(LEAVE TO FILE GRANTED ON SEPTEMBER 4, 2018)

UNITED STATES DISCTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

ROSIE D., et al.	)	
Plaintiffs	)	
	)	C.A. No.
v.	)	01-30199 - MAP
	)	
CHARLES BAKER, et al	)	
Defendants	)	

(SUBSTITUTED AND CORRECTED) STATEMENT OF MATERIAL FACTS[1]

I. FOUNDATIONAL REQUIREMENTS

The Judgment outlined several provisions that fall outside, or are duplicative of, the Judgment remedy categories. Defendants assert that, to the extent applicable, they are in compliance with these provisions as follows:

1. Defendants are in substantial compliance the Judgment Section I (¶1) regarding eligibility for services, timelines for implementation, and modifications. The majority of the requirements in Section (¶1) are explanatory and do not require that Defendants undertake specific actions. Although the Medicaid Act[2] does not include an eligibility definition for early periodic screening, diagnostic and treatment services ("EPSDT") services for children with serious emotional disturbance ("SED"), as the Judgment suggested, Defendants have adopted the definition set forth in the Individuals with Disabilities Education Act[3] and the Regulations governing the Substance Abuse and Mental Health Services Administration[4] for Intensive Care Coordination ("ICC"). Defendants require that the eligibility requirements for all other remedy services be based upon functional and clinical impairment, and are outlined in the Medical Necessity

[1] *See* Affidavit of Laura Conrad dated August 6, 2018, submitted in support of the Defendants' Motion Regarding Substantial Compliance, attached hereto as exhibit A.
[2] Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.
[3] 20 U.S.C. §1401(3)(A)(i).
[4] 58 Fed. Reg. 29422-02 (May 10, 1993).

Criteria and Provider Performance Specifications for those services.[5] These requirements were developed in consultation with the Plaintiffs and do not categorically narrow the class of children eligible for services.

2. Defendants implement the Judgment Section I (¶1) eligibility requirements by requiring its Managed Care Entity ("MCE") contractors to deliver the remedy services subject to the Medical Necessity Criteria set by the Commonwealth.[6] In 2009, Defendants began requiring its Managed Care Organizations ("MCOs") and the Massachusetts Behavioral Health Partnership ("MBHP"), Defendants' sole behavioral health vendor, to deliver the remedy services subject to this Medical Necessity Criteria.[7] In 2012, Defendants reprocured[8] the behavioral health vendor contract and, in 2017, reprocured the MCO contracts. In 2017, Defendants also procured a new type of managed care plan, Accountable Care Partnership Plans ("ACPPs"). Defendants currently contract with two MCOs, thirteen ACPPs, and MBHP. Defendants continue to mandate the Medical Necessity Criteria applicable to the remedy services in each of these contracts.[9]

3. Defendants have complied with the Judgment Section I.E (¶47) requirements by appointing a Compliance Coordinator. In 2007, the Defendants designated an individual to serve as Compliance Coordinator and created the Children's Behavioral Health Initiative ("CBHI") program. Since that time, the Compliance Coordinators or Interim Compliance Coordinators have met with the Plaintiffs typically once prior to each report to the Court. Although the Judgment requires quarterly meetings by the Compliance Coordinator with Plaintiffs, the parties historically have met with greater frequency, usually on a monthly basis from 2007 through 2012, and on a weekly basis for a six month period in 2008.[10]

4. The Defendants have further complied with the Judgment Section I.E (¶47) requirements by paying attorneys' fees to the Plaintiffs for their time spent in these regular meetings and for other time spent on this litigation. The total amount of attorneys' fees and costs

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[5] *See* Performance Specifications, available: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018). *See also* Medical Necessity Criteria, *available*: https://www.mass.gov/lists/medical-necessity-criteria (accessed August 2, 2018).

[6] *See* Excerpted Example MCO Contract Language and ACPP Contract Language, attached hereto as exhibit B. Excerpted MBHP Contract Language, attached hereto as exhibit C.

[7] MassHealth's sole behavioral health vendor, the Massachusetts Behavioral Health Partnership (MBHP), is categorized as a Prepaid Inpatient Health Plan ("PIHP") under the federal managed care rules. *See* 42 C.F.R. Part 438.

[8] For the purposes of this document, "procurement" and "reprocurement" refer to the process of soliciting, selecting, and negotiating with vendors to administer benefits to MassHealth Members under state procurement laws and regulations. *See generally* 801 C.M.R. 21.00 *et seq.*

[9] *See* Exhibit B; and Exhibit C.

[10] *See* Defendants' May 16, 2012 Report On Implementation (Docket No. 575) ("Report"), Section IX, pp. 88-89.

the Commonwealth has paid over the course of the litigation is approximately $10.4 million, of which approximately $1 million has been paid since monitoring was scheduled to end in 2012.[11]

5. The Compliance Coordinator submits, at a minimum, the semi-annual reports required by the Judgment Section I.E (¶47).[12] To date, the Compliance Coordinator has submitted 48 status reports pursuant to this Judgment and as directed by the Court.[13]

6. The Defendants are in compliance with the requirements in the Section I.E (¶48) of the Judgment relating to the Court Monitor. Between 2007 and 2017, the Compliance Coordinator has met with the Court Monitor on a weekly basis. Within the last 12 months, these meetings have transitioned to bi-monthly. 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.[14]

7. The Defendants are in further compliance with the Judgment Section I.E (¶48) based on their payment of over $2.5 million dollars to the Court Monitor since her 2007 appointment, under the rate established by the Court. The Defendants are not aware of any written reports filed with the Court by the Court Monitor nor have the Defendants been provided a copy or transcript of any briefing the Court Monitor has made directly to the Court regarding the status of the Defendants' implementation of the remedies.

8. The Judgment outlines several specific points about implementation in Section I.E (¶¶34-39) and breaks these points into four, separate "projects" to be completed by a date designated for each.[15] Since the implementation activities for each project is integral to the discussion of the remedy requirements, they are included in the discussion of Defendants' substantial compliance with each remedy ordered in the Judgment below.

