UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

ROSIE D., ***et al.,*** **Plaintiffs,** **v.** **DEVAL PATRICK,** ***et al.,*** **Defendants.**	**CIVIL ACTION NO. 01-30199-MAP**

REPORT ON IMPLEMENTATION

The Defendants hereby submit this Report on Implementation ("Report") pursuant to paragraphs 37(c)(i), 38(d)(i), 39(c)(i), and 47(b) of the Judgment dated July 16, 2007 in the above-captioned case ("Judgment").

This Report details the steps that the Defendants have taken since the last Report on Implementation, submitted to the Court on December 7, 2009, to implement the tasks in Projects One through Four in the Judgment. For this purpose, the Defendants construe Projects One through Four to include all tasks described in paragraphs 2 through 46 of the Judgment.

Taking paragraphs 2 through 46 of the Judgment in turn, the Defendants hereby report activity since December 7, 2009, as follows:

Paragraph 2*: As set forth below, the Defendants will improve their methods for notifying Medicaid-eligible individuals enrolled in MassHealth ("MassHealth Members" or "Members"), MassHealth providers, public and private child-serving agencies, and other interested parties about the availability of behavioral health services, including the services described in Section I.D. below, and behavioral health screenings in primary care settings.*

This paragraph is introductory; see detailed response below.

***Paragraph 3**: The Defendants will inform all EPSDT-eligible MassHealth Members (Members under age 21 enrolled in MassHealth Standard or CommonHealth) and their families about the availability of EPSDT services (including services focused on the needs of children with SED) and the enhanced availability of screening services and Intensive Care Coordination as soon as the EPSDT-eligible child is enrolled in MassHealth.*

As previously reported, MassHealth mails notices to MassHealth members under the age of 21 who are enrolled in MassHealth Standard or CommonHealth (1) when they are first enrolled in MassHealth; (2) when members are reenrolled in MassHealth after any break in MassHealth coverage; and (3) annually, on or around the member's birthday. The notice informs members about preventive health-care services, including EPSDT services, as well as the availability of the new behavioral health services. The most recent version of the notices, in place since April, 2010, includes additional detail about CANS assessments and lists the new MassHealth behavioral health services.

***Paragraph 4**: The Defendants will take steps to publicize the program improvements they are required to take under the terms of this Judgment to eligible MassHealth Members (including newly-eligible MassHealth Members), MassHealth providers, and the general public. As part of this effort, the Defendants will take the actions described below and will also provide intensive training to MassHealth customer service representatives, including updating scripts used by such representatives to facilitate timely and accurate responses to inquiries about the program improvements described in this Judgment*

MassHealth and EOHHS staff are working with MassHealth's Customer Service Contractor to review and, as necessary, update, training and resource materials related to the improvements pursuant to this Judgment.

MassHealth's Managed Care Contractors regularly update the training and resource materials used in their customer service departments.

Further steps that EOHHS has taken and will take to publicize the program improvements to eligible MassHealth members, providers, and the general public are described in the paragraphs below.

***Paragraph 5*: MassHealth Members - The Defendants will take the following actions to educate MassHealth Members about the program improvements they are required to take under the terms of this Judgment:**

a) Updating and distributing EPSDT notices to specifically refer to the availability of behavioral health screening and services and to describe other program improvements set forth in this Judgment.

See the response to paragraph 3 above.

b) Updating and distributing (in the normal course of communications with MassHealth Members) Member education materials, including Member handbooks created by MassHealth and MassHealth's contracted managed care entities, to include description of these improvements, and how to access behavioral health screenings and services including the home-based services described in Section I.D.

Appropriate Member education materials have previously been amended to include descriptions of the improvements under this Judgment, including how to access behavioral health screenings and services.

c) Amending Member regulations, as necessary, to describe the services described in Sections I.C. and D. below and other program improvements.

Reported complete in prior report or reports..

d) Participating in public programs, panels, and meetings with public agencies and with private advocacy organizations, such as PAL, the Federation for Parents of Children with Special Needs and others, whose membership includes MassHealth-eligible children and families.

Since the December 7, 2009 Report on Implementation, the Compliance Coordinator or her Assistant Director has held or participated in the following forums and meetings:

December 15, 2009 – Presentation to the Mental Health Coalition of the Massachusetts' Chapter of the National Association of Social Workers

January 13, 2010 – Presentation to the Manville School Parent Support Group, Judge Baker Children's Center

February 25, 2010 – Middlesex District Attorney's Office, Woburn

March 25, 2010 – Panel at Salem State College School of Social Work

May 5, 2010 – Massachusetts Continuing Legal Education, Delinquency and Child Welfare Law Conference, Boston

May 7, 2010 - Massachusetts Continuing Legal Education, School Law Conference, Boston

Paragraph 6: MassHealth Providers – The Defendants will take the following actions to educate MassHealth providers about the program improvements they are required to take under the terms of this Judgment.

a. Updating EPSDT regulations to reflect the program improvements described in this Judgment.

Reported complete in prior report or reports.

b. Updating Appendix W of the MassHealth Provider Manual, which describes medical protocols and periodicity schedules for EPSDT services, to reflect the program improvements related to screenings for behavioral health described in Section I.A.2 below.

Reported complete in prior report or reports.

The Defendants have updated the Primary Care Behavioral Health Screening Toolkit[1] for the Massachusetts Children's Behavioral Health Initiative (CBHI), to reflect the addition of the Strengths and Difficulties Questionnaires (SDQ). The updated Toolkit was made available to providers in April, 2010 and has been posted on www.Mass.gov/MassHealth/Childbehavioralhealth.

c. Drafting and distributing special provider communications related to the program improvements described in this Judgment, including how to assist MassHealth Members to access the home-based services described in Section I.D.

For more information on provider communications regarding screening, see the response to paragraph 10.

For more information on provider communications regarding assessments using the CANS tool, see the response to paragraphs 14-16.

The brochure for families, "Worried About the Way Your Child is Acting or Feeling?" and the companion "Briefing Guide" for staff, were released on May 7, 2010. The Defendants produced the Brochure in five regional versions, listing contact information for providers of Mobile Crisis Intervention, In Home Therapy and Intensive Care Coordination in that region. The Briefing Guide is intended to give the wide range of staff who come into contact with

[1] The Toolkit was developed and revised by experts in pediatric and adolescent behavioral health screening who worked for the Massachusetts Behavioral Health Partnership in 2008 and 2009 as Screening Tool Consultants. The Screening Tool Consultants conceived of the Toolkit out of their experience providing telephonic and onsite technical assistance to primary care providers implementing standardized behavioral health screening. It is a comprehensive guide to behavioral health screening in primary care, providing in-depth guidance on topics such as: "Implementation Steps for Office Staff", "Clinical Issues Related to Behavioral Health Screening", "Billing for Behavioral Health Screening". It also includes extensive materials on the five most commonly used and most broadly applicable MassHealth-approved screening tools.

MassHealth Members or prospective MassHealth Members the information they need to inform caregivers of the behavioral health services available for members under 21, and how to access them. This group includes staff such as: school personnel, health center staff, Primary Care Clinicians, Court staff, child care providers, Early Intervention program staff, behavioral health providers and staff of community and family organizations.

EOHHS Secretary JudyAnn Bigby announced the availability of these materials via email to over 2,000 organizations, networks and individuals. The Brochure is available to order free of charge in bundles of 50, and ordering information was included in the announcement and can be found on the Defendants' website. The Briefing Guide was distributed in electronic form in the email and is available to be downloaded from the website.

d. Updating and distributing existing provider education materials to reflect the program improvements described in this Judgment.

1. PCC Plan Provider Newsletters – The PCC Plan Provider Newsletter is the provider newsletter for PCC Plan providers. Since the December 7, 2009 Court report, the PCC Plan newsletter has included articles titled "In-Home Therapy for Children and Youth" and "Behavioral Health Screening Tool Updates" in the Spring 2010 newsletter.
2. MassHealth's Managed Care Organization's (MCO's) Newsletters – Each MassHealth MCO has published articles in its respective provider newsletter regarding program improvements. Since the December 7, 2009 Court report: Boston Medical Center has included an article entitled "Behavioral Health Screening Required as Part of EPSDT" and Network Health published an article entitled "Behavioral Health Screening for Your

Younger Patients" in their provider newsletters. Each MCO also maintains a website that includes relevant CBHI information for their providers.

e. Expanding distribution points of existing materials regarding EPSDT generally, including the program improvements described in this Judgment.

As previously reported, the Defendants established a website for the Children's Behavioral Health Initiative (CBHI) that is available on the EOHHS website to provide information to MassHealth providers, MassHealth members, the broader community of human service providers, and members of the general public about EPSDT generally and the program improvements that the Defendants are making in response to the Judgment. This website is frequently updated.

The Defendants also maintain an extensive and growing email distribution list and regularly distribute implementation updates to this list.

See the response to Paragraph 6(c), above.

f. Implementing any other operational changes required to implement the program improvements described in this Judgment.

No new operational changes have been necessary since the last report.

g. Holding special forums for providers to encourage clinical performance activities consistent with the principles and goals of this Judgment.

