UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.,	)	
Plaintiffs,	)	
v.	)	
	)	C.A. No.
	)	01-30199-MAP
DEVAL L. PATRICK, et al.,	)	
Defendants	)	

DEFENDANT'S REPORT ON IMPLEMENTATION

I. Introduction

On July 16, 2007, this Court issued a Judgment finding that the Defendants were in violation of two provisions of the federal Medicaid statute:

- the mandate for early and periodic screening, diagnostic and treatment services (EPSDT), 42 U.S.C. §§1396a(a)(10)(A) and (a)(43), §§1396d(r)(5) and (a)(4)(B) (2005), and
- the requirement that medical assistance be furnished with reasonable promptness, 42 U.S.C. §1396a(a)(8) (2005).

The Judgment also defined "serious emotional disturbance" ("SED") and set forth in detail the steps that the Defendants were required to take with respect to the class of children eligible for EPSDT, including programs, activities and timelines for implementation.

This Report will demonstrate not only that the Defendants have fully complied with each requirement of the Judgment, but have embraced transformation of MassHealth's EPSDT services for young members with SED. That transformation has resulted in an improved, robust service system that exceeds the requirements of the Judgment. All of the work behind the system improvements -- design and implementation, training and coaching -- is aligned

with the values and principles of "Systems of Care for Children's Mental Health" ("Systems of Care").

The Systems of Care values and principles have evolved out of thirty years of hard work by parents and clinicians to find a better way to help young members with mental health needs through genuine, respectful partnership and collaboration among those individuals, their families and professionals. The Massachusetts' Executive Office of Health and Human Services ("EOHHS") has vigorously led and managed the ambitious process of implementing system improvements in accordance with System of Care values. EOHHS's commitment to such change is reflected in the service definitions and standards and the extensive resources devoted to training, technical assistance and coaching for providers as well as to other extensive quality improvement activities

In May, 2007, EOHHS appointed a Compliance Coordinator and later that year established the Children's Behavioral Health Initiative ("CBHI") to spearhead implementation of the remedy services. The Compliance Coordinator also acts as the Director of CBHI**.** CBHI has been led by the Children's Behavioral Health Executive Committee, chaired by the Commissioner of the Department of Mental Health ("DMH"). Members of the Committee include Commissioners and senior staff of the Department of Children and Families ("DCF"), the Department of Public Health ("DPH"), the Department of Youth Services ("DYS"), and the Office of Medicaid. Other members of the Committee include the Director of the Office of Behavioral Health ("OBH") within the Office of Medicaid, the Compliance Coordinator, and senior EOHHS policy staff. Implementing the remedy in the context of CBHI has helped EOHHS optimize the connections between the remedy services and other state services for children and families.

CBHI and OBH staff have worked together closely to implement, maintain and improve the remedy services. OBH has the authority and responsibility to manage the delivery of behavioral health ("BH") services through MassHealth's Fee-For-Service program, and to develop and manage contract provisions with MassHealth's health plans (also known as Managed Care Entities, or "MCEs"), including the behavioral health carve-out, provided through its current contractor, the MassHealth Behavioral Health Partnership ("MBHP"), governing delivery of behavioral health services.

OBH has taken the lead on the design, implementation, management and improvement of the six new remedy services. OBH led the MCEs to develop an unprecedented collaborative, cross-health plan approach to network development and management of the remedy services. OBH collaborates with key stakeholders, including providers, advocates and family organizations, and develops payment methodologies for the remedy services.

CBHI staff have taken the lead on informing MassHealth members, providers, state agencies, schools, the juvenile justice system and related programs, family and community organizations, and the public about the remedy services and how to access them. CBHI staff have overseen implementation of BH Screening and have built, maintained and improved the Child and Adolescent Strengths and Needs ("CANS") application and CANS training, certification and community of practice infrastructure. Staff work with other EOHHS

agencies and other child- and family-serving systems, including schools and courts, to promote access to the remedy services and integration between the remedy services and other services and systems.

The Director of CBHI, as the Compliance Coordinator, reports on the status of implementation of the Judgment to the Secretary of EOHHS, JudyAnn Bigby, M.D., and is EOHHS's key contact with the Court Monitor, Dr. Karen Snyder, the Plaintiffs' attorneys and the Court. CBHI and OBH staff also ensure the coordination of those implementation efforts with related EOHHS initiatives.

Following is an overview of the services and improvements that EOHHS, through CBHI and OBH, have implemented in accordance with the Judgment:

A. Assessments

1. ***EPSDT Standardized Behavioral Health Screening***
   EOHHS requires all Primary Care Clinicians ("PCCs") treating MassHealth-enrolled children and youth under the age of 21(hereafter, "young members") to offer to perform a BH screen during well-child (EPSDT) visits, using one of nine MassHealth-approved standardized behavioral health screening tools. Such screening tool results are preliminary indicators of a potential BH need, not a clinical determination that a need exists[1]. For young members with a positive screen, PCCs, in consultation with parents, decide what is clinically indicated, either providing necessary follow-up services themselves or referring to a behavioral health provider.

   During the period October 2010 through September 2011, clinicians screened between 81,000 and 92,000 young members in each of the four quarters. These numbers represent 65% of all young members receiving well-child visits, and 70% of young members ages six months through 14 years. Each quarter, the screens of 7% to 8% of these young members indicated a potential behavioral health need. To ensure that PCCs provide any necessary follow-up care indicated as a result of screening, MassHealth produces a report for all PCCs listing any young member who has had a positive BH screen but who has not had either a follow-up visit with the PCC to address the potential BH need, or any other claim for a BH service.

2. ***Clinical Assessments Using the CANS***
   Since November 30, 2008, EOHHS has required nearly all[2] behavioral health clinicians treating young members to use the CANS to organize information gathered through the individual's clinical assessment. This requirement ensures that, upon

[1] When a young member is referred to a BH provider, the provider conducts a comprehensive clinical assessment, including the CANS tool, as described below.

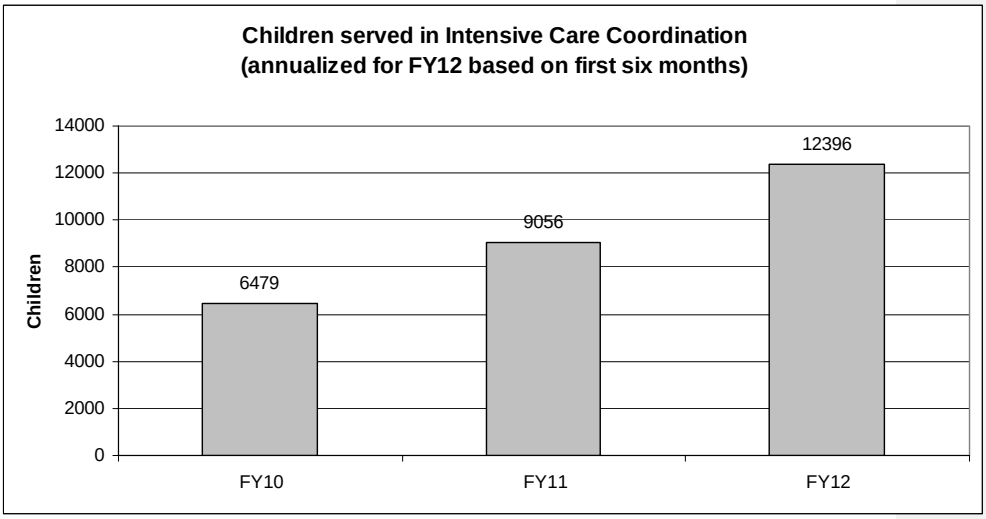
[2] Clinicians who are not required to use a CANS include providers of the "hub"-dependent services, In Home Behavioral Services, Therapeutic Mentoring and Family Support and Training. These services are delivered in accordance with an assessment and treatment plan developed in one of the clinical hubs: outpatient therapy, IHT or ICC. Also, clinicians treating a young member in a crisis, such as MCI clinicians, or ED staff, do not complete the CANS.

initiating[3] MassHealth BH services, the provider completes a comprehensive assessment of the individual. The CANS includes questions regarding the individual's needs and strengths in various "life domains" such as family, peers, school, health, healthy development, sexuality, self care and community as well as in the areas of behavioral and emotional needs, risk behaviors, cultural considerations and transition to adulthood. The tool also asks questions about caregiver resources and needs. Every month between 2,000 and 3,000 young members receiving outpatient therapy are initially assessed using the CANS. Remedy services providers, as well as providers of inpatient care, Community-Based Acute Treatment ("CBAT")and certain residential programs funded by DMH also complete the CANS. In total, approximately 6,000 CANS assessments per month are completed through EOHHS's online CANS application.

B. CBHI Services

1. Service Coordination

On June 30, 2009, MassHealth launched the largest High-Fidelity Wraparound service delivery network in the United States[4], and since that date over 14,000 young members have received Intensive Care Coordination (ICC).



[3] For some MassHealth services, such as inpatient psychiatric hospitals and community-based acute treatment settings and for intensive residential settings and continuing care programs funded by the Department of Mental Health, the CANS assessment is done at the end of the stay, in preparation for discharge.

[4] Only Arizona's care coordination service delivery system may be comparable in magnitude; it has not been possible to learn from Arizona what proportion of its graduated care coordination service meets the definition of High Fidelity Wraparound.

The caseload ratio has remained approximately 10 young members/families per Care Coordinator and the length of service, for young members completing their ICC goals, is approximately 11 months.

Care Coordinators (as well as their supervisors and managers) are trained and responsible for:

a. Developing a Risk Management/Safety Plan with the family at the first appointment
b. With the individual young member and family, completing a comprehensive home-based assessment of the individual's and family's strengths, needs and culture
c. With the individual and family, building the individual's Care Planning Team
d. Ensuring that the Team has access to any needed clinical resources
e. Facilitating the process by which the Team develops, implements, monitors and adjusts the individual's Individualized Care Plan, including the Transition Plan
f. Ensuring that Team members carry out their assigned tasks to implement the plan

MassHealth is using state-of-the-art national measurement tools, the Wraparound Fidelity Index ("WFI-4")[5] and the Team Observation Measure ("TOM")[6] to annually assess the fidelity of ICC providers' practice to the High Fidelity Wraparound model. The findings guide the training, coaching and quality improvement activities with the ICC providers. In both of the first two assessment cycles, Massachusetts's results were slightly above the national average -- an average that includes mature programs such as Wraparound Milwaukee. Eric Bruns, Ph.D., developer of the WFI and the TOM, described Massachusetts's implementation of High Fidelity Wraparound as the "most rapid scale-up in the history of wraparound."[7]

2. In-Home Support Services

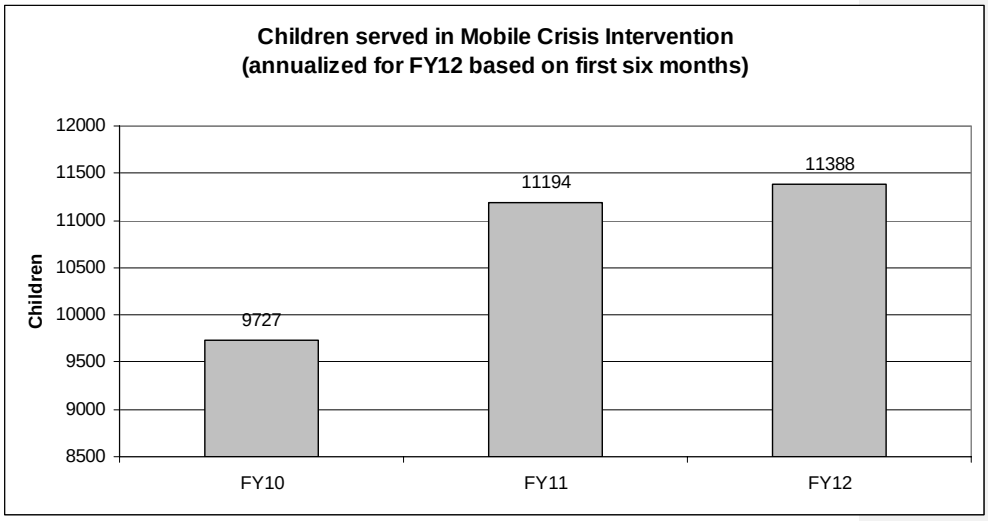
a. Mobile Crisis Intervention (MCI)

As of June 30, 2009, MCI services have been available to young members across the state.

[5] The 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 telephone interviews and ratings are conducted by Consumer Quality Initiatives (CQI) a consumer-run vendor contracted by MBHP. Each cycle involves calls to 600 randomly selected families and results in over 400 completed WFI-4 records.

[6] The TOM is a 20 item instrument used to assess adherence to standards of high-fidelity Wraparound during care plan team meetings. The TOM is used by the CSAs, whose staff (typically care coordinator supervisors), have been trained in rating the instrument. The TOM includes 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 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 require the CSAs to ensure that every individual facilitating a Care Plan Team (CPT) meeting be observed twice (at minimum) during each annual TOM cycle. The second cycle of TOM data included observation of 658 team meetings across CSAs.

[7] Slides prepared by Eric Bruns, Ph.D., and presented at the Statewide CSA meeting on June 16, 2010.



For some young members, emergency departments are the appropriate venue for the MCI encounter, particularly when a young member requires (or appears to require) immediate medical treatment for injuries or a drug overdose. Nevertheless, when there is no need for medical assessment and treatment, MCI is intended to address the young member's crisis within that individual's community. At the initiation of this service, in July 2009, 37% of MCI encounters occurred in a community-based location (such as the individual's home or school or the MCI's community-based location). As clinicians and families became more knowledgeable about the availability of services outside of emergency rooms, the percentage of community-based encounters has gradually risen. As of November, 2011, that number was 57%.[8]

Twenty-six percent of MCI encounters resulted in an inpatient admission in July, 2009, the first month of the program. Over the period July 2009 through November 2011, the rate has averaged 23%. In the most recent months for which there are data, September, October and November, 2011, the percentage of young members being admitted to inpatient units was 22%, 21% and 20%, respectively.

One of the key goals of MCI is to identify behavioral health services the young member may need and help the family secure access to those services. Recent analysis of claims data demonstrates that MCI is effectively achieving this goal: for the 31% of young members who received no behavioral health service within

[8] There is a predictable seasonal variation in which the percent of MCI encounters occurring in the community is lower during months when young members are on summer recess and climbs in the fall. For example, in July and August 2011, 45% and 47%, respectively, of the MCI encounters occurred in community. In September, October and November 2011, the percentages increased to 53%, 56% and 57%.

the 90 days prior to the MCI encounter, 70% received such a service following the encounter. For the 69% of young members who *had* received a BH service prior to MCI, 97% had a claim for a BH service following the encounter. For the 27% of young members receiving a *remedy* service prior to the encounter, 99% had a claim for a BH service following the encounter.

During 2010 and 2011, MassHealth refined the Risk Management/Safety Plan ("RMSP") process for the remedy services and has incorporated the tools and concepts into MCI, ICC, In-Home Therapy (IHT) and Outpatient therapy. MassHealth encourages providers to (with appropriate consent) give a copy of a young member's RMSP to the local MCI provider. When a family without an RMSP obtains MCI services, MCI staff help the family to develop one, including, as the family chooses, engaging existing service providers, and/or other natural supports to help in the development (or update) of the RMSP.

During November 2011, MBHP analyzed the average length of engagement with families by each of its MCI providers[9]. The average across all 17 providers was 2.4 days.

b. Crisis Stabilization

The Judgment does not require the Defendants to take any action or pay for any service unless federal financial participation ("FFP") is available. Further, implementation of the specific remedy requirements is contingent on obtaining all required federal approvals, legislative authorizations and funding, and compliance with all applicable state and federal laws. Accordingly, MassHealth filed a proposed state plan amendment ("SPA") with the federal Centers for Medicare and Medicaid Services ("CMS") seeking authority to implement each of the remedy services.

CMS disapproved MassHealth's proposed SPA to provide Crisis Stabilization as a Medicaid service. MassHealth subsequently requested CMS to approve coverage of Crisis Stabilization under the Commonwealth's 1115 Demonstration Waiver.[10] CMS did not agree to EOHHS's request to cover Crisis Stabilization for young members as a waiver service. Accordingly, EOHHS has been blocked by CMS from implementing Crisis Stabilization as a stand-alone remedy service.

The Judgment described two components of the Crisis Stabilization services: an out-of-home component and an in-home component. MassHealth determined that the in-home component of Crisis Stabilization was consistent with the purpose and structure of MCI; and that, while Community Based Acute Treatment (CBAT) differs from the Crisis Stabilization design, it can meet the clinical needs of a young member in crisis.[11] However, MCI services were generally available

[9] These data do not include data from the four DMH-operated MCI programs.

[11] CBAT services existed prior to the court-ordered remedy services, but are an integral part of the continuum of services available to young members.

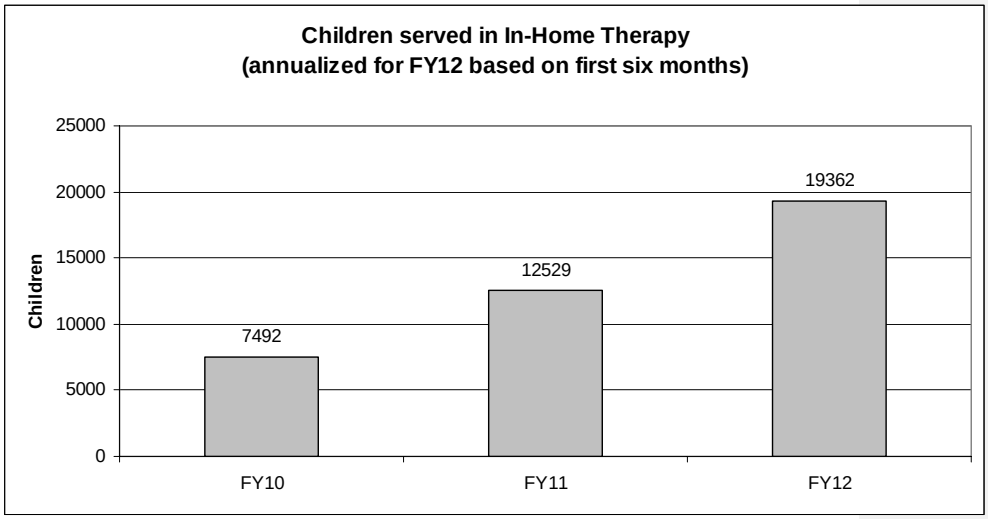
only for up to three days, and crisis stabilization, as originally envisioned, included in-home services for up to seven days. Therefore, MassHealth is increasing the availability of MCI services, when medically necessary, from its previous ceiling of three days to a heightened ceiling of seven days. This modified MCI service will be available statewide as of May 31, 2012.

3. In-Home Support Services

EOHHS ensured that as of September 1, 2009, In-Home Behavioral Services ("IHBS") and Therapeutic Mentoring ("TM") were available statewide and that as of October 1, 2009, In Home Therapy ("IHT")[12] was available statewide.

a. In-Home Therapy (IHT)

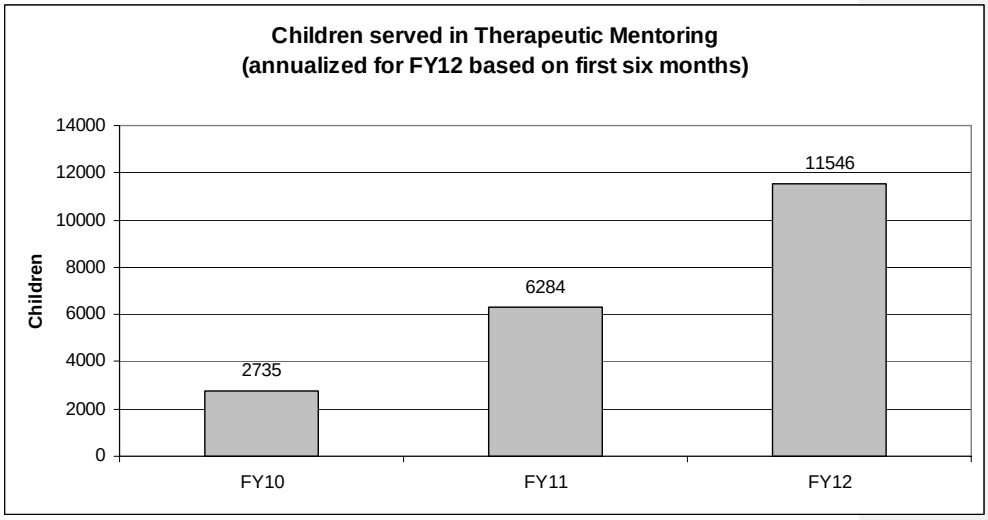
Since the October 1, 2009 inception date, 19,766 young members have received IHT.



During SFY11, young members received an average of 15 hours per month of service. A recent, but smaller, sample shows an average length of stay in IHT of 4.5 months.

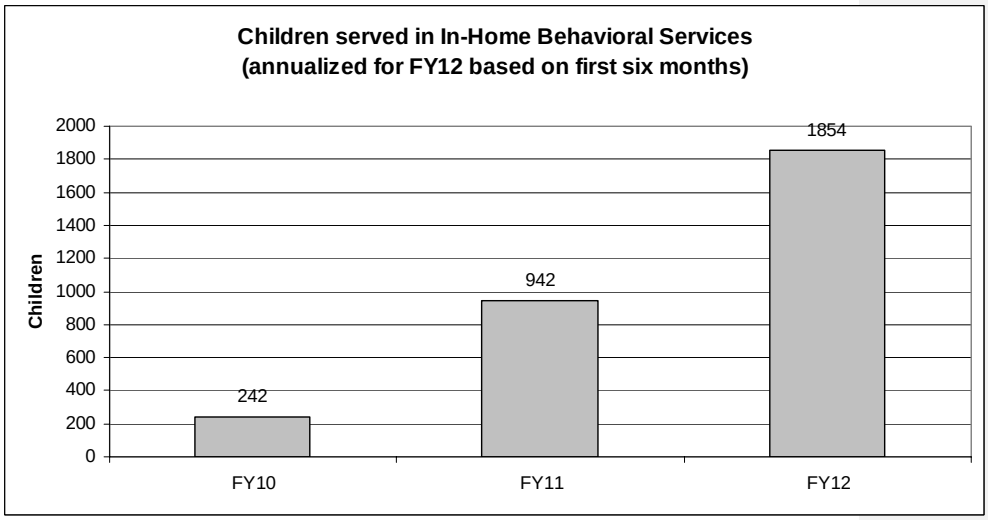
b. Therapeutic Mentoring (TM)

[12] These implementation dates were set by the Court in its February 27, 2009 modification of the July 16, 2007 judgment.



During SFY11, young members received an average of 11 hours per month of service.

c. In-Home Behavioral Services (IHBS)



In SFY11, young members received an average of 12 hours per month of service. As will be described in subsequent sections of the report, MassHealth and its

contracted health plans have devoted significant technical assistance and training resources to providers of these in-home support services to support timely communication and coordination between these services and the "clinical hub" services: ICC, IHT, and outpatient therapy.

C. Outreach

MassHealth has integrated specific information about available behavioral health services into its annual EPSDT notices. MassHealth sends such notices to all young members upon initially enrolling in MassHealth, and then annually, describing members' rights under the EPSDT program, including a list of the remedy services. In addition, MassHealth:

1. Ensures that the Member Handbook of each of its contracted health plans (managed care entities or MCEs) is sent to each member upon enrollment in the plan, and includes a description of the remedy services.

2. Has developed and distributes, free of charge, an informational brochure for parents, entitled "Worried About How Your Child is Feeling or Acting?". Providers, hospitals, health centers, schools and a variety of community based organizations order the brochure from MassHealth. Brochures are available in any quantity and are shipped free of charge. Currently available in English, Spanish and Portuguese, a Haitian Creole version will be added during the summer of 2012 and a Chinese version later in 2013. Approximately 100,000 copies have been distributed.

3. Ensures that each MCE inform members and providers about the remedy services through the MCE's website and in member and provider newsletters.

4. In partnership with the MCEs and providers, has conducted hundreds of meetings across the state with parents, community groups, childcare and early intervention providers, schools, state agencies and advocates, all to get the word out to class members, to families of potentially eligible and at-risk youth, and to the various staff and advocates who come into contact with these members or potential members.

In addition to MassHealth's own efforts, providers of remedy services have themselves prepared and distributed brochures and other materials in their communities containing information about the remedy services.

D. Commonwealth's Commitment to Ongoing Quality Improvement

Massachusetts is committed to the values and goals embodied in the Judgment and has incorporated the remedy services as an integral part of MassHealth. Accordingly, EOHHS intends to monitor and support continuous improvement in the quality of behavioral health services provided to young members. Examples of quality improvement activities include:

1. MassHealth's Office on Quality monitors provider compliance with BH screening and clinical follow-up and coordinates quality improvement activities in the PCC Plan and Managed Care Organization ("MCO")[13] Program.
2. OBH and the MCEs monitor CANS compliance and coordination of CANS quality improvement activities
3. CBHI staff continues to support and work to improve CANS compliance and overall practice improvement.
4. OBH and the MCEs work to ensure that all providers of the remedy services perform according to the Performance Specifications, including annual WFI assessment of ICC. OBH and the MCEs maintain a Continuous Quality Improvement (CQI) approach to the remedy services.
5. EOHHS continues to support coaching and TA for ICC providers.
6. EOHHS is planning to use the System of Care Process Review (SOCPR) methodology in an annual case review of a sample of young members receiving behavioral health services.
7. EOHHS, through the DMH Children's Behavioral Health Research and Training Center (CBH RTC)[14] will provide training, coaching and TA for providers serving young members and families, as a part of focused quality improvement initiatives.
8. EOHHS, through the DMH CBH RTC, and other means, will continue to build capacity for data collection and analysis, including partnerships with external researchers and evaluators.
9. EOHHS, through the DMH CBH RTC, continues to convene, and work with stakeholders in workforce development for children's BH services
10. EOHHS continues to work in partnership with the Children's Behavioral Health Advisory Council.

E. The System Transformation has Improved the Experiences of Participants

The remedy services have been applauded by families who feel more in control, providers who work in concert with families and connect them to an expanded pool of available resources, and others who work closely with children with SED. The following quotations are illustrative:

> "[I]t is the most powerful thing to be in a circle of equals." *A mother of a child who received services, during a recent CSR review.*

> "ICC is a godsend! For the *first* time since my son was born, I can sleep through the night." *Mother of a 19 year old son with a developmental disability and behavioral health needs.*[15]

[13] "Managed Care Organization" refers to health plans that provide services to address both physical health and behavioral health needs. The term "Managed Care Entity" is used by EOHHS to refer to a broader category of health plans, including specialized health plans who deliver particular benefits, such as BH services only.
[14] Established by Chapter 321 of the Acts of 2008.

