STATE OF MAINE
KENNEBEC, ss

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

PAUL BATES, et al.,

Plaintiffs

v.

COMMISSIONER,
DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,

Defendants

COURT MASTER'S PROGRESS
REPORT PURSUANT TO
PARAGRAPH 299

The following report covers the period from July 31, 2018 to August 31, 2019.

Riverview Psychiatric Center

During the past year, Riverview Psychiatric Center has continued to improve in most aspects of its performance. After a series of thorough and extensive surveys conducted by Centers for Medicare and Medicaid Services, Riverview was recertified for federal funding in February. This is an important accomplishment that makes the financial future of the hospital more secure. The hard work and expertise displayed by the staff in this effort is commendable. Although the State is required to repay all of the federal funds received after the hospital was decertified in October of 2013, I understand the balance was paid in full in September and should not impact the operating budget of the hospital.

At present, the hospital is fully staffed in all aspects and operates without undue reliance on overtime or mandated shifts. For the first time in more than twenty years, the hospital has a full staff of permanent psychiatrists and psychiatric providers, as well as medical care providers,

for both inpatient and outpatient services. In the past, the hospital was forced to rely heavily upon short term *locum tenens* physicians and providers in order to maintain the applicable staffing ratios. Staff permanence and longevity contribute greatly to patient care and safety.

In May of this year, the hospital implemented a plan to enhance active treatment and require increased participation by all patients in programs offered in both the treatment mall and on the units. The effort has lowered the average length of stay and has resulted in community placements for at least two persons who have been confined in the hospital for many years. This has allowed the hospital to keep pace with admissions and utilize the limited capacity of the hospital more effectively. Admissions for the current year are on pace to exceed the past year by 20%, going from a total of 244 to a total of 285. This represents a dramatic improvement over the conditions I have described in past progress reports. As of the end of August the hospital operates at more than 90% to 95% of capacity and has only one forensic referral awaiting admission for evaluation.

In the past few years, the Department has placed three patients in a licensed facility in South Carolina as a result of the hospital's inability to safely house those patients without resorting to coercive measures that are not permitted in a licensed psychiatric hospital. One of the three patients died while out of state but a second patient has been returned to Riverview and is being successfully managed in the hospital. The remaining patient has a long history of mental illness and has displayed life threatening violence on a number of occasions. He was placed in South Carolina after inflicting serious injuries on a member of the Riverview staff. The staff member has never been able to return to work because of the extent of the injuries. The patient is monitored carefully by Riverview staff and a helpful consultation with leading experts in psychiatric pharmacology has been conducted. The goal is to return the patient to Maine if and when it can be done without jeopardizing the safety of the patient, other patients and the hospital staff.

The incidence and duration of confinement events, i.e., the use of seclusion, manual holds, mechanical restraints, and psychiatric emergencies continues to compare favorably with national standards. In August, seclusion was employed on eleven occasions, hands on hold was used on seventeen occasions, mechanical restraints on two occasions and nine psychiatric emergencies were declared. By way of comparison, during the third quarter of 2016 hands on hold was used an average of thirty four times a month and seclusion was used an average of twenty four times a months. Then as now there are spikes in the number of confinement events but they are often caused by a single patient and are now responded to more effectively, thereby reducing the duration and number of events to normal levels.

There are two developments occurring outside of Riverview that could impede continued progress: the failure of the Department to adequately address the service and housing needs of the clients of the Office of Aging and Disability Services (OADS), and any reduction of services offered by Dorothea Dix Psychiatric Center in Bangor.

1. Shortage of OADS community placement opportunities.

   In my progress report of one year ago, I reported as follows:

   > Due to changes in the resources available in the Office of Aging and Disability Services (OADS), persons with intellectual and developmental disabilities and possibly a secondary diagnosis of mental illness are being referred to both State Hospitals. It is reported that in the last year the crisis beds available to OADS for persons presenting behavioral issues have been reduced from twenty four to eight as a result of a lapsed contract and the situation has not been remedied. When these persons find their way into emergency rooms, hospitals or jails, they are often referred to Riverview or Dorothea Dix because there is no other place to house them.