Meetings with Human Services and Behavioral Health Providers Regarding CANS Assessments and Remedy Services

The Defendants continue to meet with providers in person and by conference call to support skillful use of the Child and Adolescent Needs and Strengths tool in the clinical assessment

process in treatment planning and to track clinical progress. Beginning in September, 2009, the Defendants initiated a series of conference calls and face-to-face meetings designed to facilitate a provider Community of CANS Practice, by sharing best practices identified by the Commonwealth as well as by providers. The first call was held on September 18, followed by meetings in October, November, January, March, April and May. The Defendants anticipate that further calls and meetings will take place throughout 2010. Staff of the UMass CANS Training Program are identifying and documenting best practices culled from these calls and meetings, to be disseminated to CANS assessors.

The Defendants launched a new e-newsletter, known as, "CANSNews", in February, 2010. CANSNews is published quarterly and is a means by which the Defendants can disseminate news and provide resources to support the use of the CANS.

The Defendants plan to continue regular provider conference calls for technical support, to encourage effective use of the CANS tool and the CANS Application. There were calls twice in February and once in April and May. As long as providers find these calls useful, the Defendants will continue them, approximately monthly, throughout 2010.

List of CANS-Related Meetings:

January 6, 2010 – CANS Community of Practice Meeting, North Grafton

January 7, 2010 – Meeting with the Children's Mental Health Committee of the Association for Behavioral Healthcare, regarding CANS implementation

February 5, 2010 – CANS Technical Assistance Conference Call

February 16, 2010 – Meeting with clinical staff of Children's Hospital Medical Center Psychiatric Inpatient Unit

February 26, 2010 – CANS Technical Assistance Conference Call

March 15, 2010 – MetroWest Hospital, Children's Psychiatric Inpatient Unit, Natick

March 31, 2010 – CANS Community of Practice meeting, Boston

April 16, 2010 – CANS Technical Assistance Conference Call

April 28, 2010 – CANS Community of Practice meeting, North Grafton

May 14, 2010 – CANS Technical Assistance Conference Call

May 19, 2010 – CANS Community of Practice meeting, Pittsfield

Meetings with Human Services and Behavioral Health Providers Regarding Implementation of the Remedy Services

MassHealth's contracted health plans are sponsoring two Outpatient Provider Forums on June 2 in Worcester and June 11 in Newton. The purpose of these Provider Forums is to provide Outpatient Therapy providers with information about: the remedy services, High-Fidelity Wraparound, the CANS tool in practice, and the responsibilities of outpatient providers as one of three clinical service hubs (in addition to In Home Therapy and Intensive Care Coordination) through which youth and families can access In-Home Behavioral Services and Therapeutic Mentoring. In addition, the Outpatient Provider Forums attract Social Workers, Mental Health Counselors and Marriage and Family Therapists, who are eligible for Free Continuing Education Units for their participation.

The MassHealth Office of Behavioral Health holds regular meetings with relevant provider trade associations. This includes a monthly meeting with the Association of Behavioral Healthcare and regularly scheduled meeting times with the National Alliance on Mental Illness (NAMI) and Parent/Professional Advocacy League.

The MCEs meet monthly with a group of provider stakeholders, consisting of a group of providers delivering CBHI services from across the state, representatives from the Association for Behavioral Healthcare, and MassHealth. The purpose of this group is to work collaboratively to identify areas of strength and need, and to brainstorm options and develop creative and mutually agreeable strategies to address issues and improve the system. The first meeting occurred on November 3, 2009, and a second meeting occurred on December 1, 2009.

h. Amending MassHealth's managed care contracts to assure that all such entities educate the providers in their network about the program improvements described in this Judgment, as described in Paragraphs 6.a.-g. above.

Reported complete in prior report or reports..

i. Coordinating these efforts with the "Virtual Gateway," which is the EOHHS system for web-based, online access to programs, including MassHealth and related benefit programs such as food stamps, and which allows a wide array of hospitals, community health centers, health and human services providers, and other entities to assist children and families in enrolling in MassHealth.

Coordination meetings occur biweekly with the Virtual Gateway, Office of Behavioral Health, and the Office of the Compliance Coordinator, focusing primarily on supporting the CBHI CANS application. For additional information about the CBHI CANS Application, please refer to the response to Paragraph 39.b.

***Paragraph 7: The Public - To improve public information about the program improvements the Defendants are required to take under the terms of this Judgment, the Defendants will take the following actions to present the terms of this Judgment to public and private agencies that serve children and families*:**

a) Presenting the Judgment to appropriate Commonwealth officials in the Executive Branch and the Legislature.

Reported complete in prior report or reports.

b) Creating new pamphlets, informational booklets, fact sheets, and other outreach materials describing these improvements.

See the response to Paragraph 6(c), above.

c) Developing and implementing training programs for line staff at the Departments of Mental Health, Social Services, Youth Services, Mental Retardation, Transitional Assistance, and the Office for Refugees and Immigrants on how to access MassHealth services for children with SED.

As reported previously, the Defendants have finalized protocols and delivered trainings for: the Department of Children and Families, the Department of Developmental Services, the Department of Mental Health, the Department of Public Health – Bureau of Substance Abuse Services, the Department of Public Health – School Based Health Centers, the Department of Youth Services and the Office for Refugees and Immigrants.

The Defendants have finalized protocols for the Department of Public Health – Early Intervention Providers. Trainings for EI providers and DPH EI staff are being scheduled. After extensive consultation with the Department of Transitional Assistance, the Defendants drafted protocols, which DTA staff are reviewing. The Compliance Coordinator presented on CBHI to DTA statewide managers at their May 13, 2010 meeting. The presentation provided an overview of the Remedy and the new MassHealth Behavioral Health services and an introduction to the concept of CBHI Protocols and the plans for staff training in September.

The remaining protocols to be completed include those for the Massachusetts Rehabilitation Commission, the Commission for the Blind and the Commission for the Deaf and Hard of Hearing.

d. Distributing outreach materials in primary care settings, community health centers, and community mental health centers and posting electronic materials on the EOHHS Virtual Gateway that are designed to provide information to MassHealth Members and to public and private agencies that come in contact with or serve children with SED or their families.

See the response to Paragraph 6(c), above.

e. Working with the Department of Early Education and Care to educate preschools, childcare centers and Head Start Programs on how to access MassHealth services for children with SED.

See the response to Paragraph 6(c), above.

f. Working with the Department of Education, the Department of Public Health and Public School Districts to educate school nurses and other school personnel on how to access MassHealth services for children with SED.

Based on recommendations of the CBHI Pre K-12 Advisory committee convened by the Defendants, the Executive Office of Education and the Departments of Early Education and Care (DEEC) and Elementary and Secondary Education (DESE), the Defendants organized a series of briefings for school staff in a variety of locations around the state. These meetings have been supported by the Department of Elementary and Secondary Education and have been hosted by school districts and Special Education Collaboratives. At these meetings, the Defendants provide attendees with copies of a power point presentation describing the remedy, the services, the means by which children and youth can obtain the services, as well as the appropriate regional Family Brochure, listing providers of Mobile Crisis Intervention, In-Home Therapy and Intensive Care Coordination.

Briefings held since the December 7, 2009 Report on Implementation:

January 20, 2010 – CBHI School Briefing, Hyannis

February 3, 2010 - CBHI School Briefing, CAPS Education Collaborative, Orange

February 5, 2010 – CBHI School Briefing, Hampshire Educational Collaborative, Northampton

April 7, 2010 - CBHI School Briefing, Pittsfield

April 12, 2010 - CBHI School Briefing, North River Collaborative, Rockland

May 3, 2010 – Meeting with leadership of the Department of Public Health's School Nursing program to plan new activities for informing school nurses of MassHealth program enhancements.

May 12, 2010 - CBHI School Briefing, Lawrence

Paragraph 8: ***The Defendants will require primary care providers who perform periodic and medically necessary inter-periodic screenings pursuant to 42 U.S.C. §1395d(r)(1) to select from a menu of standardized behavioral health screening tools. The menu of standardized tools will include, but not be limited to, the Pediatric Symptom Checklist (PSC) and the Parents' Evaluation of Developmental Status (PEDS). Where additional screening tools may be needed, for instance to screen for autistic conditions, depression or substance abuse, primary care providers will use their best clinical judgment to determine which of the approved tools are appropriate for use***.

Completed. As described in paragraph 6.b., the menu of approved behavioral health screening tools has recently been updated.

Paragraph 9: The Defendants will amend pertinent MassHealth provider regulations to clarify that all primary care providers, whether they are paid through the managed-care or the fee-for-service system, are required to provide periodic and inter-periodic screens.

Completed. See response to Paragraph 8.

Paragraph 10: There will be a renewed emphasis on screening, combined with ongoing training opportunities for providers and quality improvement initiatives directed at informing primary care providers about the most effective use of approved screening tools, how to evaluate behavioral health information gathered in the screening, and most particularly how and where to make referrals for follow-up behavioral health clinical assessment. Additional

quality improvement initiatives will include improved tracking of delivered screenings and of utilization of services delivered by pediatricians or other medical providers or behavioral health providers following a screening and use of data collected to help improve delivery of EPSDT screening, including assuring that providers offer behavioral health screenings according to the State's periodicity schedule and more often as requested (described in Section I.E.2).