[15] Personal conversation with Emily Sherwood, Federation for Children with Special Needs Conference, March 2012

"We just graduated from the program in May. The many components of the program were successful to us. A family partner who was always available to meet with me and gave me names of support groups, sent me to different workshops on [my child]'s issues. I am grateful for her service. She spoke from her own experience reassuring me that everything was going to be alright. The monthly care plan meetings with all the team helping [my child] and I to be educated and wonderful suggestions has helped us achieve success. Having [my child] part of the team has helped her be more aware and she felt everyone cared so much about her. The mentoring program was a big hit with [my child]. She gained insight into herself and sharing her problems. [My child] once stated, "I'm doing so much better because I have a mentor." This is just the beginning of how the team has made a difference in our lives. I could go on with more examples, perhaps we could meet so I can share how this program has helped us recover and given us back our lives… Thank you."[16] *A mother of a teenage girl receiving ICC who reached out to CBHI staff to express her appreciation for the services she and her daughter received.*

"I just wanted to take a moment to tell you about a man who is patient, caring and non judgmental…Ben was there to

- Calm us
- Teach us
- Lead us
- Befriend us
- Listen when no one was there
- guide us
- coordinate [my child's] care
- go to school or team meetings with me so I wasn't alone…

So as a single working mother with a teenager with mental health issues, I wanted to say **THANK YOU** for sending me/us such a special person. If more people had the patients and caring manor of Ben Broderick the world would be a better place." [*Sic*] *Mother of a teenage boy receiving IHT.*

"I am a social worker in an elementary school south of Boston. I can honestly say that I breathe a sigh of relief when one of my students has MassHealth. For therapeutic services I have found the Child Behavioral Health Initiative to be unsurpassed in several areas: <u>First, access.</u> Students with MassHealth have an easy access to a local clinic and, in my experience over the past three years,

[16] CBHI and OBH staff met with this parent.

rarely have a waiting time before accessing services. Second, ease of provision of services. Students…have the option for in-home therapy, an option unheard of for private insurance companies. This option has been crucial for multi-stressed families who otherwise find it difficult or impossible to keep appointments outside the home. Third, the array of services offered. Students with MassHealth have the option of accessing a wide array of services based on their particular needs. I have seen parents given their own therapist (distinct from their child's) and frequently have a family therapy option offered as well. Children frequently benefit from having a Big Brother/Big Sister but the waiting lists from the typical sources are frequently months long. CBHI has arranged for therapeutic mentors to fill this need with minimal wait time. CBHI has also arranged for in-home behavioral therapists to work closely with parents who are struggling with their child's explosive behaviors in the home. Parents report that these therapists have been very helpful in teaching positive intervention skills to both parent and child to help maintain calm in the home. Access to child psychiatrists for the monitoring of medication has also been a need that the local clinic has been able to fill for our students. I have also found the staff of the local clinic I work with most often to be dedicated and open to sharing information and resources so that my work at school can be more effective." – *Elementary School Social Worker in a school south of Boston*

"I like working with kids in Wraparound because it integrates information and I hear a lot more about what's going on in the home than before…there is more context for understanding behavior. I can respond in a more informed way to behavioral changes and to pressure to 'fix it' with medication." – *Nurse Practitioner*[17] *from Central Mass.*

"The Peck Full Service Community School deeply values our collaboration with the Children's Behavioral Health Initiative. As a result of these coordinated services, we have formed effective relationships with local service providers and have appreciated not only the quick response, but the family-centered, strengths-based approach of the systems of care framework. As a full service community school that prioritizes family engagement, the CBHI model is one that reflects both our values and our vision." - *Megan Harding, Program Manager, William R Peck Full Service Community School, Holyoke*

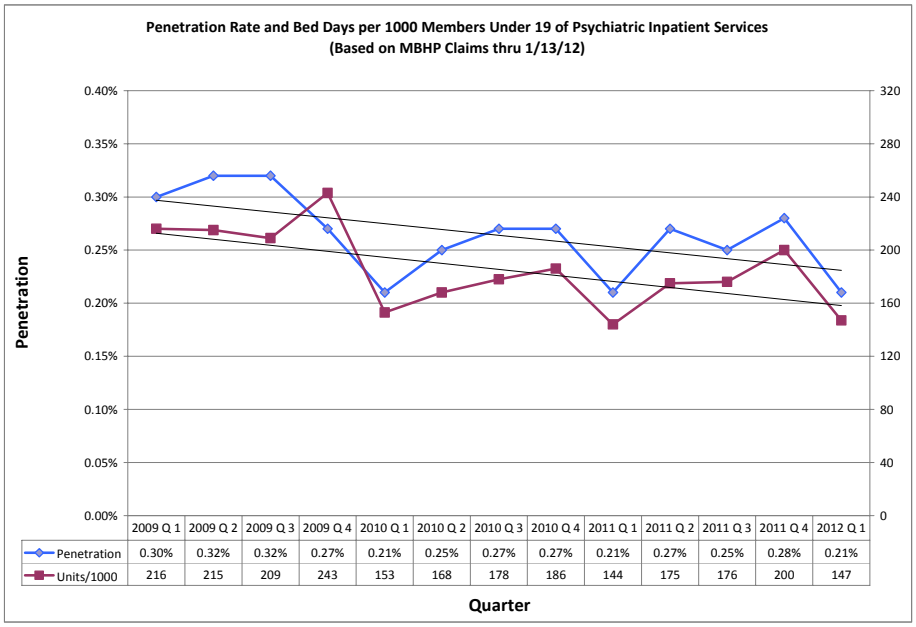
"We try to utilize community-based services for children in crisis and their families whenever possible. We are thrilled when a child

[17] Email

with a mental health disorder seen in the Emergency Department has MassHealth, because we know that we will be able to access a range of services that are not available to patients who are privately insured." - *Kate Ginnis, LICSW, MPH, Associate Director of Emergency Psychiatry, Children's Hospital, Boston*

"With IHT, instead of FST, we can REALLY give the families what they need - it's fantastic!" *Statement of an IHT Program Manager, during a meeting sponsored by the Association for Behavioral Healthcare (ABH), attended by Emily Sherwood.*

In addition to these reports from participants in the CBHI remedy services, there is evidence that those services have had an overall positive effect in a key area – in-patient hospitalization. Prior to the inception of the remedy services, the rate of psychiatric hospitalization among young members seemed to be increasing. EOHHS analyzed the rate of psychiatric hospitalizations among young members, both in terms of the percent of members hospitalized in a quarter, as well as the "bed-days" per 1000 members, from the first quarter (July-September) of FY2009 through the first quarter of FY2012. As the chart below illustrates, there has been a steady trend (with expected seasonal variations) downward in the percentage of young members hospitalized and the number of days in the hospital, and that trend corresponds to the implementation of remedy services.



	2009 Q 1	2009 Q 2	2009 Q 3	2009 Q 4	2010 Q 1	2010 Q 2	2010 Q 3	2010 Q 4	2011 Q 1	2011 Q 2	2011 Q 3	2011 Q 4	2012 Q 1
Penetration	0.30%	0.32%	0.32%	0.27%	0.21%	0.25%	0.27%	0.27%	0.21%	0.27%	0.25%	0.28%	0.21%
Units/1000	216	215	209	243	153	168	178	186	144	175	176	200	147

The remainder of this report documents compliance with the specific requirements of the Judgment. For ease of review, the relevant Judgment language is restated, followed by the description of EOHHS' compliance activities.

II. The Class (paragraph 1[18])

Paragraph one of the Remedy is explanatory and the Defendants are not required to undertake any specific actions thereunder. The Judgment defines the class as children and youth who are eligible for EPSDT (i.e. children enrolled in MassHealth Standard or CommonHealth) and who satisfy the criteria for a serious emotional disturbance set forth in the Individuals with Disabilities Education Act and its implementing regulations or the criteria set forth in the regulations governing the Substance Abuse and Mental Health Services Administration. Medically necessary remedy services are available to members of the class.

III. Informing Families, Providers, and Others of EPSDT Services for SED Children (paragraphs 2-7)

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."

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."

EPSDT Notices
MassHealth informs young members enrolled in Standard MassHealth or CommonHealth of the availability of EPSDT services (1) when members are first enrolled in MassHealth; (2) when members are reenrolled in MassHealth after a break in coverage; and (3) annually, on or around the member's birthday.

The family-friendly member notices are entitled "Welcome to MassHealth," "A Note to Remind You of MassHealth Benefits for Check-ups" and "Welcome Back" All three notices were revised in June 2007 to inform members that behavioral health screens are included in routine well-child visits. The notices were further revised in February 2008 to

[18] Paragraph references refer to paragraphs of the Judgment in Civil Action No. 01-30199-MAP.

include additional information on standardized behavioral health screening, in January 2009 to provide more detailed information on the standardized assessment process using the Child and Adolescent Strengths and Needs (CANS) tool, and in April 2010 to provide more detailed information on Intensive Care Coordination (ICC), and the new services available for children with SED, including information on how to access these services. The current version of the three notices are attached as Exhibit 1.

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."

A. Training MassHealth and MCE Customer Service Representatives

1. **MassHealth Customer Service Representatives**

Since December 2007, MassHealth has required its Customer Services contractor to train new Customer Service Representatives and provide ongoing quarterly trainings for veteran Customer Service Representatives on EPSDT services, including standardized behavioral health screens, the CANS tool, and the remedy services, including information on how to access these services. Trainings on these topics were phased in, as the BH screening, CANS assessments and remedy services were successively implemented. Once a year MassHealth and CBHI staff review and approve the training curricula used by the contractor. Sample curricula are attached as Exhibit 9**.**

The contractor also maintains, for Customer Service Representative use, a "Knowledge Center," an electronic reference library containing information for families and providers about the remedy services. The contractor, in consultation with MassHealth, annually reviews and revises Knowledge Center content to ensure that families and providers receive up to date information, including information on how to obtain remedy services through CommonHealth[19], applying for CommonHealth, and how to obtain remedy services for young members with primary commercial health insurance coverage.

Prior to implementation of BH Screening, the Customer Service contractor updated the voice menu to direct members and providers with questions about services for children to Customer Service Representative trained to answer questions about EPSDT and the various program improvements.

2. MCE Customer Service Representatives

Since 2008, MassHealth has required MBHP and its MCOs to train their own customer service representatives on EPSDT services, including standardized behavioral health screens, the CANS tool, and the remedy services, including information on how to access these services. The MCEs phased in trainings on these topics, as the BH screening, CANS assessments and remedy services were successively implemented. MassHealth and CBHI staff review and approve the training curricula used by the MCEs.

Trainings on these topics were phased in, as the BH screening, CANS assessments and home- and community-based services were successively implemented. MassHealth and CBHI staff review and approve the training curricula used by the MCEs.

B. MassHealth Members

Paragraph 5

"The Defendants will take the following steps to educate MassHealth members about the program improvements they are required to take under the terms of this Judgment:

1. **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 description of EPSDT notices, above.

2. **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 descriptions of these improvements, and how to access behavioral health screening and services, including the home-based services described in Section I.D."**

   MassHealth has updated the member education materials it produces and ensured that the member education materials produced by its contracted managed care entities have also been updated. These member education materials, and the steps taken to update them, are described below.

   a. **Special Member Mailing**
   In December 2007, MassHealth mailed a notice announcing the upcoming program improvements in children's behavioral health to every household that included a MassHealth member under the age of 21, over 350,000 households in total. In early 2009, prior to the June 30 implementation of the first remedy services, MassHealth mailed a member notice to every MassHealth household with a young member. The notice – reviewed and approved by the Plaintiffs – informed members of program improvements, including behavioral health

screening, the standardized assessment process using the CANS tool, the remedy services and how to access them.

Starting in December 2007, and continuing today, the member notice is also inserted in each distributed copy of the PCC Plan's Member Handbook, each of the MCO's Member Handbooks, and MBHP's Member Handbook. A copy of the current version of the member notice is attached as Exhibit 2**.**

b. **MassHealth Managed Care Enrollment Guide (Enrollment Guide)**
The Enrollment Guide is sent to all members newly determined eligible for MassHealth who are eligible for managed care enrollment. MassHealth issued an updated Enrollment Guide in January 2008, including information on EPSDT services and standardized behavioral health screens during preventive care visits. On November 30, 2008, MassHealth published a further revision of the Enrollment Guide, including information on the standardized clinical assessment process, including the CANS tool. In June 2009 another revision of the Enrollment Guide was published, including information about the remedy services and how to access them. This Enrollment Guide is attached as Exhibit 3**.**

c. **PCC Plan Member Handbook (PCC Handbook)**
The PCC Handbook is sent to all members who enroll in the PCC Plan and additional copies are available for members upon request. MassHealth updated the PCC Handbook in January 2008, including more detailed information on EPSDT services, such as that primary care providers would now be offering to conduct standardized behavioral health screens during preventive care visits. Since June 2009, the PCC Handbook has included a Special Member Mailing, described above, as a three page insert providing information on behavioral health screening, the CANS tool, and the remedy services and how to access them.

d. **MBHP Member Handbook (MBHP Handbook)**
MassHealth executed an amendment to its contract with MBHP to require MBHP to publish, update, and distribute a MBHP Member Handbook for members who are enrolled with MBHP but not the PCC Plan (young members in the care and custody of DCF or DYS, or members with commercial health insurance). The MBHP Handbook was created and became available in December 2007. It includes more detailed information on EPSDT services, including the fact that primary care providers would be offering to conduct standardized behavioral health screens during preventive care visits. Hard copies were distributed to DCF and DYS in December, 2007, and an electronic copy was posted on the DCF and DYS intranet sites. The MBHP Handbook is attached as Exhibit 4**.** As of June 2009, the MBHP Handbook also includes the same standard three page insert described above.

e. **MCO Member Handbooks (MCO Handbooks)**
MassHealth executed contract amendments with each MCO to require them to update their materials that describe EPSDT services. Each of the MCOs updated their MCO Handbooks by February 2008, to include, among other things, that

primary care providers would now be offering to conduct standardized behavioral health screens during preventive care visits. As of June 2009, the MCO Handbooks were further updated to include the same standard three page insert described above. An MCO Handbook is attached as Exhibit 4a.

f. The MassHealth Application Package/Member Booklet
MassHealth changed its Application Package and Member Booklet in March 2010, and page 8 of the booklet now contains the following:

> Important information for children and youth with significant mental-health needs or serious emotional disturbance (SED): MassHealth offers certain behavioral-health services for eligible children and youth under the age of 21 who are enrolled in MassHealth Standard or MassHealth CommonHealth. If your child is ineligible for MassHealth Standard and a behavioral-health assessment or other evaluation shows that your child has significant mental health needs or a serious emotional disturbance (SED), he or she may be disabled and eligible for MassHealth CommonHealth.

In addition, instructional language has been added to the MassHealth Application Disability Supplement (Supplement A: Injury, Illness or Disability Questions) on page 7, stating: "Fill out this section for you or any family member who has an injury, illness or disability (*including a disabling mental-health condition*)…"

g. PCC Health Highlights and MCO Member Newsletters
MassHealth members and their families are also informed of program improvements through semi-annual member newsletters published by the MassHealth PCC Plan and the MassHealth MCOs. Each MassHealth health plan also maintains a member-focused website that contains information on remedy services. A complete list of these articles is attached as Exhibit 5 and examples are attached as Exhibits 6 and 7.

3. Amending Member regulations, as necessary, to describe the services described in Sections I.C and D below and other program improvements
MassHealth reviewed the member regulations and determined that no changes were necessary to implement the remedy services or to otherwise comply with the Judgment.

4. **Participating in public programs, panels and meetings with public agencies and with private advocacy organizations, such as PAL, the Federation for Children with Special Needs and others, whose membership includes MassHealth-eligible children and families.**
MassHealth and CBHI staff have presented at and participated in numerous public programs, panels and meetings in order to inform families about the program improvements pursuant to the Judgment. A complete list of such activities is attached as Exhibit 8**.**

C. MassHealth Providers (paragraph 6)

Paragraph 6
"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:

1. **"Updating EPSDT regulations to reflect the program improvements described in this Judgment."**
   Effective December 31, 2007, the Defendants updated MassHealth regulations governing the EPSDT program (130 CMR 450.140-150) to require primary care providers who perform periodic and medically necessary inter-periodic screenings pursuant to 42 USC 1395d(r)(1) to select from a menu of standardized behavioral health screening tools. These regulations are attached as Exhibit 10**.**

2. **"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."**
   Effective December 31, 2007, MassHealth published the updated Appendix W along with the updated EPSDT regulations referenced above. MassHealth updated Appendix W to include a list of approved standardized behavioral health screening tools from which primary care providers must select a tool when administering behavioral health screens for young members. Appendix W is attached as Exhibit 11**.** Beginning in 2009, MassHealth annually reviews the menu of approved screening tools and the periodicity schedule, with the help of external experts in pediatric screening, including the Massachusetts Chapter of the American Academy of Pediatrics.

   As a result of the 2009 review, MassHealth amended Appendix W, effective November 1, 2009, to delete the Achenbach System Child Behavior Checklist ("CBCL"), Youth Self-Report ("YSR"), and Adult Self-Report ("ASR") and add a newly-developed tool, the Strengths and Difficulties Questionnaire ("SDQ"). (For more information on this change, see Section IV.A.)

3. **"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 a description of additional provider communications to primary care providers, see Section IV.C.4 of this report.
   - For a description of additional provider communications to behavioral health clinicians regarding the CANS, see Section VI of this report.
   - For a description of additional provider communications to behavioral health providers regarding the remedy services, see Section VII of this report.

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

a. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Preventive Pediatric Health-care Screening and Diagnosis (PPHSD) Services Billing Guidelines for MassHealth Physicians and Mid-level Providers"**
MassHealth updated the instructions for providers who bill MassHealth directly for EPSDT and PPHSD screening services. The updated Guide became available in December, 2007 and is ordered through the MassHealth PCC Materials catalog or downloaded from the Children's Behavioral Health Initiative (CBHI) website. It is attached as Exhibit 11a.

b. **PCC Plan Provider Handbook**
MassHealth updated the Handbook to describe the standardized behavioral health screening requirement. The revised Handbook was distributed to all PCC Plan clinicians in January, 2008. The updated language is attached as Exhibit 12**.**

c. **PCC Plan Provider Contract**
MassHealth updated this contract to describe the standardized behavioral health screening requirement for PCCs and mailed the updated contract to enrolled Primary Care Clinicians in January, 2008 along with the updated PCC Plan Provider Handbook.

d. **PCC Plan Provider Quarterly**
MassHealth has published 15 articles in PCC Plan Provider Quarterly on program improvements. Two more articles will appear in the June 2012 edition. A complete list of these articles is attached as Exhibit 13 and examples, are attached as Exhibits 14**.**

e. **MCO Provider Newsletters and Bulletins**
Each MassHealth MCO has also published articles in their respective provider newsletters regarding program improvements. These articles have informed providers of the universal screening requirement at well child visits and have also included information on the CANS assessment and remedy services. A complete list of these articles is attached as Exhibit 15 and examples are attached as Exhibit 16**..**

f. **MassHealth Update (no longer published)**
MassHealth has published articles for providers about using standardized behavioral health screening tools in "MassHealth Update", MassHealth's monthly online newsletter for all MassHealth providers. These articles were published in December, 2007, February, 2008, and August 2008. They are attached as Exhibit 17**.**

g. "Expanding distribution points of existing materials regarding EPSDT generally, including the program improvements described in this Judgment."
(i) *CBHI Website* - In December 2007, EOHHS launched a CBHI website to provide information on the EPSDT program improvements to MassHealth

providers, members, families, family organizations, advocates, community-based organizations, the broader community of human service providers, and members of the general public. The website can be viewed at www.mass.gov/masshealth/cbhi. EOHHS continually updates the website with informative materials for MassHealth members, prospective members, and providers, including:

a) *Information for MassHealth members and prospective members* on screening, assessment and the remedy services, and how to access them. A sample of the many materials available on the website include: the family brochure "Worried about the way your child is acting or feeling?", a tip sheet for families applying for MassHealth or CommonHealth, copies of the member EPSDT notices, copies of PCC Plan, MBHP and MCO Member Handbooks.

b) *Resources for primary care clinicians* on standardized behavioral health screening: The Primary Care Behavioral Health Screening Toolkit, a complete guide to implementing and managing behavioral health screening in a pediatric practice, resource materials on the screening tools themselves, evidence for the efficacy of screening, office management tools, resources for responding to potential behavioral health conditions identified through screening, regulations, billing guidelines, other administrative resources.

c) *Extensive CANS resources and links*, both clinical and technical: CANS forms, an FAQ on the CANS, user guides and technical resources for CANS users, and an archive of the CANS Newsletter.

d) *Performance Specifications* and *Medical Necessity Criteria* for the remedy services

e) *EPSDT and other regulations*

f) *Bulk ordering information for the family brochure and Companion Guides* tailored to various staff who might be referring families and youth to remedy services

(ii) EOHHS added to the PCC Plan's Health Education Materials Catalog materials associated with the program improvements, as described in Section IV.

(iii)EOHHS has distributed the CBHI family brochure and staff Companion Guides to providers, advocates and community groups, as described in Section III.C, below.

h. "Implementing any other operational changes required to implement the program improvements described in this Judgment."
See Sections IV through VIII of this report

i. **"Holding special forums for providers to encourage clinical performance activities consistent with the principles and goals of this judgment**."
See Sections III through X of this report.

j. "Amending MassHealth's managed care contracts to assure that the MCEs educate the providers in their network about the program improvements described in this Judgment, as described in Paragraphs 6.a-g. above."
EOHHS amended its contracts with the MCEs in 2008 to require them to educate the providers in their networks about the program improvements. Some of these activities have been described previously in this section. For a description of additional efforts made to inform primary care providers, see Section IV. For efforts to inform behavioral health providers, see **Section X**.

k. "Coordinating these efforts with the Virtual Gateway," which is the EOHHS system for web-based, on-line 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."
As described above, EOHHS has maintained a website since December 2007 that has become a repository for a wide range of information of interest to members, Providers and the public. This website is part of EOHHS's "Mass.gov" website and the CBHI section is prominently identified by large navigation buttons on the EOHHS and MassHealth home pages**.**

C. Prospective Members and the General Public
Paragraph 7
"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 list of informational sessions and meetings with public and private agencies is attached as Exhibit 35.

1. **"Presenting the Judgment to appropriate Commonwealth officials in the Executive Branch and the Legislature."**
In 2007, EOHHS sent copies of the Judgment to senior managers in:
   - the Executive Office of Administration and Finance
   - the Executive Office of Health and Human Services
   - the Office of Medicaid
   - the Division of Health Care Finance and Policy
   - the Departments of: Children and Families; Developmental Services; Early Education and Care; Elementary and Secondary Education; Mental Health; Public Health; and Youth Services

   Also in 2007, EOHHS sent copies of the Judgment to:
   - the Senate President
   - the Speaker of the House
   - the Chairs of the Senate and House Committees on Ways and Means

- the Senate and House Chairs of the Joint Committees on Health Care Financing; Mental Health and Substance Abuse; and Children and Families

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

a. **CBHI Website –** Described above in Section III.A.2.e.

b. **Facts Sheets** – EOHHS prepared and distributed two 'fact sheets' describing the program improvements. 'Fact Sheet 1' was for the general public. 'Fact Sheet 2' was for staff in various agencies and settings who would be in a position to help parents learn about and obtain needed screenings, assessments, care coordination and other remedy services. Both Fact Sheets contained information about EPSDT services available to young members. Distribution of the Fact Sheets is described in Section III.C.4 below. The Fact Sheets are attached as Exhibit 18**.**

c. **"Worried about the way your child is acting or feeling?"** is a full-color, four panel family-friendly brochure that describes the remedy services and how to obtain them. The brochure is produced in five regional versions, each containing contact information for local providers delivering Mobile Crisis Intervention, In-Home Therapy and Intensive Care Coordination (ICC). The brochure is available in English, Spanish and Portuguese. A translation into Haitian Creole will be available this summer. CBHI's plan is to produce a version in Mandarin during SFY13. Distribution of the brochure is described in Section III.C.4 below. It is attached as Exhibit 19**.**

d. **"Helping Families Access MassHealth Behavioral Health Services for Children and Youth Under Age 21: A Guide for Staff Who Work with Children and Families",** is a comprehensive companion publication to the brochure. Developed for staff who serve children and their families, this resource guide provides detailed information on program improvements and information for connecting families with young members to remedy services. The companion guide has been available from the CBHI website since July 2010. It is attached as Exhibit 20**.** Distribution of the Guide is described in Section III.C.4 below.

e. **"Helping Families Access MassHealth Home and Community-Based Behavioral Health Services: A Guide for School Personnel",** is a version of the above-described resource guide, adapted for use by teachers, school nurses, health educators, psychologists, social workers, adjustment counselors, and others who interact directly with students and their families. CBHI staff developed this Guide with assistance from the DESE and representatives of professional educational associations. The guide provides information on program improvements and information for connecting students who are young members with remedy services. It also provides guidance to school personnel on collaborating with Intensive Care Coordination (ICC) teams and on helping to build systematic behavioral health supports for students by participating in local System of Care Committee. The guide has been available from the CBHI web site since October

2011. Distribution of this guide is described in Section III.C.4 below. It is attached as Exhibit 21**.**

f. **"Helping Families Access MassHealth Home and Community-Based Behavioral Health Services: A Guide for Early Education and Care Staff",** is a version of the above-described resource guide that is currently in development for staff who work in early education and childcare settings. Staff from the Department of Early Education and Care (DEEC) and the DPH Early Intervention Program are advising CBHI staff on this guide. This guide is scheduled for release in the Fall of 2012.

g. **"How to Apply for MassHealth for Your Child,"** provides step-by-step instructions for parents and caregivers applying to MassHealth for their children. The guide's objective is to provide "tips," or advice, to ensure a smooth application process for families seeking MassHealth enrollment for their children, in order to access the remedy services. The guide is also useful for anyone who wants to apply for MassHealth. This publication has been available since October 2011. Distribution of this guide is described in Section III.C.4 below. This guide is attached as Exhibit 22**.**

h. **"CBHI Update"** – Available since December 2008, the Update is a monthly to bi-monthly email newsleter providing timely information on program implementation, new resources, upcoming events and other relevant areas of interest. EOHHS sends it to over 2,000 providers, public and private agencies, associations, educators, families, school nurses, and other interested parties. Sample CBHI Updates are attached as Exhibit 23**.**

i. "**CANSNews"** is a quarterly newsletter that offers information to providers, administrators, data entry staff and others who use the CANS application on the Virtual Gateway. Launched in January 2010, the newsletter disseminates news and information to over 10,000 CANS users. The most current edition is April 12, 2012. All issues of the CANSNews are attached as Exhibit 24**.**

3. **"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 Refugess and Immigrants on how to access MassHealth services for children with SED."** See Section V of this Report.