Riverview has been modestly successful in warding off direct admissions of persons with a primary diagnosis of dementia or other developmental or intellectual disabilities in recent months. The consent decree specifically requires that persons with such a diagnosis be referred to other treatment settings in order to ensure that scarce mental health treatment resources are used

appropriately for persons with mental illness. Unfortunately, when such persons are without housing and services they are sometimes involved in criminal activity and, when charged and jailed, are evaluated for competence, which often results in a finding of incompetence to stand trial and admission to Riverview. Such persons may very well be incompetent but not as the result of mental illness. The net result of this back door into the mental health system is that the hospital is compelled to assume responsibility for housing and serving such persons even though it has no appropriate treatment modalities. Eventually, the hospital has to arrange for a community placement, often in a setting that is designed for persons with mental illness, thereby making it more difficult to place mental health patients who no longer require a hospital level of care. At present fifty seven persons with a history of intellectual/developmental disabilities or traumatic brain injury are residing in mental health PNMIs with co-occurring diagnoses of a mental illness (typically personality disorder, mood disorder, PTSD, anxiety disorder, or depression). It can be debated how many may have a primary diagnosis of intellectual or developmental disability as opposed to mental illness. In my judgment, however, it is beyond debate that the shortage of OADS placements is having a serious negative impact on the mental health system. There are only 692 PNMI mental health units state-wide and they are always in short supply. This increased pressure on community mental health placements frustrates the hospital's efforts to place people in the community as soon as possible and also frustrates efforts by the Courts to divert mental health patients with criminal charges from jails into appropriate community settings. Available community placements are essential to an effective Court diversion program. It is imperative that the needs of persons with developmental disabilities be addressed promptly, not only for their own benefit, but also in order not to undo the progress that the Department has made in mental health.

2. The important role of DDPC.

In recent years, Riverview has been able to keep pace with the growing demand for forensic admissions only by using DDPC as an alternate placement for forensic admissions. At various times as many as twenty to thirty forensic patients have been housed in Bangor. At this point in time, DDPC is undergoing some changes. It now has a total population of thirty patients, having temporarily reduced the number of hospital units from three to two as a result of staffing. Thirteen of the thirty patients are forensic. The administrative staff of the hospital is in a state of transition. Following the resignation of a recently appointed Superintendent, the hospital now has an acting Superintendent and a new clinical director who is a *locum tenens*. (As I finish this report, I am informed that a permanent Superintendent for DDPC has just been announced along with the appointment of an interim medical director). DDPC is an older facility and is not well suited for handling the most aggressive and acute patients. It is selective in the forensic patients that it will accept and it sometimes refers difficult cases back to Riverview. The prior administration's plan to construct and operate a new secure forensic unit has been changed and the building will now be used as another inpatient unit once it is completed. I am concerned about the potential impact that the administrative transition and diminished services at DDPC is having and may continue to have on Riverview. The number of forensic referrals ebb and flow and are highly unpredictable. (As I finish this report at the end of September, there are now seven forensic referrals on the wait list for Riverview and no empty beds on either of the forensic units). Although DDPC is not expressly covered by the Consent Decree, the Legislature in 2006 provided for limited application of the Consent Decree to the hospital. 34-B M.R.S.A. Sec. 1217. In the coming months I will monitor

the situation more carefully in order to have an informed basis for reporting on DDPC's compliance with the Consent Decree and any impact on Riverview.

There is one particular aspect of the operation of Riverview that urgently requires attention. The electronic medical record system used by the hospital is an antiquated hybrid that is difficult to use and provides poor access to information that is important to daily operations and reporting, including such vital areas as medication errors. The hospital has been advocating for a new system since at least 2014 but has been unsuccessful thus far in having a new system installed. I understand that recently a new request for proposals has been issued after a prior unsuccessful effort. This is a matter of some urgency and I would hope that all of the various offices involved in the State purchasing process would move quickly to provide Riverview and the Department with a modern system for electronic medical records similar to the systems in common use in other Maine hospitals.

Developments in Community Mental Health

In July of 2016, the Department, its counsel and counsel for the clients (the parties) and I agreed that one of the major obstacles facing the Department in attempting to bring the community mental health system into a reasonable degree of compliance with the terms of the consent decree is to assure timely access to mental health services. Because the Department delivers most services through contracts and MaineCare rules with private providers, it was agreed that improved contract management and enforcement by the Department is essential. In November of 2016, the Department presented a proposed Contract Management and Enforcement Plan which was to be supported by a computerized tool (Tableau) for gathering performance data from individual providers. As the result of a reduction in staffing, the Plan was not implemented and the Tableau for gathering performance data never progressed beyond a preliminary model. Although the

Department improved the language in contracts administered by SAMHS and allowed providers to provide reimbursable services to persons in the first thirty days while completing the eligibility assessments, those changes did not overcome the need for effective oversight and enforcement.