Screening Data

In the December 7, 2009 Report on Implementation, the Defendants reported screening data for the period April 1, 2009 through June 30, 2009 on children and youth served through two of MassHealth's three service delivery systems: MassHealth's Fee-For-Service Program and Primary Care Clinician Program. The report did not include data for this period from MassHealth's third service delivery system, its Managed Care Program, due to a technical difficulty that impeded the transfer of data files from MassHealth's Managed Care Contractors into the new MassHealth information management system. The systems issue has been resolved, and data files from four of the five Managed Care Contractors have been transferred into MassHealth's system. However, data from MassHealth's smallest Managed Care Contractor, Fallon Community Health Plan, is not yet available, due to data quality concerns that MassHealth is working to resolve.

This report presents data from these updated sources for the quarter previously reported on, April-June, 2009, as well for the quarters July-September, 2009 and October-December, 2009. [2]

For the period April 1 through December 31, 2009 the number of well-child visits, behavioral health screens and the percentage of positive screens were:

[2] 18,902 claims (approximately 2% of all claims) for behavioral health screens lacked provider zip codes, and cannot be tracked to a geographical region. As a result, the Defendants include data on these claims in the state-wide figures, but not in the report of data by geographic region.

Quarter	# of well-child visits	# of screens	% of visits w/ screens	# screens w/billing modifier	% BH need identified	% of claims w/o billing modifier
Apr-Jun 2009	114,000	62,706	55.0%	53,137	9.6%	17.3%
Jul-Sept 2009	132,026	77,168	58.5%	65,038	8.4%	17.7%
Oct-Dec 2009	116,438	67,529	58.0%	57,841	8.0%	16.8%

For the period April 1 through December 31, 2009, the number of behavioral health screens performed during a well-child visit, presented as a percentage of the number of well-child visits, *by MassHealth program*, are as follows:

MassHealth Plan	Apr– Jun 2009	Jul-Sept 2009	Oct– Dec 2009
Fee For Service	43.7%	48.7%	47.4%
Primary Care Clinician	60.7%	62.32%	60.8%
MCO	55.6%	59.8%	60.2%
TOTAL ACROSS PLANS	55.1%	58.5%	58.0%

As has been reported previously, screening rates vary by age:

Age Group	Apr– Jun 2009	Jul-Sept 2009	Oct– Dec 2009
< 6 months	28.4%	31.6%	33.7%
6 months through 2 years	59.3%	63.1%	62.8%
3 through 6 years	66.2%	68.0%	67.8%
7 through 12 years	69.1%	69.9%	70.3%
13 through 17 years	61.9%	65.8%	64.1%
18 through 20 years	27.1%	31.3%	28.6%

Quality Improvement Activities

MassHealth has formed a new committee to coordinate quality improvement (QI) activities related to behavioral health screening. The CBHI BH Screening QI Committee reviews

screening data, prioritizes areas for improvement and coordinates quality improvement activities across MassHealth's three service delivery systems: Fee-For-Service, Primary Care Clinician and Managed Care Organizations. The Committee is in the process of selecting QI priorities for State Fiscal Year 2011. These QI projects, while not final, will include efforts to increase the screening rate for youth ages 18 through 20.

Referral Information for PCCs

The Defendants have ensured that the CBHI Family brochure, [3]and the Guide for Staff, described in Paragraph 6.d, has been electronically distributed to PCCs through the MCEs and various medical associations and guilds, and that the documents appear on the CBHI websites.

Paragraph 11: ***MassHealth will continue the practice of not requiring a primary care visit or EPSDT screening as a prerequisite for an eligible child to receive MassHealth behavioral health services. MassHealth-eligible children and eligible family members can be referred or can self-refer for Medicaid services at any time by other, including other EOHHS agencies, state agencies, public schools, community health centers, hospitals and community mental health providers.***

As previously reported, the Defendants do not plan to change their policy that all MassHealth members, regardless of their managed care enrollment status, may use behavioral health services without the need for a referral as a prerequisite for payment for services. This information is included in the Defendants' written educational materials and presentations to family organizations, providers, school and state agency staff and other interested parties.

Paragraph 12: ***The Defendants will provide information, outreach and training activities, focused on such other agencies and providers. In addition, the Defendants will develop and distribute written guidance that establishes protocols for referrals for behavioral health EPSDT screenings, assessments, and services, including the home-based services described in Section I.D., and will work with EOHHS agencies and other providers to enhance the capacity of their staff to connect children with SED and their families to behavioral health EPSDT screenings, assessments, and medically necessary services.***

[3] Along with brochure ordering information.

See response to paragraphs 6(c) and 7(c) above.

Paragraph 13: ***The Defendants will ensure that EPSDT services include a clinical assessment process for eligible children who may need behavioral health services, and will connect those assessments to a treatment planning process as follows:***

This paragraph is introductory; see detailed response below.

Paragraph 14: ***The Defendants will require a clinical behavioral health assessment in the circumstances described below by licensed clinicians and other appropriately trained and credentialed professionals.***

Completed. The steps that the Defendants are taking to support compliance with this requirement are described in response to paragraph 16.b. below.

Paragraph 15: ***In addition to the clinical assessment, the Defendants will require providers to use the standardized clinical information collection tool known as the Child and Adolescent Needs and Strengths (CANS) as an information integration and decision support tool to help clinicians and other staff in collaboration with families identify and assess a child's behavioral health needs. Information obtained through the CANS process provides a profile of the child which trained clinicians use in conjunction with their clinical judgment and expertise to inform treatment planning and to ensure that treatment addresses identified needs.***

Completed. The steps that the Defendants are taking to support compliance with this requirement are described in response to paragraph 16.b. below.

Paragraph 16: ***The Defendants will implement an assessment process that meets the following description:***

a. In most instances, the assessment process will be initiated when a child presents for treatment to a MassHealth behavioral health clinician following a referral by the child's primary care physician based on the results of a behavioral health screening. However, there are other ways for children to be referred for mental health services. A parent may make a request for mental health services and assessment directly to a MassHealth-enrolled mental health provider, with or without a referral. A child may also be referred for assessment and services by a provider, a state agency, or a school that comes into contact with a child and identifies a potential behavioral health need.

b. Assessment typically commences with a clinical intake process. As noted, Defendants will require MassHealth providers to use the CANS as a standardized tool to organize information gathered during the assessment process. Defendants will require trained MassHealth behavioral health providers to offer a clinical assessment to each child who appears for treatment, including a diagnostic evaluation from a licensed clinician.

Completed. The additional steps that the Defendants are taking to support ongoing use of the CANS are as follows:

To ensure proper use of the CANS, the Defendants ensure that providers of behavioral health services serving MassHealth enrolled children and youth under 21 who use the CANS are certified in the use of the CANS tool. To be certified, clinicians are required to pass a certification examination that has been approved by John Lyons, PhD, the developer of the CANS. Clinicians who fail to attain a passing score have the opportunity to retake the certification examination. Recertification is required every two years. The Defendants provide in-person and online CANS training free of charge. Certification is also free.

The first wave of clinicians who became certified in 2008 became due for recertification, beginning in May 2010. In consultation with Dr. Lyons, the UMass CANS Training team redesigned the CANS online training and the CANS certification examination, with the goal of increasing the effectiveness of the training and the accuracy of the examination. These changes have been completed and implemented in time for recertification of currently certified clinicians.

MassHealth's Managed Care Contractors began reviewing CANS compliance among providers in early 2010, starting with providers of Intensive Care Coordination. They will

continue compliance monitoring and management, prioritizing CANS use in the new home and community based services in 2010.

Other activities to support high quality use of the CANS are described in Paragraph 6.f.

c. The assessment process leads to a clinical diagnosis and the commencement of treatment planning. During the assessment process, medically necessary services are available to the child, including, but not limited to, crisis services and short-term home based services, pending completion of the assessment and the development of the treatment plan.

Completed.

d. As described in more detail in Section I.C. below, upon referral to the Intensive Care Coordination process, an intensive, home-based assessment and treatment planning process will take place, organized by a care manager and with the involvement of the child's family and other community supports.

Providers of Intensive Care Coordination are required to utilize the CANS tool as part of the intensive home-based assessment and treatment planning process. This process is described in the ICC Operations Manual. In addition, the Defendants have contracted with Vroon Vandenberg staff to train and coach ICC providers in the intensive home-based assessment and treatment planning process used in High Fidelity Wraparound, known as the "Strengths and Needs Discovery" process.

e. The assessment process described here, including the use of the CANS where appropriate, will be required as part of discharge planning for children who have been identified as having behavioral health problems who are being discharged from acute inpatient hospitals, community based acute treatment settings (CBATS), from Department of Mental Health (DMH) intensive residential settings, and DMH continuing care programs, with the goal of identifying children for whom Intensive Care Coordination services may be appropriate. For those identified children, a referral for those services will be a component of a discharge treatment plan.

Reported complete in prior report or reports.

As noted in paragraph 6.f., the Defendants have conducted several technical assistance visits with staff of psychiatric inpatient units serving children or youth.

