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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

J.K., a minor by and through R.K., *et al.*, Plaintiffs v. CATHERINE EDEN, in her official capacity as Director of the Arizona Department of Health Services, *et al* Defendants	NO. CIV 91-261 TUC JMR ***AMICUS* BRIEF OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY**

The American Academy of Child and Adolescent Psychiatry ("AACAP"), through undersigned counsel, respectfully submits this *amicus curiae* brief. AACAP's interest in this proceeding stems from its role as the leading national professional medical association dedicated to treating and improving the quality of life for the millions of children, adolescents, and families affected by mental, behavioral, or developmental disorders.

INTRODUCTION

The AACAP is a national professional association of more than 6,500 child and adolescent psychiatrists. Its members are physicians who have completed a general psychiatry residency and two years additional residency training in child and adolescent psychiatry. This medical discipline is concerned with the prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and their families. The AACAP works to promote understanding of mental illnesses and to remove the stigma associated with them. The AACAP also participates in efforts to prevent mental illnesses as well as to assure proper treatment and access to services for children and adolescents.

The AACAP submits this brief to assist the court in its evaluation of the adequacy of care provided by the state of Arizona in Maricopa County, Arizona ("the state") to Medicaid-eligible

children and adolescents in need of mental health services. The AACAP has developed standards against which the services provided by the state can be measured. These standards, attached as appendices to this brief, are summarized below. AACAP professionals have also reviewed the June 2000 report prepared by Human Systems and Outcomes, Inc. ("HSO"). The HSO Report appears to be a fair application of the AACAP's standards to the services provided by the state.

ARGUMENT

I. Background

The number of children with mental disabilities continues to grow. Studies conducted by the Congressional Office of Technology Assessment estimate that mental impairment is present in 12 percent of the 63 million American children under age 18.[1] Nearly half of these 7.5 million children are considered severely disordered or handicapped by their impairment. *Id.* Among inner-city children, who are often exposed to severe social and financial deprivation, the rate of mental disability is even higher.[2] Children burdened by poverty and disability are frequently eligible for Medicaid as a consequence of their participation in other programs, such as Supplemental Security Income (SSI).

Although state participation in the Medicaid program is optional, if a state *does* elect to participate, it must comply with all provisions of the federal Medicaid statute and implementing regulations.[3] Among other things, the federal law requires state Medicaid plans to provide

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[1] **Office of Technology Assessment, Children's Mental Health: Problems and Services – A background paper (Pub. No. OTA-BP-H-33) (1986). (Bazelon – newer stats available?)**

[2] **National Institute of Medicine, Research on Children and Adolescents with Mental, Behavioral and Developmental Disorders: Mobilizing a National Initiative (1989).**

[3] ***J.K. v. Dillenberg*, 836 F.Supp. 694, 696 (D. Ariz. 1993).**

medically necessary care to eligible participants. 42 C.F.R. § 440.230(b). Federal regulations prohibit the states "from denying or reducing the amount, duration or scope of the [Medicaid] covered services ...."[4]

As part of the AACAP's goal of assuring that children and adolescents receive adequate treatment, the AACAP has published numerous "Practice Parameters" that are designed to assist clinicians with providing high quality assessment and treatment consistent with the best available scientific evidence and clinical consensus. Of particular relevance, the AACAP has issued guidance on evaluating psychiatric disorders in infants and toddlers,[5] as well as children and adolescents.[6] The Parameters are published as Official Actions of the AACAP in the *Journal of the American Academy of Child and Adolescent Psychiatry*. Among other things, the practice parameters describe the psychiatric assessment, diagnostic and treatment planning process for clinicians evaluating psychiatric disorders. The practice parameters also contain suggested approaches for conducting parent, child and other interviews as well as a checklist of issues to consider.