II. COMPLIANCE WITH NOTICE REMEDIES

Defendants have complied with the requirements outlined in the Judgment Sections I.A (¶ 2-7), and I.E.1 (¶ 36-37) to improve their methods for notifying eligible individuals enrolled in

[11] *See* Docket Nos. 430, 522,567, 637, 675, and 756.
[12] *Id.*
[13] Docket Nos. 381, 398, 400, 405, 422, 423, 424, 427, 448, 452, 455, 463, 474, 477, 485, 491, 495, 519, 531, 562, 575, 599, 606, 613, 615, 616, 620, 639, 648, 654, 664, 673, 678, 681, 694, 701, 706, 726, 740, 741, 749, 761, 763, 807, 813, 820 and 826.
[14] Report, Section I, pp. 2-3, and Section IX, p. 89.
[15] The task categories are 1) Screening and Notice (*see* Section II and Section III of this Statement of Fact) 2) CANS development and deployment (*see* Section IV of this Statement of Fact); 3) Development of a Service Delivery Network (*see* Section V of this Statement of Fact); and 4) Development of an IT System (*see* Section VI of this Statement of Fact).

MassHealth, MassHealth providers, public and private child-serving agencies, and other interested parties about the availability of the remedial behavioral health services and screenings in primary care settings as follows:

9. Since 2007, the Defendants have been informing all eligible members and their families about the availability of remedy services as well as the enhanced availability of screening services and ICC as soon as the child is enrolled in MassHealth.[16] The Defendants notify eligible members of the availability of these services annually, issuing a notice on the member's birthday.[17]

10. Since 2007, the Defendants have been informing all eligible members and their families about how to access behavioral health services and screenings through member education materials. These educational materials include member handbooks that are accessible in multiple formats, including on the MassHealth websites.[18] The Defendants also contractually require the MCEs to provide this information to members.[19]

11. Since 2007, the Defendants have required their MassHealth customer service contractor, and, since 2008, their MCEs to train staff on remedy services and on how to access them. This ensures that customer service representatives are able to assist members who call customer service lines for assistance and information regarding behavioral health services for their children.[20]

12. Since 2007, the Defendants have been making educational materials available to stakeholders.[21] For example, the Defendants regularly hold meetings with providers of remedy services and, since 2007, have been meeting with stakeholder groups, such as the Association for Behavioral Health ("ABH") and Parent Professional/Advocacy League ("PPAL"). Additionally, since 2012, the Defendants have funded an interdepartmental service agreement ("ISA") with the Department of Mental Health ("DMH") to support outreach and education to eligible children under 21 and their caregivers by PPAL.[22]

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[16] Report, Section III.A, p. 15.
[17] *Id.*
[18] *See* Member Guides and Handbooks, *available*: https://www.mass.gov/lists/masshealth-member-guides-and-handbooks (accessed August 2, 2018); and https://www.mass.gov/files/documents/2017/11/09/mh-pcc-plan-memb-handbook.pdf (accessed August 2, 2018).
[19] *See* Exhibit B; and Exhibit C.
[20] *See* Excerpted Key Operations Services Contract, attached hereto as exhibit D.
[21] "Stakeholder" refers to any individual interested in the wellbeing of the child. *See* guides for stakeholders, *available*: https://www.mass.gov/files/documents/2016/07/oi/cbhi-guide.pdf (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/07/vk/cbhi-ecmh-guide.pdf (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/11/ub/school-personnel-res-guide.pdf (accessed August 2, 2018); and https://www.mass.gov/files/documents/2016/07/nm/cans-family-guide.pdf (accessed August 2, 2018).
[22] *See* Commonwealth of Massachusetts Interdepartmental Service Agreement, Document Identification ISAEHSPPAL0000DMH19A, attached hereto as exhibit G.

13. Effective December 31, 2007, the Defendants updated 130 CMR 450.140-150, the MassHealth regulations governing requirements for providers related to the medical protocols and periodicity schedules for EPSDT services and behavioral health screenings and Appendix W of the MassHealth provider manual.[23]

14. Between December 2007 and August 2008, the Defendants updated and distributed provider education materials to reflect the program improvements, including those described in the Judgment. For example, the requirement that providers conduct the Child and Adolescent Needs and Strengths ("CANS") assessment was included in notices to providers through multiple channels, including a MassHealth transmittal letter to Fee-for-Service ("FFS") providers[24], Network Alerts, provider forums, and notices from MCEs, and CBHI mass emails.[25] These educational materials continue to be widely distributed, including in provider handbooks, manuals, contracts, and billing guidelines.[26]

15. Since 2007, the Defendants have maintained the CBHI website, a repository of resources for providers, members, families, family organizations, advocates, community based organizations, the broader community of human service providers, and members of the general public.[27]

16. The Defendants continually update the CBHI website with informative materials, including resource and referral guides for staff working with families and children who may benefit from remedy services.[28] For example, the CBHI website includes a four-panel, full color, family-friendly brochure that describes the remedy services and how to

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[23] *See* Provider Manual, Appendix W, *available*: https://www.mass.gov/files/documents/2017/09/27/appx-w-all_0.pdf (accessed August 2, 2018).

[24] *See* Fee-for-Service Provider Transmittal Letters, *available*: https://www.mass.gov/files/documents/2016/07/qh/phy-124.pdf (for Physicians) (accessed August 2, 2018) ; https://www.mass.gov/files/documents/2016/07/sl/mhc-39.pdf (for Mental Health Centers) (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/07/ri/pih-16.pdf (for Psychiatric Inpatient Hospitals) (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/07/xc/poh-4_94404_25264.pdf (for Psychiatric Outpatient Hospitals) (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/07/ty/aih-43.pdf (for Acute Inpatient Hospitals) (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/07/of/aoh-19.pdf (for Acute Outpatient Hospitals) (accessed August 2, 2018); and https://www.mass.gov/files/documents/2016/07/ot/coh-6_0.pdf (for Chronic Disease and Rehabilitation Outpatient Hospitals) (accessed August 2, 2018).

[25] *See* Exhibit B; and Exhibit C.

[26] *See* Provider Handbook, *available*: https://www.mass.gov/files/documents/2018/04/27/PCC-H-Rev-04-18.pdf (accessed August 2, 2018); *See also* EPSDT & PPHSD Billing Guidelines for MassHealth Physicians and Mid-Level Providers, *availabl*e: https://www.mass.gov/files/documents/2016/07/sh/epsdt-pphsd-bg.pdf (accessed August 2, 2018).

