**UNITED STATES DISTRICT COURT**
**DISTRICT OF MASSACHUSETTS**

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| **ROSIE D., et al.,** | ) | |
| **on behalf of themselves and all others similarly situated,** | ) | |
| **Plaintiffs** | ) | |
| **v.** | ) | **Civil Action No. 01-CV-30199-MAP** |
| **DEVAL PATRICK, et al.,** | ) | |
| **Defendants** | ) | |

**REPORT ON IMPLEMENTATION**

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

This Report details the steps that the Defendants currently have taken to implement the tasks in Projects One through Four in the Judgment. For this purpose, the Defendants construe Projects One through Four to include all tasks described in paragraphs 2 through 46 of the Judgment.

Pursuant to the Judgment, the Defendants had until December 31, 2007 to complete Project One and have until November 30, 2008 to complete Project Two, until June 30, 2009 to complete Project Three, and until November 30, 2008 to complete Project Four.

Taking paragraphs 2 through 46 of the Judgment in turn, the Defendants hereby report as follows:

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

This paragraph is introductory; see detailed response below.

***Paragraph 3**: The Defendants will inform all EPSDT-eligible MassHealth Members (Members under age 21 enrolled in MassHealth Standard or CommmonHealth) 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.*

The Defendants have updated the three notices that MassHealth sends to MassHealth members under the age of 21 to notify them about preventive health-care services, including EPSDT services. These notices are sent to members (1) when they are first enrolled in MassHealth; (2) when members are reenrolled in MassHealth after any break in MassHealth coverage; and (3) annually, on or around the member's birthday.

These notices were first revised in June 2007 to specifically inform members that behavioral health screens are included as part of routine well-child care visits. These notices were further revised to include additional information about the standardized behavioral health screening tools. This further revised version went into distribution in February 2008.

These notices subsequently were revised to provide members more detailed information about the standardized behavioral health assessment process using the Child and Adolescent Needs and Strengths (CANS) tool. The Defendants plan to begin distribution of the updated notices in early January 2009.

The Defendants plan to revise these notices again to describe the remedy services, including how to access those services, in advance of their implementation.

***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.*

The Defendants executed a contract amendment with MassHealth's customer services contractor in December, 2007. Pursuant to the terms of this amendment, the customer services contractor:

- Conducted an initial training for all Customer Service Representatives (CSRs) about EPSDT services, including information about the standardized behavioral health screens.

These trainings took place during November and December, 2007, and were completed by December 31, 2007.

- Conducted a refresher training for all CSRs about new activities related to the behavioral health screens, which included information on the resources available to members and providers on EOHHS' Children's Behavioral Health Initiative page on the EOHHS website, and the availability of resources for primary care providers needing assistance with implementing the behavioral health screening requirement in their practices. These refresher trainings took place in April 2008 and again in September 2008.
- Conducted trainings for all CSRs on the Child and Adolescent Needs and Strengths (CANS) tool. The training included information on the purpose of the CANS tool; when, where, and by whom use of the CANS tool is required; and how providers required to use the CANS tool become certified to use it. These trainings took place between November 11 and 21, 2008.
- Will continue to train new CSRs as they are hired and provide ongoing trainings for veteran CSRs about (i) EPSDT services, including information about the standardized behavioral health screens; (ii) the CANS tool; and (iii) the remedy services, including how to access those services, once those services are implemented. The Defendants must review and approve the training curriculum used by the contractor.
- Updated its Knowledge Center, which is the library of materials accessed by CSRs, to include information about EPSDT services, including information about the standardized behavioral health screens and the standardized behavioral health assessment process using the CANS tool.
- Will continue to update its Knowledge Center to include information about (i) EPSDT services, including information about the standardized behavioral health screens; (ii) the CANS tool; and (iii) the remedy services, including how to access those services, once they are implemented.
- Revised the voice menu that directs members and providers with questions about services for children to CSRs trained to answer questions about EPSDT.