***Paragraph 17*: Deleted.**

***Paragraph 18*: Deleted.**

***Paragraph 19:* The Defendants will provide Intensive Care Coordination to children who qualify based on the criteria set forth above and who choose to have Intensive Care Coordination including a Care Manager, who facilitates an individualized, child-centered, family focused care planning team, as follows:**

This paragraph is introductory; see detailed response below.

***Paragraph 20:* The role of the Care Manager is to coordinate multiple services that are delivered in a therapeutic manner, allowing the child to receive services in accordance with his or her changing needs. Additionally, the Care Manager is responsible for promoting integrated services, with links between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.**

See response to paragraph 38 below.

***Paragraph 21:* The basic responsibilities of Care Managers are: (1) assisting in the identification of other members of the care planning team; (2) facilitating the care planning team in identifying the strengths of the child and family, as well as any community supports and other resources; (3) convening, coordinating, and communicating with the care planning team; (4) working directly with the child and family; (5) collecting background information and plans from other agencies, subject to the need to obtained informed consent; (6) preparing, monitoring, and modifying the individualized care plan in concert with the care planning team; (7) coordinating the delivery of available services; (8) collaborating with other caregivers on the child and family's behalf; and (9) facilitating transition planning, including planning for aftercare or alternative supports when in-home support services are no longer needed.**

See response to paragraph 38 below.

***Paragraph 22:* The Care Manager will either be a licensed mental health professional or will provide care management under the supervision of a licensed mental health professional. S/he will be trained in the "wraparound" process for providing care within a System of Care. The "wraparound process" refers to a planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child to achieve a positive set of outcomes. The System of Care is a cross-system coordinated network of services and supports organized to address the complex and changing needs of the child. This process will be consistent with the principles and values of the Child-Adolescent Services System Program (CASSP) which encourages care provision to be strength-based,**

individualized, child-centered, family-focused, community-based, multi-system, and culturally competent.

See response to paragraph 38 below.

Paragraph 23: ***The care planning team will be family-centered and include a variety of interested persons and entities, as appropriate, such as family members (defined as any biological, kinship, foster and/or adoptive family member responsible for the care of the child), providers, case managers from other state agencies when a child has such involvement, and natural supports such as neighbors, friends, and clergy.***

See response to paragraph 38 below.

Paragraph 24: ***The care planning team will use multiple tools, including a CANS standardized instrument, in conjunction with a comprehensive psychosocial assessment, as well as other clinical diagnoses, to organize and guide the development of an individualized plan of care that most effectively meets the child's needs. This plan of care will be reviewed periodically and will be updated, as needed, to reflect the changing needs of the child. As part of this process, further assessments, including re-assessments using the CANS or other tools, may be conducted so that the changing needs of the child can be identified.***

See response to paragraph 38 below.

Paragraph 25:
The care planning team will exercise the authority to identify and arrange for all medically necessary services needed by the eligible child with SED, consistent with the overall authority of MassHealth to establish reasonable medical necessity criteria, set reasonable standards for prior authorization, and conduct other utilization management activities authorized under the Medicaid Act, and the obligation of all direct service providers to assure that the services they deliver are medically necessary.

See response to paragraph 38 below.

Paragraph 26: ***The findings of the care planning team will be used to guide the treatment planning process. The individualized care plan is the primary coordinating tool for therapeutic interventions and service planning. The care planning team, facilitated by the Care Manager, will be responsible for developing and updating, as needed, the individualized care plan that supports the strengths, needs, and goals of the child and family and incorporating information collected through initial and subsequent assessment. The individualized care plan will also include transition or discharge plans specific to the child's needs.***

See response to paragraph 38 below.

Paragraph 27: ***The care and treatment planning process will be undertaken pursuant to guidelines and standards developed by EOHHS, which will ensure that the process is methodologically consistent and appropriately individualized to meet the needs of the child***

and family. EOHHS, in consultation with DMH, will develop an operational manual that includes these guidelines and standards for the use of the care planning teams.

Reported complete in prior report or reports.

The Defendants, through their contracted health plans, will issue an updated CSA Operations Manual in June, 2010.

Paragraph 28: ***Each individualized care plan will: (1) describe the child's strengths and needs; (2) propose treatment goals, objectives, and timetables for achieving these goals and objectives, including moving to less intensive levels of service; (3) set forth the specific services that will be provided to the child, including the frequency and intensity of each service; (4) incorporate the child and family's crisis plan; and (5) identify the providers of services.***

See response to paragraph 38 below.

Paragraph 29: ***Individualized care plans will be reviewed as needed, but at least monthly by the Care Manager and quarterly by the care planning team. In addition, such review will be undertaken when there is a change in another EOHHS agency's plan for the child.***

See response to paragraph 38 below.

Paragraph 30: ***Intensive care coordination services are particularly critical for children who are receiving services from EOHHS agencies in addition to MassHealth. In order to assure the success of the care planning team process and the individualized care plan for a child with multiple agency involvement, EOHHS will ensure that a representative of each such EOHHS agency will be a part of the child's care planning team. Operating pursuant to protocols developed by EOHHS, EOHHS agency representatives will coordinate any agency-specific planning process or the content of an agency-specific treatment plan as members of the care planning team. EOHHS will develop a conflict-resolution process for resolving disagreements among members of the team.***

See the response to Paragraph 7.

In 2009, the Defendants and the Plaintiffs developed a conflict-resolution process for resolving disagreements among members of ICC care planning teams.

Paragraph 31: ***For MassHealth Members entitled to EPSDT services, the Defendants will cover the following services for Members who have SED when such services are medically necessary, subject to the availability of Federal Financial Participation ("FFP") under 42 U.S.C. § 1396d(a) and other requisite federal approvals: assessments, including the CANS described in Section I.B above, the Intensive Care Coordination and Treatment Planning described in Section I.C above, and the services described in more detail below in this Section***

I.D. More detailed service descriptions will be developed later to assist in establishing billing codes, procedures and rates, and may be necessary or advisable for the process of seeking CMS approval of these services. EOHHS, in consultation with DMH, will collaborate with interested stakeholders (including clinical experts, child and family advocates, and managed care partners) in the development of clinical criteria for each of the covered services below.

See response to paragraph 38 below.

Paragraph 32: ***The components of this service category will include Mobile Crisis Intervention and Crisis Stabilization:***

a. Mobile Crisis Intervention - A mobile, on-site, face-to-face therapeutic response to a child experiencing a mental health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation in community settings (including the child's home) and reducing the immediate risk of danger to the child or others. Mobile crisis services may be provided by a single professional crisis worker or by a team of professionals trained in crisis intervention. Services are available 24 hours a day, 7 days a week. Phone contact and consultation may be provided as part of the intervention. Providers are qualified licensed clinicians or, in limited circumstances, qualified paraprofessionals supervised by qualified, licensed clinicians.

See response to paragraph 38 below.

b. Crisis Stabilization - Services designed to prevent or ameliorate a crisis that may otherwise result in a child being hospitalized or placed outside the home as a result of the acuity of the child's mental health condition. Crisis stabilization staff observe, monitor, and treat the child, as well as teach, support, and assist the parent or caretaker to better understand and manage behavior that has resulted in current or previous crisis situations. Crisis stabilization staff can observe and treat a child in his/her natural setting or in another community setting that provides crisis services, usually for 24-72 hours but up to 7 days. Crisis stabilization staff are qualified licensed clinicians and qualified paraprofessionals supervised by qualified licensed clinicians. Crisis stabilization in a community setting is provided by crisis stabilization staff in a setting other than a hospital or a Psychiatric Residential Treatment Facility (PRTF) and includes room and board costs.

See response to paragraph 38 below.

Paragraph 33: ***The components of this service category are In-Home Behavioral Services (including behavior management therapy and behavior management monitoring), In-Home Therapy Services (including a therapeutic clinical intervention and ongoing training and therapeutic support), and Mentor Services (including independent living skills mentors and child/family support mentors). While the services in this category may be provided where clinically appropriate, it is intended that they be provided in any setting where the child is naturally located, including, but not limited to, the home (including foster homes and therapeutic foster homes), child-care centers, respite settings, and other community settings.***

These services may be provided as a bundled service by a team or as a discrete clinical intervention depending upon the service needs of the child.

See response to paragraph 38 below.

a. In-home Behavioral Services - Behavioral services usually include a combination of behavior management therapy and behavior management monitoring, as follows:

(i) Behavior management therapy is provided by a trained professional, who assesses, treats, supervises, and coordinates interventions to address specific behavioral objectives or performance. Behavior management therapy addresses challenging behaviors which interfere with the child's successful functioning. The therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, that are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and the level of intervention required. Behavior management therapy is provided by qualified licensed clinicians.

(ii) Behavior management monitoring is provided by a trained behavioral aide, who implements and monitors specific behavioral objectives and interventions developed by the behavior management therapist. The aide may also monitor the child's behavior and compliance with therapeutic expectations of the treatment plan. The aide assists the therapist to teach the child appropriate behaviors, monitors behavior and related activities, and provides informal counseling or other assistance, either by phone or in person. Behavior management monitoring is provided by qualified paraprofessionals supervised by qualified licensed clinicians.