[27] *See* MassHealth Children's Behavioral Health Initiative Website, *available*: https://www.mass.gov/masshealth-childrens-behavioral-health-initiative (accessed August 2, 2018).

[28] *See* CBHI Brochures and Companion Guide, *available*: https://www.mass.gov/service-details/cbhi-brochures-and-companion-guide (accessed August 2, 2018).

obtain them. The brochure is available in English, Spanish, Portuguese, Haitian Creole, Chinese and Vietnamese. Print copies of the brochure are available free of charge and can be requested directly from the CBHI website.[29] Other materials include:

a. MassHealth Behavioral Health Services for Children and Youth through Age 20: A Guide for Staff Who Work with Children, Youth and Families;
b. Infant and Early Childhood Mental Health: A Resource Guide for Early Childhood Professionals;
c. MassHealth Behavioral Health Services for Children and Youth: A Guide for School Personnel and educational videos on Intensive Care Coordination and In Home Therapy; and
d. Links to external resources.

17. In 2007, the Defendants shared the Judgment with all appropriate Commonwealth officials in the Executive Branch and the Legislature.[30]

18. Between 2009 and 2011, the Defendants developed outreach materials and briefing guides[31] in order to prepare a wide range of public and private organizations for their role in referring eligible members for behavioral health services. The Defendants developed written protocols to provide guidance for staff of their child-serving agencies on how to refer eligible children and youth for screening, assessment and services.[32] The protocols are currently in effect, and 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.

III. COMPLIANCE WITH SCREENING & REFERRAL REMEDIES

The Defendants comply with the Judgment Sections I.A.2 (¶8- 10), 1.A.3 (¶11- 12), I.B (¶16), and I.E.1 (¶36), pertaining to Screening and Referral remedies, as follows:

19. In 2007, the Defendants updated 130 CMR 450.140-150 of the MassHealth regulations to require all primary care providers ("PCPs") to offer periodic and medically necessary

[29] *See* MassHealth Services for Youth and Families Brochure, *available*: https://www.mass.gov/files/documents/2018/07/16/cbhi-brochure-masshealth-services-for-children-and-youth-06-2018.pdf (accessed August 2, 2018).
[30] Report, Section III.C, pp. 23-24.
[31] *See* MassHealth Children's Behavioral Health Initiative Website, *available*: https://www.mass.gov/masshealth-childrens-behavioral-health-initiative (accessed August 2, 2018).
[32] *See* CBHI State Agency Protocols, *available*: https://www.mass.gov/lists/cbhi-state-agency-protocols (accessed August 2, 2018).

inter-periodic screenings, and to require those providers to select from a menu of standardized behavioral health screening tools when performing those screenings.[33]

20. The Defendants contract with the MCOs and ACPPs also require PCPs to offer periodic and medically necessary inter-periodic screenings.[34] The contracts include reference to the list of approved standardized behavioral health screening tools from which PCPs must select when administering behavioral health screens for young members.[35] This requirement was included in the newly-procured ACPP contracts in 2018, and has also appeared in the MCO contracts since at least 1998 with significant updates in 2007.

21. Defendants provide various resources for PCPs that reflect the emphasis on screening, the approved screening tools, and how to make referrals for follow-up.[36] For example, the Defendants manage the CBHI website giving providers and users constant access to training and resource materials.[37] In addition, on this website, users can access the Massachusetts Child Psychiatry Access Project ("MCPAP"), a resource for pediatric PCPs who identify behavioral health needs among their patients through routine visits and behavioral health screening.[38] Since 2010, the Defendants have worked in collaboration with DMH and MCPAP to offer a web-based screening toolkit for providers, and have updated that toolkit three times.[39]

22. Since 2009, the Defendants annually review the 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[40]. The list of approved screening tools includes the Pediatric Symptom Checklist ("PSC"), and the Parents' Evaluation of Developmental Status ("PEDS").[41]

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[33] *See* MassHealth-Approved Screening Tools, *available*: https://www.mass.gov/service-details/masshealth-approved-screening-tools (accessed August 2, 2018).

[34] MBHP does not cover PCP visits as the behavioral health vendor.

[35] *See* Exhibit B; and Exhibit C.

[36] *Id.*

[37] *See* MassHealth Children's Behavioral Health Initiative Website, *available*: https://www.mass.gov/masshealth-childrens-behavioral-health-initiative (accessed August 2, 2018).

[38] *See* Screening for Behavioral Health Conditions, MassHealth CBHI, *available*: https://www.mass.gov/screening-for-behavioral-health-conditions (accessed August 2, 2018).

[39] *See* Massachusetts Child Psychiatry Access Program Screening & Toolkits, *available*: https://www.mcpap.com/Provider/ScreeningNToolkits.aspx (accessed August 2, 2018).

[40] Report, Section IV.A.1, p. 30.

[41] *See* Provider Manual, Appendix W, available: https://www.mass.gov/files/documents/2017/09/27/appx-w-all_0.pdf (accessed August 2, 2018). *See also* Fee-for-Service Provider Transmittal Letters, *available*: https://www.mass.gov/files/documents/2016/07/qh/phy-124.pdf (for Physicians) (accessed August 2, 2018) ; https://www.mass.gov/files/documents/2016/07/sl/mhc-39.pdf (for Mental Health Centers) (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/07/ri/pih-16.pdf (for Psychiatric Inpatient Hospitals) (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/07/xc/poh-4_94404_25264.pdf (for Psychiatric Outpatient Hospitals) (accessed August 2, 2018); https://www.mass.gov/files/documents/2016/07/ty/aih-43.pdf (for Acute Inpatient Hospitals) (accessed August 2,

23. The Defendants continue their practice of not requiring a primary care visit or screening in order to access behavioral health services as required by Section I.A.3 (¶ 11) of the Judgment.[42] Further, a member may self-refer to behavioral health services, or may be referred by other state agencies, public schools, community health centers, hospitals, community mental health providers, PCPs, or behavioral health providers.[43]

24. Between 2009 and 2011, the Defendants developed and distributed written protocols for screenings, assessments, and remedy services to enhance the capacity of agencies and providers to connect children with remedy services.[44]

