomplishments

An entitlement to mental health services and supports in a complex healthcare system is dependent on a myriad of processes, procedures, and agency decision-makers. The important legal rights at stake are not self-actualizing, and appropriate procedural safeguards are necessary to ensure that Class Members seeking behavioral health services are afforded constitutionally and statutorily adequate due process of law. To that end, the 2015 Settlement Agreement requires many elements related to providing lawful and complete written notices and due process to Class Members as well as the development of a centralized and impartial process to address and track complaints and report upon notices of action, complaints, fair hearing requests, and outcomes. 2015 Settlement, at 20-21. Central to this effort is the required development of a Due Process Protocol that the parties agree meets the minimum state and federal requirements and shall be the authoritative guidance for YES Class Members seeking services and supports. IAP OBJECTIVE E ¶ 1., at 17. The IAP further requires that the Protocol be reviewed and updated annually. IAP OBJECTIVE E ¶ 1.d., at 17.

The Annual Report notes, among other things, that the parties collaboratively completed the Authoritative Due Process Protocol by March 31, 2022. Annual Report, at 36. The Annual Report further acknowledges that "[l]egal counsel for IDHW provided the Authoritative document to the Fair Hearings Unit in June 2022 along with a description of its purpose and required use in hearings involving Jeff D. Class Members." Annual Report, at 37. The Annual Report, however, does not disclose that the Protocol identified several areas in which the Idaho Contested Case Rules do not comply with federal Medicaid regulations and constitutional requirements, and that Defendants have refused to amend the Rules to bring them in compliance with federal law even though the Protocol requires the Defendants to comply. Counsel for IDHW indicated they have no authority and were prohibited from instructing or advising the independent Hearing Officers on how they conduct the fair hearings to ensure the fair hearing are conducted in compliance with the federal Medicaid Regulations when the Rules conflict with or do not address the required procedures.

The Annual Report alludes to the pending deadline for revising the Due Process Protocol, suggesting "the parties may agree to defer updates to the Due Process Protocol…" There is no agreement to defer the required update, and it has not been completed as required.

Objective F: Governance and Problem-Solving Accomplishments

The Governance and Problem-solving provisions of the IAP were intended to facilitate collaboration among the parties and stakeholders, oversee implementation of the 2015 Settlement, and provide a forum and process to problem-solve challenges. IAP OBJECTIVE G, at 20-23. The Interagency Governance Team (IGT) is the public fulcrum for these efforts.

The Annual Report describes IGT accomplishments in 2022. The Annual Report does not acknowledge that Defendant's obligation to "Secure staffing and funding resources from IDHW necessary to do its work no later than July 1, 2022," has not been met. IAP OBJECTIVE F ¶ 1.c., at 20. More than a year later, the full-time equivalent staff promised to support the IGT continues to be part-time with no direct reporting or accountability to the IGT. Having very limited staff support impairs the IGT's ability to achieve its purposes and obligations.

Objective G: Quality Management Improvement and Accountability (QMIA)

Although often overlooked or taken for granted, quality management is an essential aspect of an effective system of care. Quality care is essential to achieving desired clinical results. Measuring and assessing quality is fundamental to understanding system performance and evaluating compliance with the 2015 Settlement. The YES Quality Management System is animated by the QMIA Plan, drafted in March 2016, pursuant to the 2015 Settlement. 2015 Settlement ¶¶ 52-55.

The IAP required Defendants to "update the existing QMIA Plan and deliver it to the IWG by August 31, 2022." Instead, Defendants presented the IWG with a draft amended plan on July 8, 2022. That plan was rejected by the IWG as needing substantial revision. Defendants agreed to

amend the draft and the parties agreed to give Defendants additional time to do so, which, due to other delayed deliverables, ended up as a one-year extension to June 30, 2023. Absent any consultation with the IWG about the content of the plan in the interim, Defendants presented the IWG with a new draft QMIA Plan update on June 8, 2023. Even though Defendants had an additional ten months to complete the update, the latest draft was a modestly edited version of the prior unacceptable draft. The latest draft failed to meet the minimum requirements for the QMIA Plan as set forth in the 2105 Settlement (¶¶ 52-55), the Implementation Plan (OBJECTIVE 7, at 31-34) and the IAP (OBJECTIVE G ¶¶ 1, 2, at 21-22). Defendants are now more than a month late on this deliverable with considerable additional work and consultation needed.

Objective H: Idaho Behavioral Health Plan

The IAP was "intended to be the roadmap for completing implementation of the Settlement Agreement." IAP at 3. The IAP was developed, in part, to guide the YES system transition to a new Idaho Behavioral Health Plan (IBHP) contract to maximize Medicaid's role in facilitating the full implementation of services for Class Members. IAP OBJECTIVE H, at 22. The new IBHP would be Idaho's single statewide Medicaid and non-Medicaid provider network for the delivery of outpatient and inpatient behavioral health services. Annual Report at 8. The IBHP contract was required to fully incorporate the 2015 Settlement and the IAP to include the "Services and Supports Crosswalk, Access Pathways Map, Due Process Protocol, QMIA Plan and Practice Manual" IAP OBJECTIVE H ¶ 3, at 22. While the managed care organization and its network of providers and clinicians provide treatment, the Defendants have the sole responsibility for meeting the IAP's performance timelines and the deadlines. *Id.* ¶ 7.