See response to paragraph 38 below.

b. In-home Therapy Services – Therapy services include a therapeutic clinical intervention and ongoing training and therapeutic support, as follows:

(i) A structured, consistent, therapeutic relationship between a licensed clinician and the family and/or child for the purpose of meeting specific emotional or social relationship issues. The licensed clinician, in conjunction with the care planning team, develops and implements therapy goals and objectives which are incorporated into the child's treatment plan. Clinical services are provided by a qualified licensed clinician who will often work in a team that includes a qualified paraprofessional who is supervised by the qualified licensed clinician.

(ii) Ongoing therapeutic training and support to the child/adolescent to enhance social and communication skills in a variety of community settings, including the home, school, recreational, and vocational environments. All services must be directly related to the child's treatment plan and address the child's emotional/social needs,

including family issues related to the promotion of healthy functioning and feedback to the family. This service is provided by a qualified paraprofessional who is supervised by the qualified licensed clinician. This paraprofessional may also provide behavior monitoring as described above.

See response to paragraph 38 below.

c. Mentor Services – Mentor services include:

(i) Independent Living Skills Mentors provide a structured, one-to-one relationship with an adolescent for the purpose of addressing daily living, social, and communication needs. Each adolescent who utilizes an Independent Living Skills Mentor will have independent living goals and objectives developed by the adolescent and his/her treatment team. These goals and objectives will be incorporated into the adolescent's treatment plan. Mentors are qualified paraprofessionals and are supervised by a qualified licensed clinician.

(ii) Child/Family Support Mentors provide a structured, one-to-one relationship with a parent(s) for the purpose of addressing issues directly related to the child's emotional and behavioral functioning. Services may include education, support, and training for the parent(s) to address the treatment plan's behavioral health goals and objectives for the child. Areas of need may include parent training on the development and implementation of behavioral plans. Child/Family Support Mentors are qualified paraprofessionals and are supervised by a licensed qualified clinician.

See response to paragraph 38 below.

Paragraph 34: ***The Defendants will systematically execute the program improvements described in Sections I.A-D above, including a defined scheme for monitoring success, as follows. The description below of the steps that Defendants will take to implement this Judgment is subject to modification during the course of implementation in accordance with Section II below.***

This paragraph is introductory; see detailed response below.

Paragraph 35: ***The Defendants will implement this Judgment as a dynamic process involving multiple concurrent work efforts. Those efforts will be organized into four main projects, described below, which encompass all aspects of the program improvements contained in this Judgment. This Judgment assigns a timelines for implementing each project, which are subject to modification for good cause upon application of either party. It is important to note that certain elements of each project are subject to external factors that are not fully within the control of EOHHS.***

This paragraph is introductory; see detailed response below.

Paragraph 36: ***Project 1: Behavioral Health Screening, Informing, and Noticing Improvements:***

a. Project Purpose: Implementation of improvements to behavioral health screening and clear communication of new requirements about the use of standardized screening tools.

This section is a purpose statement, and requires no response.

b. Tasks performed will include:

(i) Developing and announcing a standardized list of behavioral health screening tools.
(ii) Drafting managed-care or provider contract amendments and regulatory changes to conform to the new requirements.
(iii) Improving EPSDT Member notices concerning the availability of behavioral health and other EPSDT screening, and the availability of behavioral health services.

Completed.

c. Timelines for implementation:

(i) Defendants will submit to the Court a written report on the implementation of Project 1 no later than June 30, 2007.
(ii) Completion of this project will be by December 31, 2007.

Reported complete in prior report or reports.

Paragraph 37: ***Project 2: CANS Development, Training and Development***

1. Project Purpose: To design a statewide common assessment information gathering tool, the CANS, for statewide use, and to train behavioral health providers in its appropriate use.

This section is a purpose statement, and requires no response.

2. Task performed will include:

i) developing a Massachusetts-specific short and long form CANS in conjunction with Developer John Lyons;
ii) training behavioral health providers to complete and use the CANS tool, including EOHHS-required data gathering techniques; and
iii) drafting managed-care and provider contract amendments and regulatory changes to conform with the new requirements.

Reported complete in prior report or reports.

3. Timelines for implementation:

i) Defendants will submit to the Court a preliminary report with regard to the completion of Project 2 no later than November 30, 2007; and
ii) Completion of this project will be by November 30, 2008.

Reported complete in prior report or reports .

<u>Paragraph 38:</u> Development of a Service Delivery Network

a. Project Purpose: Plan, design, and contract for a service delivery network to deliver the services described in this Judgment.

This section is a purpose statement, and requires no response.

b. Basic Project Description: EOHHS, and DMH, will engage in a process of network design and development that is directed and managed by EOHHS and DMH toward establishing a statewide network of community service agencies ("CSAs"), common across all MassHealth payers, to the extent feasible, and responsible for coordinating and providing or arranging for medically necessary home-based services.

Although a number of mechanisms are available to EOHHS, and DMH, to design and approve this system, the initial, phased network development process will be implemented through the existing Medicaid managed care behavioral health contractor under the direction of EOHHS in consultation with DMH. EOHHS, and DMH, will establish standards for CSAs that will include provider qualifications, service delivery standards, training requirements, documentation requirements, utilization management standards, and performance measures. EOHHS will amend its managed care behavioral health contract to require the behavioral health contractor to procure a network of CSAs that meets the standards established by EOHHS, and DMH.

CSAs will be providers included in the networks of MassHealth's contracted managed care entities and its fee-for-service network. All MassHealth payers, including MassHealth's managed care organizations ("MCOs") and the managed care behavioral health contractor, will offer to contract with the same entities as CSAs, subject to successful negotiations and EOHHS' determination that such entities have the capacity to serve the managed care entities' expected MassHealth enrollment. The current expectation is that the Medicaid fee-for-service population will have access to the same providers as the Medicaid managed care population.

CSAs will operate in service areas that will be defined by EOHHS, and DMH, with the following objectives in mind: that CSA service areas be generally consistent with DMH sites; that they promote consistency with DSS Family Networks provider areas; that they promote consistency, capacity, and efficiency; that they reflect linguistic or cultural characteristics, as appropriate; and that they reflect natural service areas. The current

expectation is that there will be one CSA in each area so 21 defined, and that in total there will be no fewer than 15, and may be as many as 30, CSA service areas. The Defendants will consider defining regions for certain functions.

CSAs may deliver the clinical assessment services described above in Section I.B.1 and the intensive care coordination services described above in Sections I.B.2 and I.C. CSAs will either deliver or, as a component of intensive care coordination, assist MassHealth Members to access the services described above in Section I.D. CSAs will be responsible for assisting Members to access all services described in this Judgment that they do not themselves provide.

Reported complete in prior report or reports

c. Tasks performed will include:

i) Designing delivery system approaches that maximize access to services, taking into consideration the availability and willingness of providers to provide the services.

As described in previous Reports, the Defendants directed MassHealth's contracted health plans to procure a network of 32 Community Service agencies. The Massachusetts Behavioral Health Partnership, on behalf of MassHealth and the Department of Mental Health, procured a network of 17 Emergency Services Providers (ESPs), who deliver the new remedy service for children and youth under age 21. Each of the MCOs also contracts with these ESPs to provide Mobile Crisis Intervention. In addition, the Department of Mental Health directly operates four Emergency Services Providers, for a total of 21 ESP providers statewide.

Updates on Provider Network for IHBS, TM and IHT

The tables below indicate the number of providers per region for each of these services[4].

[4] The number of providers in each region reflects providers in the MCE "common network" as well as providers "in network" for MBHP only.

REGION	NUMBER OF IN-HOME BEHAVIORAL SERVICES PROVIDERS AS OF 4-23-10
Northeast	3
Boston/Metro	4
Southeast	3
Central	5
Western	8

REGION	NUMBER OF THERAPEUTIC MENTORING PROVIDERS AS OF 4-23-10
Northeast	11
Boston/Metro	19
Southeast	17
Central	11
Western	13

REGION	NUMBER OF IN-HOME THERAPY PROVIDERS AS OF 4-23-10
Northeast	11
Boston/Metro	28
Southeast	15
Central	11
Western	12

ii) Engaging in a public process to involve stakeholders in the development of the network and services.

In addition to the activities reported in previous Reports, the Defendant is engaged in the following current, ongoing, consultative processes:

Community Service Agencies

CSA Statewide Meetings

At the request of the CSAs, CSA statewide meetings moved from a monthly schedule to an every other month schedule beginning in January 2010. These meetings allow for the opportunity for the sharing of important information and updates, discussion of CSA specific issues and concerns, mutual problem solving, and presentation on topics of special interest to CSA providers. Meeting dates with selected topics are outlined below:

MEETING DATE	TOPIC(S)
December 18, 2009	• CommonHealth Disability Determination Process (Kathleen Nichols, Customer Service Manager UMass Disability Determination Unit) • Update on required fidelity monitoring activities • Systems of Care Committees – Family participation and provider best practices • Discussion and review of guidelines for managing referrals
January 22, 2010	• Special issues in working with youth under 6 • MCE updates • Follow-up discussions from December meeting on managing referrals and best practices in systems of care meetings
March 26, 2010	• Conflict Resolution Process for Care Planning Teams • Member insurance changes and MCEs' authorizations • Best practice in operations management discussion

MEETING DATE	TOPIC(S)
	• Working with Parents and Caregivers with Mental Health Conditions
May 21, 2010	• MCE updates • Presentation by EOHHS on SAMHSA grant on youth under 6 • Provider presentation on In-Home Behavioral Services

In addition, on December 14, 2009, Peter Metz, MD from the University of Massachusetts Medical School, and John Straus, MD from MBHP convened a meeting of the CSA child psychiatrists and the DMH child psychiatrists to discuss the role of the child psychiatrist in Wraparound as well as to hear a presentation on Wraparound by John VanDenBerg.