25. According to the Clinical Topic Review, conducted in 2013 by the Center for Health Policy Research at UMMS, "The implementation of the Children's Behavioral Health Initiative has fundamentally transformed the relationship between primary care services and behavioral health services within the Commonwealth. The current study shows clearly that changes in regulation and payment have resulted in the implementation of widespread behavioral health screening in primary care practices in Massachusetts that care for children and adolescents on Medicaid."[45]

IV. <u>COMPLIANCE WITH ASSESSMENT & TREATMENT PLANNING REMEDIES</u>

The Defendants ensure that remedy services include a clinical assessment process for eligible children who may need behavioral health services and connect those assessments to treatment planning required in the Judgment Sections I.B (¶13-16) and I.E.1 (¶37) as follows:

26. Since 2008, the Defendants require each behavioral health provider to incorporate clinical assessment into their behavioral health treatment of each child.[46] Assessment typically commences with the clinical intake process when the child presents for behavioral health

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2018); https://www.mass.gov/files/documents/2016/07/of/aoh-19.pdf (for Acute Outpatient Hospitals) (accessed August 2, 2018); and https://www.mass.gov/files/documents/2016/07/ot/coh-6_0.pdf (for Chronic Disease and Rehabilitation Outpatient Hospitals) (accessed August 2, 2018). *See also See* Exhibit B; and Exhibit C.

[42] *See, e.g.,* 130 CMR 450.118(J) and 119(J) (exempting behavioral health from the referral requirement for members enrolled in the MassHealth PCC Plan or a Primary Care Accountable Care Organization Plan).

[43] Report, Section V, p. 38.

[44] *See* CBHI for Providers and State Agency Partners, *available*: https://www.mass.gov/service-details/cbhi-for-providers-and-state-agency-partners (accessed August 2, 2018).

[45] *See* Clinical Topic Review 2013 - Behavioral Health Screening Among MassHealth Children and Adolescents, executive summary. Center for Health Policy Research at UMMS, page 12, *available*: https://escholarship.umassmed.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1198&context=healthpolicy_pp (accessed August 2, 2018).

[46] [46] *See* Exhibits B, C, E, and F. See *also:* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).

treatment.[47] Clinical assessment is a component of the providers' practice that leads to a clinical diagnosis,[48] and the commencement of treatment planning.[49] For example, as described in more detail in the Services section of this document, an intensive-home-based assessment and treatment planning process will take place upon intake for ICC services.[50] Medically Necessary services are available while clinical assessment and treatment planning practices are ongoing.

27. The Defendants have continuously updated their focus on clinical assessment and intake processes. Most recently, the Defendants worked with University of Massachusetts Medical School ("UMASS") to develop an intensive web-based training on assessment and clinical understanding. Defendants expect the training to be available to all clinicians providing services to children and youth in the winter of 2019.

28. In 2008, the Defendants revised its State Plan sections related to EPSDT Services ("EPSDT SPA") and Targeted Case Management Services ("TCM SPA") to require that clinical assessment practices and treatment plans be performed by licensed clinicians and other appropriately trained professionals as part of the remedy services.[51] The requirement to perform clinical assessment for children with SED has been included in all MassHealth's MCE contracts since 2008.[52]

29. Since 2008, the Defendants have required providers to include the CANS assessment in their clinical assessment as a standardized clinical information collection tool. For example, In-Home Therapy ("IHT"), ICC, and traditional outpatient behavioral health providers must engage in clinical assessment processes that include the CANS assessment tool.[53] Inpatient behavioral health and Community Based Acute Treatment ("CBAT") services providers must complete a discharge planning process inclusive of the CANS assessment, and make referrals for any medically necessary services.[54]

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[47] *Id.*
[48] *Id.*
[49] The Judgment refers to both "treatment" and "care" plans. This document used the term "treatment plan."
[50] *See* Exhibit E; and Exhibit F. *See also:* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).
[51] *Id.*
[52] For providers receiving fee-for-service payments from MassHealth, assessment requirements are incorporated in MassHealth regulations. For providers receiving payment by contracting with an MCE, the requirement is implemented through MCE contracts. Assessments are provided by both FFS and MCE-contracted providers. *See e.g.* Exhibits B and C.

[53] *See* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).
[54] *Id.*

30. Since 2008, Defendants have incorporated into all applicable MassHealth regulations the requirement that all remedy service providers engaging in behavioral health clinical assessment practices for eligible youth must complete the CANS. For example, in 2008, the Defendants updated numerous regulations, including for example, 130 CMR 410.476 (Outpatient Hospital Services); 130 CMR 415.419 (Acute Inpatient Hospital Services); 130 CMR 425.416 (Psychiatric Inpatient Hospital Services); 130 CMR 429.432 (Mental Health Center Services); 130 CMR 433.429 (Physician Services); 130 CMR 434.427 (Psychiatric Hospital Outpatient Services), to include CANS assessments for children receiving behavioral health services.

31. Further, DMH also adopted policies and procedures to ensure that staff completes a CANS for members under the age of 21 being discharged from DMH intensive residential or continuing care programs.[55]

32. Since 2008, 28,886 practitioners have been certified to perform the CANS Assessment.

V. <u>COMPLIANCE WITH COVERED SERVICE REMEDIES</u>

A. <u>Foundational Requirements</u>

The Defendants have complied with the remedy service requirements outlined in the Judgment Sections I.C (¶19-30), I.D (¶31), and I.E (¶49) for licensing requirements, amendment of contracts, CMS approval, promulgation of regulations, development of service descriptions, and collaboration with stakeholders as follows:

33. The Defendants sought approval to implement remedy services outlined in the Judgment from the Centers of Medicare and Medicaid Services ("CMS").[56] Specifically, the Defendants received CMS approval to provide ICC services under the Targeted Case Management SPA, and CMS approval to provide the remaining remedy services as Rehabilitative Services under the EPSDT SPA.[57] As previously reported to the Court, the Defendants did not receive CMS approval to add Crisis Stabilization to the MassHealth benefit.[58]

34. The Defendants require all providers of remedy services to be licensed clinicians or supervised by licensed clinicians.[59]

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[55] *See* DMH Guide to New and Current MassHealth Behavioral Health Services, available: https://www.mass.gov/files/documents/2016/07/nf/agency-protocols-dmh.pdf (accessed August 2, 2018).
[56] Report, Section VII.C.2, pp. 70-71.
[57] *See* Exhibit E; and Exhibit F.
[58] Report Section VII.C.2, pp. 70-71.
[59] *See* Exhibit E; and Exhibit F.