4. **"Distributing outreach materials in primary care settings, community health centers, community mental health centers and post electronic materials on the EOHHS Virtual Gateway that are designed to provide information to MassHealth members and to public and private agencies that come into contact with or serve children with SED or their families"**
As described previously in this section, EOHHS has developed high-quality, targeted outreach materials for members and people who come into contact with children with SED or their families. EOHHS continues to inform target audiences of these materials

and disseminate them via targeted and broadcast emails, the CBHI portion of EOHHS's website, and in-person meetings.

a. EOHHS Virtual Gateway/CBHI Website

As reported above, EOHHS launched a CBHI website in December 2007. EOHHS publicizes the website URL at all public speaking engagements and includes it in outreach materials, such as the Brochure and the resource guides described earlier. Over the years the website has become a convenient way to link stakeholders to important information related to the remedy services, and it has become a repository for vital documents for the behavioral health provider community. For more information see **Section III.B.5.,** above.

b. **Distribution of the Fact Sheets**

The fact sheets were distributed to an extensive list of organizations, including the following, in December 2007, October 2008, and August 2009. Each time the request was for recipients to distribute the materials to their staff and/or members and to encourage them to distribute them to families and youth:

- DCF
- DDS
- DEEC
- DESE
- DMH
- DPH
- DTA
- DYS
- ORI
- All of the trade associations representing private agencies serving children and families
- community-based and advocacy organizations
- Massachusetts Medical Society
- MA League of Community Health Centers
- MA Chapter of the American Academy of Pediatrics
- MA Association of Family Practitioners
- Association for Behavioral Healthcare

The fact sheets were replaced by the CBHI family brochure and staff guides, described below.

c. Distribution of the CBHI Brochure

The Brochure is available from MassHealth free of charge in bundles of 50. Ordering information is on the EOHHS website and is publicized through the CBHI Update and through the various phases of dissemination described below.

Since May, 2010, EOHHS has distributed approximately 100,000 copies in English, Spanish and Portuguese to families, schools, family organizations,

primary care practices, mental health clinics and other community-based providers.

When the Brochure was first published, EOHHS Secretary JudyAnn Bigby, MD announced its availability in an emailed letter to over 2,000 organizations, networks and individuals with instructions on how to obtain the brochure as well as how to download the companion resource guide. The letter is attached as Exhibit 25**.** The list included medical associations such as the MA League of Community Health Centers, the MA Hospital Association, the MA Medical Society, the MA Chapter of the American Academy of Pediatrics and the MA Academy of Family Physicians, a broad range of BH and social service agencies, community-based organizations and professional educational associations.

In October 2010, EOHHS completed a second mailing targeting 400 key individuals representing a broad array of family- and child-serving organizations (e.g., YWCAs, Jewish Big Brother/Big Sister, Boys and Girls Clubs, Campfire, family homeless shelters, Community action legal aid/advocacy organizations, adoption agencies, PTAs, etc.).

In fall 2011 EOHHS sent a similar letter to all the family shelter directors across Massachusetts. In spring 2012 the Massachusetts League of Community Health Centers, on behalf of EOHHS, included a link to the brochure order form in the weekly email that it sends to member centers and posted the brochure and the Screening Toolkit on their website. The Brochure is scheduled for a reprint with updated provider contact information in the summer of 2012 and EOHHS plans another series of e-mailings to include the same groups listed above and to also target groups they have not previously directly contacted by EOHHS, such as faith communities.

d. **Helping Families Access MassHealth Behavioral Health Services for Children and Youth Under Age 21: A Guide for Staff Who Work with Children and Families**
CBHI and MassHealth staff publicize the Guide through the CBHI Website, the CBHI Update and meetings with state agency, school and community agency staff.

e. **"Helping Families Access MassHealth Home and Community-Based Behavioral Health Services: A Guide for School Personnel"**
The school version of the staff guide and the "How to Apply for MassHealth for Your Child" guide were published in October 2011. CBHI staff sent a special announcement to its entire mailing list announcing the availability of these new materials with direct links to them on the CBHI website. DESE placed it on their website and Commissioner Mitchell Chester shared this announcement in one of his twice monthly emails to all school superintendants. CBHI staff worked with school professional associations, such as the Massachusetts Association of Elementary School Principals, the Massachusetts Association of School

Superintendents and the Association of Special Educators to distribute the Guide to their members. MassHealth also shared copies of the School Personnel Guide and the "How to Apply" Guide, along with instructions for accessing these documents on the CBHI website, with providers at the December CSA statewide and Level of Care meetings (see Section VII for a description of these meetings.) In March 2012 CBHI staff disseminated the School Personnel Guide through the Massachusetts Organization of Education Collaboratives. These regionally-based organizations are funded by multiple school districts to deliver certain special education services. Educational collaboratives frequently convene a variety of trainings and meetings for their member school districts.

f. Materials available to PCCs through the Health Education Materials Catalog
Described in Sections III.C. and IV.B. of this report.

5. "Working with the Department of Early Education and Care to educate pre-schools, childcare centers and Head Start Programs on how to access MassHealth services for children with SED"

In order to inform early education and care provider staff, CBHI staff worked with DEEC to develop and distribute various outreach and educational materials as well coordinate briefings on MassHealth behavioral health services. Below is a summary of the activities done in partnership with DEEC.

a. As described above, EOHHS produced and distributed two notices. DEEC distributed the notices to all DEEC-licensed childcare providers in the Commonwealth in December 2007, Oct 2008 and August 2009. In addition to distributing the notices, DEEC sent a letter from the Commissioner in May 2009 to all DEEC-licensed childcare providers to inform them about the new remedy services and dates of implementation; and alerting them to EOHHS and DESE briefing presentations in Fall 2009. The letter is attached as Exhibit 26**.**
b. As described below, in the fall of 2011, EOHHS released a resource guide for school personnel on MassHealth behavioral health services for young members. EOHHS is now in the process of developing a resource guide for early childhood providers (i.e. early intervention, early education and care, family support programs, Headstart programs, early childhood special education, etc.) EOHHS initially approached this project as a simple adaptation of the School Personnel guide to an early childhood audience. However, feedback from colleagues in the early childhood community have led EOHHS staff to plan a more targeted guide. EOHHS anticipates completing the guide in the fall of 2012.

6. "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."

EOHHS has worked closely with staff of the DESE, EOE and DPH to develop and distribute various outreach and educational materials as well as coordinate briefings

on MassHealth behavioral health services. Below is a summary of the activities done in partnership with these agencies.

a. In March 2009 EOHHS convened a CBHI Pre K-12 Advisory committee in partnership with EOE, DEEC and DESE to discuss communication strategies with public schools. Based on the recommendations of this group, Commissioner DESE Commissioner Mitchell Chester, wrote a letter, referenced in the previous section, addressed to all school districts providing an overview of CBHI and the role that school personnel will play in connecting eligible students to the remedy services. In partnership with the DESE, EOHHS held an initial series of five briefings across the state for public school personnel in the fall 2009. The Compliance Coordinator and staff from DESE and the Office of Medicaid presented at these briefings. Subsequent to the original five, the CBHI office continues to schedule briefings with school districts and educational collaboratives either through invitations from these bodies or through EOHHS direct outreach. The letter is attached as Exhibit 27**.** Attached also is a list of school meetings held to date, Exhibit 28**.**

b. As described above, in fall 2011, EOHHS released a resource guide for school personnel on MassHealth behavioral health services for young members. The idea for the Guide came from EOHHS staff participation in the Behavioral Health and Public Schools Taskforce (the taskforce named in Massachusetts's Children's Mental Health law, Chapter 312 of the Acts of 2008). EOHHS saw an opportunity to create a resource guide specifically for school personnel based on the original Companion Guide to the family brochure. EOHHS drafted the guide and received feedback from DESE staff, members of the Behavioral Health and Public Schools Taskforce and the Plaintiffs. Like the Companion Guide, the School Personnel Resource Guide contains background information on MassHealth and descriptions of each of the remedy services. It also includes guidance on using Mobile Crisis Intervention in schools and how schools can collaborate with ICC teams. The guide is available on the CBHI website. In October, 2011, the DESE Commissioner emailed all superintendents of schools to announce the guide's availability and provide a link to it. EOHHS also emailed the announcement (and link to the guide) to the above listed school professional associations. The Guide is attached as Exhibit 21**.**

c. As described in more detail in Section V of this Report, EOHHS developed protocols for staff working within the DPH School Based Health Centers Program, Bureau of Substance Abuse Services, and Early Intervention Program to guide staff on how to refer eligible individuals for screening, assessment and services. The Director of School Health Services within DPH has partnered with the EOHHS since 2007 to bring outreach materials and training to the School Nurse Leaders supported by DPH across the state. Each of the School Nurse Leaders then disseminates materials and information to the school nurses in her area. Activities have included:

- In December 2007 - distributing the Fact Sheets, described earlier in this section, to all public school nurses in Massachusetts.
- December 5, 2007 – a training for the smaller group of School Nurse Leaders (approximately 200 school nurse managers who work with DPH to implement new policies and procedures), about the screening requirements and how to help parents obtain behavioral health screens for young members.
- May 2010 – distributed the CBHI brochure and companion guide to all public school nurses in Massachusetts..
- August 2010 – CBHI staff presented on the remedy services, and the role school nurses play in helping children access them, at the August 2010 Northeastern University School Health Institute – Summer Institute for School Nurses, Hyannis.
- September 2010 – CBHI staff provided a similar training for over 150 School Nurse Leaders selected by the Mass. Department of Public Health.
- October 2011 - the Director of School Health Services distributed the announcement of the School Personnel Guide, with a link to the document, to all public school nurses in Massachusetts.
- December 2011 – the Director of School Health Services repeated the email.

IV. Standardized Behavioral Health Screening in Primary Care (paragraphs 8, 9, 10, 36)

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) (l) 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"

A. Selecting the Screening Tools

1. Initial Selection

Prior to the December 31, 2007 implementation of the requirement that primary care providers use a standardized behavioral health screening tool to perform periodic and medically necessary inter-periodic behavioral health screenings, EOHHS worked with the Massachusetts Chapter of the American Academy of Pediatrics ("MCAAP") and a panel of pediatric behavioral health screening experts to select the list of approved behavioral health screening tools. The group used the following criteria to select the tools: good inter-rater reliability (results are very similar no matter who administers the screen), validity (the tool actually screens for the condition of interest), ease of use, low cost, and availability in multiple languages. As required by the Judgment, the list of approved tools includes the Pediatric Symptom Checklist (PSC) and the Parents' Evaluation of Developmental Status ("PEDS").

2. **Annual Review of the List**
   Each year the group of external experts reviews the list of tools to assess whether there are any new tools that should be added, potentially replacing other tools, or tools to be removed for any reason.
   a. **2009**
      The group recommended adding a new tool, the Strengths and Difficulties Questionnaire (SDQ) and removing the Child Behavioral Checklist (CBCL) a lengthy behavioral health clinical assessment tool seldom used by primary care providers. These changes were made.
   b. **2010**
      The group did not recommend any changes to screening tool menu.No changes were recommended or made.
   c. **2011**
      The external screening tool experts reviewed the published and unpublished research concerning a promising new tool for very young children and had not reached a conclusion about it by the end of the year.
   d. **2012**
      The external screening tool experts have recommended that the new tool not be adopted yet by MassHealth and that the menu of screening tools remain unchanged for 2012.
      The current list of approved BH Screening Tools is attached as Exhibit 29**.**

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."
See Section III.C, above.

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)."

B. Training Activities
1. **2007**–
   Training Forums

To support primary care providers in implementing the new behavioral health screening requirement, the PCC Plan and the MCEs developed and presented seven training forums[20] around the state for primary care doctors and nurses. The presentation and accompanying resource materials included an overview of the new screening requirement; discussion of evidence supporting the use of standardized screening tools; information on the approved tools; guidance on when to refer children and youth to a behavioral health provider; and strategies for incorporating screening tools into routine office procedures. Participants received free Continuing Medical Education credits. These materials and a training curriculum were also posted on EOHHS' CBHI website.

2. 2008

a. **Training Forums** - Additional training forums were held on June 18, 19 and 26, in Pittsfield, Hyannis and Danvers.

b. **Screening Tool Consultants** - In collaboration with the Massachusetts Child Psychiatry Access Project (MCPAP), EOHHS made Screening Tool Consultants (STCs) available to primary care providers upon request. The STCs were pediatricians with expertise in the use of behavioral health screening tools, including experience using the tools in their practice. The STCs were available to PCCs for phone or in-person consultation to answer clinical questions about screening and behavioral health referrals as well as practical questions on how to effectively implement behavioral health screening in the provider's practice. The STCs also made outreach calls to providers who were billing for few behavioral health screens at the time of well child visits, to discuss the provider's need for assistance.

c. ***Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative (CBHI).*** Based on their experience providing technical assistance to primary care providers, in late 2008, EOHHS asked the STCs to write a comprehensive guide to behavioral health screening in primary care, focusing on the four most commonly used tools. The resulting Toolkit covers topics such as "how to get started using standardized BH screening tools in your office" and guidance on clinical issues related to screening, such as how to manage the screening within the visit and how to respond to BH risks identified through screening. The Screening Toolkit is attached as Exhibit 30**.**.

3. 2009

a. **Screening Toolkit -** The Screening Toolkit was posted on the CBHI website.

b. **Training Forums**

(i) *March and April Forums* - The Toolkit was introduced to, and well-received by, providers at Primary Care Provider Forums sponsored by MassHealth's contracted health plans and hosted by the PCC Plan on March 26, 27, 30 and April 1, 2009 in Sturbridge, Westport, Waltham, and Andover. (The locations for the forums were selected based upon lower rates of billing for behavioral health screening among primary care providers in the area.) The forums also presented the Department of Public

[20] The 2007 forums were: November 6, Waltham; November 8, Springfield; November 13, Worcester; November 15, Taunton.

Health's CRAFFT Toolkit. The CRAFFT is one of the approved screening tools, and is used to screen youth for substance abuse.

(ii) *June Forums* – The PCC Plan and the MCEs also held provider forums on June 10 and 16, 2009 in West Springfield and Waltham to introduce primary care providers to the new remedy services and how to refer members to those services.

c. **CBHI Family brochure** and **Companion Guide for Staff** - Information about the guide and the brochure, including information on how to place bulk brochure orders, was electronically distributed to PCPs through the MCEs and various medical associations and guilds. They were also posted on the CBHI and MCE websites.

4. 2010

Updated Primary Care Behavioral Health Screening Toolkit – was released in May. PCCs can download the kit from the CBHI website and PCC Plan providers can order it for free from the Primary Care Clinician Plan's Health Education Materials Catalog.

C. Data Tracking

1. Collection of data on the number of screens delivered and outcome of screens

The MCOs are required to track and submit quarterly reports of the provider utilization rates of a standardized behavioral health screening tool as part of the well child EPSDT visit for young members. This data is provided to MassHealth as part of the MCO's standard package of quarterly data submissions. MassHealth also has access to this data through the encounter data submitted to MassHealth by the MCOs.

Data on behavioral health screening of young members in the PCC Plan are compiled from MassHealth's mechanized claims processing and information system, or MMIS.

The most recent Quarterly Behavioral Health Screening Report is attached as Exhibit 31**.**

2. **Collection of data on utilization of BH services following a screen indicating a potential BH need**

These data are collected through claims and encounter data, as described in detail below. In 2013, EOHHS will conduct case record reviews to learn more about referrals and follow-up services provided by PCCs following a screen indicating a potential BH need, as well as about the screening tools being used by PCCs.

D. Quality Improvement Activities (paragraph 10)

1. 2008

a. **Clinical Topic Review ("CTR") -** MassHealth requested the Center for Health Policy and Research (CHPR) at UMMS to conduct a CTR on BH screening for children with well visits during SFY2007 (July 1, 2006 - June 30, 2007). The purpose of the CTR was to assess the baseline of BH prior to implementation of the BH screening requirement. CHPR contracted with MedAssurant, Inc., a

national vendor for medical record reviews, to collect data from the records of 2000 young members, representing 2180 charts and 2966 visits. They calculated the percentage of well visits that included screenings for BH conditions and recorded whether those screenings included the use of a standardized tool, and, if so, which tool. In addition, they collected information on whether the individual was referred for BH services and, through claims data, whether that individual accessed services in the six months following the visit. MedAssurant was able to collect data from 62% of the charts.

The full report is attached as Exhibit 32**.**

b. **PCC Plan Quality Improvement Activities**

(i) *Quarterly Mailings to all PCCs who treat young members* - In August 2008, MassHealth initiated these quarterly mailings to support implementation of the BH screening requirement. The mailings are sent to all MassHealth PCCs who had at least one paid claim for a well child visit. The letter includes data specific to each PCC on: the number of paid claims for well-child visits, the number of behavioral health screens billed for, and the number of claims that included the required billing modifier. The letter also directs PCCs to resources to learn more about behavioral health screening and increasing the number of behavioral health screens performed.

(ii) *Pediatric Behavioral Health Reminder Report* - To support PCC outreach to young members who have not received follow-up care, all PCCs receive a semi-annual Pediatric Behavioral Health Reminder Report. The Reminder Report informs PCCs which young members in their panel received a behavioral health screen that identified a potential behavioral health need at the individual's most recent well-child care visit but who did not receive follow-up care for that potential need within 90 days.

2. 2009

a. PCC Plan Quality Improvement Activities

(i) *Quarterly Mailings to all PCCs who treat young members* – As the initial phase of implementation concluded, MassHealth changed the frequency of the mailings to semi-annual, in line with the Pediatric Behavioral Health Reminder Report.

(ii) *Pediatric Behavioral Health Reminder Report* – continues to be sent to PCCs semi-annually.

(iii)*PCC Plan Provider Profiles* - Every six months, the PCC Plan prepares "Provider Profiles" for PCCs with 180 or more MassHealth members. Beginning in 2008, the Provider Profile reports have included data on the provider's rate of BH screening, the percentage of young members screened with a potential need identified and the percentage of those young members for whom a provider has submitted a claim for a follow up service within 90 days of the screen. (A follow-up service is defined as a claim for a behavioral health service or a visit with the PCC for which the PCC files a claim and uses a behavioral health diagnostic code. These "claims data" do not capture all

PCC responses to a potential identified need; they only capture responses for which a provider files a claim within the 90 day window.

b. **Court Monitor's Review**
In 2009, MassHealth worked closely with the Court Monitor to support a series of fourteen visits to primary care practices across the state by Christina Crowe, M.S.W., a clinical consultant working with the Court Monitor. The sites were selected to include offices with high, average and low rates of screening. The purpose of the visits was to learn about best practices and barriers to implementing and sustaining high rates of behavioral health screening. The report analyzing these visits is attached as Exhibit 33.

3. 2010

a. PCC Plan Quality Improvement Activities
(i) *Quarterly Mailings to all PCCs who treat children and youth under 21*
(ii) *Pediatric Behavioral Health Reminder Report*
(iii)*PCC Plan Provider Profiles*

b. CBHI BH Screening QI Workgroup
MassHealth formed a new committee to coordinate quality improvement (QI) activities related to behavioral health screening. The CBHI BH Screening QI Workgroup reviewed screening data, prioritized areas for improvement and coordinated quality improvement activities across MassHealth's three service delivery systems: fee-for-service, PCC Plan and MCOs. The Screening QI Workgroup selected two quality improvement projects, each targeting "outlier" groups in the screening data.

(i) *Hospital Outpatient Departments* - The first group is hospital outpatient departments that, on average, have lower rates of billing for screening than other primary care providers. It was, in fact, discovered to be an artifact of the payment system. That system is being replaced with a new system that will fix the problem. It is scheduled to be in place later in 2012.

(ii) *Screening of Youth 18-20* - The second project was to look at screening by providers who see young people ages 18 through 20. The average rate of screening for this group is less than half of that for members 6 months old to 17 years old. Staff selected a sample of providers with high screening rates for youth 18-20, developed a questionnaire, interviewed providers and compiled "lessons learned", which were published in the Winter 2012 PCC Plan Quarterly, attached as Exhibit 14.

b. **MCO Quality Improvement Project (QIP)**
In 2010 MassHealth requested its MCOs to conduct a screening Quality Improvement Project (QIP) in FY2011 and FY2012. Each MCO has independently designed and implemented a data collection strategy to learn more about screening rates and follow-up services to young members with a positive BH screen. The MCOs presented "mid-improvement-cycle" findings to MassHealth in October and will present final result in the summer of 2012. The October findings are summarized in Section X.A.

4. 2011

a. **PCC Plan Quality Improvement Activities**
(i) *Quarterly Mailings to all PCCs who treat children and youth under 21*
(ii) *Pediatric Behavioral Health Reminder Report*
(iii)*PCC Plan Provider Profiles*

b. **CBHI BH Screening QI Workgroup**
In 2011, the Screening QI Workgroup worked with MassHealth's Department of Data and Analytics to design and build a "data cube" of automatically-refreshed screening data to permit MassHealth quality improvement staff to analyze screening data to support screening quality improvement activities.

c. **Enforcing the Use of a Billing Modifier to Report on Screening Results**
Since implementation of BH screening, MassHealth has required primary care providers to report screening results using billing modifiers on the claim. The MCOs are also required by Contract to implement the same modifiers as MassHealth uses. The percentage of claims not including a modifier has dropped from 35% during the first quarter of 2008, to 16% during the last quarter of 2010. MassHealth and the MCOs decided to take the final implementation step of making the billing modifier a critical edit in their respective claims payment systems. This means that any claim submitted without the required modifier is denied. This change became effective in July 2011.

2012

c. **PCC Plan Quality Improvement Activities**
(i) *Quarterly Mailings to all PCCs who treat children and youth under 21*
(ii) *Pediatric Behavioral Health Reminder Report*
(iii)*PCC Plan Provider Profiles*

d. **CBHI BH Screening QI Workgroup**
As a result of the reorganization of quality improvement activities at MassHealth, an Office on Quality has been established and staffed, within the Office of Clinical Affairs. In early 2012, the work of the Screening QI Workgroup was transferred to this new unit.

e. **Clinical Topic Review (CTR) -** MassHealth has requested a follow-up study to the CTR conducted by the Center for Health Policy and Research (CHPR) at UMMS in 2008. This study, to be conducted during SFY2013 (July 1, 2012 – June 30, 2013), will include reviews of medical records to record whether screens were performed, whether a standardized tool was used, and, if so, which one, and, what follow up care was recommended by the physician and whether such follow up care is documented in the records or found in Medicaid claims.

Paragraph 36
Project I: 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.**
b. ***Tasks performed will include:***
i) Developing and announcing a standardized list of

behavioral health screening tools.

See section IV.A., above.

ii) Drafting managed-care or provider contract amendments and regulatory changes to conform to the new requirements.

See Section III.C, above.

iii) Improving EPSDT Member notices concerning the availability of behavioral health and other EPSDT screening, and the availability of behavioral health services.

See Section II, above.

c. ***Timelines for implementation:***
i) Defendants will submit to the Court a written report on the implementation of Project I no later than June 30, 2007.

Submitted.

ii) Completion of this project will be by December 31, 2007.

See Section IV., above.

E. External Evaluations of MassHealth's Implementation of Standardized Behavioral Health Screens

On November 16, 2010, TeenScreen National Center for Mental Health Checkups at Columbia University released **"Rosie D. and Mental Health Screening, A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit"** documenting MassHealth's implementation of standardized behavioral health screening. According to TeenScreen: "Massachusetts has set a new standard for comprehensive mental health screening and follow-up services. Their experience can offer valuable lessons and insight for other state Medicaid programs, health care plans, and providers as they consider ways to improve upon the mental health assessment component of the well-child visit."

Based on interviews with stakeholders in Massachusetts, the case study identifies several implementation factors key to MassHealth's success, including:

- Engagement of stakeholders
- Decision to pay providers for screening
- Education of providers
- Monitoring of implementation and outcomes.

The Case Study is attached as Exhibit 34.

V. Identification of Behavioral Health Needs – The Role of Other EOHHS Agencies, and other Public and Private Agencies (Judgment, paragraphs 11, 12)

Paragraph 11

"MassHealth will continue its 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 another agency, including other EOHHS agencies, state agencies, public schools, community health centers, hospitals and community mental health providers."

MassHealth has continued its practice of not requiring a primary care visit or EPSDT screening in order to access behavioral health services. A member may self-refer to any service he or she thinks is appropriate, or may be referred by EOHHS agencies, other state agencies, public schools, community health centers, hospitals and community mental health providers.

Paragraph 12

A. **"The Defendants will provide information, outreach and training activities, focused on such other agencies and providers. "**

In order to prepare staff in a wide range of public and private organizations for their role in referring MassHealth members for behavioral health services, EOHHS developed outreach materials and briefing guides. For more detailed information on materials and outreach, see Sections III.B., III.C. and VII.E.3 of this report. A complete list of informational sessions and meetings with public and private agencies is attached as Exhibit 35**.**

B. "In addition, The Defendants will develop and distribute written guidance that establishes protocols for referrals for behavioral health EPSDT screenings, assessments and services, including 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."

1. EOHHS developed written protocols to provide guidance for staff of EOHHS' child-serving agencies on how to refer eligible children and youth for screening, assessment and services. The protocols include an introduction to MassHealth and its existing behavioral health services, descriptions of the Remedy services, eligibility information and state-agency-specific protocols for referring young members to remedy services and for coordinating other state services with Remedy service providers.

2. For a list of the protocols and their completion dates, please see Section VII.A.

3. Staff at each of these agencies received copies of the protocols. There were also in-person protocol trainings, including an introduction to Intensive Care Coordination and Wraparound. A year- by-year summary of these training activities is attached as Exhibit 36

4. In addition, EOHHS has taken a number of steps to inform and collaborate with Court Clinics, Juvenile Court Judges, Magistrates and the Massachusetts Office of Probation, to facilitate access of Court-involved youth to remedy services and to improve collaboration between the Courts, Probation and remedy service providers regarding the care of Court-involved youth.:

    a. In 2009, CBHI staff worked with staff of the Department of Mental Health's (DMH) Division of Forensic Mental Health (DFMH) to develop written "Questions and Answers" for Court Clinic staff, answering key questions about when and how the Court Clinics can help children and youth access MassHealth BH services.

    b. November 10, 2009 – CBHI Presentation to the Juvenile Court Department, Fall Education Meeting (for Juvenile Court Judges, Clerks Magistrate and Chiefs of Probation),

    c. April 6, 2011 – Meeting of DFMH Director Debra Pinals, M.D., DFMH Manager of Juvenile Court Clinics, Tina Adams, Ph.D., DMH Asst. Comm. for Child and Adolescent Services, Joan Mikula, and Juvenile Court Clinic Directors, to discuss sucesses and challenges of implementing the remedy services as they affect the Juvenile Court population. [

    d. August, 2011 – Meeting of DMH Commissioner Barbara Leadholm, Asst. Commissioner Joan Mikula, Assistant. to the Compliance Coordinator, Jack Simons, and Commissioner of the Office of Probation, Ron Corbett. This was the first meeting with Commissioner Corbett since his appointment and participants identified several steps to enhance collaboration between the Office of Probation and remedy services. Subsequently, the Office of Probation staff attended the December statewide Wraparound trainings conducted by Vroon Vandenberg for EOHHS, and other state agency staff.

    e. May 5, 2012, Meeting of DMH DMH Asst Commissioner Debra Pinals MD, Laura Conrad from MassHealth Office of Behavioral Health, First Justice Carol Erskine, Worcester Juvenile Court, Julie LaMacchia, Director, Worcester Juvenile Court Clinic, Francine Lefemine, Chief Probation Officer, Worcester Juvenile Court, First Justice Jay Blitzman, Middlesex Juvenile Court, Rebecca Pries, Director, Middlesex Juvenile Court Clinic, Stephen Allsopp, Chief Probation Officer, Middlesex Juvenile Court, and Jack Simons from the Office of the Compliance Coordinator. This was the first meeting of a workgroup that will focus on development of guidelines for collaboration between elements of the

Juvenile Court and MassHealth services, plus related matters of training and communication.