CSA Stakeholder Committee

In response to requests by CSA leadership, MassHealth arranged for its contracted health plans to convene a CSA Stakeholder Committee, which began to meet in November 2009. The Committee, consisting of representatives of the health plans, of several CSAs and of the Association for Behavioral Healthcare (a trade organization) meets monthly to discuss operational and policy issues of mutual concern. Staff from MassHealth's Office of Behavioral Health attend as the contractor of the MCEs.

All Providers

Technical Assistance

Technical assistance was offered to all providers of the new MassHealth services during this reporting period through on-site meetings at the provider agency, and/or phone conferences, as well as through integrated level of care meetings that began in December 2009.

Regional Integrated Level of Care Meetings

These integrated level of care meetings occur on a quarterly basis in each region of the Commonwealth and are facilitated by staff of MassHealth's contracted health plans. Providers of Intensive Care Coordination, Family Support and Training, Mobile Crisis Intervention, In-Home Therapy, Therapeutic Mentoring, and In-Home Behavioral services are invited to attend. In March, outpatient providers were also invited to attend. Providers of 24-hour acute behavioral health services will be invited to attend the meetings scheduled for June 2010.

These meetings offer an opportunity for providers to share best practices, discuss common issues and concerns, problem solve, and learn more about each other's roles and responsibilities and how these roles may have shifted with the changes occurring as a result of CBHI. These meetings also assist the MCEs in understanding how the system is working across levels of care, allows them to

obtain feedback from a key stakeholder group, permits a discussion of regional access and availability issues, as well as provides the MCEs the opportunity to disseminate important information and updates.

Other

The results of the CSA provider survey conducted by MassHealth on the communication processes and authorization requirements of the five MCEs—Boston Medical Center Healthnet Plan (BMCHP), Fallon Community Health Plan, the Massachusetts Behavioral Health Partnership (MBHP), Neighborhood Health Plan (NHP), and Network Health communication and authorization Survey report January 2010, was publicly distributed. It was posted on the CBHI section of the MassHealth website at the following location: http://www.mass.gov/Eeohhs2/docs/masshealth/cbhi/mh_survey-managed-care-entity-csa-interface.pdf

Finally, the Defendants continue to hold regular meetings with provider and family organizations to discuss the implementation of the remedy services.

iii) Planning concerning anticipated need and provider availability.

MassHealth contractually obligates its Managed Care Contractors to develop, manage and maintain networks of providers of the new home- and community-based behavioral health services sufficient to serve MassHealth members under 21

enrolled in Standard or CommonHealth who have a medical need for one or more of these services. The Managed Care Contractors, in selecting network providers, must ensure that selected providers are qualified to perform the required service according to the contracted service specifications. To help the plans with the initial task of network development, MassHealth made available to its Managed Care Contractors service projections prepared for MassHealth by Mercer Government Human Services Consulting. The Managed Care Contractors also drew on their own network development experience for the existing MassHealth services, and on the experience of affiliates and associates in other states with similar services.

Implementation of the new home- and community-based behavioral health services has required significant expansion of provider capacity and capacity building in particular models of care . Intensive Care Coordination, Family Support and Training, Mobile Crisis Intervention and Therapeutic Mentoring are relatively new services in Massachusetts and there is variability in provider experience with them. The Defendants have undertaken a number of training initiatives to increase provider capacity and promote consistency and quality of service delivery across the Commonwealth.

Intensive Care Coordination

As previously reported, the Defendants selected Vroon VanDenBerg LLP to deliver training and coaching in High Fidelity Wraparound to the CSAs. John VanDenBerg, PhD, the firm's president, was a pioneer in the development of high-

fidelity Wraparound and has been a leading researcher and trainer in the field for two decades. Family Partner training is provided by Susan Boehrer, Executive Director of the Oklahoma Federation of Families for Youth and Children's Mental Health.

The basic Wraparound Training consists of four full days of training, typically offered in two, two-day sessions several weeks apart. MassHealth offers Family Partners an additional two full days of training and CSA senior staff at least one additional one day advanced training.

Training focuses not only on teaching of principles, but also on imparting and refining specific skills needed for implementing High Fidelity wraparound. Training includes experiential exercises as well as expert presentations and video demonstrations. Continuing education credits are available to participants.

Training began September 16, 2009, and as of the end of May, 2010, MassHealth has ensured that all four days of the Wraparound training have been offered six times at various locations statewide. The four-day sequence will be offered twice again before and the end of June. In addition, the one-day seminar for CSA senior staff has been provided regionally, once in April, once in May, and once more in June.

John VanDenBerg also provided a training, in collaboration with Peter Metz, MD from UMass Medical School, on the role of psychiatry and psychopharmacology in Wraparound, on December 15, 2009. This training meeting, for psychiatrists and psychiatric nurse clinical specialists attached to CSAs, was sponsored by MassHealth's MCEs.

Since MCE staff interact with CSA staff, both to provide technical assistance and to authorize care, Vroon VanDenBerg principals also provided an orientation to Wraparound for MCE staff in January.

Training has a much greater impact on behavior when combined with follow-up coaching, and therefore, six experienced coaches from Vroon VanDenBerg have been working with the thirty-two CSAs building on skills introduced in the trainings. Each CSA has one coach, with other Vroon VanDenBerg staff available if needed for consultation on specific issues. Coaches completed initial visits to their CSAs in November and have continued to work with CSAs through a combination of onsite and telephonic consultation. Each CSA has an individualized coaching plan. As of the end of May, Vroon VanDenBerg will have provided 118 on-site days of coaching..

Planning is currently underway for training and coaching for CSA staff in FY2011.

In-Home Therapy (IHT)

The Defendants, through their contracted health plans, arranged for two one-day trainings for IHT staff persons on April 6 and 7th. These trainings were conducted by: Rick Shepler, PhD from the Center for Innovative Studies and Practice at Kent State University; Victoria Taylor, MEd. from Butler Behavioral Health Services; and Catherine Bixenstine, MSEd., from Catholic Charities of Cuyahoga County. Training topics included: engagement and partnering with families, basic components and phases of IHT, solution-focused and family therapy approaches, risk management and safety planning in IHT, and ethics, boundaries, and safety issues in home-based therapy. Approximately 623 persons attended these trainings.

On May 4th, 5th, and 6th the Defendants, through their contracted health plans, arranged for Rick Shepler to provide a series of regional supervisory skill development trainings for In-Home Therapy supervisors. These sessions were designed to address challenges and barriers that had been identified by In Home Therapy providers in the following areas: clinical practice, administrative issues, implementation, and CBHI and System of Care Integration. Dr. Shepler discussed solutions to these barriers and challenges and shared best practice solutions.

Therapeutic Mentoring

The Defendants, through its their contracted health plans, arranged for a 2 day training for Therapeutic Mentoring providers that occurred on April 1-2, 2010. The training was conducted by Marci White, MSW; DeVault Clevenger, MA, LPC; and Lori Douglas, MSW from North Carolina Mentor. The first day of the training focused on skill development of the therapeutic mentoring staff. Approximately 388 individuals, including staff persons from the managed care entities, attended the first day. The second day was an advanced seminar for supervisors of therapeutic mentors. Approximately 138 persons attended this session. On May 25th and 26th Marci White and her colleagues from North Carolina Mentor returned to conduct regional consultation sessions for providers. These sessions focused on integrating CBHI service values and philosophy into practice and identifying challenges, barriers, and solutions to challenges in the clinical and supervisory practice arenas as well as in the administrative infrastructure.

Mobile Crisis Intervention

The Defendant's contractor, the Massachusetts Behavioral Health Partnership (MBHP), holds monthly Emergency Service Provider (ESP) statewide meetings on the second Friday of the month. A segment of every meeting is dedicated to youth Mobile Crisis Intervention and special issues for providers of this ESP service

component. In addition, the Defendants hold a monthly statewide meeting for the CEOs of the ESP provider organizations.

Throughout this reporting period, the Defendants ensured that Kappy Maddenwald, MSW was available to provide coaching and technical assistance onsite at MCI provider organizations . These onsite coaching visits are designed specifically to target the individual needs of the provider organization and its staff persons. Additional specialized trainings and regional coaching/trainings the Defendants sponsored include:

Mobile Crisis Intervention Paraprofessional / Family Partner Training

This training was conducted by the Parent Professional Advocacy League (PAL) on December 1, 2009. Specific training topics included: Family Partner history, principles, role; family journey; culture, partnership, communication and listening, conflict management, boundaries and confidentiality.