35. The Defendants have amended all MCE contracts to require the MCEs to provide remedy services to their eligible enrollees.[60] In 2009, the Defendants promulgated rate-setting regulations for the remedy services. The Defendants have raised rates for remedy services eight times following regulatory review.[61] For example, between 2009 and present, ICC rates have increased approximately 29% (for Master's level clinicians) and 25% (for Bachelor's level), FS&T rates have increased approximately 23%, and MCI, IHBS, TM and IHT rates have all increased approximately10%. Since the introduction of the remedy services in 2009, MCEs have been required to pay at least MassHealth's regulatory rate for remedy services. In 2017, the Defendants sought and obtained approval from CMS to continue imposing this rate floor on the MCEs under the new federal managed care directed payment regulations.[62]

36. The Defendants developed the Performance Specifications to provide service descriptions for each remedy service.[63] Since 2009, these Performance Specifications have defined the program models, staffing expectations and service standards for all remedy services.[64] The Defendants contractually obligate the MCEs to manage the operation of all remedy services using this set of Performance Specifications.[65] This approach ensures that the service is provided consistently across all MassHealth payers. The Defendants oversee the performance of the MCEs to their contract standards based on standard contract reporting on claims payment, customer service, authorizations, appeals and grievances, and provider accessibility and availability.[66]

37. Between 2007 and 2009, the Defendants collaborated with interested stakeholders, including the Plaintiffs, to create the Medical Necessity Criteria, which outline member eligibility and clinical criteria for the remedy services.[67] These Medical Necessity Criteria are incorporated into the MCE contracts and are available on the CBHI website.[68]

B. <u>Service Delivery System</u>

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[60] *See* Exhibit B; and Exhibit C.

[61] *See* 101 CMR 352. Because all remedy services are delivered through managed care, no MassHealth program regulations were needed to implement the covered services provisions of the Judgment.

[62] *See* 42 CFR 438.6(c).

[63] *See* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).

[64] *Id.*

[65] *See* Exhibit B; and Exhibit C.

[66] *See* Data Collection discussion, Section VI.B of this Statement of Fact.

[67] *See* Exhibit B; and Exhibit C. *See also:* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018). *See also* Medical Necessity Criteria *available*: https://www.mass.gov/lists/medical-necessity-criteria (accessed August 2, 2018)

[68] *See* Exhibit B; and Exhibit C. *See also* Medical Necessity Criteria, *available*: https://www.mass.gov/lists/medical-necessity-criteria (accessed August 2, 2018).

The Defendants have complied with the requirement to plan, design, and contract for a Service Delivery Network as described in the Judgment in Section I.D.1 (¶35) and Section I.E.1 (¶38) as follows:

38. In 2009, the Defendants, through the MCEs, established a statewide network of Community Services Agencies ("CSAs"). All CSAs deliver ICC as well as Family Support & Training ("FS&T"), and some CSAs also provide other remedy services.[69]

39. The Defendants require the MCEs to contract with the network of CSAs in the Commonwealth. The Defendants also contractually obligates the MCEs to provide ongoing management of the network of remedy service providers, including the CSAs. For example, the MCEs must ensure that network providers are qualified to perform the required service in accordance with the contracted Performance Specifications.[70]

40. The Defendants defined CSA service areas to promote consistency, capacity and efficiency.[71] There are 29 regional CSAs (whose service areas align with the 29 Department of Children and Families Service Areas), and there are three additional CSAs operated by provider organizations whose missions are limited to particular populations, for example, the Deaf and Hard of Hearing. All 32 CSAs have been providing services since July 30, 2009.[72]

41. After extensive review of provider capacity for all of the remedy services, the Defendants recognized the need to have numerous behavioral health providers, in addition to the CSAs, to provide remedy services.[73]

42. Other than CSAs, the MCEs continue to add providers and grow their networks of providers of remedy services.[74] In 2009, there were 66 IHT providers, 21 In-Home Behavioral Services ("IHBS") providers, and 66 Therapeutic Mentor ("TM") providers contracted with MassHealth MCOs or MBHP to provide services. In 2018, there are 162 IHT providers, 58 IHBS providers, and 163 Therapeutic Mentoring ("TM") providers in the MassHealth MCE networks.

43. Defendants evaluate the geographic availability of other providers of remedy services. For example, MBHP conducts a detailed geographic analysis of all IHBS, TM, and IHT providers, across MCEs, twice a year. This regular analysis assesses the geographic

[69] Report, Section VII.C.2, pp. 66-67.
[70] *See* Exhibit B; and Exhibit C.
[71] Report, Section VII.C.2, pp. 66-74
[72] Report, Section VII.B, pp. 57-58.
[73] Report, Section VII.C.2, pp. 66-67.
[74] *See* Exhibit B; and Exhibit C.

availability of providers based on a 20-mile radius of the center of all cities and towns in Massachusetts. This assessment demonstrates that the majority of towns have providers located within a 20-mile radius.[75]

44. In 2018, the Defendants also analyzed the geographic availability of IHBS, TM, and IHT providers in the new ACPP and MCO networks by conducting a "time and distance" analysis for members enrolled in these plans. The analysis confirmed that over 99% of all youth enrolled in these plans had access to at least two IHBS, TM, and IHT providers within 30 miles or 30 minutes of their home.

45. Because the remedy services are delivered through the MCEs, Defendants maintain active and ongoing oversight over the MCE administration of the remedy services. For example, the MassHealth Office of Behavioral Health ("OBH") convenes all of the behavioral health directors from the MCEs, or their designees, every two months and on an ad hoc basis, as needed to discuss matters relating to remedy services. 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 MCEs on provider management activities. Quarterly, OBH meets individually with the behavioral health directors to review the quality improvement and network management plans of each MCE.