VI. Assessment and Diagnosis (paragraphs 13-16, 37)

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:"

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."

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."

Prior to the implementation deadline of November 28, 2008, MassHealth revised MassHealth provider regulations, rate regulations, and MCE contracts to implement the requirement for clinical assessment processes inclusive of the CANS. Specifically,

- BH providers in most levels of care must complete clinical assessment processes inclusive of the CANS . These levels of care include Outpatient, In-Home Therapy, and Intensive Care Coordination, all "hub" services that are responsible for coordination of care.
- For providers of twenty-four hour levels of care (inpatient and Community Based Acute treatment, or CBAT) the CANS is completed as part of the discharge planning process.
- For providers receiving fee-for-service payments from MassHealth , the requirement is incorporated in MassHealth regulations.
- For providers receiving payment under contract with a MassHealth-contracted MCE, the requirement was implemented through MCE contract amendments.

- For outpatient services, MassHealth implemented a rate increase, through either regulation or contract, for diagnostic sessions and expanded the number of sessions allowed from one to two.[21]

The CANS is not required for emergency services or for certain services that do not involve a comprehensive treatment plan and coordinated care, such as the "hub dependent services" Family Support and Training, Therapeutic Mentoring and In-Home Behavioral Services. These services are delivered pursuant to clinical assessment processes inclusive of the CANS, and a treatment plan, completed by one of the "hub" services, as described above.

Providers were informed of the CANS requirement through multiple channels, including a MassHealth transmittal letter to Fee for Service providers, Network Alerts from managed care entities, provider forums, and CBHI mass emails.

As the Judgment requires, DMH adopted policies and procedures to ensure that staff complete a CANS for young members being discharged from DMH intensive residential or continuing care programs.

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.

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.

[21] While no separate rate enhancement was offered in In-Home Therapy or Intensive Care Coordination (because assessment is not billed as a separate event in those services), MassHealth clarified that assessment is a billable activity in those services.

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.

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."

EOHHS implemented the CANS tool through a lengthy and complex implementation process with several essential components:

- Including the CANS requirement in regulations and contracts (described above.)
- Modifying and revising the CANS tool to serve its intended purpose in Massachusetts
- Building and maintaining a web-based system to collect and report CANS data, and an associated system for tracking member consent
- Training and periodically certifying a large behavioral health workforce to rate the CANS accurately
- Informing and educating providers, managed care entities, consumers and other stakeholders on the CANS requirement, and on all related elements and activities. Due to the breadth, complexity and novelty of the CANS implementation, this informative and educational component has been a major ongoing effort.

EOHHS's accomplishments in specific areas are described below.

A. Modifying and revising the CANS tool to serve its intended purpose in Massachusetts

1. Development of the Massachusetts CANS

   The CANS is used in many state and county service systems across the country and is designed to be modified to meet the specific needs of different jurisdictions and populations. Massachusetts had some experience with the CANS prior to 2006, as DCF had been using the CANS for several years for a subset of the DCF population with particularly complex needs. DCF had developed a web-based CANS data system and had trained agency and provider staff in rating the CANS.

   In 2006, EOHHS convened a workgroup to choose items for the version of the CANS to be used by MassHealth. The group included representatives from MassHealth, the Department of Mental Health (DMH), the Department of Youth Services (DYS), the Department of Social Services (DSS)(now the Department of Children and Families)(DCF), the MassHealth Office of Clinical Affairs (OCA), the

Commonwealth Medicine Division of the University of Massachusetts Medical School, the Department of Public Health (DPH), and a child psychiatrist. Consulting with Dr. John Lyons, developer of the CANS, EOHHS selected CANS items, modifying some, and added some additional items to produce the two versions of the Massachusetts CANS. The first version is called Birth Through Four, and includes items appropriate for early childhood. The second version is called Five Through Twenty and covers the rest of the EPSDT age range. Both versions include a section of items assessing cultural factors relevant to treatment (formerly Acculturation, now the Cultural Considerations domain), and a section assessing family needs. Both versions are attached as Exhibit 37**.**

The judgment requires EOHHS to "develop a Mass-specific short and long form CANS, in conjunction with John Lyons." As EOHHS worked with John Lyons and EOHHS stakeholders, the consensus developed that there would be little value in a short form of the CANS with a reduced number of questions. EOHHS discussed this issue with the Plaintiffs and the Court, and as a result, the two age-specific CANS tools include a full complement of assessment questions.

The work on the Massachusetts CANS tools was completed in early 2008, in order to permit large scale training of clinicians in advance of the CANS requirement becoming effective on 11/30/2008. Subsequently, DCF agreed to modify its CANS to align with the MassHealth version, and DMH and DYS agreed to adopt the MassHealth CANS for use with their child and youth populations.

2. <u>The SED Cover Sheet</u>

EOHHS developed a cover sheet to accompany both of these CANS tools that requires clinicians to identify whether the member has an SED, according to the two definitions used in the Judgment. The cover sheet is attached as Exhibit 38**.**

3. <u>Improvements to the CANS since 2008</u>

In 2010, the Commonwealth sponsored a major revision of the Acculturation domain (described below) of the CANS to ensure that the CANS is a clinically useful tool that providers will value and integrate into their practice.

The *Acculturation* domain captures information about cultural factors that a provider needs to understand in order to provide effective treatment. In 2010, CBHI staff worked with the Committee on Reducing Health Disparities of the Children's Behavioral Health Advisory Council and others, to convene a working group of clinicians who regularly work with culturally diverse clients and are familiar with the research literature on culture in the provision of Behavioral Health services. The working group undertook this task over a series of lengthy meetings with great thoughtfulness and care. The revised domain was successfully piloted with three groups of clinicians in the spring of 2011
The new items replaced the old on November 30, 2011.

The *Cultural Considerations* domain is clearer and more clinically relevant than the *Acculturation* domain that it replaces. The revised items in the Cultural Considerations domain are designed to foster a more effective therapeutic alliance, develop culturally-informed treatment plans that could improve outcomes, and help to reduce health care disparities.

The *Cultural Considerations* domain has been shared with other jurisdictions using the CANS and will be featured at the 2012 Annual CANS Conference. It is attached as Exhibit X, along with the previous Acculturation Domain. Exhibit 39**.**

Recently, EOHHS received this feedback from the Walden School for the Deaf CSA:

> We are the Deaf Specialty CSA, and thus we have many cultural and language issues that present themselves. The new format affords us many more options that more accurately reflect the needs of our families. The most unique issue, that is reflected very nicely in this version of the CANS, is the fact that we often have parents and children who do not share the same culture and language! …. The new CANS domain reflect quite accurately some of the struggles our families with multi-cultural and linguistic needs face. As well, discrimination and disparity of health care service needs are huge for our population, and until now, there was not a great way to reflect that need. We love the new domain in that it helps us operationalize some very challenging issues our families deal with….For us, and the families we serve, it is wonderful to have a place to formally mark the concerns, and measure progress, without adding additional blame or shame on the family.

The complete text of the email is attached as Exhibit 40**.**

B. Building and maintaining a web-based system to collect and report CANS data, and an associated system for tracking member consent

1. <u>2007 – 2008: Preparation to launch the system</u>

   EOHHS designed and built a web-based system to collect essential data including demographic data, the determination of Serious Emotional Disturbance, and CANS data for each young member receiving a behavioral health assessment. Providers access this system through the Virtual Gateway (VG), EOHHS's secure web portal for business transactions.

The system was launched on 11/30/2008.[22] Ten software updates have been completed since 2008, enhancing the performance and capacity of the system.

2. 2008 to present: System maintenance and improvement

From November 2008 to the present there have been approximately ten such updates, major and minor. Significant updates have included: changes to speed up the application response; connecting to the new MassHealth information system NewMMIS; adding best-practice dropdown lists for capturing Race, Ethnicity and Language (REL) data; new reports and data exports for providers and for MassHealth; a process for sending daily member CANS data to MCEs; and the new Cultural Considerations items.

Two important systems improvements are currently in early stages of development:

a. a mechanism for providers to view CANS created by other providers (with member consent)
b. an electronic data interface that will allow provider Electronic Health Record (EHR) systems to exchange data with the CANS database directly, eliminating the need for staff to access the VG in order to input CANS data. Staff would complete the CANS through their agency's EHR system.

Each of these pending system improvements address key provider needs and will both improve the value of the CANS to providers as well as simplify the process for providers.

Successful implementation of the CANS data system has required more than creating and managing the system: it has also required training and supporting users. That task is described in Section D, below.

C. Training and periodically certifying a large behavioral health workforce to rate the CANS accurately

The Judgment requires EOHHS to "train providers to use the CANS tool, including EOHHS-required data gathering techniques". John Lyons, the CANS developer and copyright holder, requires that jurisdictions implementing the CANS use approved training and certification methods, including periodic recertification.[23] In 2007 EOHHS contracted with Dr. Lyons to help us design large scale training for assessors. EOHHS also entered into an Interagency Services Agreement with the University of Massachusetts Medical School (UMMS) to develop and manage a training system including the following elements:

- Face-to-face training sessions using trainers who are trained by Dr. Lyons
- An online training system that assessors may use in place of face-to-face training

[22] The CANS system on the VG should be distinguished from the separate CANS certification database system maintained by the UMass CANS training program. The two systems are linked, however, since the CANS system on the VG needs to draw assessor certification information from the CANS certification database.

[23] In Massachusetts, recertification is required every two years.

- An online system for examination of assessors; assessors must pass the exam to become certified
- A database system to track assessor training, certification, and periodic recertification, and to feed certification information to the CANS application
- An informational website
- A customer service system

In addition, UMMS provides trainings (online and in person) for "post-certification support"; that is, to help clinicians and clinical administrators, who have already been certified, to use the CANS more effectively.

1. Initial CANS training and certification

   The initial CANS training and certification implementation approach focused on ensuring that all Mass Health providers were trained and certified by November 30, 2008. In preparation to meet the start date, the CANS certification training was provided in person up to two sessions per day for six days a week (beginning in May 2008) and was made available online (July 2008). This rigorous training schedule resulted in over 5300 providers being certified by the CANS start date. Continuing education credits (CEUs) for completing the CANS training were available free of charge for most professional disciplines.

   The online training system became available in June, 2008. Clinicians completing the training can receive continuing education credit (5.5 hours for most professional disciplines, 6.5 hours for registered nurses).[24]

   The number of providers trained and certified has steadily increased since that time:

   - The November 27, 2008 CANS Training Program Report, issued just prior to the November 30 implementation deadline, showed that 6,962 clinicians had registered for training, 6,296 had completed training and 5,330 had been certified.
   - The December 10, 2009 (cumulative) CANS Training Program Report showed that 10,515 clinicians had registered for training, 9,183 had completed training and 8,723 had been certified.
   - The November 12, 2010 Report showed that 13,444 clinicians had registered for training, 11,301 had completed training and 9,161 had been certified.
   - The December 29, 2011 Report showed that a total of 9,737 clinicians were currently certified. Of these, 5,046 had been recertified to use the CANS for a second 2-year certification period and 4,691 had become CANS certified for the first time.

[24] To view the training and related materials, go to the UMass CANS training website (https://masscans.ehs.state.ma.us) and follow the instructions to create a User ID and Password.

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- The April 26, 2012 CANS Training Program Report shows a total of 17,569 people registered on the CANS training website. Of these, 10,183 clinicians are certified. Of these, 11 are certified for the third time, 5,410 are certified for the second time and 4,762 are certified for the first time.

2. Revision of the CANS certification examination

   In April of 2010, the CANS certification exam was revised to ensure more accurate user knowledge of CANS items. Instead of rating all CANS items based on a single clinical vignette (the original exam format), the new exam presents relevant clinical material in a "mini-vignette" for every CANS item. The new method is superior since it is difficult to write a clinical vignette for which each CANS item would be relevant; the old method in effect left the assessor untested on many CANS items. The new format also leads to higher certification rates: since introducing the revised certification exam the successful pass-rate has increased from 72% to 95%.

   Changes to the CANS training program

   Due to significantly reduced demand, face-to-face training was offered quarterly through 2010. As of January 2012, training is now only available online. Last year (2011) the majority of clinicians getting CANS training and certification chose to use the web-based training system.

3. CANS Birth to Four training

   The CANS training is sufficient to prepare clinicians to use both the CANS Birth through Four and the Five though Twenty. However, for those seeking more detailed training on the CANS Birth through Four tool, in 2009 EOHHS developed an additional online training module that reviews the Birth through Four domains, key characteristics, and the ratings. [25]

4. Cultural Considerations training

   Release of the Cultural Considerations domain in November 2011 required the release of a major IT update, a communications plan and user training resourses. The training offers a rationale for culturally informed clinical work, and guidance for clinicians about how to conduct a discussion with clients about race, ethnicity, language and culture. The standard CANS training has been revised to incorporate the new material.

5. Training for practice beyond CANS ratings

   EOHHS' discussions with providers suggested a need for more training for CANS users on practice issues: how to integrate information from multiple sources and perspectives, how to use the CANS in the treatment planning discussion with the

[25] Anyone interested in viewing the Birth Through Four training may register at the UMass CANS Training Website, https://masscans.ehs.state.ma.us. Then click on MASS CANS Post-Certification Resources.

family, and how to use the CANS to track progress in treatment. Accordingly, the UMass CANS Training Program is developing an online training module that uses hypothetical case material to demonstrate excellence in these aspects of practice. Using video segments produced by Vroon VanDenBerg LLC, the training shows how an in-home therapist might capture information for the CANS in the course of an interview with a parent. The training is intended to help clinicians understand how the CANS supports a family-driven collaborative model of care. The new training module will be released in the fall of 2012.

D. Informing and educating providers, managed care entities, consumers and other stakeholders

Adoption of the CANS required significant changes in provider practice. Providers had to become certified in use of the CANS, ask parents or guardians for consent to enter the data into the CANS application, potentially expand the scope of their customary clinical assessment process; and record CANS data either in the application on the VG (if the member consents to this), or on paper (if member declines consent). Many providers complained that this was an unprecedented level of intrusiveness into the details of their practice and expressed the opinion that the CANS was a burdensome, bureaucratically motivated change. Provider agencies worried that data entry via the VG would strain their technology and staff resources.

It was clear that providers would need education and technical support over a prolonged period of time in order to employ the CANS effectively. EOHHS's efforts to support CANS users -- a campaign for the CANS -- is described below.

1. Provider information, education, support and monitoring

   In order to implement the CANS, an outpatient clinic, for example, typically needed to: understand the new CANS regulations and the MCE notices of new requirements; write new assessment policies and procedures; amend standard clinical documentation; add consent documentation to the patient packet; add new billing procedures; send clinicians to become trained and monitor their certification status; enter into a legal agreement with the Virtual Gateway; assign a VG Access Administrator; enroll staff as Certified Assessors or Data Entry Operators with the VG; ensure adequate computers properly configured with internet access; and train and supervise staff on the new procedures. For clinics with many part-time staff, the task of orienting and supervising everyone on the new CANS tool, consent, and data entry was very challenging.

   In order to support providers in this transition, EOHHS provided information and technical assistance through a variety of channels, using large and small meetings, conference calls, MCE communications, MCE technical assistance (TA) teams, a CANS newsletter, help desks at the UMass CANS training program as well as the Virtual Gateway, the CBHI website, online documentation and computer-based training modules, the UMMS website, and many phone and email contacts with individuals.

2. CANS and MCEs

To equip the MCEs with the necessary knowledge and expertise to help implement the CANS requirement, MassHealth and CBHI staff worked, and continues to work, closely with MCE staff.

MassHealth meets regularly with the MCE Behavioral Health Directors. CANS implementation and management is frequently addressed in these meetings. In addition, in 2010, MCE representatives joined an ongoing EOHHS CANS Implementation Workgroup that had began meeting weekly during the early implementation phase to ensure communication and coordination of implementation activities between representatives from CBHI, VG, Mass Health, and the UMass CANS Training Program. This Implementation Workgroup now meets quarterly.

MCE TA teams monitor CANS compliance and address implementation or compliance issues in their regular and ongoing meetings with ICC and IHT providers.

To support CANS implementation at all levels of care, including outpatient, MassHealth's MCEs sponsored a Outpatient Forums in Boston and Worcester in June, 2010, and Promising Practices Forum in Worcester in May, 2011, that included "best practices" CANS presentations by providers.

3. Help desks / Customer service

Among the thousands of users of the CANS application are a substantial number who struggle to learn complex new technology. EOHHS has made a great effort to support all users of the system, regardless of their skills and learning style. Both the CANS Training Program and the Virtual Gateway provide customer service support by telephone and online phone and email response to user questions. VG staff responds to questions about entering CANS data in the VG, user names and access issues directly related to the VG. The UMMS CANS Training Team provides phone and e-mail support for questions related to training and certification. In addition, many calls and emails come directly to CBHI staff, who respond primarily to questions about the CANS requirements, policy and clinical use of the CANS. While customer service capacity remains in place at all three sources, the volume of calls and emails has steadily declined over time as many providers now understand the basics and go to the CBHI website and the UMass website for CANS information as needed.

As of April 20, 2012, the UMMS CANS Training Program had responded to 3,981 calls for technical assistance using the CANS website and training program.. From the launch of the CANS application through April 18, 2012, the VG Customer Service desk had responded to 11,519 calls for technical assistance and information regarding the CANS application.

In addition, anyone using the CANS application can click a link within the application that allows them to send an email inquiry directly to CBHI staff. CBHI staff respond to about one inquiry each day through this route, with follow-up phone consultation whenever needed.

4. CBHI CANS page

A variety of supports have been created for CANS users about CANS requirements, the CANS tool and the web based CANS application. The CBHI website includes a CANS page that provides a wide range of information including:

- CANS Frequently Asked Questions (FAQ) which explains the CANS requirement, training / certification requirements and resources, information on how to use the CANS application on the VG, and how to get further help. It is attached as Exhibit 41.
- Extensive printable "user guides" for the CBHI application on the VG (describing how to use the application for each of a variety of user security roles). These are attached as Exhibit 42.
- Interactive instructional videos ("Flash files") that run in the user's browser and walk a user through a task involving the CANS application. These videos are available for download from the CBHI web site and are attached herein as hyperlinks: Exhibit 43 (Learn how a CBHI Data Entry Operator adds a SED/CANS Assessment) and Exhibit 44 (Learn how a CBHI Certified Assessor edits a SED/CANS Assessment). You may also access these files by going to the CANS section of the CBHI website, http://www.mass.gov/masshealth/cans and then clicking on Using the CANS Application on the Virtual Gateway and then scrolling down Online Tutorials.

- The CANS web page now has a "friendly" url: www.mass.gov/masshealth/cans.

5. *CANSNews* – CANS Newsletter

   CANSNews, produced by the UMass CANS training program, is designed for electronic distribution to CANS stakeholders, including all certified assessors and individuals registered in the CANS Training and Certification system. Thus, the primary audience is BH providers. The newsletter provides updates and pertinent information about the CANS requirement, good practice using the CANS, and appropriate use of the CBHI CANS Application on the VG. Since the first release in January, 2010, six issues of *CANSNews* have been published and distributed. Providers have contributed feature articles for the May, 2011, August, 2011 and April 2012 issues. The April 2012 issue includes a lead article from the Gandara Center describing a positive experience with the new Cultural Considerations domain shared by a parent, In-Home Therapist and site supervisor.

   All issues of *CANSNEWS* are attached as Exhibit 24.

6. Meetings with providers -- CANS "Community of Practice"

   Beginning in 2008, CBHI staff, in partnership with the UMMS CANS Training Team, began a series of technical assistance conference calls (seven in all) with providers regarding the CANS requirement, consent, and the use of the CANS application on the VG. These calls had a high level of participation: one had over 100 connections (and probably some connections were with multiple participants). CBHI staff discontinued the calls when interest dropped off, as more providers became comfortable with the CANS requirement and the operational details of entering data into the CANS application. The remaining participants had very varied needs – and included those who objected to the CANS requirement because they didn't like the tool or what they described as government intrusion into their professional practice.

CBHI staff felt face-to-face meetings would give us both a better understanding of these providers' needs and provide a better forum for addressing these needs.

Consequently, starting in 2009, CBHI staff sponsored a series of face-to-face "CANS Community of Practice"(CoP) meetings with interested providers. In 2009, four CoP meetings were held at the offices of the UMMS CANS Training Team in Grafton. In 2010, eight CoP meetings were held in Boston, Pittsfield, Lawrence, New Bedford, Fall River, Framingham, Randolph, and Hyannis. In 2011, two CoP meetings were held in Framingham and Springfield. Meeting attendance ranged from eight to over fifty. The meetings were useful not only in disseminating information and demonstrating EOHHS's commitment to the CANS, but also in listening to provider concerns and experiences with the CANS.

A complete list of Community of Practice sessions is attached as Exhibit 45.

7. Consumer Education

Please see Sections III.A and III.C.

E. Monitoring CANS implementation and compliance

1. Implementation

In addition to the ongoing communication with providers as described above, in May 2011 the UMMS CANS Training Program conducted telephone interviews with key informants who had participated in CANS CoP meetings during the past two years. Ten people were interviewed with roles including Program Director, Clinical Director, Regional Director, Director of Quality Management, Director of Out-patient Mental Health Programs, and Training Supervisor. The responses suggest that providers have successfully overcome the initial hurdles of understanding the complexities of the CANS tool, the consent process, and the use of the CANS application on the Virtual Gateway. Respondents also reported that CANS use in daily practice is growing and steadily improving with the help of EOHHS's CANS quality improvement activities. A written report of the findings from the telephone interviews is attached as Exhibit 46**.**

The results of the survey were consistent with our observations of the last CoP meeting at Wayside Family Services in Framingham, in April of 2011. In contrast with past meetings, providers at this meeting were more focused on clinical use of the CANS and less focused on technical obstacles.

2. Compliance

MassHealth directed MCEs to focus on the remedy services -- on ICC and IHT -- in monitoring provider compliance with the CANS requirement. MassHealth's MCE technical assistance teams review CANS compliance in their regular meetings with CSAs and with IHT providers. The MCEs expect these providers to obtain reports and to use them in managing staff compliance with completing CANS assessment. A recent increase in provider inquiries to CBHI and to Virtual Gateway Customer

Service about how to obtain these reports reflects this heightened level of supervision by MCEs.

In contract management meetings with the MCE's, MassHealth ensures that the plans are continuing to address CANS compliance with their providers and is requiring them to develop next steps to continue increasing compliance.

Paragraph 37
Project* 2: *CANS Development, Training and Deployment
a. *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.
b. *Tasks performed will include:*
i) Developing a Massachusetts-specific short and long form CANS in conjunction with Developer John Lyons.

See Section VI.A., above.

Ii) Training behavioral health providers to complete and use the CANS tool, including EOHHS-required data gathering techniques.

See Section VI.C., above.

iii) Drafting managed-care and provider contract amendments and regulatory changes to conform with the new requirements.

See the beginning of Section VI., above.

c. *Timelines for implementation:*
i) Defendants will submit to the Court a preliminary report with regard to the completion of Projeet 2 no later than November 30, 2007.

Submitted.

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

See Section VI.

VII. Intensive Care Coordination and Other Covered Services (paragraphs 19-35)

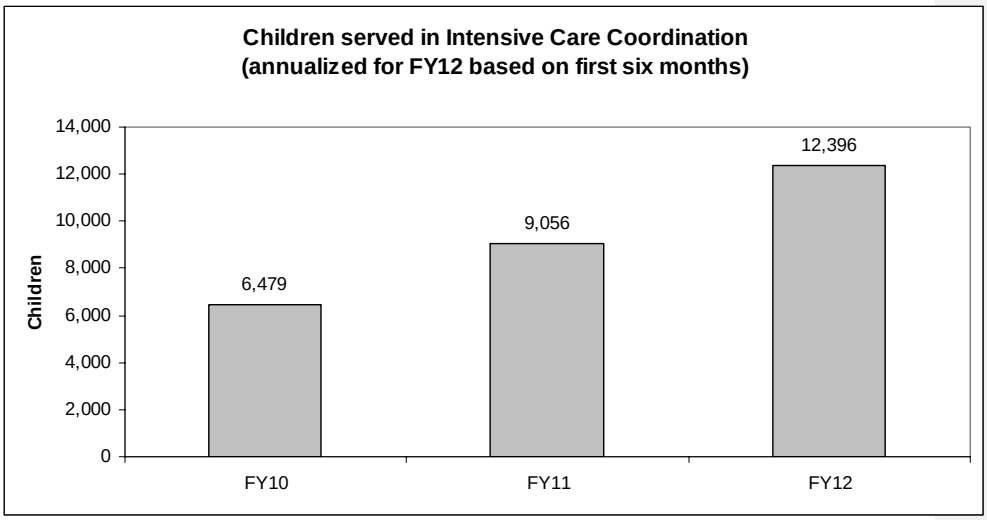
A. Intensive Care Coordination and Treatment Planning (paragraphs 19-30)

Paragraph 19

"The Defendants will provide Intensive Care Coordination to children who choose to have Intensive Care Coordination including a Care Manager, who facilitates an individualized, child-centered, family focused care planning team , as follows:"

On June 30, 2009, 31[26] Community Service Agencies (CSAs) opened their doors to provide ICC and FS&T across Massachusetts.

The numbers of children and youth receiving ICC has increased since the services started, as the following chart illustrates:



Data Source: CBHI Service Utilization Reports for SFY10, 11, 12, attached as Exhibits 47, 48, 49**.**

Service design and network development processes for the remedy services, including ICC, are described in Section VII.C, below.

Services for Children Not Previously Enrolled in Managed Care

Prior to implementation of the remedy services, children and youth who had commercial insurance or Medicare in addition to MassHealth were unable to enroll in MassHealth's managed care health plans. Since the Remedy Order was entered, MassHealth now

[26] One CSA had not met the readiness criteria and was not allowed to begin operating until July 20, 2009. For more information, see Section VII.B.

enrolls these young members into the Massachusetts Behavioral Health Partnership (MBHP) to receive their behavioral health services. These members or their parents or guardians are notified of their enrollment in MBHP and receive information about the services available through MBHP, including coverage of the remedy services.

EOHHS also executed amendments to the MBHP contract requiring MBHP to coordinate MassHealth behavioral health benefits with Medicare or an available commercial insurer.

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 according to 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.

Paragraph 21

"The basic responsibilities of a Care Manager are:

1. **Assisting in the identificatiother 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, 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 (sic) informed consent;**
6. **Preparing, monitoring, and modifying the individualized care plans 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;**
9. **Facilitating transition planning, including planning for aftercare or alternative supports when in-home support services are no longer needed."**

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, familyfocused, community-based, multi-system, and culturally competent."

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."

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 ofthe 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 ofthe child can be identified."

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.

Individualized Care Plan
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 ofthe 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.

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.

Paragraph 28
Each individualized care plan will: (I) 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) identiry the providers of services.

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.

All of the provisions of paragraphs 19 through 29 are addressed in either the ICC Performance Specifications, attached as Exhibit 50, or the ICC and FS&T Program Description and Operations Manual, attached as Exhibit 51.

For a description of training, coaching and quality improvement activities designed to ensure provider adherence to these standards, see Section X of this Report, "Technical Assistance and Quality Improvement".