As a result, beginning in December of 2017, the parties and I jointly developed a statutory proposal to improve timely access to services in three discrete areas by establishing a procedure for prompt Departmental review and the possibility of a private right of action to enforce the Department's contract with the provider by the person wrongfully deprived of services. This proposed legislation was presented to the Legislature near the end of the Second Regular Session in 2018 and near the end of First Regular Session in 2019. In neither case was the bill acted upon, although introduced and supported by the Department, the Attorney General's Office, Disability Rights of Maine, and the Consumer Council of Maine. (A copy of the bill submitted in 2019, LD 1822, is attached hereto). The bill has been held over to the next session of the current Legislature. I continue to support its passage but it faces opposition from the providers of mental health services.

The most significant example of the need for improved contract management addressed in the legislative proposals relates to a long standing problem that I first described in a progress report in the following terms in 2016:

> There is one area of service, however, that chronically presents problems. When clients at Riverview no longer require hospitalization and are clinically ready for a less restrictive placement, such as a group home or supported apartment, there is often significant delay as the social workers and SAMHS' gatekeepers negotiate with community providers to accept the referral. For example, during the week of January 18, 2016, there were twelve civil clients awaiting placement after being declared clinically ready to leave the hospital. Those twelve, one quarter of the hospital's civil capacity, had been waiting anywhere from fifteen to ninety days for placement. Collectively, they represent 444 days of unnecessary hospitalization at a time when the hospital is struggling with staffing and has other clients waiting for admission. The delays in placement are sometimes occasioned by the fact that there are no vacancies, but even when placements are available unnecessary time is consumed in securing the providers

agreement to accept the referral. This practice exists in violation of the Paragraph 277 of the Consent Decree, which provides that the Department's:

> contracts with agencies for the provision of mental health services shall require the individuals or agencies to accept referrals of all class members. Once the interdisciplinary team determines that the class member requires specific services, no agency under contract with the (Department) may refuse those services except when, in the case of a residential facility, there are no vacancies, and in the case of other services, the extension of services would cause the agency to exceed pre-established staff/client ratios.

Paragraph 51 provides that agencies under contract shall be subject to sanctions for non-compliance. The enforcement of Paragraph 277 would substantially reduce the delay that Riverview experiences in placing clients in less restrictive settings once clinical readiness has been achieved. . . .

I recommended that commencing July 1, 2016, the Department enforce the provisions of Paragraph 277 and 51 for providers receiving referrals from treatment teams at Riverview for community mental health services. As my recommendation became binding, the Department included, for the first time, the language of paragraph 277 in provider's contracts. The insertion of the language alone produced little change in the wasteful referral process that had existed for at least the last twenty years. It was this experience that gave rise to the parties' discussions regarding the need for improved contract management and the presentation of LD 1822.

The wasteful and time-consuming bargaining process between Riverview and providers that I described in 2016 continues to this date and affects not only Riverview but every other hospital in Maine that refers mental health patients for community placements. There are numerous examples of this type of violation of the consent decree. In one particular case a treatment team at Riverview made seven referrals for PNMI residential services for a patient, and were refused each time for reasons other than capacity or staffing ratios. The patient's discharge from the hospital was delayed a total of sixteen months. Admittedly, this was an unusual case,

but the same wasteful practice continues to occur. At times, providers have dictated the terms of their acceptance of a referral, i.e., by insisting upon a court approved Progressive Treatment Plan prior to the commencement of service. Compliance with the Consent Decree can only be achieved if there is an efficient method for resolving disputes and enforcing the contractual obligations of providers. In FY18, State and MaineCare funded PNMI contracts accounted for $84M with daily rates averaging $450 per day and some approaching $900. To my knowledge, despite a long history of bargaining delays and refusals of service in violation of the terms of the Consent Decree, the Department has never filed an action to enforce a State funded PNMI contracts nor imposed any sanctions in at least the last sixteen years. Clearly improved contract management and enforcement is required.