Pursuant to contract requirements, MassHealth's behavioral health services contractor, the Massachusetts Behavioral Health Partnership (MBHP), and MassHealth's contracted Managed Care Organizations (MCOs), have completed intensive training for their CSRs about when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services, and have established a schedule for refresher trainings on updates to the behavioral health screens. In addition, MBHP and the MCOs have conducted extensive CSR training on the use of the CANS tool as part of a standardized behavioral health assessment process. Both MBHP and the contracted MCOs will ensure that all new CSRs will be trained about (i) when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services and (ii) the CANS tool; and (iii) the remedy services, including how to access those services, once they are implemented. Both MBHP and the MCOs will ensure that veteran CSRs will be trained on an ongoing basis about (i) when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services, including information about the behavioral health screens; (ii) the CANS tool; and (iii) the remedy services, including how to access those services, once they are implemented. The Defendants will review and approve the training curricula used by the contractors.

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

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

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

See the response to paragraph 3 above.

Also, in December 2007, the Defendants mailed a new member notice to every household that included a MassHealth member under the age of 21 to inform these members about the program improvements described in the Judgment. This member notice also is being included in each distributed copy of the PCC Plan's member handbook, each MCO's member handbook, and MBHP's member handbook.

Prior to implementation of the remedy services, the Defendants will mail an updated member notice to every household that includes a MassHealth member under the age of 21 to inform these members about the program improvements described in the Judgment, including the remedy services and how to access those services. This member notice also will be included in each distributed copy of the PCC Plan's member handbook, each MCO's member handbook, and MBHP's member handbook.

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

The Defendants (or, where applicable, contractors) have taken or are currently undertaking the steps described below to update and distribute the following materials:

1. MassHealth Managed Care Enrollment Guide
   The MassHealth Managed Care Enrollment Guide is sent to all members newly determined eligible for MassHealth who are eligible for managed care enrollment.

   The Guide has been updated to include more detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The updated Guide went into use in January, 2008.

   The Enrollment Guide has been updated to educate members on the CANS tool, including information on how the tool will be used by behavioral health providers as

part of the standardized behavioral health assessment process. The updated Guide will go into circulation November 30, 2008.

The Defendants plan to further revise the Guide to include information about the remedy services, including information about how to access those services, when those services are implemented.

2. PCC Plan Member Handbook
The PCC Plan member handbook is sent to all members who enroll in the PCC Plan and additional copies are available for enrolled members upon request.

The Handbook has been updated to include more detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The updated Handbook went into use in January, 2008.

The Defendants plan to further revise the Handbook to include information about the standardized behavioral health assessment process using the Child and Adolescent Needs and Strengths (CANS) tool and the remedy services, including how to access them, in Spring 2009.

3. MBHP Member Handbook
The MBHP member handbook is for members who are enrolled with MBHP but not the PCC Plan (children in the care and custody of the Departments of Children and Families (DCF) (formerly the Department of Social Services (DSS)) or Youth Services (DYS)). It includes detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The Handbook went into use for the first time in December, 2007. Hard copies were distributed to DCF and DYS in December, 2007, and an electronic copy was posted on the DCF and DYS intranet sites. In October 2008, the Defendants mailed copies of the Handbook to DCF and DYS members.

The Defendants plan to direct MBHP to further revise this Handbook to include information about the standardized behavioral health assessment process using the Child and Adolescent Needs and Strengths (CANS) tool and the remedy services, including how to access those services, in Spring 2009.

4. MCO Member Handbooks
Each MCO sends its own Member Handbook to members who enroll in that MCO and additional copies are available for enrolled members upon request.

Each MCO has updated its Member Handbooks to include more detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening

tool during preventive care visits. Each MCO had completed updates to its member handbooks by February, 2008.

The Defendants plan to direct each MCO to further revise these handbooks to include information about the standardized behavioral health assessment process using the Child and Adolescent Needs and Strengths (CANS) tool and the remedy services in Spring 2009.

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

The Defendants revised relevant portions of MassHealth's regulations (130 CMR 450.000) to describe program improvements, effective December 31, 2007. For more information about these regulations, see the response to paragraph 6.a. below.

The Defendants are in the process of revising relevant portions of the following MassHealth regulations to implement the use of the CANS tool during behavioral health assessment for MassHealth members under the age of 21:

- Physician Services (130 CMR 433.000);
- Mental Health Center Services (130 CMR 429.000);
- Outpatient Services (130 CMR 410.000);
- Acute Inpatient Hospital Services (130 CMR 415.000);
- Chronic Disease and Rehabilitation Inpatient Hospital Services (130 CMR 435.000);
- Psychiatric Inpatient Hospital (130 CMR 425.000); and
- Psychiatric Hospital Outpatient Services (130 CMR 434.000).