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.

CBHI staff have worked with leadership of all of the child-serving state agencies within EOHHS to develop agency-specific "Children's Behavioral Health Initiative (CBHI) protocols". They are attached as Exhibit 52.

Chronology of State Agency Protocol Implementation:

June 2009	DCF, DMH
September 2009	DPH: Bureau of Substance Abuse (BSAS)
December 2009	Department of Developmental Services (DDS), DPH: Early Intervention, DPH: School-based health centers, DYS
May 2010	Department of Transitional Assistance (DTA)
June 2010	Office of Refugees and Immigrants (ORI)
September 2010	Massachusetts Rehabilitation Commission (MRC)
February 2012	Massachusetts Commission for the Blind (MCB)

June 2012	Commission for the Deaf and Hard of Hearing (MCDDH)

The protocols require state agency staff to participate as a member of a child's ICC care planning team to coordinate any agency-specific service planning process or treatment plan with the ICC care planning process. The protocols also include the conflict resolution process developed in consultation with the plaintiffs in 2009, attached as Exhibit53.

EOHHS has conducted numerous trainings for state agency staff on the protocols, as described in **Section V.B.**

B. Covered Services (paragraphs 31-33)

Summary (or paraphrase) of the provisions of paragraphs 31-33

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."

EPSDT Services
The Judgment requires EOHHS to provide the following medically-necessary EPSDT services[27] to class members:

- Intensive Care Coordination and Treatment Planning (ICC)
- Crisis Management services including Mobile Crisis Intervention (MCI) and Crisis Stabilization (CS)
- Home and Community Based Services including In-Home Behavioral Services (IHBS), In-Home Therapy Services (IHT) and Mentor Services including Therapeutic Mentoring[28] (TM) and Family Support and Training[29] (FS&T).

[27] Subject to the availability of Federal Financial Participation ("FFP") under 42 U.S.C. s 1396d(a) and other requisite federal approvals.
[28] This service was labeled "Independent Living Skills Mentors" in the judgment, but prior to implementation, and with the approval of the Court Monitor and the Plaintiffs, the service was renamed "Therapeutic Mentoring".
[29] This service was labeled "Child/Family Support Mentors" in the judgment, but prior to implementation, and with the approval of the Court Monitor and the Plaintiffs, the service was renamed "Family Support and Training".

The Judgment set June 30, 2009 as the implementation date for these seven services. However, on February 27, 2009, at the request of EOHHS, the Court modified the Judgment setting new implementation dates for four of the services, as follows: IHBS and TM - October 1, 2009; IHT - November 1, 2009; and CS - December 1, 2009. June 30, 2009 remained the implementation data for ICC, FS&T and MCI.

On June 30, 2009, 31 Community Service Agencies (CSAs) opened their doors to provide ICC and FS&T across Massachusetts. One CSA had not met the readiness criteria and was not allowed to begin operating until July 20, 2009. [30]

The 21 Emergency Services Providers (ESPs) launched statewide MCI services on the same day.

On October 1, 2009, 66 providers of TM and 21 providers of IHBS, covering all areas of the state, began delivering services. On November 1, 2009, 66 providers of IHT, covering all areas of the state, began delivering services.

In a letter dated January 20, 2010, CMS formally denied MassHealth's proposed State Plan Amendment for CS. In the alternative, MassHealth subsequently sought CMS approval to provide the service under its 1115 waiver authority, which was not granted.

MassHealth has determined that it can provide the "in-home[31]" portion of CS through an expansion of the existing MCI service. MassHealth expects these services to be available to members starting May 31, 2012. Note: MassHealth pays for a service that, while it is not CS, meets some of the same clinical needs. That service is Community-Based Acute Treatment (CBAT), which provides therapeutic intervention and specialized programming for children and youth who require a 24-hour-a-day, seven-day-a-week, staff secure (unlocked) group setting.

For a more detailed discussion of MassHealth's efforts to obtain CMS approval for CS and to implement the in-home portion of CS, please see Section VII.C.4, below.

Members Receiving Remedy Services

The numbers of children and youth receiving remedy services has increased since the services started, both in terms of raw numbers, and in terms of the percentage of MassHealth members under the age of 21.

State Fiscal Year 2010 (July 1, 2009 – June 30, 2010) Utilization	
Average # Members < 21 in Standard & CommonHealth:	**478,661**

[30] To ensure access while the CSA worked to meet readiness criteria, nearby CSAs were alerted to the situation and referrals were routed to these providers. In addition, the area covered by this CSA is also covered by one of the contracted specialized CSAs. Following intensive technical assistance provided by the MCEs, this provider was able to hire and train staff and meet the readiness criteria and began accepting referrals on July 20, 2009.

[31] This can be the child's home or other "natural setting" in which s/he normally resides – see paragraph 32.a. of the Judgment.

CBHI Services	# Members	% MassHealth Members <21
ICC	6,479	1.35%
FS&T	5,281	1.10%
IHBS	242	0.05%
TM	2,735	0.57%
Avg. # Mbrs. < 21 in all Elig. Categories except Limited:		**521,321**
CBHI Services	**# Members**	**% MassHealth Members < 21**
IHT	7,492	1.44%
MCI	9,727	1.87%
ALL CBHI Services	18,473	3.54%

State Fiscal Year 2011 (July 1, 2010 – June 30, 2011) Utilization		
Average # Members < 21 in Standard & CommonHealth:		**490,661**
CBHI Services	**# Members**	**% MassHealth Members <21**
ICC	9,056	1.85%
FS&T	7,608	1.55%
IHBS	942	0.19%
TM	6,284	1.28%
Avg. # Mbrs. < 21 in all Elig. Categories except Limited:		**550,282**
CBHI Services	**# Members**	**% MassHealth Members < 21**
IHT	12,529	2.28%
MCI	11,194	2.03%
ALL CBHI Services	25,684	4.67%

Data Source: FY 10 & 11 CBHI Service Utilization Reports, attached as Exhibits 47 and 48,.

Detailed descriptions of the service design and network development processes for the remedy services can be found in Sections VII.C. below.

Paragraph 32
***"Crisis Management* - 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.[32]
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."

Paragraph 33
" *Home and Community-Based Services* - The components of this service category are IHBS, IHT 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.
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

[32] "Where provider qualifications appear in the descriptions of the services in this section of the Judgment, the following applice: As used in this Judgment, the terms "qualified, licensed clinician"' and "qualified paraprofessional" refer to individuals with specific licensure, education, training, and/or experience, as will be set forth *in* standards to be established by the Defendants. Such individuals will be authorized to provide specific services referred to herein. A licensed clinician is an individual licensed by the Commonwealth to provide elinical services within a particular scope as defined by the applicable licensing authority or statute, including, but not necessarily limiLed to, physicians, psychiatrists, licensed clinical psychologists, licensed independent clinical social workers, licensed clinical social workers, and licensed mental health counselors. A paraprofessional is an individual who, by virtue of certification, education, training, or experience is qualified to provide therapeutic services under the supervision of a licensed clinician."

behavior and compliance with therapeutic expectations ofthe 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.
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.
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."

All of the provisions of paragraphs 31 through 33 are addressed in the Performance Specifications for each service, attached as Exhibit 50 or the ICC and FS&T Program Description and Operations Manual, attached as Exhibit 51. For a description of training, coaching and quality improvement activities designed to ensure provider adherence to these standards, see Section X of this Report, "Technical Assistance and Quality Improvement".

Paragraph 34

***Implementation* – "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."**

C. <u>Implementation of Project 3: Development of a Service Delivery Network (paragraphs 35 and 38)</u>

<u>Summary (or paraphrase) of the provisions of paragraphs 35 and 38</u>

Paragraph 35
***" Implementation Project Planning* - 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."**

Paragraph 38
"Project* 3: *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.
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-far-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 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.I and the intensive care coordination services described above in Sections 1.8.2 and I.e. CSAs will either deliver or, as a component of intensive care coordination, assist MassHealth Members to access the services described above in Section 1.0. CSAs will be responsible for assisting Members to access all services described in this Judgment that they do not themselves provide.
c. *Tasks performed will include:*
(see below for provision c.*i))*
ii) Engaging in a public process to involve stakeholders in the development of the network and services."

1. **EOHHS's Network Design Venues and Processes**
   In 2007, EOHHS created an interagency Network Development Workgroup to undertake the process of designing the remedy service delivery system. Chaired by Joan Mikula, Assistant Commissioner for Child and Adolescent Services for the Department of Mental Health, members included the Compliance Coordinator, Senior Central Office managers from the Departments of Social Services and Youth Services, top field clinical managers from DSS and DMH, and managerial and line staff from MassHealth and DMH. At EOHHS' request, MBHP supplied staff involved with developing the Coordinated Family-Focused Care (CFFC) program as resources to the Workgroup.

   Recommendations prepared by the Workgroup were presented to an Executive Committee, which consisted of the Assistant Secretary of Health and Human Services for Children and Families, Marilyn Chase, the Director of the Office of Medicaid, Tom Dehner, the Commissioner of DMH, Barbara Leadholm, Commissioner of DCF, Angelo McClain, and Commissioner of DYS, Jane Tewksbury, as well as the senior agency staff from the Workgroup.

In early 2008, EOHHS reconfigured their implementation management structure to reflect the accelerating shift from policy development to program implementation, creating the following executive structure and workgroups:

a. **Children's Behavioral Health Initiative (CBHI) Executive Committee** – Chair: Commissioner of the Department of Mental Health. Members: Assistant Secretary of the Executive Office of Health and Human Services for Children, Youth and Families; Director of the Office of Medicaid; Commissioner of the Department of Social Services; Commissioner of the Department of Youth Services; Commissioner of the Department of Public Health and senior staff from EOHHS, CBHI and MassHealth's Office of Behavioral Health.
b. **Interagency Implementation Team** – Co-Chairs: Emily Sherwood, Compliance Coordinator and Joan Mikula, Asst. Comm., DMH. Members: Senior staff from the Departments of Mental Health, Mental Retardation, Public Health, Social Services and Youth Services, staff from the MassHealth Behavioral Health Unit and the Office of the Compliance Coordinator. Focus: Oversight and coordination of all inter-agency implementation activities.
c. **MassHealth Implementation Team** – Chair: Suzanne Fields, Director, MassHealth Office of Behavioral Health. Members: Representatives of all involved business units within MassHealth, senior staff from the Departments of Mental Health, Social Services and Youth Services and staff from the Office of the Compliance Coordinator. Focus: Oversight and coordination of all MassHealth implementation activities.
d. **Managed Care Entity (MCE) Workgroup** – Chair: Sharon Hanson, Director, MassHealth Managed Care Program. Members: MassHealth Staff, Compliance Coordinator's Assistant Director, and the Behavioral Health Directors from each of MassHealth's MCOs and MBHP Focus: Implementation of the remedy.

2. Expert and Stakeholder Consultation Processes

a. **Prior to Implementation**

(i) *The Children's Behavioral Health Advisory Council* - The CBHI Executive Committee established a Children's Behavioral Health Advisory Council, which met for the first time on March 3, 2008. In 2009, the Council was reconfigured in accordance with Chapter 321 of the Acts of 2008: "An act relative to children's mental health". The Council is chaired by the DMH Commissioner, and consists of 29 members representing a broad range of stakeholders including families, youth with mental health needs, mental health providers and guilds. Senior staff from EOHHS child-serving agencies, the Director of Special Education for the Department of Elementary and Secondary Education, and representatives from the MCEs attend as observers. The purpose of the Advisory Council is to advise the Governor, the General Court, the Secretary of Health and Human Services and EOHHS agencies on matters concerning children's behavioral health. The Council offered advice and counsel on critical remedy service design issues prior to implementation. In 2008, the Council formed two sub-

committees, a Clinical Sub-Committee and an Outcomes Sub-Committee, to inform the new service delivery system in these areas.

(ii) *Request for Information (RFI)* - EOHHS solicited responses from the public and interested stakeholders in accordance with state procurement rules through the use of an RFI, issued in early 2008. The RFI elicited comments and feedback on the EOHHS system design work to date including preliminary plans for the service areas, the Community Service Agencies, the clinical model for Intensive Care Coordination, and descriptions of the other services and how they would be delivered as part of a coherent system of services. EOHHS received nearly 80 responses to the RFI, which were carefully compiled and analyzed. The RFI significantly informed service delivery system design. A copy of the RFI is attached as Exhibit 54**.**

(iii) *Meetings and Stakeholder Forums* - EOHHS conducted meetings and stakeholder forums to present the design work to date and to solicit input from providers, families and advocates. Constituencies consulted included Family Partners, family organizations, clinical managers from the five Coordinated Family Focused Care (CFFC) sites, provider organizations such as the Children's League of Massachusetts and the Association for Behavioral Healthcare (ABH), Judge Baker Children's Center, the Massachusetts Infant and Early Childhood Mental Health Coalition, the Massachusetts Early Childhood Comprehensive Systems project (MECCS) and the Children's Mental Health Taskforce of the Massachusetts Chapter of the American Academy of Pediatrics. For more information on these meetings, including a list of meetings with dates, see Sections III.B, C, E, above.)

(iv) *Consultants* - EOHHS consulted extensively with national consultants provided by the Court Monitor.

b. Since Implementation

(i) *Provider Survey* - In July and August, 2009, with ABH's help, EOHHS distributed a provider survey asking for feedback on the MCE/provider relationship including the timeliness of MCE decisions, clarity of the service authorization process, problems or concerns, and successes. Surveys were returned directly to MassHealth. A paper summarizing the results of the survey was publicly distributed and posted on the CBHI website. It is attached as Exhibit 55**.**

(ii) *Monthly CBHI Provider Stakeholder Meeting* - At the request of remedy services providers, the MCEs started convening, in November 2009, a monthly CBHI Provider Stakeholder meeting. The purpose of the meeting is to provide a venue for the providers and MCEs to collaboratively identify strengths and needs in areas such as communication, authorization processes, and access to care and to develop mutually agreeable strategies to address issues and improve the operation of the service delivery system. MassHealth staff attend these meetings.

(iii) *Children's Behavioral Health Advisory Council* – CBHI and OBH staff participate in these bi-monthly meetings.

(iv) *Family Representatives added to the CBHI Executive Council*. Starting in 2010, a representative from PPAL and from the Federation for Children with Special Needs (FCSN) were added to the membership of the CBHI Executive Committee.
(v) *Monthly meeting between ABH and OBH*
(vi) *CBHI meeting with the Parent/Professional Advocacy League (PPAL)*; as of January 2012, this meeting is monthly.
(vii) *OBH staff meet regularly with staff of PPAL*
(viii) *CBHI staff are in regular contact with staff of FCSN.*
(ix) *CBHI staff are in regular contact with the staff of the Massachusetts Children's League, and periodically attends League meetings.* The Children's League is an association of child welfare and behavioral health providers serving children, youth and families.
(x) *CBHI staff regularly meet with a wide range of constituencies and stakeholders, including school staff, court staff, community organizations, health care provider groups, etc.* For more information on these meetings, including a list of meetings, with dates, see Sections III.B, C, E, above.)

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

iii) Planning concerning anticipated need and provider availability"

a. Initial Network Implementation

MassHealth contractually obligates its MCEs 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 behavioral health service. The MCEs, must ensure that selected providers are qualified to perform the required service in accordance with the contracted Performance Specifications. To help the MCEs with the initial task of network development, MassHealth provided the MCEs with service usage projections prepared by Mercer Government Human Services Consulting. The MCEs 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.

MassHealth consulted with DMH and other internal and external stakeholders, including the Court Monitor and the Plaintiffs to develop Service Definitions, Specifications and Medical Necessity Criteria. These documents were also substantially informed by national consultants made available by the Court Monitor.

(i) CSAs

The Executive Committee adopted a preliminary recommendation by the Network Development Workgroup to use the 29 DCF service areas as the CSA Service

Areas. The size of the DCF Area is small enough that the Community Service Agencies (CSAs) can be well-integrated into their communities, while not leading to so many CSAs that establishing and maintaining statewide standards and quality becomes nearly impossible. This recommendation was "preliminary", pending consideration of RFI responses and other stakeholder input.

In addition, EOHHS decided to include up to three "Specialty CSAs" operated by provider organizations whose missions are limited to particular populations, for example, the Deaf and Hard of Hearing.

Responses received through the RFI validated the basic design approach, including using the use of DCF Areas as CSA Areas.

The CSAs were selected by a joint workgroup of MassHealth's MCEs, using criteria developed by EOHHS in consultation with the Plaintiffs. The MCEs released the jointly-prepared Request for Responses on October 24, 2008 and selected 32 CSAs, 29 area CSAs and three specialty CSAs, on March 6, 2009.

Prior to June 30, 2009, all MassHealth MCEs executed contracts with all 29 geographic CSAs and the three specialized CSAs.

On June 30, 2009, 31 of 32 CSAs had met all readiness criteria and began providing services; and all 32 CSAs were operating by July 20, 2009.

(ii) MCI Providers

EOHHS, in consultation with DMH, decided to utilize Emergency Services Providers to provide mobile crisis intervention services. EOHHS directed MBHP to re-procure the network of ESP providers on behalf of DMH and MassHealth, and to incorporate into the new contract the requirements for MCI. In March 2009 MBHP selected 17 ESPs, in addition to the four ESPs operated by DMH, using provider qualifications established by DMH and MassHealth. The MCEs are required to contract with the selected network of ESPs.

As of June 30, 2009, one MCE had executed new contracts with all 17 ESPs. Two MCEs had signed new contracts with 15 ESP providers, and two MCEs had signed new contracts with 8 ESP providers. For those MCEs that were still negotiating new ESP contracts, the ESP providers agreed to honor existing ESP contracts and/or negotiate single case agreements to ensure that MassHealth members had access to MCI services as of June 30, 2009.

(iii) Crisis Stabilization

As described in Section VII.C.iv below, CMS denied approval for Crisis Stabilization services as defined in the Judgment.

After exhausting all avenues for obtaining CMS approval for the service, MassHealth reviewed the service description in the Judgment again and

determined that the in-home crisis stabilization component of Crisis Stabilization was consistent with the purpose and structure of MCI. To comply with the provision of the Judgment that in-home Crisis Stabilization services be available for up to seven days per encounter, effective May 31, 2012, MassHealth is expanding the length of MCI engagement with families and youth from up to three days to up to seven days. MBHP, the manager of the 17 contracted ESP providers across the state has worked with the MassHealth, the ESP providers and consultant Kappy Madenwald to design and implement this service enhancement. As of the writing of this Report, Ms. Madenwald's two sets of regional trainings for ESP providers have been completed and readiness assessments are underway. Four providers are already providing MCI for up to seven days and the remaining 13, as well as the four state-operated ESPs, are on track to start the extended service as of May 31, 2012.

In addition, while the specifications for MassHealth's Community Based Acute Treatment (CBAT) differs from the draft specifications for Crisis Stabilization, CBAT can meet the clinical needs of a child in crisis.[33]

EOHHS and the MCEs have communicated with the CBAT providers to highlight the current requirements of the CBAT Performance Specifications requiring that services: 1) be individualized, reflecting the needs of the youth; 2) be medically-necessary – for example, the child or youth's length of stay should be neither shorter nor longer than is medically necessary; and 3) include coordination with the youth's community-based clinicians or other providers.

(iv)Providers of other remedy services

After extensive review of provider capacity for all of the remedy services, EOHHS recognized the need to have numerous providers in addition to the CSAs in order to provide statewide capacity for all services. CSAs are *required* to deliver ICC and FS&T and *may* provide other remedy services.

Networks of providers for In-home Therapy, In-home Behavioral Services and Therapeutic Mentoring were developed by the MCEs, using the specifications developed by EOHHS. On January 30, 2009, the MCEs posted a common Application for Network Affiliation (ANA) on each of their websites, to solicit applications from prospective providers of In-home Behavioral Services, Therapeutic Mentoring and In-home Therapy. The MCEs worked to align their networks for these services and, in large part succeeded. MBHP, with a higher population of children and youth who use behavioral health services, has a larger network for some of the services.

On October 1, 2009, 66 providers of Therapeutic Mentoring and 21 providers of In-home Behavioral Services began delivering statewide services

[33] CBAT services existed prior to the court-ordered remedy services, but are an integral part of the continuum of services available to children and youth with behavioral health needs.

On November 1, 2009, 66 providers of In-home Therapy began delivering statewide services.

b. Ongoing Network Development

(i) *Ensuring sufficient capacity* – The MCEs continue to consider Applications for Network Affiliation and to add providers to meet the demand for services:

	Nov. 2009	Nov. 2010	Nov. 2011
IHT	66	101	122
IHBS	21	45	44
TM	66	99	125

(ii) *Ensuring geographic access* – During 2011, MBHP prepared a detailed geographic analysis of all IHBS, TM and IHT providers, across MCEs, to ensure that there were providers located within a 20 mile radius of the center of all cities and towns in Massachusetts. The vast majority of towns had providers located within a 20 mile radius, and for those that did not, sufficient numbers of providers agreed to serve these cities and towns.

(iii) *Expansion of Family Support and Training* – In 2011, the availability of FS&T was expanded to include children and youth receiving IHT or Outpatient Therapy. In 2009 and 2010, due to the need to hire and train an entirely new workforce, FS&T was limited to children and youth receiving ICC services. The MCEs have sponsored a number of activities to recruit staff to permit an expansion of FS&T to include children and youth who are not receiving ICC. Activities to support this service expansion include:

1. MCEs issued provider alerts and informational emails in September to inform providers of the availability of FS&T and how to access it for children and youth receiving IHT or outpatient therapy.
2. The MCE TA teams worked with the CSAs to prepare for and implement this change.
3. At the December 2011 CSA Statewide meeting, the agenda included a "check-in" with CSAs about the experience of providing FS&T in partnership with IHT and outpatient providers.

(iv) *Expansion of Services for Deaf and Hard of Hearing Children, Youth and Families*

a) August 3, 2010 – CBHI, OBH and MCE staff participated in a Deaf Culture workshop at the Walden School for the Deaf, the specialty CSA for the Deaf and hard of hearing.

b) The March, 2011 CBHI Level of Care meetings included a presentation on "Understanding Deaf Culture and Resources." This meeting was instrumental in providing a better understanding of Deaf culture and available resources for individuals who are Deaf or hard of hearing.

c) During 2011, the MCEs convened two meetings with the Walden School, to explore how to increase access to CBHI services for this population. The MCEs have provided, and continue to provide, extensive technical

assistance to the Walden School, designed to help this particular provider serve more Members, including expanding the remedy services it delivers. The MCEs invited representatives from various other Schools for the Deaf in Massachusetts to the second meeting. The MCEs continue to work with both the Walden School and the Beverly School for the Deaf on potential remedy service expansion in 2012.

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

On March 24, 2008, MassHealth submitted two proposed State Plan Amendments (SPAs) for review and approval by the Centers of Medicare and Medicaid Services (CMS). One proposed adding ICC to the State Plan, as a "Targeted Case Management"(TCM) service; and the other proposed adding the remaining remedy services as Rehabilitative Services under the "EPSDT Services" section of the State Plan. Prior to submission, MassHealth requested a pre-submission meeting with Central Office and Regional Office CMS staff to brief them on this case, the Judgment and the proposed SPAs. The two SPAs are attached as Exhibit 56 (TCM) and 57 (EPSDT)**.**

On June 17 and 18, CMS issued "Requests for Additional Information" (RAIs) on both the TCM SPA and the EPSDT SPA. EOHHS submitted a written response to the RAIs by the deadline of September 15, 2008. The RAI responses were reviewed by the Plaintiffs and by the Monitor's consultants prior to submission. They are attached as Exhibits 58 (TCM) and 59 (EPSDT)**.**

MassHealth received CMS approval for the ICC SPA on December 2, 2008, with an effective date of June 30, 2009. It is attached as Exhibit 60**.**

In response to the EPSDT Services SPA, CMS requested that MassHealth withdraw its written response to the RAI on this SPA, to avoid a potential denial and allow time for additional discussion. MassHealth withdrew its RAI response on October 21, 2008. Subsequently, MassHealth and CMS conducted a number of phone calls and informal exchanges of draft state plan language. CMS questioned whether federal financial participation would be available for the Family Support and Training Service and the Crisis Stabilization Service. CMS requested that EOHHS remove Crisis Stabilization Services from the SPA and re-submit it as a separate SPA

On June 4, 2009, EOHHS received CMS approval for the EPSDT SPA, with Crisis Stabilization Services removed. It is attached as Exhibit 61**.**

On July 17, 2009, EOHHS submitted a new proposed SPA for Crisis Stabilization. In response, CMS issued a RAI, on August 3, 2009, which MassHealth responded to on October 30, 2009. As part of the RAI, CMS asked EOHHS to submit a rate method for the service that established rates for each type of individual practitioner who might deliver the service at the Crisis Stabilization services facility, as opposed to the

rate method EOHHS first submitted, which established a Crisis Stabilization facility per diem rate. Massachusetts' Division of Health Care Finance and Policy (DHCFP) developed this methodology and held public hearings on the rates. MassHealth's response to CS RAI is attached as Exhibit 62**.**

The outstanding issue remained CMS' determination that FFP (Federal Financial Participation) is not available for costs related to room and board for services other than, as relevant here, services provided by hospitals and psychiatric residential treatment facilities. The Crisis Stabilization service that EOHHS described in its SPA was designed to be delivered in a non-hospital-level, 24-hour facility located in the community. CMS requested MassHealth to state that no funds would be used to pay for the costs of room and board. MassHealth, in its response, stated that room and board costs were "essential to the efficient and effective" delivery of this service.

On January 20, 2010 CMS informed MassHealth that it had denied MassHealth' proposed Crisis Stabilization State Plan Amendment.

Despite CMS' denial, EOHHS continued to seek possible solutions to the problem. Later in 2010, MassHealth included a request for the described Crisis Stabilization Services in its 1115 waiver renewal letter. CMS approved the waiver in December 2011, noting specifically that it was not approving these "Crisis Stablization Services".

"v) Defining CSA Service Areas."
See Section VII.C.3.a, above.

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

"vii) For each service described in Section 1.0. 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). "

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

Defining performance specifications, Medical Necessity Criteria, etc.

a. Preparation for the work

In 2007, to increase clinical resources available to support the service design work, MassHealth hired staff and, in 2008, as previously described, a clinical sub-committee of the Children's Behavioral Health Advisory Council was convened to serve as a resource to the remedy service implementation process.

b. Developing the service standards

Provider qualifications, service delivery standards, training requirements, clinical criteria, performance specifications and measures, credentialing criteria - these elements, once finalized, were expressed in two documents for each service: Performance Specifications (PS) and Medical Necessity Criteria (MNC). These documents were then incorporated by amendment into MassHealth's contracts with the MCEs.

The development of documentation requirements and utilization management standards are discussed in Section xii, below.