Accordingly, based upon the foregoing account which I find as fact, I conclude that the Department is not in compliance with Paragraph 277 of the Settlement Agreement. Pursuant to Paragraph 298 of the Settlement Agreement, I recommend that at the next annual renewal of provider's contracts, the Department amend its standard agreement to purchase mental health services in the following respects:

Amend Rider E page 4, paragraph II (A) by adding the following:

The Provider acknowledges that it is required to accept all referrals for services from the Department and refrain from terminating services without authorization from the Department in order to insure that it provides services in a manner consistent with the Department's obligations under the "AMHI Consent Decree". (Bates vs. DHHS, Civil Action No. 89-88, Me. Superior Ct., Kennebec County). Accordingly, the Provider in consideration of the receipt of payments for services from the Department for services under this contract, hereby agrees and consents that any individual who the Department refers to the Provider for service or services, who is not

provided with that service within a reasonable time or whose service or services are terminated without authorization from the Department, shall be entitled, in addition to all other remedies provided by Law or in Equity, to specific enforcement of the Providers obligation to provide such services under the terms of this contract in a State court of competent jurisdiction. Provider acknowledges and agrees that the individuals referred for services or who are receiving services cannot be adequately compensated by monetary damages in the event of declining to accept referrals or terminating services in breach of this agreement.

The Department and Provider further agree that individuals who have been referred for services or who are receiving services are intended beneficiaries of this Contract and are to be given the benefit of performance by the Provider.

Amend Rider E page 6, paragraph 16 to read as follows:

The Provider shall accept all referrals for services provided under their contract with the Department except as provided in paragraph 277 of the Settlement Agreement portion of the AMHI Consent Decree.

Enhanced enforcement of existing Contract:

If a Provider refuses to accept a referral from the Department within 7 days of Referral from the Department, the Department shall begin enforcement actions pursuant to Rider E, Page 9 paragraph G.

If after 30 days from the date of the referral the provider has not accepted the referral from the Department, the Department will provide the Court Master and Counsel for Plaintiffs with a detailed report of the enforcement steps the Department has engaged in and the current

state of contract compliance actions with the provider, including a copy of any corrective action plan..

If after 60 days from the date of the referral the provider has not accepted the referral from the Department, the Department will provide the Court Master and Counsel for Plaintiffs with a detailed statement of the reasons why the Department's Contract Compliance measures have been unsuccessful and the measures the Department proposes to take to enforce its contract with the Provider which may include termination of the Provider's contract.

I understand that the foregoing recommendation does not apply to MaineCare funded services but rather only to those contracts that are state-funded. The Department is currently considering amendments to the MaineCare Rules that would accomplish improved compliance with Paragraph 277. I await the results of the Department's efforts.

I make this recommendation, which is only a first step, with appreciation for the fact that in the last two months, the Department's gatekeepers for PNMI services have made a serious effort to respond to refusals or delays by PNMI providers in accepting referrals. Their efforts have made a difference and demonstrate the efficacy of Departmental oversight and action. Although the effort is appreciated, it is neither adequately staffed nor funded. Such *ad hoc* responses have been tried in the past but in order to endure, the response must be systematized, data driven, and adequately supported if reasonable compliance with the Consent Decree is ever to be achieved. The hardships experienced on a daily basis by persons with severe and persistent mental illness who are unnecessarily denied timely access to needed mental health services, requires action.

Dated: October 2, 2019

Daniel E. Wathen, Court Master

129th MAINE LEGISLATURE

FIRST REGULAR SESSION-2019

Legislative Document **No. 1822**

H.P. 1299 House of Representatives, June 3, 2019

An Act To Protect Access to Services for Adults with Serious and Persistent Mental Illness

Submitted by the Department of Health and Human Services pursuant to Joint Rule 204. Reference to the Committee on Health and Human Services suggested and ordered printed.

Robert B. Hunt

ROBERT B. HUNT
Clerk

Presented by Representative GATTINE of Westbrook.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 34-B MRSA §3613 is enacted to read:

§3613. Access to services

1. Mental health services. For purposes of this section, "mental health service" includes only the following services, as described in the department's MaineCare rules or in the provider's contract with the department:

A. Assertive community treatment;

B. Behavioral health homes;

C. Community integration;

D. Community rehabilitation;

E. Crisis services, including any crisis stabilization unit;

F. Daily living support;

G. Skills development;

H. Day support;

I. Medication management; and

J. Residential treatment.

2. Department review and dispute resolution. An adult with serious and persistent mental illness, as defined in rules adopted by the department pursuant to this section, who is receiving or is eligible to receive any mental health service from a provider pursuant to a contract with the department to provide such a service may obtain upon request, with prior notice to the provider, an informal review by the department of the provider's actions under the following circumstances:

A. When a hospital's treatment or discharge planning team has determined that a mental health service is necessary for the adult with serious and persistent mental illness to transition from a hospital into the community and has made a referral to a provider under contract with the department to provide the service and the provider has refused to accept the referral in violation of the terms of the provider's contract;

B. When the adult with serious and persistent mental illness is not hospitalized and has applied for or been referred to a provider under contract with the department to provide community integration services or assertive community treatment and the provider has refused to accept the referral or application in violation of the terms of the provider's contract; or

C. When the adult with serious and persistent mental illness is receiving a mental health service and has that service terminated or suspended by a provider in violation of the terms of the provider's contract with the department to provide that service.

An adult with serious and persistent mental illness may not obtain department review of a provider's refusal to provide residential treatment if there was no vacancy or if the department did not authorize the service.

The informal review process must include an opportunity for the provider and the person requesting the review to provide relevant information to the department and for informal dispute resolution by the department to facilitate access to the service.

3. Department findings. At the conclusion of the informal review and dispute resolution process provided for in subsection 2, if access to the service has not been provided, the department shall issue written findings regarding whether the provider's action is in violation of the provider's contract with the department. These findings do not constitute final agency action as defined in Title 5, section 8002, subsection 4 and are not appealable.

4. Private right of action. An adult with serious and persistent mental illness who is aggrieved by the action of a provider as described in subsection 2 and who has not been provided access to the mental health service by the provider within a reasonable period of time in response to department review may bring a private civil action in Superior Court for declaratory and injunctive relief to enforce by restraining order or injunction, temporarily or permanently, the terms of the provider's contract with the department. The department must be notified of the action in writing prior to filing.

A. To be accepted for filing, an action filed under this subsection must be accompanied by true and accurate copies of the department's findings issued pursuant to subsection 3 and the provider's contract, both of which are admissible as evidence in the proceeding.

B. Nothing in this section may be construed to create a cause of action by the provider or the individual plaintiff against the department. The department may not be named by the provider or the individual plaintiff as a defendant, 3rd-party defendant or party in interest in an action filed under this section, but the department is not precluded from bringing an action to enforce the provider's contract with the department or moving to intervene in a private right of action under this section.

C. An individual bringing an action under this subsection is not required to allege or prove that the refusal, termination or suspension of services would cause irreparable injury or harm to that individual, but to obtain injunctive relief the individual must prove by a preponderance of the evidence that the provider's action violates the terms of the provider's contract with the department.

D. An individual bringing an action under this subsection is not required to post a bond.

E. The remedies available in an action under this subsection include both mandatory and prohibitory injunctive relief.

F. An individual who obtains injunctive relief in an action under this subsection may recover reasonable attorney's fees and costs, not to exceed $1,000, from the provider against whom judgment was entered.

G. An individual who brings an action under this subsection is not liable to the provider for damages resulting from bringing or pursuing the action unless the action was brought in bad faith or without a reasonable belief that the provider was not acting in compliance with its obligations under its contract with the department.

H. The members of an individual's hospital treatment or discharge planning team may not be compelled by subpoena to appear in person to testify in an action brought under this subsection but may submit sworn testimony by affidavit unless otherwise ordered by the court upon a showing of good cause.

I. There may be no discovery in any action filed pursuant to this subsection unless agreed to by the parties or ordered by the court upon a showing of good cause.

J. Court proceedings in any action filed pursuant to this subsection must be closed to the public unless the individual plaintiff has requested a public hearing, and the court's case file must be kept confidential and may not be released except to the department, subject to confidentiality protections, without the written permission of the individual plaintiff.

5. Rulemaking. The department shall adopt routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A governing the process for informal department review described in this section, which must include a definition of "adult with serious and persistent mental illness."

SUMMARY

This bill establishes the right of an adult with serious and persistent mental illness who is denied access to certain services by a provider contrary to the terms of the provider's contract with the Department of Health and Human Services to seek informal department review of the provider's action and informal dispute resolution by the department to facilitate access to the service. If the adult continues to be denied access to the mental health service following department review, the adult may bring a private civil action in Superior Court for injunctive relief to enforce the terms of the provider's contract with the department. The bill requires the department to adopt routine technical rules governing the process for informal department review, which must include a definition of "adult with serious and persistent mental illness."