C. Services

The Defendants comply with the Judgment Sections I.C. (¶19-30) and I.D (¶ 31-33) requirements to cover remedy services for members entitled to remedy services when medically necessary as follows:

i. Intensive Care Coordination

The Defendants comply with the ICC remedies in Judgment Section I.C (¶ 20-30) as follows:

46. The Defendants provide ICC to children who meet medical necessity criteria for and choose to have ICC.[76] Between July 2016 and June 2017, 8,116 youth received ICC.

47. Since 2010, the providers have been paid over $200 million to deliver over 50,000 ICC services to eligible members. Throughout this time, 78% of youth began their ICC

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[75] Exhibit I, MBHP Assessment of CBHI Provider Radius within 20 Miles of Massachusetts' Town and City Centers, 2018

[76] *See* Exhibit E. *See also:* Provider Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018). *See also:* ICC & FS&T Program Description and Operations Manual, *available*: https://www.mass.gov/files/documents/2016/07/qh/icc-program-description-and-operations-manual.pdf (accessed August 2, 2018).

treatment within 14 days of being referred to the service; 84% began treatment within 21 days; and 88% began treatment within 28 days. Since July 2010, the average wait time to obtain ICC is 11 days, and over half of the youth seeking ICC began treatment within 3 days.

48. The Defendants require the ICC services to include a Care Manager who coordinates and integrates multiple services in accordance with the member's needs and with links to interested stakeholders and services.[77]

49. The Care Manager is required to be a licensed mental health professional, or to be working under the supervision of a licensed mental health professional. The Care Manager must involve stakeholders in the treatment planning process.[78]

50. The Defendants also require that ICC services include the formation of a Care Planning Team. The Care Planning Team is required to be comprised of a variety of interested stakeholders, including relevant state agency staff, school personnel, and natural supports.[79]

51. Based upon consent of the custodian, the Care Planning Team can include a representative of other child-involved state agencies.[80] Representatives to the Care Planning Team are responsible for coordinating agency-specific planning and treatment.[81]

52. The Defendants also require that ICC services include the development of a treatment plan specific and individualized for the youth.[82] The individualized treatment plan is the primary tool for therapeutic interventions and service planning, and is developed pursuant to MassHealth guidelines and standards.[83]

53. The Care Planning Team is required to identify and arrange for all medically necessary services for the youth as part of the development of the youth's treatment plan.[84]

54. Treatment plans must be reviewed at least monthly by the Care Manager and quarterly by the Care Planning Team, and with more frequency as needed.[85]

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[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] *Id.*

ii. Crisis Management

The Defendants comply with the Crisis Management remedies in the Judgment Section I.D.1 (¶32) as follows:

55. Since 2009, the Defendants have been providing Mobile Crisis Intervention services to eligible members.[86] The Defendants use Emergency Services Providers ("ESPs") to provide mobile crisis intervention services. The Defendants obligate MBHP to manage the 21 ESP teams through their contract.[87] The other MCEs are required to contract with this network of ESPs to deliver MCI to their enrolled members.[88]

56. Between July 2016 and June 2017, the Defendants provided MCI services to 14,846 members. Since July 2010, providers have been paid over $101 million to provide MCI services to members.

57. The Defendants provide MCI services as a mobile, on-site, face-to-face therapeutic response to a child experiencing a mental health crisis for the purpose of treating and stabilizing the situation in community settings to reduce the immediate risk of danger to the child or others.[89] MCI services, in part, can help identify and connect children to community-based services so youth can avoid inpatient or other 24-hour level of care admissions.

58. In 2017, 60% of the youth who received MCI services during a mental health crisis did not require behavioral health related inpatient treatment.

59. The Defendants require MCI services to be provided by professionals trained in crisis intervention, who are qualified licensed clinicians, or working under the supervision of licensed clinicians.[90]

60. The Defendants require MCI services to be available 24 hours a day, 7 days a week.[91]

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[86] Report, Section VII.C.2, p, 65.
[87] *See* Exhibit C. *See also:* Provider Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).
[88] *See* Exhibit B; and Exhibit C.
[89] *See* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018). *See also* Medical Necessity Criteria, *available*: https://www.mass.gov/lists/medical-necessity-criteria (accessed August 2, 2018).
[90] *See* Exhibit F.
[91] *See* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018). *See also* Medical Necessity Criteria *available*: https://www.mass.gov/lists/medical-necessity-criteria (accessed August 2, 2018).

61. As previously reported to the Court, CMS declined to approve the Defendants' State Plan Amendment to add the Crisis Stabilization Services to the MassHealth benefit, as contemplated in Section I.D.1 (¶32) of the Judgment.[92]

iii. Home and Community-Based Services

The Defendants comply with the In-Home and Community Based remedies in the Judgment Section I.D.2 (¶33-34) as follows:

62. The Defendants provide In-Home and Community Based remedies through the following services: IHBS (which consist of In-Home Behavioral Monitoring and In-Home Behavioral Therapy), IHT, TM, and FS&T services.[93]

63. Between July 2016 and June 2017, 5,226 youth received FS&T; 2,505 youth received IHBS; 13,835 youth received TM, and 15,976 youth received IHT. Since 2010, the providers have been paid approximately $83 million to deliver IHBS services, $593 million to deliver IHT services, $275 million to deliver TM services, and $109 million to deliver FS&T services for youth.

64. The Defendants provide IHBS, TM, and FS&T as adjunct services used in conjunction with IHT, ICC, or traditional outpatient therapy when part of the member's treatment plan.[94] IHBS, IHT, TM and FS&T services are provided in community settings where the child is naturally located.[95]

65. Defendants require that IHBS services be supervised by a licensed clinician and consist of two activities: Therapy and Monitoring. [96] IHBS Therapy is provided by a qualified and trained clinician who coordinates interventions to address specific behavioral objectives of the member, and incorporates those interventions into the treatment plan.[97] IHBS Monitoring is provided by a qualified and trained paraprofessional who

[92] Report, Section VII.C.iv, pp. 70-71.

[93] *See* Provider Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).

[94] *Id.*

[95] *See* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018). *See also* Practice Guidelines, *available*: https://www.mass.gov/lists/practice-guidelines (accessed August 2, 2018).