The regulations will require:

- Certain behavioral health clinicians to obtain and maintain certification in the use of the CANS tool;
- Providers in outpatient settings to use the CANS as part of the comprehensive evaluation each member under the age of 21 receives before initiation of therapy and update the CANS at least once every 90 days as part of the review of the member's treatment plan;
- Providers in inpatient settings to use the CANS during the discharge planning process; and
- Providers to report data collected during each CANS assessment to EOHHS.

Defendants have published proposed revisions to each of the regulations identified above and will promulgate final regulations following the close of the public comment period, which ended on November 21, 2008.

The Defendants plan to further revise MassHealth regulations, as needed, to implement the remedy services.

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

Since the May 30, 2008 Report on Implementation, the Defendants' Compliance Coordinator or her Assistant Director has held or participated in the following forums and meetings:

- **Youth at Risk Conference**, Endicott College, Beverly. June 11, 2008. This conference brings together staff of youth-serving state agencies, school departments and private human services agencies on the North Shore.
- **Executive Office of Education (EOE) Meeting**, July 3, 2008. EOHHS staff and EOE staff, including representatives of the Department of Early Education and Care and the Department of Elementary and Secondary Education.
- **Department of Public Health Central Office Staff**, August 21, 2008.
- **Program in Education Afterschool and Resiliency (PEAR) Annual Conference,** Cambridge, September 19, 2008.
- **Family Forum**, Worcester, September 24, 2008.
- **Family Forum,** Springfield, October 16, 2008.
- **Family Forum,** Lawrence, November 20, 2008.

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

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

The Defendants revised relevant portions of MassHealth's regulations (130 CMR 450.000), which include the EPSDT regulations (130 CMR 450.140-150), effective December 31, 2007. These amendments, among other things, mandate that primary care providers offer to conduct screens required in MassHealth's EPSDT Medical Protocol and Periodicity Schedule (Appendix W of the MassHealth Provider Manual); refer children for treatment when a screen reveals the need for follow-up care; and use a standardized behavioral health screening tool when conducting behavioral health screens.

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

Effective December 31, 2007, the Defendants updated Appendix W to include a list of MassHealth-approved standardized behavioral health screening tools from which primary care providers must select a tool when administering behavioral health screens for

MassHealth enrolled children. The Defendants published the updated Appendix W along with the updated EPSDT regulations described in subparagraph a. above.

In collaboration with the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP), the Defendants have begun the process of reviewing the menu of approved screening tools and the schedule for behavioral health screenings in Appendix W. In the event of any changes to the menu of approved screening tools or to the frequency of behavioral health screening, the Defendants will publish a further revised version of Appendix W.

The Defendants plan to review the menu of approved screening tools and the schedule for behavioral health screenings on an ongoing basis, in collaboration with the MCAAP.

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

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

For more information on provider communications regarding assessments using the CANS tool, see the response to paragraphs 14-16. In addition, the Defendants prepared an article on implementing the CANS tool that was published in the August 8, 2008 edition of "Focus", the newsletter of the Massachusetts Chapter of the National Association of Social Workers.

Prior to implementation of the remedy services, the Defendants will produce and distribute information for MassHealth providers describing MassHealth behavioral health services for children and youth and how to access them.

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

The Defendants have updated (or have required the contractor responsible for their publication to update) the following materials that currently are distributed to providers to inform providers about using standardized behavioral health screens and using the CANS tool during behavioral health assessments:

1. PCC Plan Provider Newsletters – The PCC Plan Provider Newsletter is the provider newsletter for PCC Plan providers. The Newsletter included articles in the December, 2007 and March, 2008 issues that provided information on the requirement for PCCs to use standardized behavioral health screening tools. The PCC Plan included articles in the Spring 2008 and Summer 2008 issues of the Newsletter that provided information on implementing standardized behavioral health screening and using the Child and Adolescent Needs and Strengths (CANS) tool.

2. 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 – The Defendants updated this Guide for providers who bill MassHealth directly for EPSDT and PPHSD screening services to explain how to bill for standardized behavioral health screens. The updated Guide became available in December, 2007.

3. PCC Plan Provider Contract – The Defendants 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.

4. PCC Plan Provider Handbook – The Defendants updated this Handbook for providers who are enrolled as PCCs to describe the standardized behavioral health screening requirement. The updated Handbook was mailed to all enrolled PCCs with the updated PCC Plan provider contract.