The process began with drafts prepared by MBHP and OBH staff and reviewed by the MassHealth Implementation Team, the Interagency Implementation Team and the CBHI Executive Committee. From early spring into September 2008, the parties, the Monitor, and her team of consultants met weekly to conduct a line by line review and revision of these documents. The parties completed their work on the PSs in September, 2008, in time to inform the State Plan Amendment process with CMS, and for the MCEs to use the PSs to begin provider selection activities. The parties completed their review of the MNC prior to June 30, 2009.

c. Revisions to Performance Specifications (PS)

(i) *IHBS* - In order to ensure the quality of this important service, the MCEs, with MassHealth's approval, added additional credentialing criteria to the IHBS PS in 2009, to require providers to be trained and certified in Applied Behavioral Analysis (ABA), the most commonly-held certification for behavioral therapy and the only approach with a national standard and process for certification.[34] At the same time, at the Plaintiffs' request, MassHealth directed the MCEs to add additional clarifications to the credentialing criteria in order to effect a broadening of the pool of qualified providers, while at the same time retaining a focus on necessary provider competencies. In 2011, at provider request, and with the approval of the Plaintiffs, the IHBS credentialing criteria were slightly broadened again, to include Master's level clinicians with two years of relevant experience. The revised IHBS PS, including the new clinician credentialing criteria is attached as Exhibit 50.

(ii) *ICC, IHT and MCI* – These PS were slightly revised early in 2012 to reflect refinements to the process of developing Risk Management and Safety

[34] Applied Behavioral Analysis is "the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior." (Baer, Wolf & Risley, 1968; Sulzer-Azaroff & Mayer, 1991).

Plans (RMSP), including the use of a more family- and youth-friendly RMSP form. The revised PS for these services are attached as Exhibit 50.

(iii) *MCI* – This PS was further updated in early 2012 to reflect the expansion of the length of MCI engagement with young members and their families from up to three days to up to seven days. The revised MCI PS is attached as Exhibit 50.

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

d. Contracts

e. MassHealth's contracts with the MCEs were amended to incorporate the remedy services and other program improvements. **Rate Development**
Massachusetts's rate setting agency, the Division of Health Care Finance and Policy (DHCFP), began to work with MassHealth in 2007 to develop fee for service (FFS) rates for the remedy services. MassHealth required the MCEs to pay providers the DHCFP rate, at a minimum. Completion of the rate development work depended on completion of the Performance Specifications. The rates were finalized in early 2009.

f. **Federal Claiming Protocols**
CMS's approval of the six out of seven remedy services in effect authorized federal claiming for the services.

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

MassHealth's MCEs developed a collaborative, cross-MCE approach to managing the new provider networks, including ensuring provider readiness to perform.
CSA Readiness Activities included:

g. **Monthly statewide implementation meetings**
Beginning in April 2009, with the MCEs and all 32 CSAs.

h. MCE monitoring of CSA readiness work plans
The MCEs prepared a list of readiness requirements for the CSAs. The CSAs each prepared readiness work plans and MCE network management staff monitored CSA progress toward completing their work plans through monthly onsite visits and weekly telephone calls.

i. **CSA Readiness Assessment Tool**
The MCEs developed a structured CSA readiness assessment tool and used it to evaluate each CSA's implementation readiness.

j. CSA Operations Manual
MassHealth developed a CSA Operations Manual and requires the MCEs to manage ICC services using the Manual. The MCEs require CSAs to deliver ICC according to the PSs and the Operations Manual.

k. **MassHealth's oversight of the MCEs during the readiness review period**
In April, May and June of 2009, MassHealth staff met onsite every other week with each of the MCEs to ensure that they were appropriately readying their

authorization and claims systems and personnel in time for the launch of Intensive Care Coordination, Family Support and Training and Mobile Crisis Intervention.

l. **List of cities and towns served by each CSA**
The MCEs produced this list and put it on their respective websites, to help families and other referral sources find the nearest CSA.

m. **"Wraparound 101" training**
The MCEs sponsored this two-day training in April for CSA Program Directors and executive staff.

n. **CSA Job Fair**
Also in April, the MCEs invited the CSAs to participate in a "job fair" for prospective care coordinators and family partners at Northeastern University.

More information on initial and ongoing training activities for providers can be found in Section E. Network Management and Section F. Wraparound Training, below.

The results of the readiness activities are described in Section VII.D.8, above.

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

The work done to inform MassHealth members, the public, providers and stakeholders is described in Section II of this report. The work done to prepare providers to deliver the remedy services is described in Section XI of this report.

"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."

MassHealth contracts with six Managed Care Entities (MCEs) to ensure the delivery of timely, high-quality and accessible care for MassHealth members. In order to promote standardized implementation of the CBHI services, MassHealth's Office of Behavioral Health(OBH) established a contract management structure with the MCE's that relies on both individual management and collective interventions that involve all of the MCE's in assessing compliance with the MassHealth requirements for CBHI.

The CBHI Program Manager for OBH convenes all of the BH directors or their designees every two weeks. Standing agenda items include managing access to services, training, provider network management, CANS compliance, review of standard reports, implementation of new policies, agendas for statewide meetings, and updates from MCE's on provider management activities. Every other month the OBH staff meet individually the BH Directors to review the quality improvement and network management plans of each MCE.

1. **MCE Management of Program Specifications**– The MCE's manage the operation of all CBHI services using a consistent set of program specifications performance

standards for the service. OBH has required all MCE's to use these approved performance standards for the consistent management of these services across all MassHealth payers. These performance standards define the program models, staffing expectations and service standards for all CBHI services. This approach ensures that the service is provided consistently across all MassHealth payers. OBH oversees the performance of the MCE's to their contract standards with MassHealth based on standard contract reporting on claims payment, customer service, authorizations, appeals and grievances, and provider accessibility and availability. For CBHI services, OBH collects extensive data on access and availability to closely monitor the timeliness of service provision.

2. Reports

A description of data reports required of the MCEs can be found in Section VIII. Data Collection, below.

3. Quality Improvement Projects

The statewide implementation of six new or improved services, many of them relatively new to Massachusetts, has required unprecedented levels of network development by MassHealth and its MCEs. This work is described in detail in the Section XI, Technical Assistance and Quality Improvement, as is EOHHS' provision of three years of Wraparound training and coaching and EOHHS' workforce development activities. These efforts are all in service to the goal of developing a high-performing network of remedy service providers and are all quality improvement projects.

4. Utilization Management Review

a. **Contract Requirements**

MassHealth requires its MCEs to provide all services in accordance with MassHealth's medical necessity regulation (130 CMR 450.204) and the Medical Necessity Criteria (MNC) developed by MassHealth for the remedy services. Medical Necessity Criteria are used by providers to determine whether a young member has a medical need for a remedy service and are used by the MCEs to review providers' determinations of medical necessity during prospective, concurrent and retrospective utilization management activities.

b. **Utilization Management Methods**

(i) *Service authorization processes* - are an example of a prospective utilization management method. The MCEs were contractually obligated to develop and implement service authorization procedures in advance of the service implementation dates. MassHealth worked closely with the MCEs to ensure their readiness at the time of each of the service implementation dates. From these reviews MassHealth concluded that all of the MCEs had, for each of the services:

1. Developed service authorization policies and procedures
2. Developed training materials for their staff and conducted internal trainings

3. Developed a common set of service authorization parameters for ICC, FS & T, IHT, IHBS and TM across MCEs.
4. Developed and use a common set of clinical review questions to use when working with providers to complete initial and concurrent service authorization requests.
5. Used a variety of methods to inform and assist the provider network with the authorization procedures for the remedy services, including in-person trainings, email communication, network alerts, website postings, and addendums to provider manuals.

(ii) *MassHealth's oversight of the MCEs' implementation of the service authorization processes* - EOHHS closely monitored the implementation of service authorization processes by:

1. Negotiating and executing MCE contract provisions that require MCEs to obtain MassHealth prior review of all proposed changes to MCE authorization parameters or procedures.
2. Reviewing and monitoring monthly MCE authorization reports to identify trends or areas of concern. These reports include the number of authorizations requested, approved, and denied by plan and have allowed MassHealth to compare service "penetration rates" across plans. It should be noted that, since service implementation, denial rates have remained extremely low – less than 1%.
3. Reviewing denials of any services requested by a care planning team for a young member receiving ICC.
4. Meeting regularly with representatives PPAL to hear if there are any access concerns.
5. Meeting regularly with representatives from the Association of Behavioral Health, the statewide trade organization of community-based mental health providers, to hear if there are any concerns from the provider community.
6. As described in Section VII.D.b.(i) above, working with ABH to distribute a survey to providers at the end of July and August 2009 inquiring about the MCE interface, timeliness of decisions, clarity of the authorization processes, concerns and successes.

(iii) *Concurrent reviews* – EOHHS reviews the policies and procedures of the continuing authorization procedures as part of contract management. In addition, MassHealth OBH staff:

1. review the individual MCE reports on utilization to identify any trends upward or downward and follow up with individual MCE's to provide more detail to explain unusual patterns of utilization
2. Engage with individual MCE's to conduct more detailed follow up if concerns are raised about continuing authorizations for specific providers or services. .

(iv) *Ensuring Appropriate Levels of Care for Members* - the MCEs have employed a variety of strategies for identifying young members who might be appropriate for ICC, including:

1. Prior to service implementation, reviewing young members currently enrolled in care management programs and/or Family Stabilization Services for possible referral (with parent/guardian consent).
2. During clinical reviews with a child or young member's provider, discussing possible referrals to ICC and/or other remedy services.

5. Administrative Services

The MCEs are required by contract to perform a wide range of network management and quality management activities for the remedy services.

a. **MassHealth's Preparation of the MCEs**

(i) *CBHI Institute, Wraparound 101 and Technical Assistance Resources* - To assist the MCEs in preparing to perform all necessary Network and Quality Management activities, EOHHS designed and hosted the "CBHI Institute" in October, 2008. This was a day long meeting for MCE staff and prospective remedy service providers. EOHHS, with the assistance of the Court Monitor and her consultants, brought together leading practitioners of all of the proposed remedy services to present on the Wraparound model of care planning, the role of the Family Partner, and to describe and discuss the Performance Specifications for all of the remedy services. In addition, with the help of the Court Monitor, consultants with expertise on managed care utilization management approaches provided consultation to MassHealth MCE managers. MCE leadership also participated in a "Wraparound 101" training conducted by Anthony Irsfeld in February 2009.

(ii) *Collaboration with MCEs to Develop Collaborative Management of the Remedy Services* - Throughout 2008 and 2009 MassHealth worked with the MCE Behavioral Health Directors to develop unprecedented collaborative approaches to network development, network management and quality management. The MCEs have developed a number of novel collaborative approaches to this work. For example, each MCO has assigned a staff person to be responsible for network management activities for each CSA, and to work in tandem with the assigned MBHP staff person for that CSA. So, each CSA works with an assigned two person TA team. Section XII. Technical Assistance and Quality Improvement describes the extensive network and quality management activities performed by the MCEs.

b. **Preparatory Work by the MCEs**

The MCEs implemented a variety of strategies to ensure that they could meet the increased demands on their staff at all levels, including:

(i) Using web-based and Interactive Voice Response (IVR) technologies to receive authorization requests

(ii) Hiring dedicated CBHI clinical and/or network management staff

(iii) Re-deploying existing staff to CBHI specific responsibilities
(iv) Cross-training staff in different clinical departments
(v) Hosting "Wraparound 101" trainings and CANS trainings for their clinical and network management staff members. All the plans held additional trainings on the new MassHealth services and program improvements, performance specifications and medical necessity criteria for staff who have member and/or provider contact.
(vi) Training Customer Service Representatives (CSRs) and updating CSR training and resource materials to ensure that they could accurately inform MassHealth Members about how to access EPSDT screenings, diagnostic services, and treatment services.

6. Claims Payment Protocols

The DHCFP Rate Setting process identified the CPT[35] codes to be used for each of the remedy services. Prior to each of the service implementation dates, the MCEs made necessary changes to their claims systems in order to be able to pay claims once the services started.

VIII. Data Collection (paragraphs 39-46)

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.

b. Tasks performed will include:

i) Defining existing system capacities."

As described in Section VI.B.1 above, during January through March 2007, EOHHS worked with an outside consultant to determine whether an enterprise-wide service management (ESM) system currently under development for EOHHS would meet the all the reporting requirements of the Judgment. After consulting with program managers and IT professionals from MassHealth, EOHHS IT, DSS, DYS and DMH to gather high-level system requirements, EOHHS determined that the ESM system would not have the required functional capacity. As a result, EOHHS decided to develop a web-based CANS Application that, subject to consent from the young member, parent or guardian, could collect CANS data from behavioral health providers serving young members.

EOHHS concluded that it could meet the reporting requirements of the Judgment with the data from the CANS Application, MassHealth's claims payment system, and encounter data and specific management reports from the MCEs.

[35] Current Procedural Terminology. These are codes assigned by the American Medical Association to every task or service a medical professional might provide, and used by insurers to pay providers for these services.

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EOHHS IT next conducted an internal review of existing agency data systems to determine if any of these systems could be leveraged to meet the needs of the Judgment. It was determined that certain components of the DSS STARS system provide functionality that is similar to that which is required to administer the CANS tool. Therefore, the Defendants decided to take this system as the starting point for developing the IT platform for the CANS Application.

"ii) Gathering requirements for new functionality, including assessing whether development should be in-house or outsourced."
Two full-time Business Analysts were assigned to the CANS Application development project. Business Analysts are experts who translate the needs of the system users into "use cases" -- functional requirements that programmers can use for software design and testing.
"iii) Obtaining legislative authorization and funding."
Authorization was not needed. Necessary funding was provided by the Legislature.
"iv) Drafting contract and procurement documents, including detailed architectural standards, privacy standards, and performance standards."
Since the Application was developed within EOHHS, no procurement documents were necessary. The Business Analysts drafted the architectural standards, privacy standards and performance standards.
"v) Working with CMS to obtain necessary federal approvals of contracting documents." No CMS approval was necessary.
"vi) Issuing an RFR, reviewing responses, and selecting bidder(s)."
Not applicable.
"vii) Negotiating contract(s)."
Not applicable.
"viii) Confirming business requirements and technical specifications."
The Use Cases were reviewed by CBHI staff and EOHHS IT managers.
"ix) Performing construction, testing, and provider training."
Three full-time JAVA programmers developed the Application over a period of several months. It was then sent to a separate team for extensive testing. Provider training and technical assistance has been extensive, as described in Section VI.B.

"c. Time lines for implementation:
i) Defendants will submit to the Court a written status report with regard to Project 4 no later than November 30, 2007.
Completed.
ii) Full completion of this project will be by November 30, 2008."
The first release, which allowed EOHHS report on the number of CANS assessments performed and the outcomes of the SED determinations, became available in December, 2008. The second release, which, with consent, permitted entry of the full CANS, became available April 23, 2009.

Data Collection
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."

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 was 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."

MassHealth receives standard quarterly reports from the MCEs on:

- Rates of BH Screening in Primary Care
- CANS compliance in all levels of care (new reports, still being refined.)
- Key performance indicators for MCI (from MBHP)
- Cost and utilization of remedy services
- MCE Authorizations

MassHealth receives standard monthly reports from the MCEs on:

- CSA referrals, enrollments, wait times, waitlists, staffing levels and caseloads
- A few MCI performance indicators
- Access to ICC, IHT, IHBS, TM

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."

Small samples of clinical record reviews are conducted each year to evaluate clinical practice as well as administrative requirements, such as documentation. Since the inception of the services, a valuable management tool has been the TA meetings with providers, which are described in Section X. OBH clinical staff attend many of these meetings with providers in which a wide range of clinical and management issues are addressed

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. Al though the Defendants are not required by the Medicaid Ac t (42 U.S. c . §1396 et~) 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 expendi ture 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."

The analysis that led to the design of the CANS Application, and the development of the Application, are described in SectionVIII, above.

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."

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."

MassHealth collects data on the number of EPSDT visits or well-child visits and other primary care visits, the number of BH screens provided and the number of BH screens indicating a potential BH need through its claims data (for young member receiving services through fee-for-service Medicaid and through the Primary Care Clinician plan) and through encounter data received from the MCEs. The most recent BH Screening Report is attached as Exhibit 31**.**

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.

Outpatient Therapy - The vast majority of clinical assessments are performed in outpatient therapy. Outpatient therapy providers file distinct claims for assessments. MassHealth produces a quarterly report of the number assessments billed and the number of assessment claims using a modifier indicating completion of the CANS. The most recent CANS in Outpatient Report is attached as Exhibit 63.

ICC, IHT, CBAT and Inpatient – The MCEs have measured CANS compliance through chart reviews and provider-level TA meetings. Prior to 2012, for technical reasons MCEs could not easily access data from the CANS database to use as a check on CANS compliance in multiple services. The technical issues have been resolved, the MCEs have access to the data and are currently preparing CANS compliance reports using this data.

DMH IRTPs and Residential Programs – CANS in these settings are completed on paper and kept in the medical record. DMH monitors and manages staff compliance with the CANS requirement.

Number of clinical assessment that meet SED clinical criteria and indicate that a member could benefit from ICC

The data from the CANS Application show that 97% of CANS clinical assessments completed by all types of providers find that the child meets at least one of the definitions of Serious Emotional Disturbance (SED) used in the Judgment.

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 pf 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."

Every young member in ICC receives an intensive home-based assessment, referred to in the language of high-fidelity Wraparound as the "Strengths, Needs and Culture Discovery" (SNCD). Preparation of the SNCD provides information that informs the completion of CANS. ICC staff are over 90% compliant with the requirement of completing the CANS through the CANS IT application.

The data on members receiving ongoing ICC services are gathered from two sources and published in two reports. The providers report monthly to MBHP on the number of receiving ICC. The most recent CSA Monthly Report is attached as Exhibit 64**.** In addition, MassHealth prepares quarterly CBHI Service Utilization Reports based on encounter data from the MCEs. The most recent CBHI Service Utilization Report is attached as Exhibit 49**.**

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."

While MCEs can track a member's utilization of remedy services, their data systems do not have access to the services "as prescribed under an Individual Care Plan, including the type, duration, frequency and intensity of home-based services." As a proxy, MassHealth and CBHI staff monitor the rate of denials of authorizations for remedy services by the MCEs. As reported previously, it remains under 1%.

EOHHS has also found the Community Service Review (CSR) process a helpful tool for learning how CPTs develop goals and strategies, including the use of one or more of the remedy's home-based services. The findings of the CSR corroborate what EOHHS has consistently seen in the authorization data: that there isn't evidence of MCE denial of services recommended in ICPs.

Starting in the fall of 2012, EOHHS intends to implement a case review process using a different tool, the System of Care Process Review, SOCPR. These reviews will continue to provide important information on the functioning of teams and on "member-level utilization of services as prescribed under an ICP…".

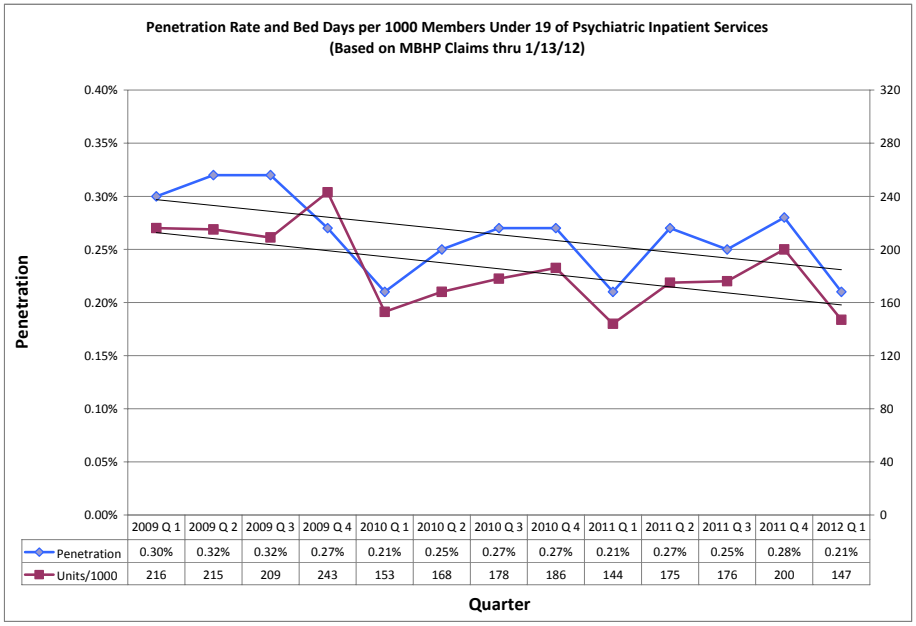
"ii) Provider- and system-level utilization and cost trends of intensive home-based services."
This data is available through the quarterly CBHI Service Utilization Report.

"Child and System 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."

EOHHS has worked diligently to develop approaches to understand the implementation and its impact, using administrative data, fidelity data, assessment data and other available sources of information. Staff have consulted providers, evaluators and the academic literature.

Psychiatric Hospitalizations - The Massachusetts Behavioral Health Partnership has analyzed the rate of psychiatric hospitalizations among its members up to age 21, both in terms of the percent of membership hospitalized in a quarter, as well as the "bed-days" per 1000 members, from the first quarter (July-September) of FY2009 through the first quarter of FY2012. As you can see in the chart below, there has been a steady trend (with expected seasonal variations) downward in the percentage of young members who are hospitalized and the number of days in the hospital.



	2009 Q 1	2009 Q 2	2009 Q 3	2009 Q 4	2010 Q 1	2010 Q 2	2010 Q 3	2010 Q 4	2011 Q 1	2011 Q 2	2011 Q 3	2011 Q 4	2012 Q 1
Penetration	0.30%	0.32%	0.32%	0.27%	0.21%	0.25%	0.27%	0.27%	0.21%	0.27%	0.25%	0.28%	0.21%
Units/1000	216	215	209	243	153	168	178	186	144	175	176	200	147

This downward trend reverses, beginning in 2009, the trend of previous years of increased inpatient utilization. It also counters the national trend toward increasing psychiatric hospitalization of youth.[36]

CANS and child outcomes

[36] Blader, J.C. (2011). Acute inpatient care for psychiatric disorders in the United States, 1996 through 2007. *Archives of General Psychiatry*, Published online August 1, 2011. doi:10.1001/archgenpsychiatry.2011.84

Because the CANS has the potential to measure child status and functioning over time, EOHHS has focused considerable effort on understanding the characteristics of the Massachusetts CANS tool and identifying ways to use CANS data to measure service impact. In May 2011 CBHI, MassHealth and DMH staff met with Dr. Carl Fulwiler of the UMass Center for Mental Health Services Research, followed, in 2011 and 2012 by five additional consultation sessions with a team of research methodologists from the Center for Mental health Services Research and the Department of Quantitative Health Sciences. These experts included Carl Fulwiler MD PhD, Bruce Barton PhD, Valerie Williams PhD, and Milena Anatchkova PhD. CBHI staff also revisited the academic literature regarding CANS and outcomes measurement.

In addition, CBHI staff collaborated with Hannah Karpman LICSW and John Hull PhD, who conducted a study of CANS reliability using certification examination data, and confirming an acceptable level of interrater reliability for the Massachusetts CANS.

Ms. Karpman is focusing her dissertation research at the Heller School for Social Policy and Management at Brandeis on the CANS as a CBHI outcome measure, as mentioned in previous reports. She is also actively involved in the data consultations with UMass Medical School.

This is an ongoing effort. For a number of reasons -- some relating to sensitivity of CANS items, others related to the complexity of services and the number of unmeasured factors affecting outcomes -- EOHHS does not anticipate simple answers about service impact from the CANS

Wraparound Fidelity Measures – WFI, DRM and TOM

MassHealth has reported on its use of elements of the Wraparound Fidelity Inventory 4.0 (WFI-4)[37], the Team Observation Measure (TOM)[38], and the Document Review Measure

[37] The 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. The CQI telephone interviews and ratings are conducted by Consumer Quality Initiatives (CQI) a consumer-run vendor contracted by MBHP. Each cycle involves calls to 600 randomly selected families and results in over 400 completed WFI-4 records.

[38] The TOM is a 20 item instrument used to assess adherence to standards of high-fidelity Wraparound during care plan team meetings. The TOM is used by the CSAs, whose staff (typically care coordinator supervisors), have been trained in rating the instrument. The TOM includes 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, 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 require the CSAs to ensure that every individual facilitating a Care Plan Team (CPT) meeting be observed twice (at minimum) during each annual TOM cycle. The second cycle of TOM data included observation of 658 team meetings across CSAs.

(DRM)[39] to assess the fidelity of Wraparound practice in ICC. MassHealth has now completed two cycles of measurement with all three tools.

The raw data for all three tools were reported to Eric Bruns, PhD, the developer of the instruments, who analyzed the data and prepared reports for the MCEs. As previously reported, Massachusetts providers' overall WFI score for the first cycle was 78 (out of 100), four points above the current national average. Massachusetts scored above the national average in nine out of the ten Wraparound Principles measured by the WFI. TOM results were comparable, with an average score of 83, six points above the national average of 77, and above-average scores on nine out of ten Wraparound Principles. Eric Bruns concluded by describing Massachusetts' implementation of High Fidelity Wraparound as "the fastest implementation of Wraparound in the history of Wraparound!" The presentation of the 2010 results is attached as Exhibit 65**.**

Results of the second assessment cycle are reported in the WFI Presentation, attached as Exhibit 66**.** Briefly, there were some modest gains and losses in fidelity in the second cycle as compared to the first, but overall fidelity scores remained high compared to national norms. Massachusetts is rated especially strong in Family Voice and Choice, Collaboration and Cultural Competence. These principles align strongly with central CBHI values. Perhaps the most concise summary is a comment from a parent from the WFI-4: "I have never felt as empowered or as listened to as I have in this program."

Opportunities for improvement include better development of natural supports, engagement of older youth, and preparing families to sustain gains beyond ICC.

Additional data on system performance

In addition, EOHHS has used anecdotal data collected through a range of avenues, both opportunistic and systematic, to understand and improve the quality of service implementation. Sources include the reports of MCE TA Teams, feedback from group meetings of providers and from training sessions, CSA coaching reports, meetings with various stakeholders, and the Court Monitor's CSR process (in which employees from MassHealth, EOHHS, and DMH participate as reviewers).

Ad hoc reports

Court Monitor's Request for MCI Follow-up Data
This report studied data on 4142 MCI encounters with young members between 10/1/2010 and 12/31/2010 to learn how many of them had received behavioral health services in the 90 days prior to and post the MCI intervention. The study found that 69% of young members had received a BH service in the 90 days prior to the MCI intervention and that 89% received a BH service in the 90 days following the encounter. *This report will now be prepared quarterly.*

[39] The Document Review Measure (MA DRM) is a 26 item measure used by MCEs in CSA chart reviews. MCE raters are trained to assess conformance to principles of Wraparound as evidenced by materials present in medical record (e.g. individual care plan; strengths, needs, culture discovery documentation; risk management safety plan; CANS; transition plan, meeting notes, etc.) Although the MA DRM is derived from a standard template, it has been modified for Massachusetts and scores on the MA DRM cannot be used to compare Massachusetts to national norms. The second cycle of DRM data included data from 322 chart reviews.

Study of Average Length of MCI Encounter in Days
This report studied data from the fourth quarter of State Fiscal Year 2011 (April 1, 2011 through June 30, 2011). The average length of encounter, by provider, ranged from 1.2 days to 3.4 days, with a statewide average of 2.4 days.