On January 6, 2020, a Request for Information was issued requesting interested parties to submit responses by February 2, 2020. An invitation to negotiate (ITN) to potential vendors for the new IBHP contract wasn't issued until late December 2021. Annual Report at 8. Proposals were due by April 15, 2022. Three vendors were considered for the contract. A Notice of Intent to Award the new IBHP contract was issued to Beacon Health Systems in December 2022. *Id.* The two other vendors who were not selected, Magellan of Idaho and Optum Idaho, appealed the award. *Id*. A hearing officer disqualified the award to Beacon Health Systems and the MCO contract was awarded to the second highest bidder, Magellan of Idaho in May, 2023. Optum Idaho and Beacon Health Systems have filed state court actions for declaratory and other relief challenging the procurement process and the award to Magellan of Idaho. *See infra* nn.42, 43.

After the Annual Report was filed, Defendants reportedly executed a new four-year, $1.2 billion IBHP contract with Magellan of Idaho dated June 16, 2023.[38] Defendants have confirmed that the start date for the contract is March 1, 2024. These two dates are important Implementation milestones, and provide timelines for much of what remains to be done pursuant to the IAP.

[38] Kyle Pfannenstiel, *Idaho Awards $1.2 Billion Contract for Behavioral Health. Both Losing Bidders Sue*, Idaho Capital Sun, July 5, 2023. https://idahocapitalsun.com/2023/07/05/idaho-awards-1-2-billion-contract-for-behavioral-health-both-losing-bidders-sue/

IV. Compliance Issues and Remedial Efforts

Paragraph 67 of the 2015 Settlement directs Defendants to: "identify potential or actual compliance issues that need attention, including a summary of proposed or actual remedial efforts made to address these compliance issues…" 2015 Settlement, at 25.

Defendants list seven "challenges" or "additional work needed" in their Annual Report:

A. Availability of Services and Service Rollout;
B. Medicaid Approvals;
C. Budgetary Constraints;
D. Mental Health Early and Periodic Screening, Diagnostic, and Treatment (MH EPSDT) Review;
E. Compliance Measures and Exit Criteria;
F. Collaboration Challenges; and
G. Treatment of Individual Cases.

Annual Report, at 47-52.

Class Counsel disagrees with Defendants' Compliance Challenges list. Medicaid Approvals and Budgetary Constraints are not issues as the Center on Medicaid and Medicare Services ("CMS") approvals are in place and the requested Medicaid budget was approved by the Legislature. Collaboration Challenges are real, but not a Settlement compliance issue. The degree to which Class Counsel involves individual Class Members in our advocacy may be a problem for Defendants, but the individual cases do reflect systemic Settlement compliance issues in Class Counsels' view.

Class Counsel agree that compliance issues exist with Defendants' Availability of Services and Service Rollout, Workforce Development, and the IBHP transition. Class Counsel also agree that serious compliance problems exist within the Mental Health Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") program. Completing Compliance Measures and Exit Criteria are issues, as are other missed IAP requirements. Lastly, Class Counsel has raised serious Due Process compliance issues with Defendants that should have been Included in the Annual Report.

In addition to identifying compliance issues, paragraph 67 requires Defendants to present a summary of proposed or actual remedial efforts made to address the identified compliance issues. 2015 Settlement, at 25. Defendants largely failed to do this in their Annual Report Section V., Challenges and Additional Work Needed, and Review of Collaborative Efforts. Class Counsel address the compliance issues Defendants did identify and the concerns related to proposed or actual remedial efforts found in the Annual Report in this Section. Class Counsel also address compliance issues not identified in the Annual Report, as well as Class Counsel's concerns regarding the adequacy of Defendants' remedial efforts.

A. Availability of Services and Service Rollout

i. Availability of Services

Defendants' data reviewed in Section II above depict an inadequate system of mental health services and supports in reverse. Access to services has declined, both in terms of number of children served and average units of service per youth for key services. The data indicate that services for youths with intensive needs are severely limited. The availability of services and supports in rural and frontier areas is worse than in more highly populated urban areas.

Defendants acknowledge that "the availability and delivery of publicly funded children's mental health services continues to be a challenge." Annual Report, at 47. Also, "IDHW acknowledges that implementation has been slower than anticipated and that access to care and service rollout is challenging, particularly for children with intensive needs." Annual Report, at 51. Indeed,

> "Youth who face the most significant mental health challenges have the worst care experiences. This is evidenced by Family Survey results showing that youth with higher CANS scores were significantly less likely to have access to community-based services than providers recommended and caregivers felt were necessary. Deficits were especially pronounced in the area of access to a community-based service array, suggesting youth with the most severe needs do not have adequate access to an intermediate range of services necessary to support them in the community."

Annual Report, at 29.

Defendants also observe in the Annual Report that the array of services available is "disproportionately focused on services which are appropriate for youth with mild to moderate behavioral health concerns." Annual Report, at 29 (citation omitted). Additionally, "the care youth received was often delayed, not well matched to the intensity of their needs, and [only] somewhat collaborative. *Id*. (citation omitted).

Added to the lack of available services, is the fact that Defendants' 2022 QR reported that care for Class Members did not meet quality standards, *supra,* at 23. Indeed, during the first 90 days of service—the most important period for effective interventions—treatment was "grossly inadequate for youth with serious, impairing mental health concerns." *Id.* Inadequate care resulted from system-wide failures involving timeliness, assessments, treatment planning, service "fit", and case management and care coordination. *See* § II.e., *supra*, at 18-24.

Faced with these challenges, Defendants offer the following as remedial efforts:

> To address availability to care, YES partners continue to research best practices to increase the effectiveness of services, enhancing coaching and training, implementing new strategies for increasing the number of healthcare providers and increasing the focus on development and expansion of the use of telehealth.

> IDHW is optimistic that the expansion of the IBHP, further development of the CoE, and other strategies like value-based healthcare initiatives will assist in
>
> building the workforce. Additionally, this challenge is a focus of IDHW in the Agile Sprint process referred to above.