5. MCO newsletters – Each MassHealth-contracted MCO included articles in their respective MCO provider newsletters to inform providers about the requirement for using standardized behavioral health screening tools. These newsletters were published between November, 2007 and January, 2008. In addition, each MCO published newsletter articles about implementing standardized behavioral health screening and using the Child and Adolescent Needs and Strengths (CANS) tool between May and August, 2008.

6. MassHealth "Update" article – MassHealth included articles containing information for providers about using standardized behavioral health screening tools in MassHealth "Update", which is MassHealth's online newsletter to all MassHealth providers. These articles were published in December, 2007, February, 2008, and August 2008.

The Defendants will assess which materials need to be updated to inform providers about the remedy services, including how to access those services, once those services are implemented.

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

The Defendants created a website for the Children's Behavioral Health Initiative (CBHI)[1] that is available on the EOHHS website to provide information to MassHealth providers, MassHealth members, the broader community of human service providers, and members of

[1] CBHI is an EOHHS interagency initiative whose mission is to strengthen, expand and integrate Massachusetts state services into a comprehensive, community-based system of care, to ensure that families and their children with significant behavioral, emotional and mental health needs obtain the services necessary for success in the home, school and community. CBHI will include activities to implement the Final Judgment in this case.

the general public about EPSDT generally and the program improvements that the Defendants are makings in response to the Judgment.

The CBHI webpage became available in December 2007. To date, the Defendants have posted on this website many of the materials referenced in the paragraphs above and below that describe the requirements for primary care providers to use standardized behavioral health screening tools as well as information about the CANS tool and information about the remedy services, including:

- EPSDT member notices described in paragraph 3;
- Member notice described in paragraph 5.a;
- PCC Plan Member Handbook described in paragraph 5.b;
- MBHP Member Handbook described in paragraph 5.b;
- MCO Member Handbooks described in paragraph 5.b;
- EPSDT regulations described in paragraphs 5.c and 6.a and Appendix W described in paragraphs 6.b;
- The EPSDT/PPHSD fact sheets described in paragraph 7.b;
- EPSDT Billing Guide described in paragraph 6.d;
- CANS-specific materials, including a CANS Frequently Asked Questions reference, the CANS forms, a CANS Item Glossary for scoring the CANS, CANS registration and training information, and CANS reference materials; and
- Information presented at the CBHI Institute described in paragraph 6.g.

The Defendants have also posted certain court documents and other information about the Defendants' implementation efforts, including information about provider trainings on the behavioral health screening tools and CANS tool, as well as resources for providers regarding the implementation of behavioral health screening tools in their practice. The Defendants continue to update the website regularly with general announcements and notices sent to providers regarding revisions to applicable MassHealth regulations.

The Defendants plan to update this website to include additional information about implementation efforts as they become available.

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

The Defendants have implemented changes to the Medicaid Management Information System (MMIS) to allow MassHealth primary care providers to be reimbursed for the administration and scoring of the standardized behavioral health screening tools, and to allow the Defendants to track the rate at which providers are utilizing a standardized behavioral health screening tool when administering behavioral health screens

MassHealth has developed and approved a billing code with a modifier that outpatient behavioral health providers will use to bill for behavioral health assessments using the CANS tool, and also has developed and approved enhanced rates to accompany the code. MCO and MBHP network providers have been permitted to bill the new code since September 15,

2008. MassHealth fee-for-service providers will be permitted to begin billing this new code November 30, 2008.

The Defendants will implement other operational changes that are identified as necessary to implement the projects described in the Judgment.

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

**Meetings with Primary Care Clinicians Regarding Standardized Behavioral Health Screening**

- Since the last court report, the Defendants have conducted three more forums to educate primary care clinicians about the requirement to offer to use a standardized behavioral health screening tool when screening children for behavioral health issues. These forums took place on June 18, 19 and 26, 2008 in Pittsfield, Hyannis and Danvers.
- The Compliance Coordinator presented on the Judgment, the new screening requirement and resources to support pediatric behavioral health screening at a meeting for primary care clinicians sponsored by Harrington Hospital in Southbridge, on September 18, 2008.