In addition to the practice parameters, which are targeted directly to clinicians treating individual patients, the AACAP has issued guidance designed to assist decision makers who must select managed mental health care system providers. This document, titled *Best Principles for Managed Care Medicaid RFPs* ("*Managed Care Principles*") (Exh. 3), defines principles that

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[4] ***J.K.*, 836 F.Supp. at 696.**

[5] **AACAP Official Action, *Practice Parameters for the Psychiatric Assessment of Infants and Toddlers*; J. Am. Acad. Child Adolesc. Psychiatry, 36:10 Supplement (Oct. 1997) (Exh. 1).**

[6] **AACAP Official Action, *Practice Parameters for the Psychiatric Assessment of Children and Adolescents*, J. Am. Acad. Child Adolesc. Psychiatry, 36:10 Supplement (Oct. 1997) (Exh. 2).**

should be inherent in high-quality programs. *Managed Care Principles* is intended as an aid for the drafting of Requests for Proposals ("RFPs") to solicit bids from managed care vendors. It may also serve as an *ex post* guide for evaluating the adequacy of programs already in place.

Taken together, the practice parameters and the *Managed Care Principles*, define a standard of care against which this court may assess the services provided by the state. These materials represent the collective work of dozens, if not hundreds, of mental health care professionals. Although the standards speak for themselves, the discussion below provides an introduction to, and summary of, the materials and addresses the general principles found therein.

II. Best Principles of Managed Care

The AACPA has identified ten characteristics usually found in successful mental health care delivery systems. As a general matter, effective intervention requires a comprehensive, culturally sensitive assessment that considers the weaknesses of both child and family, builds on strengths, and facilitates services in the least restrictive environment possible. Successful outcomes are usually the result of early identification and intervention and effective follow-up. An effective system is characterized by its ability to provide rapid identification and intervention, as well as its capacity to provide a full array of cross-disciplinary services, along with care providers, in partnership with the individual and family, able to customize treatment plans.

In evaluating the adequacy of the services provided by the state, the Court should consider whether the administrative structures and processes identified below are in place and actually providing necessary services. While the existence of these structures does not guarantee that children will, in fact, receive adequate services, the absence of such structures should raise serious doubts about the adequacy of care provided by the managed care vendor.

1. *Governance.* The managed care vendor should have an advisory board that includes representatives of the agencies with which it must work to deliver services. *Managed Care Principles* at 3. As the managed care vendor is responsible for delivering the necessary services through contractual agreements with all appropriate agencies, the division of responsibilities should be well-defined and agreed upon in writing by all parties. In order to assure quality of services, each agency should provide oversight of its area of responsibility. Mechanisms should be in place to assure that the vendor receives feedback from the care-administering agencies. *Id.* at 3-4.

2. *Benefit Design.* Resource allocation should be based on clinical protocols and criteria that ensure patients and families receive services in accordance with their needs. *Id.* at 5. With appropriate structure and oversight of services, benefit limits should be unnecessary. Thus, the provider should be able to demonstrate a flexible benefit design through a credentialed provider network capable of delivering a variety of specialized services tailored to children with serious emotional disturbances. *Id.*

3. *Access to Services.* Delivery systems should remove barriers that impede access to necessary services to ensure access for all individuals. Access protocols must be sufficiently flexible to ensure access by clients with varying developmental, socio-economic, geographic, and cultural needs. Specifically, children and families must have access to early intervention, prevention, family peer support and advocacy services. Furthermore, delivery mechanisms must be appropriate to client populations, communities and regions. *Id.* at 7.

4. *Care Plan Development.* Because care plan development is the basis for treatment delivery, procedures for treatment plan development must be in place that provide for the allocation of interagency responsibilities, coordination and integration of services, as well as

documentation requirements. *Id.* at 8. The initial care plan should be developed by an interdisciplinary team, including all relevant child mental health and related service professionals. Appropriate treatment plans identify problem areas and deficits of function that prevent the child and family from functioning properly. The plan must further identify appropriate interventions to address these problems, as well as the individuals and agencies responsible for each intervention. Finally, there must be procedures for regularly reviewing and revising the plan as appropriate.

5. *Triage and Assessment.* Plan development is a function of, and depends upon, proper up-front assessment. Comprehensive assessments require obtaining information from all other child-serving agencies that have been or currently are involved with the child and family. Procedures should be in place for obtaining this information. Assessments must go further, however, and consider educational history, family, and peer group issues. Assessments should utilize standardized as measures, as appropriate, and when clinically useful, but should be sufficiently flexible so as to allow for other considerations, as well.