Annual Report, at 47.

Rather than spelling out remedial actions and work plans identifying who is responsible for specific tasks and timelines that will result in actual services for youths with intensive needs,[39] Defendants identify additional challenges that have impeded the availability and accessibility of services for youth with intensive needs.

> "The availability of mental health providers in Idaho (a designated healthcare provider shortage for mental health statewide), difficulties in both recruiting new qualified providers and in retaining providers, the growth of the state population, and access in both rural and frontier areas of the state are factors that impact the availability of services."

Annual Report at 47.

Additionally, "the delay in the awarding of the new IBHP contract, due to procurement appeals, is an additional challenge." Annual Report, at 47. As "is the difficulty in planning for a future system of care administered largely through an MCO while simultaneously administering the current system with a dwindling workforce[29] and recognized gaps." Annual Report, at 47 (footnote omitted).

Defendants provided a fuller description of their remedial efforts as accomplishments in Section II of the Annual Report, at 9-19. The infrastructure projects described will increase access to care (or, in the case of PRTFs, bring youths closer to home and families) for an important, but small, population of youths. These steps will not significantly impact the thousands of YES youths who need intensive home and community-based mental health treatment.

The fundamental challenge facing Defendants remains: how to comply with the 2015 Settlement by substantially expanding high-quality intensive home and community-based services for youths with serious mental illness? Defendants indirectly acknowledge where the solutions lie, albeit framing them as the challenges related above: developing an adequate mental health workforce and successfully and expeditiously standing up the new IBHP. Class Counsel reviews these system challenges below.

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[39] Defendants point to planning efforts that are generating recommendations for future action, providing examples of two such efforts. "Create, and publish online, a CANS-based algorithm for determining the need for care coordination." And, "Provide specialized assistance to therapists working with youth with co-occurring disorders and complex needs. Make available and promote consultation billing codes. Recruit expert clinical consultants and make them available statewide to therapists working with these youth." IAP, at 48. These are constructive steps to improve the YES SoC, however the first effort does not address availability of services, and the second ignores the identified problem of a lack of therapists and specialists.

ii. Workforce Deficiencies

The slow roll-out of home and community-based services, limited access to virtually *any* care across broad swaths of the State, and an inability to provide adequate treatment intensity for many youths is directly related to Idaho's mental health workforce challenges.[40] Defendants catalog numerous workforce issues, much of which is described in Section II above, including:

- "[H]igh turnover among treatment professionals"; 2022 QR, at 17.
- "The lack of providers able to provide a full array of services is creating particularly acute care shortages for youth with the greatest community treatment needs." 2022 QR, at 29, *supra* at 23.
- "[A]gencies are having difficulty recruiting staff who are qualified and will work the hours desired by agencies." 2022 QR, at 12.
- "[D]ifficulties in both recruiting new qualified providers and in retaining providers…" Annual Report, at 47.
- "Only about 10% of agencies indicate that they provide Intensive Outpatient Programs, Intensive Home and Community-Based Services, or Drug and Alcohol Testing. Only about 5% indicate that they provide Day Treatment or Therapeutic After School and Summer Programs." 2022 QR, at 29.
- "[U]nsustainable reimbursement rates, administrative burdens to standing up new services, workforce shortages, and the high costs and productivity losses associate with training staff." Annual Report, at 30.

Defendants' 2022 QR summarizes the situation thus: **"**the network of providers appear to be responding to the cumulative impact of low margins, high administrative burden, and multiple oversight bodies. Their response is to pull back from the Medicaid network, either leaving altogether or reducing the breadth of service types and service hours provided." 2022 QR, at 42.

Defendants acknowledge these challenges, noting for example that the 2022 QR:

> …identified needs to proactively expand services, including: reimbursement rates consistent with service costs, less onerous paperwork and more understandable policies and procedures, specialized training that is accessible and low cost, and assistance developing and recruiting from a sufficient pool of practitioners. Legislative appropriations have made providing competitive reimbursement rates challenging.

Annual Report, at 35.

The Annual Report does not specifically address the workforce shortages as a compliance problem, nor identify proposed or actual remedies in Section V, *Challenges and Additional Work Needed and Review of Collaborative Efforts*. Fortunately, a close read of the entire Annual Report assures there is more going on than the vague promise of "implementing new strategies for increasing the number of healthcare providers and increasing the focus on development and expansion of the use of telehealth." Annual Report, at 47.

[40] See Annual Report, at 47.

Likely the "biggest impact on the provider network" was funding a reimbursement rate increase for July 2022 "by fifteen percent (15%) for nine (9) services." Annual Report, at 33. Defendants promise that "Medicaid *intends to* raise provider rates again next year." *Id*. (emphasis added).

Other administrative efforts by Defendants and the Medicaid managed care provider include implementing consultation billing codes, Annual Report 48; requiring Annual Network Development and Management Plans, *Id.* at 33; creation of a registry for paraprofessionals, *Id.* at 35; and steps to continue the decreased administrative burdens that expire with the end of the COVID emergency rules, *Id*. at 34. It is unclear whether these actions will be sustained through the transition to a new managed care organization.

The Annual Report also lists various training efforts for Therapeutic Behavioral Services, Wraparound, and Treatment Foster Care providers, Annual Report at 33, and for providers of Targeted Care Coordination, Respite, and Youth Support. *Id*. Notwithstanding these efforts, the data demonstrate little or no success in building out these services, save for Youth Support. *See supra*, Table 1.