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

Since the last court report, the Defendants have participated in the following meetings:

- **Statewide Provider Meeting,** Hoagland-Pincus Conference Center in Shrewsbury, July 16, 2008. Discussed CANS implementation and presented an introduction to the remedy services.
- **Meeting with Mental Health and Substance Abuse Corporations of Massachusetts (MHSACM)**, September 8, 2008. MHSACM is a trade organization of mental health and substance abuse providers.
- **Meeting with Behavioral Health Staff**, Harrington Hospital, Southbridge, September 18, 2008. Discussed the Judgment, CANS implementation and the remedy services.
- **Statewide Provider** Meeting, Hoagland-Pincus Conference Center in Shrewsbury, September 19, 2008. Presented an overview of the remedy services and how the services connect to one another.
- **Meeting with the Massachusetts Children's League**, September 22, 2008. The Mass League is the trade organization for child welfare providers.
- **Minority Provider Forum**, One Ashburton Place, Boston, October 1, 2008. Presented an overview of the remedy services and how the services connect to one another.
- **Statewide Provider Conference Call regarding CANS Implementation**, October 10, 2008.
- **Deaf Provider Meeting**, One Ashburton Place, Boston, October 15, 2008

- **"CBHI Institute",** full-day conference presented free-of-charge to over 350 providers. The purpose of the Institute was: (1) to provide an introduction to "System of Care" principles and values underlying the Children's Behavioral Health Initiative; (2) to provide in-depth presentations on the specifications for each of the remedy services; and (3) to explain the provider selection processes the managed care contractors will use in selecting providers for the remedy services.
- **Statewide Provider Conference Call regarding CANS Implementation**, November 20, 2008.

In addition, the MassHealth Behavioral Health Unit conducts regular monthly meetings with MHSACM at which CBHI implementation issues are discussed. Additional meetings are held when necessary. The Compliance Coordinator participates when necessary.

The Defendants will continue to sponsor provider conference calls and meetings at regular intervals.

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

The Defendants have executed amendments to its contracts with MBHP and the MCOs to specifically require them to educate their network providers about the program improvements described in sections a. through g. of this paragraph.

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

As described in paragraph 6.e, the Defendants have created a Children's Behavioral Health Initiative (CBHI) webpage that is available on the EOHHS website to inform MassHealth providers, MassHealth members, the broader community of human services providers, and members of the public about EPSDT generally and the program improvements that the Defendants are making in response to the Judgment. The Defendants plan to update this website as implementation of the Judgment proceeds.

Additionally, as more fully described in paragraph 39.b, the Defendants have developed a web-based training and certification application to facilitate CANS training and certification for behavioral health clinicians, and are developing a web-based CANS application that will be available through the EOHHS Virtual Gateway for behavioral health providers who are required to use the CANS tool to report data collected to EOHHS.

***Paragraph 7: The Public - To improve public information about the program improvements the Defendants are required to take under the terms of this Judgment, the Defendants will***

***take the following actions to present the terms of this Judgment to public and private agencies that serve children and families*:**

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

The Defendants have conveyed copies of the Remedial Plan or Proposed Judgment to senior managers in:

- the Executive Office of Administration and Finance;
- the Executive Office of Health and Human Services;
- the Office of Medicaid; and
- the Departments of Mental Health, Mental Retardation, Public Health, Children and Families (formerly, Social Services), and Youth Services.

A copy of the Judgment was included with a copy of the November 30, 2007 Report on Implementation and was sent to:

- the Senate President;
- the Speaker of the House;
- the Chairs of the Senate and House Committees on Ways and Means and the Senate and House Chairs of the Joint Committees on: Health Care Financing; Mental Health and Substance Abuse; and Children and Families
- the Secretary of Administration and Finance;
- the Secretary of Health and Human Services and her senior management staff;
- the Medicaid Director;
- the Commissioner of the Division of Health Care Finance and Policy; and
- the Commissioners of the Departments of: Education, Early Education and Care, Mental Health, Mental Retardation, Public Health, Children and Families, and Youth Services.

The May 30, 2008 Report on Implementation was sent to the legislative offices listed above, the Secretary of Health and Human Services, the Medicaid Director, and the Commissioners of Children and Families, Mental Health, and Youth Services.

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

The Defendants developed and distributed two notices, in the form of 'fact sheets', for the purposes of outreach. 'Fact Sheet 1' is for the general public. 'Fact Sheet 2' is for agencies/groups that work with children and whose staff are likely to help parents learn about and access needed screenings, assessments and services for their children. Both Fact Sheets contain information about EPSDT services, including standardized behavioral health screening services, available to children enrolled in MassHealth.