6. *Treatment and Other Services.* Treatment and other services should be specific and targeted to the unique needs of client children and their families. Patient goals should be focused and, to the extend feasible, measurable. Standardized measures should be selected based on reliability, validity, clinical utility, programmatic feedback utility, and cultural relevance to the population being served. The vendor should have providers with demonstrably appropriate training, skills and experience. *Id.* at 11-12. Specific services should be available for so-called "high-utilizers" who require more intensive services. Criteria for access to the high utilizer track should be well-defined and based on criteria including available support systems and risk factors. *Id.* at 12.

7. *Case Management.* On-going case management involves coordination and integration of the various interventions chosen in a particular case. Case management also involves continued assessment, need determination, and the revision of services provided, as appropriate. The patient and his or her family should be participants in the case management process, with shared responsibility with professionals for utilizing and coordinating services. Providers should demonstrate the existence of qualified staff to provide case management services.

8. *Quality Assurance / Improvement.* The state Medicaid program must establish minimum quality standards and performance measures to assure proper monitoring of managed care vendors. Thus, periodic measurement, reporting, and analysis of well-defined indicators of service quality, including surveys of patent/family satisfaction with various aspects of the program, are essential. Regularly scheduled assessments of clinical and functional outcomes should be conducted, along with special analyses of negative outcomes.

9. *Provider Support Services.* The allocation of responsibilities among state health and human service agencies providing services to the Medicaid-eligible population must be well-defined and documented. Procedures for providing services outside the ordinary scope of the plan, as well as for initiating special education curricula, should be clearly delineated. The managed care vendor should take measures to streamline providers' administrative burden and paperwork.

10. *Information Management.* Collecting and reporting key data is critical to monitoring and evaluating outcome performance. The managed care vendor must maintain a comprehensive, unified clinical database on all patients or members it has served, with data fields based on the content of the unified clinical record. This database should be well-defined

and contain detailed information to assist in cost analysis, outcome evaluation, and quality assessment and improvement activities.

As articulated in *Managed Care Principles*, the above-identified factors provide a framework for evaluating the adequacy of services provided by the state in Maricopa County.

III. The Evaluation Prepared by Human Systems and Outcomes, Inc. Adheres to AACAP Guidelines

Although the Court will have to determine, as a factual matter, the adequacy and accuracy of the HSO Report, it is *amicus*' view that the Report adheres to the principles articulated in *Managed Care Principles*. Thus, the HSO Report appears to constitute a comprehensive and well-reasoned evaluation of the services provided to mentally disabled Medicaid-eligible children in Maricopa County. As explained in the Report, the evaluation team's approach consisted of five major activities:

(1) Analysis of quantitative date currently collected by the state that describes which children are receiving services, the types of problems they present with, the number and kinds of services they are receiving, from whom they are receiving services, and the cost associated with providing the services.

(2) Descriptive and qualitative analysis of how well the behavioral health system performed in serving a stratified sample of children. Each child in the sample was evaluated using a protocol for examining both child status and system performance. These reviews permitted the study team to determine whether the child was evaluated appropriately, whether a treatment plan that matched the child's needs was developed, and whether the plan was implemented and monitored. The review also considered the degree to which services were

based on family-specific considerations, including family strengths and weaknesses, preferences and cultural considerations.

(3) Individual psychiatric reviews were also conducted, including direct evaluation of the youth. Therapists, case managers and other individuals involved with the sample cases were also individually consulted. This granular evaluation permitted the researchers to determine the extent of coordination between and among direct care providers, case managers, and other involved agencies.

(4) The team also evaluated plan documentation and procedures, as well as the extent to which those plans are actually implemented. This evaluation permitted the study team to compare the state's practices with national standards and to determine the extent to which plan protocol impedes or enhances progress in individual cases.

(5) Finally, the team conducted numerous interviews with those involved in serving eligible children, including families, Regional Behavior Health Authority management and staff, vendor staff, juvenile court judges and personnel, Arizona Department of Economic Security staff, special education staff from public schools, case managers, advocates, provider network representatives, and staff of other public agencies serving client children.

This comprehensive approach to evaluating the services provided to Title XIX eligible children placed the study team in an excellent position to evaluate the adequacy of the services provided by the state. Although *amicus* is not in a position to actually endorse the HSO Report's findings and conclusions, *amicus* does conclude that the Report appears to adhere to accepted practices and procedures for conducting such evaluations.

Respectfully submitted,