Defendants' Annual Report includes numerous statements regarding ideas or work planned for the future,[41] recommendations or activities to be considered,[42] and issues addressed.[43] Class Counsel view these items as too speculative and uncertain to include as actual, or even proposed remedies, given frequent past failures to follow through. For example, the 2022 Quality Review described a series of Recommendations and Action steps to address the mental health workforce shortage. 2022 QR, at 42-48. To date, they have identified two action steps to pursue (make available and promote consultation billing codes, and create and publish online, a CANS-based algorithm for determining the need for care coordination) of the 11 action steps recommended. Only consultation billing codes is actively being implemented; the CANS-based algorithm is still in planning and prioritizing status.[44]

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[41] *E.g.,* "Work with the new IBHP contractor on improving access, reducing wait times to care, and supplying a trained workforce *will be essential*. The CoE *will be ready to begin* providing low cost training and working to support IBHP providers in the fall of 2023." IAP, at 30 (emphasis added). *Also*, "[F]ocusing their work *in the near future* on an approach to ensure Idaho Medicaid is meeting compliance with the network adequacy provision within the latest CMS Managed Care Final Rule" IAP, at 35 (emphasis added).

[42] *E.g.,* "The ICC Sprint team *considered* how other states utilize Family Care Coordinators, instead of licensed clinicians, to perform ICC and TCC services as one idea for addressing a workforce shortage." "Additionally, that team *recommended* assessing workforce development needs focused on challenges specific to targeted geographic areas." IAP, at 30 (emphasis added). "The report *recommends* increasing the number of specialized providers by making it more rewarding to serve youth with complex needs." IAP, at 42 (emphasis added). "It also *recommends* focusing the system on providing engaging, high-quality care within the first thirty days of a youth's treatment and systematizing access to intensive care coordination for youth with highly complex needs." *Id*. (emphasis added).

[43] *E.g.,* "The group *addressed* the need to provide greater frequent, low-cost training to providers across the state, focusing on areas with lower penetration of services." IAP, at 30 (emphasis added).

[44] *See supra* n.38.

Defendants' remedial efforts to stem a contracting workforce and diminishing access to services and supports have been unsuccessful. Additionally, Defendants' approach lacks a clear and coordinated strategy, having failed to develop the required YES Workforce Plan. The strong reliance on the new IBHP to resolve the State's workforce issues is exceedingly optimistic given that the new managed care organization will face similar workforce challenges and is required to build its service provider network in six months.

iii. Delay in IBHP Contracting

The IAP timelines and due dates for completing implementation of a sustainable, accessible, comprehensive, and coordinated behavioral health services delivery system under the 2015 Settlement "are contingent upon the execution date of the new IBHP contract (defined as the date the new contract is signed) and the service start date of that contract (defined as the date the state and the contractor mutually agree that the contractor will assume daily operations for the IBHP)." Annual Report, at 20. When the Annual Report was filed, Defendants were months overdue on executing a new IBHP contract, and the deadlines tied to the execution of the IBHP were delayed. Two weeks after filing the Annual Report, according to counsel for Defendants, "the Magellan contract was executed on June 16, 2023, the service date is in fact March 1, 2024."[45]

Although Defendants have signed a contract for a new IBHP with Magellan Health, Optum Idaho is seeking preliminary and permanent relief enjoining IDHW and its officials from awarding the contract to Magellan Health including participating in any transition activities and a jury trial.[46] A third managed care entity, Beacon Health Systems, is seeking a declaration that it was qualified as the highest bidder, was not barred from bidding on the contract, should not have been disqualified, and should be awarded the contract.[47]

Defendants' Annual Report anticipated a quick resolution to these challenges. Defendants' optimism about the outcome of the legal challenges and the expectation that full implementation of the IBHP transition scheduled for March 1, 2024—in under seven months—seems overly optimistic given how many deadlines have been missed to date and the complexity of transitioning Idaho's behavioral health system. The key concern is that many children who are receiving services from Optum providers will lose access to care while Magellan Health gets organized and staffed up. The Annual Report provided no information as to how this transition will be successfully accomplished, or what assurances there may be that Class Members will continue to receive mandated services and supports during and after the transition on March 1, 2024.

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[45] Email from Alan Foutz, Deputy Attorney General, to Class Counsel, dated July, 14, 2023.

[46] *See United Behavioral Health, Inc. d/b/a Optum Idaho v. State of Idaho,* cv01-23-07834 filed on May 12, 2023 (Complaint and Demand for Jury Trial and Application for Writs of Prohibition and Mandate).

[47] *See Carelon Behavioral Health, Inc. F/D/A Beacon Health Options, Inc. v. State of Idaho*, cv01-23-07547 filed on May 8, 2023 (Complaint for Declaratory Relief and Petition for Extraordinary Writ).

B. Mental Health Early and Periodic Screening, Diagnostic, and Treatment (MH EPSDT) Review

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions or 'Children's Medicaid' are a broad and deep entitlement to health care assistance for beneficiaries under age 21.[48] EPSDT mandates coverage for "any treatment or procedure if that treatment or service is necessary to correct or help defects, physical and mental illnesses, or conditions, and is specified as a Medicaid-covered service in the Social Security Act."[49] The 2015 Settlement specifically adopted EPSDT as a core delivery mechanism to build on Idaho's existing mental health services framework and maximize federal matching funds. 2015 Settlement ¶ 36.

While EPSDT covers all Medicaid medical assistance services for youths, Idaho more narrowly focused its mental health EPSDT Program on "medically necessary services that are not specifically included in the Idaho Medicaid State Plan…" YES Practice Manual, *supra* n.49, at 49. In practice, Idaho's mental health EPSDT Program deals primarily with requests for residential services, whereas OPTUM Idaho covers outpatient behavioral health services. *Id*.