The Defendants distributed an initial version of 'Fact Sheet 1' to the Massachusetts Medical Society, the Massachusetts League of Community Health Centers, the Massachusetts Chapter of the American Academy of Pediatrics, the Massachusetts Association of Family Practitioners, and the Mental Health and Substance Abuse Corporation of Massachusetts in December 2007, requesting each organization to make the materials available to their provider networks and to encourage their provider networks to circulate the materials to their patients and families. The Defendants re-distributed 'Fact Sheet 1' to the above named organizations in October 2008. The Defendants reminded the organizations that 'Fact Sheet 1' describes EPSDT services available to children enrolled in MassHealth and requested each organization to make the materials available to their provider networks and encourage their provider networks to circulate the materials to their patients and families. The Defendants also provided updated information about the types of behavioral health providers and settings that will be required to use the CANS tool during the behavioral health assessment process and the deadlines for doing so.

The Defendants distributed an initial version of 'Fact Sheet 1' and 'Fact Sheet 2' to staff working with the following agencies/groups in December 2007, requesting that each agency/group distribute 'Fact Sheet 2' to their respective staff/provider groups and encourage their staff/provider groups to circulate 'Fact Sheet 1' to their clients:

- Department of Children and Families;
- Department of Youth Services;
- Department of Mental Health;
- Department of Transitional Assistance;
- Office for Refugees and Immigrants;
- Department of Early Education and Care;
- Department of Public Health; and
- Department of Education.

In October 2008, the Defendants re-distributed the original cover letter sent in December 2007 along with 'Fact Sheet 2' to the above mentioned agencies/groups. The Defendants reminded the agencies that 'Fact Sheet 2' describes EPSDT services available to children enrolled in MassHealth and requested the agencies to re-circulate it to school nurses using the cover sheet. The Defendants also provided updated information about the types of behavioral health providers and settings that will be required to use the CANS tool during the behavioral health assessment process and the deadlines for doing so.

The Defendants plan to update the fact sheets to include information on the remedy services, including information on how to access those services, when those services are implemented.

The Defendants also are developing and will distribute, prior to implementation of the remedy services, a brochure for MassHealth parents describing behavioral health services for children and youth available through MassHealth, and how to access them.

The Defendants prepared articles on implementing the CANS tool and the Wraparound Process that were published in the Summer and Fall issues of "Newsline", the newsletter of the Federation for Children with Special Needs.

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

The Defendants distributed 'Fact Sheet 1' and 'Fact Sheet 2' to agency line staff at the agencies noted above. See paragraph 7.b above for more details. These fact sheets will be updated to include information about MassHealth services, including the new services required by the Judgment, as these services are implemented.

Planning is underway with the Departments of Children and Families, Education, Early Education and Care, Mental Health and Public Health to produce protocols that will inform their staff about the remedy services, including how to access those services. Similar planning will commence in January 2009 with the Department of Transitional Assistance and the Office for Refugees and Immigrants.

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

The Defendants have coordinated with the associations for these provider types, and will continue to do so, to ensure that updated versions of 'Fact Sheet 1' are made available to the public at provider sites.

For more information, see the response to paragraph 7.b. above.

For more information about the Virtual Gateway, see the response to paragraph 6.i. above.

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

The Department of Early Education and Care (DEEC) distributed the Fact Sheets to all DEEC-licensed childcare providers in the Commonwealth. In October 2008, the Defendants requested that DEEC distribute the updated Fact Sheets to all DEEC-licensed childcare providers in the Commonwealth.

The Defendants will continue to work with DEEC on strategies to inform childcare providers and the families and children they serve about behavioral health screenings, CANS assessments and services for their children.

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

The Compliance Coordinator meets regularly with the Director of Planning and Program Development for the Executive Office of Education to develop strategies for communicating necessary information about the Judgment, the remedy services and how to access them to child care providers and school personnel, including superintendents, principals, special education directors, school counselors and school nurses. Planning for these outreach and education activities have recently been moved under the umbrella of Governor Patrick's recently-convened "Readiness Council", which is co-chaired by the Secretary of the Executive Office of Health and Human Services and the Secretary of the Executive Office of Education. A CBHI Implementation Working Group is being created through the Readiness Council to support CBHI implementation with public schools.