[96] *See* Exhibit E. *See also* Provider Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018). *See also* CBHI In-Home Behavioral Health Services (IHBS) Practice Guidelines, *available*: https://www.mass.gov/files/documents/2017/01/pz/practice-guidelines-ihbs.pdf (accessed August 2, 2018).

[97] *See* Exhibit E. *See also* Provider Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018). *See also* CBHI In-Home Behavioral Health Services (IHBS) Practice Guidelines, *available*: https://www.mass.gov/files/documents/2017/01/pz/practice-guidelines-ihbs.pdf (accessed August 2, 2018).

implements and monitors the specific behavioral objectives and interventions developed by the IHBS clinician.

66. Defendants require that IHT services include a therapeutic clinical intervention, as well as ongoing training and therapeutic support to address specific emotional or relational issues. IHT therapeutic clinical services are provided by a qualified and trained clinician, who develops and implements therapy goals in conjunction with the ICC Care Planning Team. IHT training and support services are provided by a paraprofessional, supervised by a licensed clinician, in a variety of community settings. [98]

67. Defendants require that TM services provide a structured one-on-one relationship for the purpose of addressing socialization needs. TM services must include the development of independent living goals to be included in the Treatment Plan.[99] TM services are provided by paraprofessionals supervised by a licensed clinician.[100]

68. Defendants require that FS&T services provide a structured, one-on-one relationship with the parent(s) or caregiver(s) for the purpose of addressing issues directly related to the child's emotional and social needs.[101] FS&T services are provided by paraprofessionals supervised by a licensed clinician.[102]

iv. Services Provision Data

69. Since 2010, providers have been paid over $1.3 billion to provide remedy services to over 125,000 individual eligible members. In 2017 alone, 36,238 individual eligible members received services. Many eligible members receive more than one remedy service.

70. Utilization of remedy services has been increasing. For example, during the first year of service availability, 31,956 remedy services were delivered to members.[103] During the past year, 63,857 remedy services were delivered to members.[104]

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[98] *See* Exhibit E. *See also* Provider Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).
[99] *See* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).
[100] *See* Practice Guidelines, *available*: https://www.mass.gov/files/documents/2016/07/tb/practice-guidelines-tm.pdf (accessed August 2, 2018).
[101] *See* Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).
[102] *See* Practice Guidelines, *available*: https://www.mass.gov/files/documents/2016/07/tb/practice-guidelines-tm.pdf (accessed August 2, 2018).
[103] Based on the State Fiscal Year period between July 1, 2009 and June 30, 2010.
[104] Based on the State Fiscal Year period between July 1, 2016 and June 30, 2017.

71. Between July 2016 and June 2017, 82% of youth who received remedy services did not require admission to any 24-hour level of behavioral health related treatment (e.g., hospitalization, Community Based Acute Treatment ("CBAT")) at any time during the year.

VI. COMPLIANCE WITH INFORMATION TECHNOLOGY DEVELOPMENT & DATA COLLECTION REMEDIES

A. Information Technology

The Defendants comply with the Information Technology remedies in Judgment Sections I.E.1 (¶39) and I.E.2 (¶44) and have developed and implemented a web-based application to facilitate identification and monitoring of BH Service delivery to SED children as follows:

72. Defendants developed a web-based CANS Application that collects essential data for each member from the service providers.[105] Providers access this system through the Virtual Gateway, the secure web-portal that hosts the web-based CANS Application.[106] The Defendants continue to support all users of this system through customer services and technical assistance.

73. Additionally, the Defendants implemented, and continues to manage, extensive training and technical assistance for providers.[107] For example, the Defendants began providing in-person CANS certification and training beginning in 2008.[108] In 2010, the CANS training was revised to ensure more accurate user knowledge.[109] As of 2011, the CANS training has been available online, and the majority of clinicians use the web-based online training and certification system.[110]

74. As previously reported to the Court, several of the contemplated technology requirements in the Judgment were found to be unnecessary to Defendants' implementation of the Judgment and are therefore not further discussed here.[111]

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[105] Report, Section VI.B, pp. 44-45, and Section VIII, pp. 78-79. *See also* 130 CMR 410.000; 130 CMR 415.000; 130 CMR 425.000; 130 CMR 429.000; 130 CMR 433.000; 130 CMR 434.000.
[106] *See* Provider Performance Specifications, *available*: https://www.mass.gov/lists/performance-specifications (accessed August 2, 2018).
[107] Report, Section VI.C, pp. 45-48.
[108] Report, Section VI.C.1, pp. 46-47.
[109] *Id.*
[110] Report, Section VI.C.2, p. 47.
[111] Report, Section VIII, pp. 78-79. For example, legislative authorization, CMS approval, and contracting with vendors were not required to implement the web-based application.

B. Data Collection

The Defendants have complied with the basic ("existing") and potential ("contemplated") data collection systems outlined in the Judgment, Section 1.E.2 (¶¶40-46) as follows:[112]

i. Existing Data Collection Systems

The Defendants collect the basic data outlined in the Judgment Section I.E.2 (¶¶40-44) to support the ability to track, monitor, and evaluate a system of behavioral health care for children with SED as follows:

75. Defendants use the Medicaid Management Information System ("MMIS") as the primary source for Medicaid utilization and spending tracking.[113]

76. All MCE Contracts include data collection requirements.[114] For example, MCOs and ACPPs are required to submit standard quarterly reports that include the rates of behavioral health screens performed during Primary Care visits. All MCEs are required to report CANS compliance at all levels of care and cost and utilization of remedy services. MBHP reports on key performance indicators for MCI Services.[115] MCEs are also required to submit standard monthly reports that include CSA referrals, enrollments, wait times, waitlists, staffing levels, staff caseloads, and MCI performance indicators.[116]

77. Beginning in 2013, the Defendants developed and implemented the Massachusetts Practice Review ("MPR") as a tool to perform in-depth clinical record reviews of ICC and IHT practice. Reviews are conducted annually and include an evaluation of member outcomes, as well as clinical and administrative practice.[117] Prior to utilizing the MPR, the Defendants utilized the Clinical Service Review ("CSR") in 2011, under the direction of the Court Monitor, and in 2012, the Defendants implemented the Systems of Care Practice Review ("SOCPR"). The Defendants have performed 650 clinical record reviews since 2011 using these tools. The Defendants continue to use the MPR today to monitor the quality of clinical practice in the delivery of ICC and IHT. The reviews often include specific comments from the reviewers regarding the strengths and weaknesses of the clinical practice. For example, in 2017, an MPR reviewer of ICC practice noted the "extraordinarily good service planning, service delivery, cultural responsiveness, and overall clinical understanding" of the provider and the comprehensive care team