Inpatient and residential behavioral health services in Idaho include psychiatric hospitalization, Psychiatric Residential Treatment Facility (PRTF), and Residential Treatment Center (RTC). Other YES services that include out-of-home or clinical care are Partial Hospitalization (PHP), Day Treatment, Therapeutic Foster Care (TFC), Crisis Residential, and Group Home.

The failure to provide adequate residential treatment, or alternative intensive home and community-based services, can have tragic consequences. Individual cases brought to Class Counsel's attention[50] have involved:

- An eleven-year-old with SED and developmental disabilities was stranded in the ER for a total of 35 days**.** His arms, hands, and ankles were restrained to a metal chair, waiting for Medicaid to authorize a placement in a psychiatric treatment facility. Medicaid had refused to enter a single case agreement with a Texas facility who would admit him. His mother wrote that: "Your help was invaluable to ensuring the hospital administration, Medicaid, and so many others began to pay attention to actually trying to move toward helping SS. Things absolutely changed in people's attitudes and actions after you started to contact agencies about our situation."

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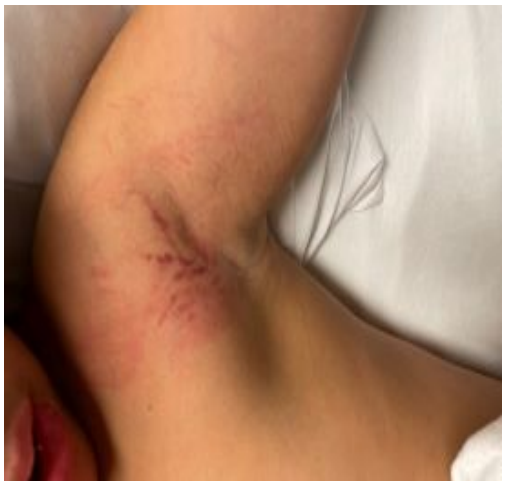
[48] Social Security Act, codified at 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(A), 1396a(a)(43) and 1396d(a)(4)(B).

[49] YES Services Practice Manual, at 49 (April 7, 2020).

[50] Class Counsel's duty to represent the *Jeff D.* class and monitor implementation of the 2015 Settlement requires contact with many parents of youth who are Class Members, including parents who are seeking assistance in gaining access to YES services. Counsel use these contacts to identify systemic challenges and opportunities, advance compliance with the 2015 Settlement, and problem-solve non-compliant and severe cases.



- A fourteen-year-old with severe developmental and mental health needs resided in a rural community which made it difficult to access intensive services. He was discharged from SHW and transferred home, after a determination he was not a danger to himself or others, without appropriate intensive community-based services. He removed a 2x6 board from a porch step and began to chase his mom after she returned home. He then used a six-foot metal windmill with a spiked bottom to damage BS's pickup. She ran to a neighbor's yard for safety and called 911. The youth had previously punched holes in the house walls and broken a 65-inch TV. The youth caused over $20,000 in damages. The youth was arrested and charged with felony Malicious Injury to Property and Aggravated Assault and was incarcerated in a juvenile detention center without any mental health services.

- A 14-year-old youth, discharged from hospital and denied adequate alternative care mostly living on the street, not attending school, abusing drugs, and engaging in physical confrontations when visiting home.
- Parents who are afraid to take their child home from the hospital without intensive home services because their child (who regularly threatens harm and has a history of violence) is a danger to themself, their parents and/or their siblings, are accused of abandonment and reported to the police. Mother cannot work because, without home and community-based services, she must supervise the child 24/7.

Class Counsel assess the individual safety and therapeutic needs of Class Members brought directly to their attention, as well as evaluating the facts of the individual cases for evidence of systemic challenges. Reviewed cases that were determined to reflect serious problems with the ESPDT system were brought to Defendants by Class Counsel, [51] as were demands to rectify service failures that put Class Members and their families at risk of harm. Defendants' complaints about Class Counsel's involvement with individual cases would seem to insist that Class Counsel ignore 2015 Settlement and Medicaid compliance failures including specific known and preventable harms to Class Members.

The Annual Report does not address potential or actual compliance issues relating to residential care, except to observe that Class Counsel "has raised concerns about IDHW's delivery of the benefit, including the application process, the review and approval process, the access to care provided through delivery of the benefit, and the due process procedures associated with the processing and denial of the benefit." Annual Report, at 49.

Defendants agreed with Class Counsel's proposal to initiate a broad review of Idaho's EPSDT program pertaining to behavioral health services. Annual Report, at 49-50. The delay in conducting the review has been significant, however. Class Counsel requested in October 2022

[51] In an email to Defendants and their counsel, dated June 3, 2022, Class Counsel pinpointed a number of EPSDT problems, to wit:
"…[I]t is apparent that the step-down process from State Hospital West is broken. We have now been apprised of another youth at the hospital with serious mental health needs who is about to be discharged without a transition/treatment plan suited to his needs for living at home and in the community. There seems to be an assumption on the part of Children's Mental Health and Medicaid that the denial of an EPSDT service, in this case a PRTF placement, relieves the State of its obligation to provide medically necessary YES services upon discharge. That assumption would be wrong. Indeed, sending a youth home from institutional care without adequate services is a clear violation of the Jeff D. Settlement Agreement, as well as state and federal law. It is also both inappropriate and a violation of the Settlement Agreement to obligate the youth's parent to perform case management on behalf of their child. Case management is a Medicaid-covered service and required under the Settlement Agreement. Additionally, sending a youth home without a crisis plan, or with a crisis plan that amounts to "call the police," is not compliant with the Settlement Agreement. Failing to provide special education services under an existing IEP while hospitalized also violates federal law and is inconsistent with the Settlement Agreement. Informing a parent that a child with acute problems regarding self-harm or risk to others is a juvenile justice matter, and not a children's mental health concern, as has occurred in this case, is an astonishing deviation from the promises made to the YES class and to the very notion of system reform. Moreover, these enumerated concerns only skim the surface of this additional case, according to what we have learned."

that the review and recommendations *be co*mpleted by March 2023. On information and belief the review was instead scheduled *to begin* in June 2023.