The Compliance Coordinator presented at the semi-annual conference of Administrators for Special Education on June 6, 2008 on the Judgment, remedy services and CBHI implementation plans.

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

As explained in response to paragraph 6.a. above, 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.

As explained in paragraph 6.b. above, the menu of approved screening tools, which includes the Pediatric Symptom Checklist (PSC) and the Parents' Evaluation of Developmental Status (PEDS), as well as other tools to screen for autistic conditions, depression or substance abuse appears in Appendix W of the MassHealth Provider Manual, which became effective December 31, 2007.

***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.***

As explained in paragraph 6.a. above, the Defendants have updated MassHealth regulations governing the EPSDT program (130 CMR 450.140-150) effective December 31, 2007 to clarify that all primary care providers are required to provide periodic and medically necessary inter-periodic screens.

***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).***

As described in paragraph 6.g, the Defendants have held a series of provider training forums to inform primary care providers about the most effective use of the approved screening tools, to educate them on how to evaluate behavioral health information gathered during the screening, and to provide information on how and where they can refer members needing further behavioral health clinical assessment. Additional provider training forums are being planned for Spring 2009. These upcoming forums will focus on educating providers about MassHealth-approved screening tools and suggest strategies for implementation of behavioral health screening in the provider's practice.

Quality improvement efforts also are being implemented by the Defendants to further support the implementation of behavioral health screenings at all well child visits. These include:

- In August 2008, the Defendants mailed a letter to all primary care providers that had submitted at least one paid claim for a well child visit to MassHealth. The letter included provider-specific data on the number of paid claims for well child care visits and the number of behavioral health screens (including the number of claims for behavioral health screens that used a U-modifier). The letter identified resources available to providers to learn more about behavioral health screening and to increase the number of behavioral health screens provided to members under the age of 21. The Defendants plan to do another mailing of such provider-specific data in early December 2008.
- In collaboration with the Massachusetts Child Psychiatry Access Project (MCPAP), the Defendants have made Screening Tool Consultants (STCs) available, upon request, to help providers implement the behavioral health screening requirement. STCs are pediatricians who have expertise in the use of behavioral health screening tools, including experience using the tools in their practice. The STCs are available to answer questions on how to effectively implement behavioral health screening tools in the provider's practice.

- The Defendants have directed the STCs to outreach to providers who are billing only a few behavioral health screening codes and to discuss the provider's need for assistance.
- The Defendants and the MCOs have convened a Joint Quality Improvement Workgroup. The focus of this workgroup is to share successful practices, facilitate discussion, and generate ideas and suggestions related to quality improvement activities. Furthermore, through the workgroup, the Defendants are able to ensure that the MCOs are actively working on quality improvement activities. The group first met in October 2008.

The Defendants are tracking the number of delivered behavioral health screenings and are developing a plan for updating existing systems and methods to allow the Defendants to track the utilization of services following a screening. The Defendants plan to monitor the data gathered from such systems and use the data to help improve delivery of EPSDT screening, including assuring that providers offer behavioral health screenings according to the State's periodicity schedule.

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

The Defendants do not plan to change their policy that all MassHealth members, regardless of their managed care enrollment status, may access behavioral health services without the need for a referral as a prerequisite for payment for services. MassHealth-eligible children and eligible family members can continue to be referred, or to self-refer, for Medicaid services at any time by others, including other EOHHS agencies, state agencies, public schools, community health centers, hospitals and community mental health providers.

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

As described in the response to paragraph 7 above, the Defendants have developed and distributed written guidance that establishes protocols for referrals for screenings. The Defendants are in the process of developing written protocols with the child-serving state agencies to guide their staff in accessing screening services, clinical assessments and the remedy services. The Defendants are working with the training departments in the child-serving state agencies to plan for staff training in these protocols prior to June 30, 2009.

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

This paragraph is introductory; see detailed response below.

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

MassHealth has executed contract amendments with MBHP and the MCOs requiring them to use the CANS by November 30, 2008 as described below and allowing MBHP and the MCOs to use the CANS as part of a behavioral health assessment and pay their provider networks at an enhanced rate as of September 15, 2008.

MassHealth is in the process of promulgating regulations which will require that behavioral health clinicians who serve MassHealth members on a fee-for-service basis to use the CANS tool as described below. The public comment period for these regulations ended on November 21, 2008. The Defendants will publish the regulations accordingly. Fee-for-service providers who will receive an enhanced rate to perform the CANS (Physicians and Mental Health Centers) may begin billing the enhanced rate for services provided on or after November 30, 2008.