Study of BH Service Utilization by MBHP Members Prior to Receiving ICC
This study reviewed the data of 480 MBHP members who started receiving ICC in July, August or September 2011. Of these 480 young members, 462 (96%) received either outpatient therapy, IHT, IHBS, TM or a non-24 hour diversionary service (does not include MCI).

MBHP Study of Units of 24-Hour Care Consumed by MBHP Members 0-18
In this study, MBHP tracked utilization of Inpatient Care, Community Based Acute Treatment (CBAT) services and Intensive Community-Based Acute Treatment (ICBAT) over State Fiscal Years 2007 through 2010 (July 1, 2006 through June 30, 2010). During this period, utilization of all of these services declined by 25.5%. Inpatient care declined by 15.5%. Interestingly, there were minimal declines between 2007 and 2008 (2.1%) and between 2008 and 2009 (.5%), but a large decline between 2009 and 2010 (13.2%). It isn't possible to know, from this study, the reason for the decline, but it coincides with implementation of the remedy services.

"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."

The MCEs have surveyed all CSAs and confirmed that they all use some method for collecting satisfaction data. The MCEs are in the process of surveying all other remedy service providers to learn whether they collect satisfaction data. Providers who don't will be required to add it to their development plan.

With the support of DMH, CBHI has been able to engage the Shriver Center at UMMS to design and build a web-based application for young members and families to use to report on satisfaction with remedy services. CBHI staff anticipate the website becoming operational toward the end of CY2012.

The WFI-4 is a measure of Wraparound Fidelity and not technically a measure of member satisfaction, however, it is based on caregiver interviews and certain scales overlap heavily with key elements of consumer satisfaction. In particular, Family Voice and Choice as measured by the WFI-4 is very relevant to family satisfaction. CSA providers have consistently ranked especially high on this dimension of the WFI-4.

High member satisfaction and high family engagement have been consistent findings of the Court Monitor in her qualitative studies of children and families involved in ICC and IHT through the Community Service Review.

IX. Reporting and Monitoring (paragraphs 47, 48)

Paragraph 47

"Compliance Coordinator - The Defendants shall designate an individual to serve as their Compliance Coordinator. The Coordinator shall have the necessary authority to review, evaluate, design, and implement strategies to facilitate compliance with this Judgment by the Defendants, their agencies, agents, and employees. The Coordinator shall identify any obstacles to timely compliance and have the authority to implement actions that effectively address such obstacles."

EOHHS hired Ms. Emily Sherwood in May 2007 to serve as Compliance Coordinator. She has served continuously in that role since that date.

a. **"Compliance Meetings - The Plaintiffs will meet quarterly with the Defendants and Defendants' Compliance Coordinator to discuss the implementation of this Judgment and any obstacles to its full and timely implementation for at least 18 months from the date of this Judgment."**

   The parties have generally met monthly since July 2007, including weekly or bi-weekly meetings during the period of spring through fall 2008, when the parties were working on the Performance Specifications and Medical Necessity Criteria for the remedy services.

b. **"Compliance Reports - The Compliance Coordinator shall develop semiannual reports that describe the Defendants' actions to address each provision or section of this Judgment. The report also shall identify any obstacles that have impeded compliance with these provisions."**

   EOHHS has previously submitted all 10 semi-annual reports, and as well as 2 interim reports requested by the Court. The reports have thoroughly documented EOHHS' actions to implement each provision of the Judgment and have openly addressed any implementation obstacles.

Paragraph 48

"Court Monitor - According to the steps described in more detail herein, the Court shall appoint a Monitor acceptable to both Defendants and Plaintiffs to oversee the implementation of this Judgment. The Monitor shall serve at the discretion of the Court, and shall undertake those tasks described herein:
a. The Monitor shall have the authority to: (1) receive information relevant to the Defendants' obligations under this Judgment; (2) coordinate and facilitate meetings between the parties; (3) independently review the Defendants' compliance with this Judgment; (4) respond to complaints concerning compliance or other actions of the

Defendants; (5) recommend corrective or further actions necessary to redress any problems identified in implementing this Judgment; (6) mediate disputes between the parties; and (7) take whatever actions are useful to facilitate the timely implementation of this Judgment.
b. The Monitor shall have relevant expertise in behavioral health, health care, or Medicaid program administration.
c. The Monitor shall have access to all data, reports, records, or related documentation in the possession of the Defendants, their agents, contractors, evaluators, and providers that is necessary to perform the above functions.
d. The Monitor shall be compensated by the Defendants at a rate established by the Court. The Monitor shall prepare an annual budget for approval by the Court. The parties shall be afforded an opportunity to review and comment on the budget prior to its submission to the Court.
e. The Plaintiffs and Defendants shall attempt to agree on a Monitor with relevant experience. The parties will report to the Court, in writing, no later than March 23, 2007, regarding their efforts to agree upon a Monitor. If they agree on a Monitor, the name of this party, along with the proposed Monitor's curriculum vita and a budget, will be submitted at that time. In the event that the parties are unable to agree on a Monitor, each side will submit a list of three names, along with the curriculum vita of each, no later than April 6, 2007. The Court will thereafter select a Monitor from the proposed names. At the time the names are submitted, the parties will also submit a proposed budget for the Monitor. In the event that the Monitor resigns or otherwise is unable to continue to serve, the same process shall be used to select a replacement."

EOHHS has paid the Court Monitor at the rate established by the Court in 2007 and has provided the Court Monitor an office in Worcester. The Compliance Coordinator has met weekly with the Court Monitor since 2007. The Compliance Coordinator has provided the Court Monitor access to all data, reports, records or related documentation in the Commonwealth's possession requested by the Court Monitor.

X. TECHNICAL ASSISTANCE AND QUALITY IMPROVEMENT ACTIVITIES

A. Standardized Behavioral Health Screening: Data Analysis and Quality Improvement

In each of the last three quarters for which we have screening data (see table below), between 119,000 and 140,000 MassHealth-enrolled young members attended well-child visits. Of these young members, 65% received BH screens. Of children between the ages of six months and 14 years, 70% were screened. The percentage of screens indicating a potential BH need averaged from 7.5% to 8%.

For young members with a positive screen, PCCs, in consultation with parents, decide what is clinically indicated, either providing necessary follow-up services themselves, referring "internally" to a co-located BH provider, or referring "externally" to an outside BH provider. Screening tool results are preliminary indicators of a potential BH need, not a clinical assessment of that need. When a young members is referred to a BH provider,

the provider will conduct a comprehensive clinical assessment, including the CANS tool, as described below.

Quarter	number of well-child visits	number of screens	% of visits with screens	% of screens positive
Jan - Mar 2011	119,486	80,802	66%	7.5%
Apr - Jun 2011	125,731	86,663	67%	8.0%
July-Sept 2011	140,573	91,891	64%	7.6%

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

	Jan – Mar 2011	Apr - Jun 2011	July-Sept 2011
<6 mos	43%	44%	41%
6 mos to 2 year	73%	73%	70%
3 to 6 yrs	76%	77%	73%
7 to 12 yrs	77%	78%	73%
13 to 17 yrs	71%	72%	69%
18 to 20 yrs	34%	34%	35%

Discussion

Overall screening rates are high, with the exception of screening for infants under six months of age and young adults ages 18 through 20. To provide some context to the screening data, it may be helpful to review the published results of two screening projects in Massachusetts, one at Children's Hospital Boston and the other conducted by Cambridge Health Alliance. In the Children's Hospital Boston project, Dr. Alison Schonwald, a pediatrician at Children's Hospital Boston and one of MassHealth's screening tool consultants, implemented routine screens at 2 sites with 34 full and part time clinicians using one screening instrument to screen children from 6 months to age 8. After 12 months of implementation, clinicians screened these children 61.6% of the time. Of the children who were screened, 11% were identified with a "developmental concern".

In the Cambridge Health Alliance project, Dr. Karen Hacker, an adolescent medicine specialist and another of MassHealth's screening tool consultants, implemented routine screening in 7 practices using one instrument to screen children between 4 years, 11 months and 19 years. After five years, this project has reached a relatively steady screening rate of 75%. Of the children screened at these sites, 6% have been identified as possibly having a behavioral health condition.

The cumulative Quarterly Behavioral Health Screening Report from January 2008 through September 2011, is attached as Exhibit 31.

Measuring Follow-up Care

To ensure follow-up care by pediatric PCCs , all PCCs enrolled in MassHealth's PCC Plan, which constitute a large proportion of the Commonwealth's pediatric primary care clinicians, are sent a Reminder Report every six months, noting any member under age 21 who has had a positive BH screen but who has not had either a follow-up visit with the PCC to address the potential BH need, or any other claim for a BH service.

In addition, every six months the PCC Plan prepares Profile Reports for all PCCs with 180 or more MassHealth members on their enrollment roster. These reports give the provider data on their rate of BH screening, the percent of children with a positive screen and the percent of children with a follow-up service[40] within 90 days of the positive screen. Aggregate data from these reports is displayed in the table below.

New Measures Beginning in Profile Report Cycle 27	PR27 1/1/08-6/30/08	PR28 7/1/08-12/31/08	PR29 1/1/09-6/30/09	PR30 7/1/09-12/31/09	PR31 1/1/10-6/30/10	PR32 7/1/10-12/31/10
% Visit w/Screen	49%	50%	62%	65%	69%	71%
% Need identified	9%	9%	9%	8%	8%	7%
% With 90 day F/U	57%	60%	55%	53%	53%	54%

Each of MassHealth's contracted managed care organizations (MCOs)[41] is in the process of concluding a two year quality improvement project designed to improve rates of BH screening and follow-up services to positive screens. As part of the project the MCOs collect and report data on screening rates and the rate of follow-up within 90 days of a screen indicating a potential BH need.[42] Data from the first year of the project, CY2010, is displayed in the table below:[43]

% Visit w/Screen	BMCHP	Fallon	NHP	Network
Young members 0-20	86%	83%	76%	74%
0-12	87%		79%	76%
13-18	83%		72%	69%
19-20	38%		37%	34%
% Follow up				
Young members 0-20	32%	5%	23%	32%
0-12	29%		18%	31%

[40] For this report, follow up is defined as a claim for any BH service, or an office visit with the PCC for which the PCC recorded a BH diagnosis code.
[41] Boston Medical Center/HealthNet, Fallon Community Health Plan, Health New England, Neighborhood Health Plan and Network Health
[42] In this report, follow-up is defined as a claim for a BH service delivered by a BH provider.
[43] MassHealth started contracting with Health New England in SFY2010. HNE will submit data for CY2011.

13-18	47%		40%	38%
19-20	38%		46%	29%

Each of the MCO's has implemented activities designed to increase the rates of screening and follow-up care. These include, for example, educational efforts such as newsletter articles and emails, as well as targeted outreach to providers with low screening rates.

Appropriate levels of follow-up care are hard to discern using claims data. A provider may conclude, after further conversation with the parents or other caregivers, that no further follow-up is necessary. In addition, PCCs frequently report that families do not follow-up on PCC referrals to BH services.

To learn more about the follow-up care either being provided directly by the PCCs, or through referrals to BH clinicians, MassHealth has commissioned a second chart review study by the Center for Health Policy and Research (CHPR) at UMMS to be conducted during SFY2013. Prior to implementation of standardized pediatric screening, MassHealth engaged CHPR to conduct a baseline study of screening by primary care clinicians. The study analyzed 1355 medical charts of a random sample of 2000 MassHealth-enrolled young members. Study findings included that for 83% of the visits, there was some indication of behavioral health screening in the record, but only 4% of those screens included the use of a standardized tool. The baseline study, "Clinical Topic Review: Behavioral Health Screening" is attached at Exhibit 32.

As in the baseline study, the repeat study will document screening rates and screening tools used, but the new study will also document referrals and other follow-up actions taken by the PCC in response to a screen indicating a possible BH need.

Finally, MassHealth's Office on Quality is in the process of designing a small qualitative study to be conducted in SFY13 in which an evaluator will interview a sample of families of young members with positive screens who did not receive follow-up care to learn what the barriers were to accessing care. In addition, the plan is for the evaluator also to interview a small sample of families of young members in one or more of the remedy services to learn more about their "pathway" into care.

B. Clinical Assessments Using the CANS: Data Analysis and Quality Improvement

Based on data from the CANS Application, since the implementation of the CANS requirement, over 60,000 MassHealth-enrolled children and youth under the age of 21 have received clinical assessments including the CANS. In addition, claims data and MCE record reviews indicate that there are additional young members whose clinicians have completed the CANS on paper but not entered it into the CANS Application through the Virtual Gateway.

For these young members, the primary purpose of the CANS requirement has been achieved: they have received a comprehensive assessment of their needs, risk factors and strengths, as well as an assessment of their parents' or caregivers' needs.

For the past two years, MassHealth directed the MCEs to focus their CANS compliance efforts on ICC and IHT. Based on information gathered through individual TA meetings and sample record reviews, the plans report high levels of ICC and IHT compliance. At this time, MassHealth, CBHI and MCE staff are in the final stages of refining a methodology for measuring CANS compliance in all levels of BH services, relying not on claims data, but on whether the CANS has been entered into the CANS Application.[44] This will give the MCES a powerful new tool for manage their providers' CANS compliance.

The vast majority of clinical assessments are performed in outpatient therapy. Outpatient therapy providers file distinct claims for initial assessments and are required to use a billing modifier to indicate that a CANS has been completed. In the most recent quarter for which we have claims data, July 1, 2011 through September 30, 2011, 6,247 claims related to 4,497 individual children and youth, were filed for clinical assessments, with 3,297 of the claims (54.4%) included a billing modifiers indicating the completion of the a CANS.The MCE's access to data from the CANS Application will give them the ability to audit the accuracy of the billing modifier data as well as assess compliance with the requirement that providers update the CANS quarterly. Quarterly updates are not billed separately so do not generate claims data.

Data from the CANS Application show that 97% of CANS clinical assessments completed by all types of providers find that the child meets at least one of the definitions of Serious Emotional Disturbance (SED) used in the Judgment.

C. **EOHHS' Development of the ICC and FS&T Workforce: Wraparound Training and Coaching**

Prior to implementation of ICC and FS&T, in Massachusetts there were perhaps 100 clinicians trained in High Fidelity Wraparound and 50 Family Partners.

In 2009, EOHHS procured Vroon VanDenBerg LLP (VVDB) to train and coach CSA staff, including Care Coordinators, Family Partners, supervisors and managers, in high-fidelity Wraparound Care Planning.

EOHHS has sponsored three years of VVDB training and coaching. In that time, VVDB has worked with the CSAs to take on the task of training new staff, using VVDB curriculum. The training and coaching contract with VVDB expires on June 30, 2012. EOHHS is in the process of developing a plan to support ongoing coaching and technical assistance for ICC providers, provided by in-state consultants.

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1. 2009

a. MassHealth posted a *Request for Proposals (RFP) for Training, Coaching and Ongoing Learning Support for Intensive Care Coordination and Caregiver Peer-*

[44] EOHHS has had to build, implement and support an IT interface between the CANS Application and the MCEs. Other challenges have included the fact that different systems, such as the CANS Application and the various MCEs' claims payment systems, use different identification numbers for providers.

to-Peer Support Services for the Children's Behavioral Health Initiative on March 10, 2009. MassHealth selected Vroon VanDenBerg LLP to be the contractor, starting July 1, 2009, and signed a twelve-month contract with options to extend for two one-year terms. John VanDenBerg, 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.

b. Training began September 16, 2009. The basic Wraparound Training consisted of four full days of training, typically offered in two, two-day sessions several weeks apart. Family Partners received an additional two full days of training and CSA senior staff at least one additional one day advanced training. Training focused on teaching the specific skills needed to deliver High Fidelity wraparound, as well as the values and principles of Wraparound. By the end of the year all four days of Wraparound Training had been delivered four times across that state.
c. In addition, six experienced coaches from VVDB were assigned to work with the thirty-two CSAs. By the end of the year the coaches had completed initial visits to their CSAs and drafted a coaching plan for each CSA.
d. December 15, 2009, John VanDenBerg and Peter Metz, MD from UMass Medical School, conducted a training on the role of psychiatry and psychopharmacology in Wraparound for CSA psychiatrists and psychiatric nurse clinical specialists.
e. VVDB staff also held five meetings across the state to provide stakeholders with an orientation to Wraparound. EOHHS worked with providers, state agencies and family organizations to publicize the meetings.

2. **2010**
   a. January – VVDB provided an orientation to Wraparound for the MCEs' Network Management and Utilization Management staff, who interact with CSA staff to, respectively, provide technical assistance and to authorize care.
   b. VVDB delivered four full sets of trainings by end of June.
   c. VVDB presented a one day seminar for CSA Senior staff, regionally, in April, May and June.
   d. As of the end of May, VVDB had provided 118 on-site days of coaching.
   e. July - In collaboration with the MCEs and the CSAs, MassHealth planned and launched a second year of training and coaching on high fidelity Wraparound with VVDB. While the focus of the first year was largely on initial training of a large workforce of Care Coordinators, Family Partners and their supervisors, the focus of the second year was on increasing fidelity and on developing the capacity of CSAs to train and coach their own staff. As a result, the format is changed from large-group training of staff to seminar-style training of supervisors.
   f. VVDB provided supervisor training at five locations across the state in September and October; and two statewide training series in November. VVDB also revised its Wraparound curriculum materials for use by CSAs in small group trainings.
   g. Coaching of all 32 CSAs by VVDB staff continued.

3. 2011
   a. CSAs trained their own staff, individually, or in partnership with other CSAs, using VVDB curriculum.
   b. In addition, EOHHS sponsored additional centralized trainings for CSA line staff in recognition of the expansion and turnover within CSAs.

c. Coaching of all 32 CSAs by VVDB staff continued.
d. VVDB expert on Family Partners, Susan Boehrer, developed and provided a series of introductions to the Family Partner role in eleven sessions across the state, targeted to individuals interested in becoming Family Partners.
e. EOHHS and VVDB also developed and implemented a series of trainings (ten morning sessions across the state) on Wraparound for staff who might serve on Care Planning Teams, including staff from state agencies, courts and schools.
f. Dr. Jim Rast, the principal VVDB trainer and coach in Massachusetts, then trained CSAs on presenting this training to local stakeholders.
g. Other training topics for CSAs have included a "webinar" on the use of an updated format for the Individual Care Plan.

4. 2012

a. By the end of May, VVDB will have conducted ten trainings for In-Home Therapy and Outpatient providers on applying Wraparound principles to care coordination in these services, on how to coordinate care as a "hub" service, and on how to collaborate as a Wraparound team member for children and youth involved in Intensive Care Coordination.
b. Also by the end of May, VVDB will have conducted 10 days of training for CSA Direct Staff, 8 sessions for Family Partners and 5 sessions for CSA Senior Staff.
c. Coaching continues throughout January through June with each of the 32 CSAs.

D. **Other EOHHS Workforce Development Activities**

1. 2007

Assistant EOHHS Secretary Marilyn Chase and the Compliance Coordinator held a meeting on November 28, 2007, with leaders of clinical training programs in Massachusetts from the fields of Social Work, Psychology and Counseling, to discuss the need for professional and paraprofessional staff in the new behavioral system. Follow-up meetings were scheduled.

2. 2008

a. On March 28, 2008, EOHHS convened a second briefing for representatives from schools of social work, professional psychology, and nursing.
b. A working meeting was held on April 18, 2008 to discuss both short and long term strategies for training and education of the existing and future clinical workforce. The April meeting resulted in the formation of a smaller workgroup to help EOHHS plan a one day Intercollegiate Faculty Retreat to: (1) provide an overview of the significant changes underway in the public children's behavioral health system in Massachusetts; (2) provide an in-depth introduction to the research base and "best practices" for Systems of Care and Wraparound Practice; and (3) facilitate exploration of the potential implications for clinical education, informed by models and resources from other states.
c. The Intercollegiate Faculty Retreat was held on November 14, 2008. Over 20 schools, representing clinical preparation programs in social work, psychology, nursing, education and medicine, attended the retreat. Featured speaker, Carol MacKinnon-Lewis, PhD, Director of the System of Care Curriculum Initiative at the University of South Florida, provided an overview of how other

colleges/universities and states have collaborated across disciplines and departments to create new courses and infuse existing courses with Systems of Care Principles. Following her presentation, each school's delegation of faculty met during breakout sessions to begin discussing how they could apply Systems of Care principles and CBHI values their existing curriculum and collaborate across disciplines and departments.

d. MBHP, in partnership PPAL held informational meetings around the state for prospective Family Partners.

3. 2009

a. CBHI staff met with faculty of the Simmons College School of Social Work on February 2.

b. EOHHS hosted a faculty-student conference in April 2009. Faculty participated in workshops on teaching system of care-based competencies and breakout discussions facilitated by their peers on topics ranging from infusing existing curriculum with system of care principles and competencies to developing an interdisciplinary certificate based on system of care principles. Students participated in interactive workshops focused on the skills required to run successful Wraparound Teams, such as conducting strength-based assessments and facilitating group decision making. They were also introduced to career opportunities resulting from the new MassHealth behavioral health services: Community Service Agencies (CSAs) and Emergency Service Providers (ESPs) were invited to participate in a career fair in order to meet potential job candidates.

c. In April 2009 EOHHS hosted a career forum at Holy Cross College to introduce working clinicians to the career opportunities resulting from the new MassHealth behavioral health services. As with the Student-Faculty conference described above, CSAs and ESPs were invited to participate in a career fair in order to meet potential job candidates.

d. CBHI Higher Education Workgroup met with CANS developer John Lyons on June 9th and 10th.

e. CBHI staff presented an implementation update to the Deans of the Massachusetts' Schools of Social Work, in a meeting organized by the Massachusetts chapter of the National Association of Social Workers.

f. MBHP continued to hold informational meetings around the state for prospective Family Partners (who deliver "Family Support and Training").

g. EOHHS learned that the Simmons School of Social Work offered a course in high-fidelity Wraparound. Other schools that have modified their clinical training curriculum in response to the new remedy services include Bridgewater State College, Westfield State College and Western New England College.

4. 2011

a. EOHHS executed an amendment to DMH's contract with PPAL to fund outreach by culturally appropriate staff to cultural and linguistic minority communities in Boston, Quincy and Brockton. These staff are also, simultaneously, working with the local Community Service Agencies to identify potential Family Partners from these minority communities.

b. At the request of EOHHS, VVDB's Family Partner trainer, Susan Boehrer, held ten informational sessions across the state for potential Family Partners. EOHHS worked with family organizations and providers to publicize the informational sessions.
c. CBHI and OBH staff worked closely with DMH in planning the launch of the Children's Behavioral Health Research and Training Center (CBH RTC), established by Chapter 321 of the Acts of 2008.

5. 2012

a. Pending the outcome of the SFY13 appropriations process, EOHHS intends to renew its amendment to DMH's contract with PPAL to continue funding outreach and Family Partner recruitment efforts in cultural and linguistic minority communities in Boston, Quincy and Brockton.
b. EOHHS intends to reconvene interested higher education stakeholders to explore potential collaborations to expand e-learning and other flexible learning opportunities for staff delivering remedy services.

E. **EOHHS Commitment to CBHI Quality Improvement**

1. MassHealth's Office on Quality monitors provider compliance with BH screening and clinical follow-up and coordinates quality improvement activities in the PCC Plan and MCO Program.
2. OBH and the MCEs monitor CANS compliance and coordination of CANS quality improvement activities
3. CBHI staff continues to support and work to improve CANS compliance and overall practice improvement.
4. OBH and the MCEs work to ensure that all providers of the remedy services perform according to the Performance Specifications, including annual WFI assessment of ICC. OBH and the MCEs maintain a Continuous Quality Improvement (CQI) approach to the remedy services.
5. EOHHS continues to support coaching and TA for ICC providers.
6. EOHHS is planning to use the System of Care Process Review (SOCPR) methodology in an annual case review of a sample of young members receiving behavioral health services.
7. EOHHS, through the DMH CBH RTC will provide training, coaching and TA for providers serving young members and families, as a part of focused quality improvement initiatives.
8. EOHHS, through the DMH CBH RTC, and other means, will continue to build capacity for data collection and analysis, including partnerships with external researchers and evaluators.
   a. CBHI and OBH staff collaborated with DMH in the selection and design of initial CBH RTC research and training projects, currently underway:
      (i) *a study to document the culturally-informed practices of the three Specialty CSAs,* conducted by leading children's mental health researchers from the University of South Florida
      (ii) a rapid-cycle study of the practices of inpatient units and CBATs, in the context of the CBHI service delivery system

(iii) a white paper on the role of family partners in helping families access appropriate educational services for their children
(iv) a paper on best practices in mental health treatment for adopted children
(v) *design and development of a web platform to collect feedback from young members and their families on remedy services.*

9. EOHHS, through the DMH CBH RTC, continues to convene, and work with stakeholders in workforce development for children's BH services
10. EOHHS continues to work in partnership with the Children's Behavioral Health Advisory Council.

F. **MCE Provider Network Management, Training and Technical Assistance**

The MCEs joint activities to select providers, assess provider readiness and support the launch of remedy services are described in Section VIII above.

For ongoing network management, consultation, training and technical assistance, the MCEs have developed a variety of meeting types and venues:

- **Individual Provider TA meetings** between MCE Network Management staff and individual provider agencies. Each provider of ICC, FS&T, IHT and TM has a two-person TA Team, consisting of a MBHP representative and a representative of one of the MCOS. The goal of these meetings is to increase the TA teams' awareness of provider challenges and accomplishments as well as to identify areas for provider improvement and to develop action plans as needed.

- **Local and Regional Provider Meetings** include meetings of providers of a particular service, such as ICC or MCI, or for all remedy service providers in a particular region.

- **Statewide Provider Meetings** are usually held for providers of a single service, or for ICC and FS&T.

- **Monthly MCE Joint Management Meetings** are held to coordinate network management activities across MCEs.

Each type of meeting facilitates different work: individual TA meetings focus on provider-specific issues and goals; meetings of providers of one service allow for shared learning and problem-solving related to that service; and regional meetings of multiple providers focus on the coordination and smooth operations *between* services.

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What follows is a description of the wide range of network management, training and TA activities performed by the MCEs over the past four years. (Because MBHP is the sole manager of the network of ESPs, these activities will be described separately, below.)

1. 2009

a. Individual Provider TA Meetings

(i) *CSA pre-implementation meetings* - Prior to June 30, the MCEs engaged each of the CSAs in a series of individual TA meetings to support their preparations for implementation and to assess their readiness to start ICC and FS&T services.

(ii) *Onsite CSA TA Meetings* - Throughout 2009, the MCEs conducted monthly on-site TA visits and weekly phone check-ins with each of the CSA providers to closely monitor and quickly address any provider level issues or concerns.

(iii) *IHT, IHBS, TM pre-implementation meetings* - MCE network management staff visited every IHT, IHBS and TM provider prior to implementation to assess readiness.

b. **Local and Regional Provider Meetings**

(i) *IHT, IHBS, TM Regional Meetings* - The MCEs sponsored a series of regional meetings in December for these providers to focus on a wide range of issues related to operations, quality and staffing.