The delay in concluding the review from prior to executing a new contract until well into the transition period from Optum Idaho to Magellan Health will make implementing EPSDT changes more difficult. Also concerning is the reluctance by Defendants to include Class Counsel and the IWG stakeholders in the review process. Class Counsel and the IWG stakeholders have a wealth of knowledge about EPSDT challenges that ought to be presented to the consultants doing the review. An objective and comprehensive written review of the EPSDT program that identifies challenges and provides actionable recommendations on how to fix them, if heeded, will be an important contribution to implementing the 2015 Settlement.

C. IAP Compliance Measures and Exit Criteria; Collaboration

The Annual Report did not identify missed or delayed IAP deadlines as a key compliance issue. Defendants do list Compliance Measures and Exit Criteria as "a difficult task," Annual Report, at 50, but take the view "that it has substantially met all of the IAP deadlines or has obtained agreement with Class Counsel and the IWG to extend the IAP deadlines." Annual Report, at 20. As described in § III.B., *supra,* at 26, Class Counsel does not agree that Defendants are meeting IAP deadlines.

In fact, Defendants are far behind in basic design and execution of essential plans, requirements that have been in place since the Implementation Plan was completed and ordered by this Court on May 17, 2016. The IAP was intended to aid Defendants in completing Implementation by focusing their efforts and setting timetables to complete important planning tasks and increasing accountability—hence the title, Implementation *Assurance* Plan.

Defendants' failure to meet deadlines set in the IAP is problematic because these delays mean access to services and supports is postponed or denied for thousands of Class Members. Also concerning is that without these design documents, the YES Principles of Care and Practice Model, and the array of required services and supports will not become embedded in the new IBHP as required.

Also troubling is Defendants' effort to disavow their present obligation to serve Class Members. Defendants assert that: "*Ultimately*, the IAP requires IDHW, who will provide services through the use of a new IBHP Contractor, to provide Class Members with medically necessary access to the full array of services." Annual Report, at 26 (emphasis added).

Defendants' characterization is fundamentally at odds with and dismissive of the clear intent of the 2015 Settlement. "The Defendants agree to timely fulfill the Commitments . . . during the pendency of this Agreement." 2015 Settlement ¶ 16. These commitments include, "Class Members shall be provided all of the services set forth in the Services and Supports document, defined in Appendix C, that are necessary to meet their individualized mental health strengths and needs as recommended by a practitioner of the healing arts." *Id*. ¶ 18. "Defendants shall

have a period of up to four (4) years to fulfill the Commitments by completing the Implementation Plan." *Id.* ¶ 69. In order to dispel any doubts about Defendants' obligation to fully provide appropriate care during Implementation, the 2015 Settlement assures that, "Substantial compliance with the Commitments, including timelines provided herein, is enforceable *during the pendency of this Agreement. Id*. ¶ 17. The 2015 Settlement is as clear as Lake Coeur d'Alene that Defendants have the current duty to timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to their individual strengths and needs. *Id*. ¶ 71.d.

Defendants raise "the collaborative relationship between IDHW and Class Counsel" as a "significant challenge." Annual Report, at 50. Defendants go so far as to implicate Class Counsel as a cause for delay. Annual Report, at 51. Defendants' argument is at odds with the plain fact that the IAP obligations to produce a Crosswalk[52] and an Access Pathways Map[53] were first set out in the Implementation Plan approved *seven years ago*. These obligations were underscored and carefully described jointly *by the parties* in the IAP that was Ordered more than 19 months ago. Class Counsel has provided Defendants with clear and concise written feedback within days or at most a few weeks after Defendants take many months, or even years, to complete their work. That Class Counsel may impede a last-minute rush to meet a long overdue deadline by identifying errors or proposing changes needed to comply with the IAP, Implementation Plan, or 2105 Settlement is not the cause for months and years of delay.

Most damaging to the collaborative relationship has been Defendants' failure to perform and the disturbing admission that eight years after creating and committing to a YES system of care vision in the comprehensive 2015 Settlement, "The Department does not have a shared vision within and among the Divisions involved in YES."[54]

Defendants' collaborative attitude over the last year or more was underscored by the filing of its Annual Report with the Court—without prior notice to Class Counsel and in violation of a

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[52] The 2016 Implementation Plan required Defendants to:
A. "Operationally define the array of services/supports that shall be provided to the Class per the Agreement by October 30, 2016.
1. Define the services/supports available to Class Members in sufficient detail to guide the provision and reimbursement methodologies used by the state. Implementation Plan, at 8 ¶¶ A., A.1.

[53] The 2016 Implementation Plan required Defendants to "Develop business flow diagrams that describe the existing pathways into, through, and out of the SoC for each agency's identification, screening, assessment, referral, planning, treatment, and transition process and policies. Implementation Plan at 15 ¶ A. 1.

[54] Email from KayT Garrett, Deputy Attorney General, to Class Counsel dated 11/8/2022. "…[T]hree things are getting in the way of moving the Department forward in developing the children's mental health system that the children of Idaho deserve. Those things are:

1. The Department does not have a shared vision within and among the Divisions involved in YES
2. The Department has major challenges in service delivery
3. The Department has not fully organized the collective governing of the new IBHP[.]" *See also*, "…DBH and Medicaid were not looking at the implementation process in the same way. Historically, the programs have operated through different processes, perspectives, and goals." [ANNUAL REPORT at 11-12.]

specific agreement by the parties to continue negotiating a joint report[55]—on the Friday afternoon before Memorial Day.[56] The two Deputy Attorneys General who filed the report noted they had resigned effective the following week in a subsequent e-mail to Class Counsel.