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[112] *See* Information Technology discussion, Section VI.A of this Statement of Fact.
[113] The MMIS System has been updated since 2007, as contemplated by the Judgment. Report, Section VIII, p. 80.
[114] *See* Exhibit B; and Exhibit C.
[115] Report, Section VIII, p. 80. *See also* Exhibit B; and Exhibit C.
[116] Report, Section VIII, p. 81.
[117] Report, Section VIII, pp. 78-88.

formation which included the child's numerous service providers, prescriber, school representatives (including assistance principal, school psychologist, special education coordinator and others), and two pastors.[118]

78. The Defendants synthesize and incorporate the data collected through the clinical care reviews to inform development and improvement of services and programming. For example, using the data from the clinical case reviews, the Defendants identified the need to develop a holistic and detailed practice profile for IHT providers. The Defendants, in partnership with DMH and seasoned IHT clinicians, developed a comprehensive practice profile ("Practice Profile") for IHT, offering detailed guidance regarding the core elements of IHT services for providers.[119] The Practice Profile helps support IHT providers in delivering higher-quality services for eligible members.

ii. Potential Data Collection Systems

Unlike the other remedy requirements in the Judgment, the discussion of potential data collection systems recognizes that the suggestions are "conceptual and subject to a complete inventory of the business requirements and data elements necessary for creating an appropriate tracking system…"[120] The Defendants have undertaken the review contemplated by the Judgment, Section I.E.2 (¶45-46) and complied as follows:

a. Data Collection – Utilization

79. The Defendants collect data on the number of behavioral health screens indicating that referral or follow-up is required.[121] Between January 1, 2012 and December 30, 2017, providers completed 2,315,665 behavioral health screens, and 8.12% of those screens indicated referral or follow-up was required.

80. The Defendants also collect clinical assessment data.[122] The majority of clinical assessments are performed by a traditional outpatient provider, and the outpatient provider must file a distinct claim for clinical assessments.[123] Since 2010, outpatient providers have been paid over $40 million to administer the CANS assessment to eligible members. The Defendants use these claims to produce a quarterly report of the number

[118] Community Healthlink, North Central. Massachusetts Practice Review (MPR) Individual Case Review Report, Review 2. Friday September 22, 2017, attached hereto as exhibit J.
[119] See In-Home Therapy (IHT) Practice Profile: Overview, *available*: http://www.cbhknowledge.center/iht-practice-profile-1/ (accessed August 2, 2018).
[120] Judgment, Section I.E.2, ¶45.
[121] Report, Section VIII. p. 82.
[122] *Id.*
[123] *Id.* These clinical assessments must include the CANS assessment.

of assessment claims.[124] Additionally, MCEs measure CANS clinical assessments through chart reviews and the CANS database.[125] From this data, the Defendants have been able to determine the number of clinical assessments that meet SED clinical criteria.[126] Since 2008, approximately 97% of CANS assessments meet the SED clinical criteria.

81. The Defendants also collect data relating to ICC. MBHP collects data from ICC providers relating to the number of members receiving ICC services each month and provides this data to the Defendants.[127] Additionally, the Defendants collect MCE claims data and specific cost and utilization reports related to delivery of remedy services. [128]

b. Data Collection – Outcomes and Satisfaction

82. The Defendants track outcome measures for purposes of program improvement and member satisfaction. The Defendants implemented a variety of systems for evaluating program outcomes as they relate to quality improvements, including compiling administrative data, fidelity data, and assessment data, as well as consulting providers, evaluators, and academic literature.[129] For example, the Defendants implemented two nationally validated tools for measuring Intensive Care Coordination: 1) the Wraparound Fidelity Inventory ("WFI2") 2.0; and 2) the Team Observation Measure ("TOM").[130] These instruments are used to assess the fidelity of the program and develop opportunities for improvement.[131]

83. The Defendants also require their MCEs to undertake review and management of the remedy service providers for the purpose of program improvement. For example, the MCEs are required to perform approximately 500 ICC and IHT clinical chart reviews annually and develop a report for the Defendants based on this review.[132] Additionally, the Defendants and the MCEs meet with each CSA quarterly to semi-annually to review data related to the performance of the CSA for the purposes of program improvement.[133]

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[124] *Id.*
[125] *See* Exhibit B; and Exhibit C.
[126] Report, Section VIII, pg. 82.
[127] *See* Exhibit C.
[128] Report, Section VIII, p. 83.
[129] Report, Section VIII, p. 84.
[130] Report, Section VIII, p. 85. Defendants also previously used the Document Review Measure (DRM), but this was phased out as the MCE clinical chart review practices began.
[131] Report, Section VIII, p. 86.
[132] *See* Exhibit B; and Exhibit C.
[133] *See* Exhibit B; and Exhibit C.

84. The Defendants convene 64 annual family voice forums in order to solicit direct feedback from caregivers and young adults receiving any remedy service.[134]

85. The Defendants use the MPR, TOM, and WFI4 review tools, in conjunction with provider satisfaction surveys to determine overall satisfaction. Further, the Defendants confirm that all service providers continue to use some method for collecting member satisfaction data.[135] These data collection methods consistently indicate high member and family satisfaction with the remedy services.

86. The Defendants have incorporated these reviews, reports, forums, and assessments into quality improvements. For example, the development of the IHT Practice Profile,[136] and the assessment and clinical understanding training was based on feedback obtained from these sources.

Respectfully submitted,

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DATED August 6, 2018

[134] Exhibit I, Second Amended and Restated Statement of Work for Wraparound Coaching Contract with the Technical Assistance Collaborative, Inc. Executed April 18, 2018.
[135] Report, Section VII, pp. 87-88.
[136] *See* In-Home Therapy (IHT) Practice Profile: Overview, *available*: http://www.cbhknowledge.center/iht-practice-profile-1/ (accessed August 2, 2018).