MCI Training- for MCI clinicians and paraprofessionals

(repeat of previous introductory training) Kappy Maddenwald and MCI content experts at MBHP conducted the training held on January 15, 2010**.** Training content included: an overview of the service, core competencies, characteristics of effective crisis staff, understanding the crisis continuum, understanding "crisis" factors that contribute to and mitigate a crisis, mobile crisis response, safety in the field, risk assessment, environmental scanning, resolution-focused interventions,

solution-focused mental status exam, person-centered planning, safety planning, least-restrictive interventions and dispositions.

Regional MCI Coaching and Training Sessions

Additionally, Ms. Maddenwald conducted a series of day long regional training and coaching sessions in April and May 2010. These advanced coaching and technical assistance sessions were focused on honing the role of the clinician and paraprofessional individually and as a team, using a 72-hour time frame as a tool in delivering family driven, resolution-focused and least restrictive treatment services, and differential strategies in working with youth and families to meet their needs within the emergency services system.

iv) ***Working with CMS to obtain approval of services to be offered and of managed care contracting documents.***

Completed for all remedy services except Crisis Stabilization Services.

As reported in the May 11, 2010 Interim Report on Implementation, the Defendants are reviewing three State Plan Amendments (SPAs) and rate methodologies received from the Centers for Medicare and Medicaid Services (CMS) as examples of CMS-approved services that are similar to Crisis Stabilization Services.

The purpose of the Defendants' review of these documents is to determine whether the services CMS approved in those other states could help MassHealth develop a SPA to obtain FFP for Crisis Stabilization Services.

v) Defining CSA Service Areas.

Reported complete in prior report or reports.

vi) Defining standards with respect to provider qualifications, service delivery standards, training requirements, documentation requirements, utilization management standards, and performance measures.

Reported complete in prior report or reports.

vii) For each service described in Section I.D. above, defining the following: clinical criteria (including admission criteria, exclusion criteria, continuing stay criteria, and discharge criteria); performance specifications (including service definition and philosophy, structural requirements, staffing requirements, service, community and collateral linkages, quality management, and process specifications); credentialing criteria (for licensed clinicians and paraprofessionals); and utilization management standards (prospective and retrospective).

Reported complete in prior report or reports .

The Defendants expect to issue Operations Manuals for In Home Therapy (June 2010), Therapeutic Mentoring (August 2010) and In Home Behavioral Services (October 2010). These Manuals provide additional information and guidance to providers, designed to help providers operationalize the performance specifications.

viii) Drafting contract and procurement documents, including the production of a detailed data set of contractors and the creation of detailed performance standards for contractors and providers.

Reported complete in prior report or reports.

ix) Negotiating contracts, setting rates for new services, and arranging for appropriate federal claiming protocols.

Reported complete in prior report or reports.

x) Performing reviews of new service providers to assure readiness to perform contract requirements.

Reported complete in prior report or reports.

xi) Designing strategies to educate providers, MassHealth Members, and the general public about the new services offered.

See the responses to Paragraphs 3 through 7, above.

xii) Designing a system of contract management for managed care contracts that includes performance standards or incentives, required reports, required quality improvement projects, and utilization management review, administrative services, and claims payment protocols.

Completed for the first year of operation, as previously reported. These tasks are revised as needed and as circumstances change.

d. Timeline for implementation:

i) Defendants will submit to the Court a written report with regard to completion of Project 3 no later than November 30, 2007. Further status reports thereafter may be required.

ii) Full implementation of this project will be completed by June 30, 2009.

The Defendants submitted a report dated November 30, 2007 that fulfilled the requirement in subpart i. As described in paragraphs 19-38 above, the Defendants completed this project by June 30, 2009, as required by subpart ii.

Paragraph 39: Project 4: Information Technology System Design and Development

a. Project Purpose: The design and development of a web-based application to facilitate identification and monitoring of behavioral health service delivery to children with serious emotional disturbance.

This section is a purpose statement, and requires no response.

b. Tasks performed will include:

i) Defining existing system capacities.

ii) Gathering requirements for new functionality, including assessing whether development should be in-house or outsourced.

iii) Obtaining legislative authorization and funding.

iv) Drafting contract and procurement documents, including detailed architectural standards, privacy standards, and performance standards.

v) Working with CMS to obtain necessary federal approvals of contracting documents.

vi) Issuing an RFR, reviewing responses, and selecting bidder(s).

vii) Negotiating contract(s).

viii) Confirming business requirements and technical specifications.

ix) Performing construction and testing based upon the Unified Process

x) Provider training development and delivery. In person training and web based training will be available.

Introduction

As previously reported, EOHHS has completed the development and implementation of two web-based applications to support the use of the CANS tool and to assist the Defendants to meet reporting requirements with respect to the CANS. The process of defining system capacities, designing and building the secure CBHI CANS Application hosted on the Virtual Gateway has been described in previous reports. The steps that the Defendants will take with respect to all other reporting requirements are described in Paragraph 46.

CANS Certified Assessor Training and Certification Application

The first CANS Application was the CANS Certified Assessor Training and Certification Application, which: (1) permits clinicians to register for face-to-face Certified Assessor

Training; (2) provides web-based Certified Assessor Training for those that choose not to take the face-to-face training, and (3) administers the Certified Assessor Examination, and issues credentials to clinicians who pass the examination. As previously discussed, the Defendants have updated the application in consultation with Dr. John Lyons, to permit a more accurate assessment of examinees' CANS rating skills.

CANS Application

The second application is the CANS Application on the Virtual Gateway, which allows clinicians to enter client CANS and SED determination information into a secure EOHHS database, subject to necessary consent, and provide the Defendants data needed for court reporting, and for other clinical and administrative purposes. The Defendants have developed three releases of this software, made available to users in December 2008, April 2009, and February 2010. The February release included various technical improvements as well as user enhancements including improved gathering of race, ethnicity and language data, posting of announcements on the log-in screen, and improved export of data for analytic purposes. The Defendants are currently developing a further release, to be made available in Fall 2010, which will simplify and improve the transfer of CANS data to the MCEs.

Virtual Gateway (VG) Enrollment and User Activity

The Defendants require provider organizations to set up their Virtual Gateway accounts and to set security roles that will provide access to the CANS Application for appropriate end users. The number of organizations enrolled with the Virtual Gateway (VG) for the CANS

Application continues to increase, as does the number of individuals enrolled as Certified Assessors.

The number of organizations entering CANS records has steadily risen, from 225 at the end of November 2009 to 260 in May 2010. The number of trained and certified CANS assessors has topped 9,300 and continues to grow, although more slowly.

User Training and Support

As previously reported, the Defendants have developed materials to assist providers in using the CANS Application. These materials, which include interactive training modules, are made available to providers through a number of pathways, including through the CBHI website. In addition, VG Help Desk personnel provide technical user support. Many questions are also fielded by the UMass CANS Program and by the Office of the Compliance Coordinator.

In addition, Defendants have produced a CANS newsletter for electronic distribution to a variety of CANS stakeholders, including providers. The newsletter provides updates and refreshers about the CANS requirement, good practice using the CANS, and appropriate use of the CBHI CANS Application on the VG. The first issue was released in January, 2010, and the second issue in April. Subsequent issues are scheduled to appear quarterly, and are distributed electronically to all CANS Application users.

c. Timelines for implementation

i) Defendants will submit to the Court a written status report with regard to Project 4 no later than November 30, 2007.

ii) Full completion of this project will be by November 30, 2008.

The Defendants submitted a report dated November 30, 2007 that fulfilled the requirement in c. subpart i.

Paragraph 40: ***There are multiple sources of data available to the Medicaid agency and multiple methods for data collection. This Judgment outlines a basic data set that, based on sound principles of program management, will ultimately provide very useful data that will support the agency's ability to track, monitor and evaluate a system of behavioral health care for children with SED. Some of the data points outlined here are presently available or easily accessible, while others are not.***

This paragraph is introductory in nature, and requires no response.

Paragraph 41: ***The primary source for Medicaid data is MassHealth's claims payment system, known as the Medicaid Management Information System (MMIS). While MMIS can collect claims level data on utilization and spending, it is not a good source for much of the data required to evaluate the implementation beyond that otherwise necessary for providers to claim reimbursement from MassHealth. EOHHS is currently part way through a major multi-year project to develop a replacement MMIS (New MMIS), currently anticipated for implementation in August, 2007.***

New MMIS has been implemented.

Paragraph 42: ***A secondary means of collecting data commonly used in MassHealth program management originates from contract requirements, typically of managed care entities. MassHealth often requires managed care entities to collect data or report information in a particular form as an obligation of the contract. This method of collecting data is not limited by the capacities of the MassHealth payment system, but may be hampered by the managed care entities' own system limitations. Any business requirements placed on contractors generally require time to make business process changes and systems modifications as well as some form of reimbursement of costs.***

See response to paragraph 46, below.

Paragraph 43: ***For detailed clinical and provider performance data, MassHealth's clinical staff and contracted reviewers undertake clinical record reviews. This method of collecting data is appropriate in very limited circumstances and is time-intensive and costly.***

See response to paragraph 46, below.