There may be, however, cause for optimism. The parties met face-to-face for the first time in three years on Thursday and Friday, August 10 and 11, 2023. The meeting resulted in general agreement on the status of several IAP procedural deliverables and generated ideas on how to expeditiously complete them. Additionally, there was agreement to improve communications among the parties and the IWG, and for more transparent information sharing. In particular, Defendants committed to informing the IWG and Class Counsel on procedures for transitioning to the new IBHP and sharing the new IBHP contract as soon as possible. The parties expect to meet again in person in about six weeks.

D. Due Process

Class Members and their families must be afforded constitutional and federal rights to appeal when services are denied, reduced, or terminated.[57] The 2015 Settlement, at 20-21 underscored this duty by committing Defendants to a series of actions to ensure that the YES system of care "Affords due process to Class Members." 2015 Settlement, at 14. The IAP sought to operationalize this commitment by requiring Defendants to "develop and operate constitutionally and federal-compliant fair hearing systems." IAP, at 17. Defendants have failed to achieve this requirement, and should have included due process in the Annual Report as an "actual compliance issue needing attention."

Based on Class Counsel's participation in the Due Process Workgroup and the complaints Class Counsel have received from parents of Class Members seeking information about service availability, reductions or denials, or to complain or appeal agency action, it is evident that due process is not being afforded to Class Members in violation of the law and the 2015 Settlement. Additionally, Defendants have not complied with due process requirements in the IAP. Significant problems include:

(1) The Centralized Complaint Process is a work in progress. Defendants report that "each partner agency has its own individual process for addressing and responding to complaints," Annual Report, at 37, but do not have a centralize complaint system. *Id.* at 38. Defendants have not developed and standardized across agencies administrative hearing rights and procedures. Implementation Plan ¶ A.3.c, at 26-27. There is no formal tracking process of Medicaid EPSDT complaints, and IDHW's Medicaid's EPSDT, DBH and FAC divisions do not track administrative hearing outcomes.

(2) The Implementation Plan requires Defendants to develop and implement informational materials into each media platform to inform Class Members of rights related to complaints and

[55] Court Report Update, Docket 772, April 27, 2023.
[56] Notice of Filing Annual Report, Docket 775, May 26, 2023.
[57] 42 C.F.R. § 431.210 citing 42 C.F.R. § 431.206(c)(2).

administrative hearing rights and procedures related to the services and supports. Implementation Plan, at 27 ¶ 4. The review and update of the Practice Manual has not occurred and the present version does not incorporate the Due Process Protocol. The Practice Manual is currently being reviewed with Class Member and stakeholder input.

Class Counsel requested the Due Process Workgroup prepare informational materials but IDHW's former counsel objected because she preferred to have the Communications Workgroup prepare them. Nothing has been proposed by IDHW. The Communications Workgroup is either unwilling or unable to prepare informational materials. The Due Process Workgroup has been prevented from creating informational materials and is not currently working on any involving how to conduct fair hearings appeals, the Medicaid Regulations, IDHW's Rules, or EPSDT application process and review. However, during the IWG meeting last week, it was agreed that the Due Process Workgroup would produce the content for the informational materials.

(3) IDHW's Contested Case Rules provide the procedural rights governing Medicaid appeal. IDAPA 16.05.03. IDHW's Rules do not reference or incorporate or comply with the due process fair hearings requirements in the Medicaid Regulations, 42 CFR 431.200 *et. Seq* or the United States Supreme Court's decision *Goldberg v. Kelly*.[58] IDHW's Rules are too restrictive and do not provide the required notice and hearing due process procedures. IDHW's Rules need revisions to comply with the Medicaid Regulations and minimal constitutional standards. IDHW's Rules are far more complicated and more difficult for parents to understand than the Medicaid Regulations.

The Due Process Protocol ("Protocol") was drafted because IDHW's Rules were not aligned with the 2015 Settlement, the Implementation Plans, and the federal Medicaid Regulations.[59] The Defendants have refused to amend or revise the IDHW's Rules to comply with the Medicaid Regulations due to the Governor's Executive Order. Annual Report, n.23 at 32. As Defendants would not agree to any changes in the IDHW's Rules, the parties agreed in the IAP to prepare a Due Process Protocol with the federal case law and regulatory due process requirements that would be provided to the hearing officers.[60] The Protocol was intended to address the additional safeguards from the applicable IDHW's Rules, Medicaid Regulations, case law, the 2015 Settlement, the Implementation Plans, and the Agreed Upon Standard. Protocol, at 1-2. Further, "in order to ensure that Class Members are aware of and notified of their procedural due process rights – as guaranteed by the Constitution, federal and state law – and that those rights are provided to Class Members" the IAP affirmed that "The Authoritative Due Process Protocol will be controlling." IAP, at 17 ¶¶ 1., 1.c.

The Protocol, standing alone, cannot substitute for ensuring proper notice of the due process procedures and informational materials to assist a Class Member seeking to complain or appeal.

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[58] *Goldberg v. Kelly*, 397 U.S. 254 (1970). *See also* 42 C.F.R. § 431.205(d).
[59] *See* https://yes.idaho.gov/wp-content/uploads/2022/04/YES-DP-Protocol-2022-for-YES-Website.pdf
[60] *See* 42 C.F.R. § 431.240(c).