(ii) The first CBHI level of care[45] meetings were held in December 2009.

c. **Statewide Provider Meetings**

(i) *CSA Statewide Meetings* - Prior to the June 30, 2009 start date for ICC and FS&T, the MCEs conducted a series of statewide meetings for CSA providers (April 24, May 8, May 29 and June 26.) The statewide CSA meetings are a forum for disseminating information, sharing best-practices, engaging in mutual problem solving, and generally assisting providers with questions and concerns. Post implementation, the MCEs conducted monthly statewide meetings. A list, by year, of the dates and agenda items of each of the CSA Statewide meeting is attached as Exhibit 67

(ii) *IHT, IHBS, TM "Kick-Off" Meeting, September 9, Worcester* - The MCE-sponsored meeting for these providers featured presentations by national experts on the services, a review of the performance specifications for each service, a question and answers session, as well as distribution of MCE service authorization processes and parameters.

d. MCE Joint Management Meetings

(i) *MCE pre-implementation coordination* - Beginning in June, MCEs network management staff began meeting together monthly to review region-specific CSA and MCI readiness and to prioritize needed interventions to ensure readiness as well as to discuss and plan for any necessary remedial actions necessary to improve early implementation.

2. **2010**

a. Individual Provider TA Meetings

(i) *CSA TA Teams* - The MCEs continued individual TA meetings with CSA managers in 2010, varying meeting frequency from monthly to bi-monthly depending on the provider's Wraparound Fidelity Scores and other

[45] In the language of managed health care, various BH services, including the remedy services, constitute various "levels of care" in the service delivery system. In "level of care" meetings, the MCEs convene all of the remedy services in a particular region to work on coordination of care between services and collaboration among providers.

measures of performance. During these TA meetings, special attention was given to ensuring ICC collaboration with the larger system of care for young members and families, including MCI and the other remedy services, other behavioral health providers, primary care physicians, state agencies, schools, inpatient and Community Based Acute Treatment (CBAT) facilities.

(ii) *IHT, IHBS and TM TA Teams* - TA Teams were formed for these providers in 2010 and worked with them in onsite meetings, phone conferences as well as Level of Care meetings. The TA Teams conducted 79 onsite meetings with IHT providers, 22 onsite meetings with IHBS providers and 74 onsite meetings with TM providers. A list of the areas of practice addressed in the 2010 TA meetings is attached as Exhibit 68**.**

b. **Local and Regional Provider Meetings**

(i) *Training for IHT Supervisors* - On May 4th, 5th, and 6th, Rick Shepler provided 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.

(ii) *Regional Consultation Sessions for TM Providers* - 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.

(iii) Regional CBHI Level of Care Meetings

(i) *March* - Outpatient providers were invited to attend

(ii) *June* - Inpatient providers and Community-Based Acute Treatment (CBAT) providers were invited to attend. Topics for this second set of meetings included:"lessons learned" in holding Care Planning Team meetings in hospitals and CBATs; risk management/safety planning with young members in acute care; and the implications of using the Strengths Needs Culture Discovery in acute care settings.

(iii) *September* - These meetings focused on themes raised by providers during TA meetings: strengthening the documentation regarding the goals for the young member; integration of care; processes for updating/disseminating the Risk Management/Safety Plan and other pertinent documents among providers; role clarification among TM, IHT and Community Support Program(CSP) staff; how/when to involve siblings in goals or interventions; the TM model and the young member's engagement in group activities within this model; lessons learned in improving access to care; differentiating between outpatient services delivered in the home and IHT; understanding the IHBS model.

(iv) *December* - In addition to updates from the MCEs and providers, these meetings focused on successful system partnering regarding transitioning

young members and families to and from the various levels of service and the need to focus on the sustainability of the young member in the community. The discussion centered on what each of the system partners (ICC, IHT, TM, IHBS, MCI) can do to improve the transition experience for youth and families, including concrete steps to be implemented by the providers.

c. Statewide Provider Meetings

(i) *CSA Statewide Meetings* - At the request of the CSAs, the frequency of CSA statewide meetings was reduced from monthly to bi-monthly. For a list of agenda items, see Exhibit 67.

(ii) *Training for TM Providers* - On April 1st and 2nd, the MCEs sponsored a two-day training for TM providers. 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.

(iii) *Training for IHT Providers* - On April 6 and 7th, the MCEs sponsored two one-day trainings for all IHT staff and supervisors. 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.

d. MCE Joint Management Meetings continued to be held monthly.

3. 2011

a. Individual Provider TA Meetings

TA teams continued to work with providers of ICC, FS&T, IHT, IHBS and TM in 2011. The TA Teams conducted 199 onsite meetings with CSAs, 313 onsite meetings with IHT providers, 86 onsite meetings with IHBS providers and 275 onsite meetings with TM providers. A list, by service, of the areas of practice addressed in the 2011 TA meetings is attached as Exhibit 68**.**

b. **Local and Regional Provider Meetings**

(i) *Regional Consultation Sessions on System of Care Committees* – The MCEs sponsored five regional consultation sessions for CSAs to support the functioning and sustainability of the System of Care Committees

(ii) Regional CBHI Level of Care Meetings

(i) *March* - In addition to updates from the MCEs and providers, which included an overview of the MABHAccess website, these meetings included a presentation organized by the Massachusetts Commission for the Deaf and Hard of Hearing on "Understanding Deaf Culture and

Resources", providing a better understanding of Deaf culture and available resources for people who are Deaf or hard of hearing.

(ii) *June* - In addition to updates from the MCEs and providers, these meetings included a presentation by, and discussion with, PPAL, focusing on the history of the family movement, PPAL's history and mission, the effectiveness of family partners, supporting emerging family leaders and family-driven care planning.

(iii) *September* - In addition to updates from the MCEs and providers, these meetings included a presentation by and discussion with representatives of the Black Mental Health Alliance (BMHA), the focus of which was enhancing provider cultural competence in the delivery of remedy services, with an emphasis on Black young members.

(iv) *December* –

c. Statewide Provider Meetings

(i) *CSA Statewide Meetings* - At the request of the CSAs, the meeting frequency was reduced from a bi-monthly to quarterly. For a list of agenda items, see Exhibit 67.

(ii) *CSA Child and Adolescent Psychiatrist Guide and Training Sessions* – The MCEs collaborated with Peter Metz, M.D., to develop a guide for CSAs regarding the role of CSA child and adolescent psychiatrists. The guide was disseminated to the CSAs in October. Two training sessions were held in October for CSA Directors, supervisors and psychiatrists. A copy of the guide is attached as Exhibit 69**.**

(iii) *Wraparound Online Data Entry and Reporting System* – MBHP held three webinars in October as a refresher for CSA staff.

(iv) *Team Observation Measure (TOM) training* – The MCEs sponsored two trainings for new and existing CSA supervisory staff on using the TOM, one of two standardized tools used to measure providers' fidelity to the Wraparound model.

d. MCE Joint Management Meetings continued to be held monthly.

4. 2012 (November 1, 2011 – April 30, 2012)

a. **Individual Provider TA Meetings**

While TA teams continued to work with remedy service providers in 2012, the MCEs reduced the number of routine meetings and focused the TA resources where needed. TA Teams conducted 52 onsite meetings with CSAs, 157 onsite meetings with IHT providers, 46 onsite meetings with IHBS providers and 151 onsite meetings with TM providers. A list, by service, of the areas of practice addressed in the 2012 TA meetings is attached as Exhibit 68**.**

b. **Local and Regional Provider Meetings**

(i) *Five regional trainings for IHT providers* on "Building Team Competence in Strengths-Based Treatment"

(ii) *Five regional trainings for providers of MCI, ICC, FS&T and IHT* – "MCI Model Enhancement Part I"

(iii) *10 Regional Level of Care Meetings* including all CBHI service providers and outpatient providers

(i) *December 2011* – Presentation by Dr. Hisla Bates, Associate Medical Director, MBHP, on substance use screening for young members, using the CRAFFT substance use assessment tool. Other topics included the provision of FS&T in conjunction with IHT and outpatient hubs as well as a review of MBHP's Massachusetts Behavioral Health Access (MABHA) directory's data entry terms and definitions, to ensure integrity of the data.

(ii) *April 2012* – Presentation on trauma-informed care by the MA Child Trauma Project.

(iv) 96 local System of Care meetings, attended by MCE staff

c. **Statewide Provider Meetings**

(i) *Two CSA Statewide Meetings* - For a list of agenda items, see Exhibit 67

(ii) A meeting of CSA Child Psychiatrists – A discussion among CSA psychiatrists and program directors of the shared decision-making process for psychiatrists, families and their Care Planning Teams. The meeting included a presentation by Family Partners describing how psychiatry can be experienced by families.

(iii) One CSA Workbook Webinar to help ensure the integrity of the CSA Monthly Report.

d. MCE Joint Management Meetings continued to be held monthly.

G. MBHP's Management of the Network of Emergency Services Providers (ESPs)/Mobile Crisis Intervention (MCI)

MBHP directly manages 17 of the 23 ESPs, who provide MCI to MassHealth-enrolled youth under age 21. The four remaining ESPs are operated by DMH. MBHP collects performance data from DMH and includes it in the MCI report to MassHealth. The contract management activities described below are those conducted by MBHP with the 17 providers in its network. As noted below, DMH ESP programs are included in all training activities and statewide ESP meetings.

MBHP collects data from the ESPs on data elements such as the timeliness of MCI visits, percentage of visits occurring in the community and disposition of the referrals at the end of the service. These data are a foundation for the network management meetings conducted with MCI providers.

Similar to the strategies employed by the MCEs in collaboratively managing the networks of other remedy services, MBHP uses a combination of individual and group, local, regional and statewide meetings to manage the ESP network. In addition MBHP has provided MCI programs training and coaching by national consultant Kappy Madenwald, MSW.

1. Standing Meetings

a. Monthly

ESP statewide meetings in which a segment of the meeting is dedicated to MCI and special issues for MCI providers.

b. **Quarterly**
MBHP holds quarterly meetings with the ESP Chief Executive Officers.

2. Network Management and Quality Improvement Activities, by year:

a. 2009

(i) *Pre-implementation coordination with MCEs* - MBHP and the other MCEs met in May to coordinate various ESP contract implementation issues.

(ii) *Madenwald Presentation* - On June 26, 2009 MBHP sponsored a presentation by Kappy Madenwald, MSW, a nationally recognized expert on psychiatric emergency services for the MCEs, ESP/MCI providers and CSAs, on the topic of integration and collaboration between ICC and MCI.

(iii) *Individual Provider TA Meetings* - MBHP worked with the contracted ESPs to inform and train them regarding MCI policies and procedures. MBHP also contracted with Kappy Madenwald, MSW to provide TA to MCI providers. This work included formal trainings with ESP CEOs, ESP Directors, MCI managers, MCI clinicians and MCI paraprofessionals during May and June.

(iv) *Readiness Assessment* - Each ESP/MCI provider received TA/readiness assessment visits throughout June, as well as additional face to face, phone and email communication as needed. A structured MCI readiness assessment tool was completed on every ESP's MCI program.

(v) *MCI Paraprofessional / Family Partner Training* – On December 1, 2009 MBHP sponsored a training conducted by PPAL. Topics included: Family Partner history, principles and role; family journey; culture, partnership, communication, conflict management, boundaries and confidentiality.

b. 2010

(i) *Individual Provider TA Meetings* - MBHP network management staff conducted ongoing TA with each of the 17 MCI providers, on an approximately monthly basis, totaling 102 meetings. In many cases, MBHP staff had weekly and sometimes even daily contact with these providers.

(ii) *MBHP Regional ESP/MCI Meetings* - MBHP regional network management staff also conducted regional ESP/MCI meetings approximately monthly.

(iii) *MCI Promising Practices conference* – Held in June 2010 to highlight successful MCI practices developed by MCI providers during the first year of MCI services. Presentations included family members and providers of other remedy services. The conference also identified several opportunities for improvement to form the basis of training and TA activities in FY11.

(iv) *Madenwald MCI Training for MCI clinicians and paraprofessionals* (repeat of previous introductory training). Kappy Madenwald, MSW 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.

(v) *Madenwald Regional Training and Coaching Sessions* - Ms. Madenwald conducted a series of day long regional training and coaching sessions in April and May 2010. These advanced coaching and TA 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 young members and families to meet their needs within the emergency services system.

(vi) *Madenwald MCI Regional TA Forums* - The MCI regional TA forums, also facilitated by Ms. Madenwald and attended by MBHP staff, focused on resolution-focused interventions, the strategic use of bi-disciplinary teams and service delivery spanning the 72-hour timeframe.

(vii) *Madenwald Provider-Specific TA Meetings* – Ms. Madenwald conducted 13 individual MCI provider TA meetings addressing: MCI theory and philosophy, Risk Management & Safety Planning (RMSP), family voice and choice, the role of the Family Partner, communication between clinicians and family partners, review of individual children and families served, supervision of MCI teams, triage/dispatch – maximizing efficiencies, utilization of the 72-hour timeframe, creative diversions, community education.

(viii) *Management of access issues* - MBHP became aware of several concerns about access to MCI services and developed an action plan to address identified areas for improvement, including planned follow up on the statewide, regional and provider level. This included: an e-mail to all ESP/MCI CEOs informing them of the general feedback received; phone calls to several individual CEOs where warranted; addressing training protocols and MCI staffing with ESP/MCI managers during statewide ESP/MCI meetings; reviewing program specifications, such as the 24/7/365 MCI hours of operation, with managers; requesting MCI family and stakeholder satisfaction data from the providers that collect it; updating the ESP/MCI directory and reminding providers of the continuing opportunities for TA from Kappy Madenwald and statewide trainings including presentations by PAL.

c. 2011

(i) *Individual Provider TA Meetings* - MBHP network management staff conducted ongoing network management meetings with each of the 17 MBHP-managed ESP/MCI providers, on approximately a monthly basis, totaling approximately 191 such meetings. In many cases, MBHP staff had weekly and sometimes even daily contact with these providers.

(ii) *MBHP regional ESP/MCI meetings* - regional network management staff also conducted regional ESP/MCI meetings on approximately a monthly basis, totaling approximately 47 meetings.

(iii) *Madenwald MCI Regional TA Forums* - Kappy Madenwald, MSW, presented five regional forums in October on the CBHI Crisis System of Care, for MCI, ICC, Outpatient and IHT providers. This is described in more detail in Section VI.C below.

(iv) *Madenwald Provider-Specific TA Meetings* – Ms. Madenwald conducted 38 individual TA sessions with MCI providers during this six month period, addressing topics including: integration within the MCI team, expanding and integrating the role of the Family Partner within the team, engaging and collaborating with families in MCI services, best practices in triage and dispatch in order to maximize efficiencies and increasing interventions conducted in the community, use of community based levels of care in MCI disposition planning, short term behavior plans, finding resolution when community providers want young members to be placed in higher levels of care than MCI is recommending, interventions for young members who are transitioning to adulthood, strategies to engage and educate hospital EDs about MCI, establishing Memoranda of Understanding (MOUs) with individual schools and school systems to memorialize the relationship between the school and the MCI and review of interventions and plans for specific young members and families served.

d. **2012 (Nov. 2011 through April, 2012)**

(i) *Individual Provider TA Meetings - Individual Provider TA Meetings* - MBHP network management staff conducted ongoing network management meetings with each of the 17 MBHP-managed ESP/MCI providers, on approximately a monthly basis, totaling approximately 120 such meetings.

(ii) *MBHP regional ESP/MCI meetings* - regional network management staff also conducted regional ESP/MCI meetings on approximately a monthly basis, totaling 20 meetings..

(iii) *MCI Model Enhancement Training – Phase I* – MBHP held five regional forums in March and again in April with providers of MCI, ICC, and IHT on the MCI Model Enhancement. These sessions were led by Kappy Madenwald.

(iv) *MCI Model Enhancement Training – Phase II* – MBHP held four regional trainings for MCI providers on the MCI Model Enhancement in April and May, led by Kappy Madenwald.

(v) *Madenwald Provider-Specific TA Meetings* – Ms. Madenwald conducted 15 individual TA sessions with MCI providers during this six month period.

A complete list of MCI topics addressed in network management meetings, TA meetings and trainings, by year, is attached as Exhibit 70**.**

H. **Statewide Activities to Support Network Management and Quality of Care**

In addition to the activities described in Section XI.B above, the MCEs also implemented various quality improvement activities *across* the CBHI system of care, including:

1. 2011

a. **CBHI Educational Activities for Outpatient Providers**

(i) *Meetings*

(i) *MBHP Outpatient Provider Practice Analysis Meetings* -In February, July, August and September, 2011, the five MBHP regions held Outpatient Provider Practice Analysis (OPPA) meetings with individual outpatient provider agencies in which CBHI education was part of the agenda. Specifically included was the role of the outpatient provider as a hub service, including care coordination and treatment planning, the role of the outpatient provider as part of a Care Planning Team, and how to access the Common Network of CBHI providers. During these meetings the regional staff also educated outpatient providers on the role of the outpatient provider as a first responder in crisis and use of ESP/MCI services.

(ii) *MBHP Substance Abuse Provider Practice Analysis Meetings* - These same CBHI agenda items were also incorporated into similar meetings for Substance Abuse Providers in February, July, August and September.

(iii) *NHP, BMCHP, Fallon Outpatient Chart Review Meetings* - Outpatient providers were given information about billing for collateral contact and clinical hub responsibilities during chart review meetings.

(iv) *NHP, BMCHP, Fallon – Other Provider-Level Meetings* - One-to-one education provided to Outpatient providers as Network Managers identify the need for education or as the CBHI TA team see a need. The need is most often identified through provider report during a telephonic review.

(v) *MBHP Regional Outpatient Meetings* - In July, 2011, the Western and Central regions held regional Outpatient Provider meetings with outpatient providers in their respective regions. During these meetings CBHI education was part of the agenda, specifically the role of the outpatient provider as a hub providing care coordination and treatment planning that informs hub dependent services. MBHP also educated Outpatient Providers on the role of the outpatient provider as a first responder and role of Outpatient Provider in use of ESP/MCI services.

(vi) *NHP, BMCHP, Fallon CBHI Regional Quarterly Meetings* - Outpatient providers were invited to a round of these meetings, early in the year.

(vii) *Quarterly Regional MBHP/Outpatient/DYS Meetings* - All regions have quarterly meetings with DYS and outpatient providers, in which system integration with CBHI is addressed. These meetings were held during January through February, 2011 and April through May, 2011.

(ii) *Training Forums*

(i) *MCE's Outpatient Forum Distance Learning Activity* - Outpatient providers were the target audience of the MCEs CBHI Outpatient Forum Distance Learning Activity. This included both individual practitioners and providers working at outpatient agencies/clinics. This activity was available between January 1, 2011 and June 30, 2011. Upon registration, participants received a DVD set from the 2010 CBHI Outpatient Forum. After viewing the DVDs, they were encouraged to take a post-test and complete an evaluation. Those who received a passing score of 80% or higher on the post-test received CEUs.

(ii) *MBHP CBHI Promising Practices Forum* - Outpatient providers were in attendance at MBHP's CBHI Promising Practices Forum on May 23, 2011. The full-day event covered a broad range of topics and highlighted exemplary practices in the following areas: promoting families' strengths, transitions and sustainability, IHBS – everything you need to know, integration of psychiatry and CBHI services, family-driven care planning, working with transition age young members, CANS milestones and promising practices, systems integration within CBHI services – lessons learned from families.

(iii)Communications and Materials

(i) *MBHP's Informational CBHI E-mails to Outpatient Providers*

1. 3/17/11 – Reminder Communications re: Access to Virtual Gateway
2. 4/8/11 – Promising Practices Forum invitation/details/registration
3. 4/15/11 – Final Crisis Planning Tools
4. 3/1/11, 5/2/11, 6/3/3 - Reminders re:OP Distance learning activity
5. 5/10/11 – CBHI CANS Newsletter, May
6. 5/19/11 – MCE Clarification: young members who may be appropriate for IHBS
7. 5/25/11 – Assistance with CANS Reports & Verification of CANS Certification
8. 6/2/11 – CBHI Update (from CBHI at EOHHS)
9. 6/2/11 – MCE CBHI Health Record Documentation Standards
10. 6/27/11 – CBHI Update (from CBHI at EOHHS)
11. 6/28/11 – MCE CBHI Health Record Documentation Standards – REVISED
12. 8/10/11 – Upcoming Webinar: Functional Behavioral Analysis and Wraparound

(ii) *MBHP's Distribution of MCI Materials* - All regions distributed ESP/MCI materials to MH and SA outpatient providers during scheduled regional meetings with local area providers.

(iii)MCEs' Outpatient Tip Sheet - The MCEs have developed and distributed a tip sheet for outpatient providers on CBHI and their roles and responsibilities as a hub provider.

b. **Revision of the CBHI Risk Management/Safety Plan (RMSP) and creation of the new CBHI Crisis Planning Tools and Companion Guide**

(i) *Development of the Crisis Planning Tools and Companion Guide* - At the request of MassHealth, MBHP led a process for revising the tools that had been used to develop and document RMSPs since the start of ICC and MCI services. MBHP engaged Ms. Madenwald to develop a revised RMSP and a companion guidebook. As part of this process, Ms. Madenwald gathered feedback from families, staff and providers who've used these crisis plans, including PPAL; providers of CSA/ICC, ESP/MCI and IHT services inclusive of family partners, clinicians, BA level staff, clinical directors and managers; MCEs; and others. The goal was to develop a format that is more useful to young members and families, that will help them manage crises and reduce risk, and that could be used with young members of varying ages and families

with varying preferences and priorities. The revised CBHI Crisis Planning Tools include forms for a Safety Plan, Advance Communication to Treatment Providers and Supplements to Advance Communication. These are accompanied by the Safety Plan Companion Guide for Providers. These new crisis planning tools and guide are attached as Exhibit 71**.**

(ii) *Trainings for Providers on the Crisis Planning Tools*

(i) *Regional Crisis Planning Tools Trainings for Managers* – Five trainings were held in June, one in each region, facilitated by Ms. Madenwald. MCI, ICC and IHT providers attended. The trainings focused on using the new tools with families, developing staff training plans on the new tools, how to implement the new tools in MCI, ICC and IHT.

(ii) *Regional Crisis Systems Level of Care Meetings* - Five meetings were held in September, one in each region, facilitated by Ms. Madenwald. MCI, ICC and Urgent Outpatient Services (UOS) providers attended. The meetings focused on the current status of the "Crisis System of Care" within each region, how to engage others in the Crisis System of Care and move the system forward, and planning for Crisis System of Care trainings to be held in October.

(iii)*Crisis System of Care – Building Competencies Across Services* – Five trainings were held in October, one in each region, facilitated by Ms. Madenwald. MCI, ICC, FS&T, IHT, UOS and Child Outpatient providers attended. The trainings focused on the roles various providers have across the system to help families and young members navigate crisis situations, strengthening the Crisis System of Care, and identifying roles, responsibilities, strategies and opportunities for the system to collectively offer a stronger safety net for children and families.

c. Addition of CBHI services to the Massachusetts Behavioral Health Access (MABHA) website

In June 2009, at the request of DMH and MassHealth, MBHP created a website for providers to use to locate openings for new patients in 24-hour BH services such inpatient units and CBAT. Since that time, ESPs and hospital emergency departments (EDs) have used the MABHA website to locate beds in 24 hour level of care settings. Early in 2011, MBHP expanded MABHA to include information on the availability of ICC, IHT, IHBS and TM services. Further, the website is now accessible to as families, members of the public, and providers. Information on IHT was added as of February 1, 2011 and information on ICC, IHBS and TM was added as of March 1, 2011. Providers of these services update their program's available capacity each week, and update waitlist related data each month. MCEs use the MABHA website to manage their provider networks to address access issues with CBHI providers in real time, to ensure providers are compliant in entering their data in a timely fashion, and to address total capacity and available capacity within the region/network.

2. 2012

a. Family Partner Forum

In January 2012, the MCEs held a statewide Family Partner forum for providers of ICC, FS&T, MCI, IHT, and OP as well as DCF, DMH, DYS, DDS, and BSAS. The full day event covered a broad range of topics and highlighted exemplary practices in the following areas:

- Overview and history of the family movement
- The impact of family partners within the broader system
- Family Partner skills
- Becoming a family-centered organization
- Family Support and Training supervision, boundaries, and building one's workforce
- Working with families involved with DCF
- Family Partners' work with caregivers of Transition-Age Youth (TAY)

b. **Building Team Competence in Strengths Based Treatment**
In November 2011, the MCEs held 5 regional trainings facilitated by Kappy Madenwald. IHT providers attended and the trainings focused on the following topics:
   - Techniques for coaching staff in understanding the connection between "world view" and strengths identification
   - Recognizing the risk of deficit thinking in clinical practice
   - Breaking deficit "habits of thought" and applying strengths-based strategies during the engagement, intervention, crisis planning and resolution phases of working with young members and families

c. **MCI Model Enhancement Training – Phase I**
In March and April 2012, MBHP held 5 regional trainings with ESP/MCI, CSA/ICC and IHT. These trainings were led by Kappy Madenwald and focused on the following topics:
   - MCI Enhancement - What it is/what it isn't, review of medical necessity criteria, review of performance specifications
   - Resources: Staffing model, service demand, creating capacity, and developing a service menu
   - MCI Service Day 2-7 team competencies
   - System of care implications: MCI/IHT/CSA collaboration, developing service menus, and communicating changes to families and system partners

3. **Stakeholder collaboration to support the CBHI system of care-** The MCEs have collaborated with many stakeholders to discuss the CBHI system of care and address network management and training issues on a systemic level. In particular, the MCEs meet regularly with the following:
   a. Bi-monthly MCE/CBHI CEO Meetings including ABH
   b. Quarterly meetings with the Black Mental Health Alliance
   c. MBHP has involved PPAL in planning and conducting various MCI trainings and TA sessions, including inviting PPAL to lead or co-lead training and TA sessions.
      (i) PPAL collaborated, and co-led five Regional MCI trainings with Ms. Madendwald.

(ii) MBHP continues to support the participation of Family Partners and other paraprofessionals in PPAL's monthly family partner support meetings and discussed strategies for increasing attendance in FY 11.
(iii) MBHP engaged PPAL to help revise the Risk Management/Safety Plan which resulted in the new Crisis Planning Tools. PPAL wrote the forward to the companion guide and gave opening remarks at the provider trainings.
(iv) MCE staff attended the PPAL "Getting Real About Family Voice and Choice" conference.
(v) The MCEs invited PPAL participation on a panel at the May 23, 2011 CBHI Promising Practices Conference.

4. **Systems of Care (SOC) Committee Meetings**
Each of the CSAs convenes a monthly SOC Committee meeting in its area. These meetings facilitate coordination and collaboration among local schools, state agencies, courts, providers, community organizations, and others. MCE representatives attend many of these meetings.

CONCLUSION

As detailed above, the defendants report that, as of May 31, 2012 – except where open items are identified in the preceding text – they have fully implemented all remedy services required by the July 16, 2007 judgment, and are in substantial compliance with all tasks set forth in that judgment.

Respectfully submitted,

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Date: May 16, 2012

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. Because exhibits to this document were too numerous to be filed through the Court's electronic filing system, a paper copy of this report, together with a compact disc containing all referenced exhibits, has also been filed with the Court and served upon Steven J. Schwartz, Esquire, counsel of record for the plaintiffs, by first-class mail, postage pre-paid.

/s/ Daniel J. Hammond

Daniel J. Hammond
Assistant Attorney General