Paragraph 44: ***For collecting and managing all of the data points associated with this Judgment, EOHHS will need to develop a new information technology (IT) application. Although the Defendants are not required by the Medicaid Act (42 U.S.C. §1396 et seq.) to collect this data, EOHHS believes that the data will assist in assessing its performance of the requirements of the Judgment, to improve the quality of Medicaid behavioral health services for children, and to reassure the Court of success. However, an IT systems development project is a significant undertaking. The Defendants will need specific legislative authorization and appropriation in order to proceed with an IT project of the size contemplated below, since it would involve a capital appropriation and expenditure authorization. Following that, the Defendants can engage one or more vendors through a competitive procurement process; design business specifications with input from the MassHealth provider community; allow time for the vendor to build and test the data collections and management system(s); amend provider agreements and contracts, as necessary; and train providers to report required information using the new IT application. Timetables for such large-scale IT projects usually range from 18-24 months from the time that legislative authorization and appropriation is received, and often include multiple rollouts of advancing sophistication and breadth to assure that providers can successfully use the application and that the data collected is accurate and timely.***

As described in the November 30, 2008 report, the Defendants, after extensive analysis, determined that the CANS Application, along with MassHealth MMIS data, MCE "encounter data" and other MCE data reports, would provide sufficient data collection and management capacity to meet the requirements of the Judgment.

Paragraph 45: ***With these considerations in mind, the Judgment includes the following as a preliminary data collection strategy to assess Member access to, and utilization of, EPSDT behavioral health screenings, clinical intake assessments, intensive care coordination, comprehensive assessments, and intensive home based services. Data points described below that are not available from MMIS are conceptual and subject to a complete inventory of the business requirements and data elements necessary for creating an appropriate tracking system or systems.***

As previously reported, the Defendants are using claims data from MMIS and encounter data from the MCOs and MBHP. Encounter data is client- and service-specific data reported by the MCOs and MBHP to MassHealth. Claims data is data the claims providers submit to MassHealth for services provided to MassHealth members on a fee for service basis.

As explained in more detail in response to paragraph 46 below, there are some measures which require the collection of new data or the combination of new data with existing claims and encounter data.

Paragraph 46: ***Potential Tracking Measures***

a. EPSDT Behavioral Health Screening

i) Number of EPSDT visits or well-child visits and other primary care visits.

ii) Number of EPSDT behavioral health screens provided. An EPSDT behavioral health screen is defined as a behavioral health screen delivered by a qualified MassHealth primary care provider.

iii) Number of positive EPSDT behavioral health screens. A positive screen is defined as one in which the provider administering the screen, in his or her professional judgment, identifies a child with a potential behavioral health services need.

The Defendants use MMIS claims data and MCE encounter data to report on all three of these measures.

b. Clinical Assessment

i) Number of MassHealth clinical assessments performed. A MassHealth clinical assessment is defined as any diagnostic, evaluative process performed by a qualified MassHealth behavioral health provider that collects information on the mental health condition of an EPSDT-eligible MassHealth Member for the purposes of determining a behavioral health diagnosis and the need for treatment.

ii) Number of clinical assessments that meet SED clinical criteria and indicate that the Member could benefit from intensive care coordination services.

The Defendants are reporting on the number of clinical assessments performed through MassHealth claims data, MCE encounter data and through the CANS Application.

The vast majority of clinical assessments are performed in outpatient therapy. Outpatient therapy providers file distinct claims for assessments. The Defendants introduced a billing modifier, that, when used on the claim, indicates that the provider used the CANS as part of the assessment process, and triggers an additional payment to the provider, in addition to the standard fee for the assessment.

Assessments conducted in all other behavioral health services, such as the remedy services, inpatient care or Community Based Acute Treatment, are not paid through distinct claims, but payment is built into the overall rate for the service. The Defendants count the number of assessments in these other services through the CANS Application.

The Defendants count the number of clinical assessments that indicate that the child meets either of the definitions of Serious Emotional Disturbance (SED) used in the Judgment through the CANS Application.

c. Intensive Care Coordination Services and Intensive Home-Based Assessment

i) Number of intensive home-based assessments performed as the first step in intensive care coordination. Such assessment processes shall result in the completion of a standardized data collection instrument (i.e. the CANS tool). As part of the treatment planning process, that standardized tool will be used, and the resulting data collected on a Member level at regular intervals.

ii) Number of Members who receive ongoing intensive care coordination services.

The Defendants count the number of home-based assessments performed in Intensive Care Coordination through the CANS Application.

The Defendants count the number of Members receiving Intensive Care Coordination in two ways: through provider-generated reports submitted to MBHP, who integrates the data into one report for MassHealth; and through counting in MCE encounter data the number of unique children and youth for whom the MCEs have paid claims for ICC.

d. Intensive Home-Based Services Treatment

i) Member-level utilization of services as prescribed under an individualized care plan, including the type, duration, frequency, and intensity of home-based services.

ii) Provider- and system-level utilization and cost trends of intensive home-based services.

The Defendants review claims data on members for whom providers billed ICC and other behavioral health services during the quarter in order to determine the percentage of ICC utilizers accessing other behavioral health services. The data are submitted to MassHealth by each plan and aggregated by Office of Behavioral Health Analytic staff.

MassHealth amended its contracts with the Managed Care Contractors to require cost and utilization reports on Intensive Care Coordination, Family Support and Training, Mobile Crisis Intervention, In Home Therapy, In Home Behavioral Services and Therapeutic Mentoring. The Defendants prepared detailed data specifications and definitions and have extensively reviewed these reports for accuracy, and for consistency among the Managed Care Contractors. Reports covering July through December 2010 are now complete.

e. Child and Outcome Measures - Member-level outcome measures will be established to track the behavioral health of an EPSDT-eligible MassHealth Member with SED who has been identified as needing intensive care coordination services over time. Defendants will consult with providers and the academic literature and develop methods and strategies for evaluating Member-level outcomes as well as overall outcomes. Member-level outcome measures would be tracked solely for the purpose of program improvement and would not be useable as a basis for arguing that Defendants are not complying with any order of the Court.

Member-level Outcome Measures

The Defendants will use CANS data and data on Member utilization of Mobile Crisis Intervention services and Inpatient care to measure member-level outcomes for children and youth receiving Intensive Care Coordination.

System-level Outcomes Measures

MassHealth is issuing, through its Managed Care Contractors, two state-of-the-art assessment tools for measuring whether ICC provider practice conforms to the standards of High Fidelity Wraparound: the Wraparound Fidelity Index 4.0 (WFI-4) and the Team Observation Measure (TOM).

The Wraparound Fidelity Index 4.0 (WFI-4) is a 40-item instrument used to assess adherence to the Wraparound model. In Massachusetts, the WFI-4 is completed through brief, confidential telephone interviews with the parent or caregiver. The WFI-4 interview is organized by the four phases of the Wraparound process (Engagement and Team Preparation, Initial Planning, Implementation, and Transition). In addition, the 40 items of the WFI interview are keyed to the 10 principles of the Wraparound process, with 4 items dedicated to each principle. In this way, the WFI-4 interview is intended to assess both

conformity to the Wraparound practice model and adherence to the principles of Wraparound in service delivery.

Beginning on January 2, 2010, Consumer Quality Initiatives (CQI) a vendor contracted by MBHP, began making phone calls to caregivers of youth enrolled in ICC to complete the Wraparound Fidelity Index (WFI-4). As of May 20th CQI had completed 474 WFI interviews with families and caregivers. The interviews are scheduled to be completed by the end of June and the final report will be available in early Fall.

Also in January, the CSAs began utilizing the Team Observation Measure (TOM) as an additional method for monitoring fidelity to the Wraparound model. The TOM is a 20 item instrument used to assess adherence to standards of high-fidelity Wraparound during care plan team meetings. There are two items dedicated to each of the 10 principles of Wraparound. Each item consists of 3-5 indicators of high-quality wraparound practice as expressed during a care plan team meeting. Trained raters, typically care coordinator supervisors, measure whether or not each indicator was in evidence during the care plan team meeting. These ratings are translated into a score for each item as well as a total fidelity score for the session overall. The MCEs have required the CSAs to ensure that every individual facilitating a Care Plan Team (CPT) meeting be observed twice (at minimum) between January 2 and June 30, 2010.

f. Member Satisfaction Measures - Defendants will develop sampling methods and tools to measure Member satisfaction of services covered under this Judgment. Member satisfaction would be measured solely for the purpose of program improvement and would not be useable as a basis for arguing that Defendants are not complying with any order of the Court.

As described above, MassHealth's Managed Care contractors use the Wraparound Fidelity Index to measure Member satisfaction with their experience with Wraparound in ICC. MBHP is conducting this survey on a sample of 20 ICC members per CSA, which will include members from all the MCEs. These surveys will be completed by the end of June, 2010, with the report available in early Fall, 2010.

During the Winter of 2010-2011, the Defendants plan to conduct member satisfaction surveys of members who have had some experience with the services covered under the Judgment.

RESPECTFULLY SUBMITTED,

MARTHA COAKLEY
ATTORNEY GENERAL

/s/ Daniel J. Hammond
Daniel J. Hammond, BBO #559475
Assistant Attorney General
Government Bureau
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-2200, Ext. 2078

Date: June 1, 2010

I hereby certify that a true copy of this document was served electronically upon counsel of record through the Court's electronic filing system on today's date.

/s/ Daniel J. Hammond
Daniel J. Hammond
Assistant Attorney General