The Protocol is directed to the Hearing Officers; and the Class Member is not notified of the Protocol in the notice of their right to appeal. What is more, notwithstanding having received the Protocol that includes Medicaid procedural requirements, Hearings Officers are not required to follow the Protocol or address and apply the Medicaid Regulations in rendering a written decision in appeals. The result is inconsistent compliance with the Due Process Protocols and Constitutional and federal safeguards, and failure to comply with the Settlement and IAP requirements.

Defendants report they are working on aspects of the challenges outlined above. Annual Report, at 33-35. But many of these activities have been ongoing for months, if not years, without results. In the meantime, Class Members have been denied due process of law when appealing improper delays, reductions, or denials for mandated services and supports.

Class Counsel and a parent on the Due Process Workgroup continually raised deficiencies with IDHW's Notice of Medicaid Appeals Rights because it did not comply with the Due Process Protocol and Medicaid Regulations. The Notice informs the parent and youth who has had services denied, reduced or changed of the deadline and methods for filing an appeal or an expedited appeal, if necessary, and how to request a fair hearing. Importantly, it also provides notice of the right to the continuation of benefits during the pendency of the appeal.
Class Counsel drafted proposed revisions to the Notice to make it more understandable for parents and correct inaccuracies in the eligibility for expedited appeals. Medicaid did not acted on the proposed changes and continued to provide inaccurate information to Class member on their right to appeal and the due process procedures.[61] A revised version of the Medicaid Appeals Rights Form was finally presented to the Due Process Workgroup on August 18, 2023. Class counsel and the parent representative is currently reviewing the new format and content.

E. Summary of Compliance Issues and Remediation

Class Counsel and Defendants agree, with variations on emphasis and degree, that fundamental challenges remain in meeting the Implementation requirements of the *Jeff D.* 2015 Settlement. The remedial steps Defendants have taken to date do not in Class Counsel view to be sufficient to overcome these challenges. Seven years into the agreed-upon system reform that was promised in four years[62] Defendants offer many hopes and intentions as their remedial solutions going forward. While continuing work and actions under consideration or awaiting prioritization may be promising, they are inadequate to allay concerns that completing

[61] Class Counsel did not approve the Medicaid Appeals Rights Form in mid-2018. Annual Report, at 36. The Form was presented to the Due Process Workgroup in a Draft version dated 09/13/2019. Class Counsel has objected to the Notice for at least three years and on March 18, 2022, emailed Defendants' counsel a copy of the "09/13/2019 Draft" that was presented to the Workgroup. Appendix 2. Class Counsel has been told for months that it is being reviewed by Medicaid before it can be finalized by the Due Process Workgroup.
In August 2022 Medicaid's counsel indicated she needed the counsel in the *KW v. Armstrong* case to review the revisions and was waiting for a response. Class Counsel offered to consult with KW's counsel to obtain his input on the Form. This was accomplished in late 2022. On March 1, 2023, not in May, Class Counsel emailed the approved revisions to Medicaid counsel. Appendix 3.

[62] Implementation Plan, at 5, *supra,* at 4.

implementation of the 2015 Settlement is a distant and uncertain possibility. What is needed, in Class Counsel's estimation, is greater accountability for making decisions, executing plans, and achieving results.

V. Conclusion

At its core, the 2015 Settlement requires Idaho to accomplish the following:

¶71. Defendants shall:

a. Establish and annually update the range of expected Class Members service utilization, as set forth in paragraph 24;

b. Develop statewide capacity to timely provide Services and Supports in appropriate scope, intensity and duration to Class Members for whom it is medically necessary;

c. Provide the full array of Services and Supports, as defined in Appendix C, statewide as needed by and clinically appropriate for Class Members;

d. Timely provide Class Members with Services and Supports that are appropriate in scope, intensity and duration to meet to their individual strengths and needs, as described in paragraphs 18, 22, 23 and 36; and

e. Provide ICC, as defined in Appendix C, to Class Members with more intensive needs, as set forth in paragraphs 19 through 21.

2015 Settlement, at 26.

Defendants' data provided by QMIA reports, supplemented with managed care organization reports and Defendants' Annual Report demonstrate that Defendants *have accomplished one of these obligations since 2015*: Establish and annually update the range of expected Class Members.[63] 2015 Settlement, at ¶ 71.a. All of the other requirements are unmet more than seven years after the Implementation Plan was ordered by the Court, and more than three years after the 2015 Settlement's deadline for full implementation.

Defendants' fundamental reliance on a new IBHP to achieve compliance is problematical as the contracting process has significantly slowed implementation, and is now embroiled in multi-party litigation in state court. Defendants' assurances that the litigation will be quickly resolved seems implausible. Even if this $1.2 billion bidding contest is not an impediment to transitioning, the new IBHP contractor has less than seven months to refashion Idaho's entire behavioral health system. Moreover, it is unclear how the new managed care organization can be more successful at building and operating an adequate, quality service network than the existing managed care organization. What is certain is that transitioning tens of thousands of beneficiaries from one managed care system to another will be difficult. In brief, Defendants are likely to be more challenged in delivering YES services and supports in 2024 while the transition is underway than they have been in 2022 and 2023.

[63] Defendants have contracted with Boise State to estimate the range of expected class member utilization and reports the same in its quarterly QMIA reports. Defendants' latest estimate ranges from 20,205 to 20,690. QMIA #24, at 4, 56.

In light of Defendants' record of accomplishments and results, as presented in the Annual Report and this Response, Class Members need further assurance that the promises made by Defendants to provide children and youths with SED timely access to appropriate mental health services and supports will be fulfilled after four decades. Thousands of Class Members and their families should not have to wait many more years for the relief promised by Defendants in 2015 and before.