The steps that the Defendants are taking to require that the assessment using the CANS tool be conducted by licensed clinicians and other appropriately trained and credentialed professionals is described in response to paragraph 16.b. below.

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

The Defendants convened a workgroup, which met regularly in 2006 and 2007 with John Lyons, Ph.D., developer of the CANS tool. The group included representatives from MassHealth, the Department of Mental Health (DMH), the Department of Youth Services (DYS), the Department of Children and Families (DCF), the 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. The workgroup developed a Massachusetts CANS tool in two forms: one form for children under the age of five and another form for children and adolescents ages five to 21.

The Defendants presented draft versions of the Massachusetts CANS tool to providers, families and the Plaintiffs to gather their input. Both forms of the CANS tool are now complete and are available on the CBHI website along with explanatory and reference materials.

In addition, EOHHS developed cover pages to accompany both forms of the CANS tool that requires the clinician to identify whether the member has a serious emotional disturbance. This cover pages were provided to the Plaintiffs for review and comment. These cover pages are part of the CANS forms that are available on the CBHI website.

***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.***

The Defendants are requiring managed care entities to provide MassHealth-enrolled children with an assessment and record the results using the Massachusetts CANS tool when a child presents for treatment, whether the child's visit follows a behavioral health screening and referral from a primary care provider; whether the child presents following a referral from a provider, state agency, or school; or whether the child presents without a referral.

Providers have been informed of this requirement through multiple channels, including Network Alerts from managed care entities, provider forums, and CBHI mass emails. MassHealth will send a transmittal letter explaining these requirements to MassHealth fee-for-service providers when the CANS regulations become effective.

***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.***

MassHealth has required its managed care entities to ensure that assessments using the CANS tool are provided by clinicians trained and certified on the use of the CANS tool. MassHealth-contracted providers of behavioral health services will also be required to ensure that behavioral health clinicians who utilize the CANS are certified in the use of the CANS tool. To be certified, clinicians are required to pass a certification examination that has been approved by John Lyons. Clinicians who fail to attain a passing score have the opportunity to retake the certification examination. Recertification is required every two years.

The Defendants executed an Interdepartmental Service Agreement (ISA) with the Commonwealth Medicine Division of the University of Massachusetts to assist in developing the CANS certification training and examination program, in collaboration and consultation with Dr. John Lyons. The training program includes both in-person trainings with continuing education unit (CEU) credits and also a web-based training opportunity.

The Defendants started providing the in-person trainings in May, 2008. The web-based training became available in July, 2008. In-person training continues to be offered multiple times per week, including weekends, at locations across the state. Total in-person training sessions to date are 256, including 183 sessions at provider locations and 73 sessions at public locations.

It is impossible to determine the precise, unduplicated number of behavioral health clinicians that will use the CANS because, among other things, contracted providers are often entities such as mental health centers and hospital outpatient departments rather than individual clinicians. However, the Defendants estimated the total number of individual clinicians eligible for training and certification, including those employed or under contract to entities to be between five and six thousand. As of November 20, 2008, the number of clinicians trained and certified already exceeded these estimates. As of that date, 6,606 clinicians had registered for training, 4,692 clinicians had received in-person training, and 1,195 clinicians had received training via the Web-based training. In total, 5,887 clinicians had received training. In addition, 4,668 have become CANS certified.

To illustrate the intensity of current training efforts: during the one week ending November 6, 2008, 370 clinicians were trained and 342 were certified. At the current rate, the Defendants will have trained close to 7,000 clinicians and certified over 5,000 clinicians before November 30, 2008. Defendants will continue to offer in-person and Web-based training as needed going forward.

***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.***

The assessment process, as described in paragraphs 15 and 16.a above, will lead to a clinical diagnosis and the commencement of treatment planning. While the assessment process and treatment planning process is underway, medically necessary MassHealth-covered services will be available.

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

Providers of Intensive Care Coordination will utilize the CANS tool as part of the intensive home-based assessment and treatment planning process.

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

The Defendants are requiring that MassHealth fee-for-service providers use the CANS for members under the age of 21 as a part of the discharge planning process from acute inpatient hospitals, chronic disease and rehabilitation inpatient hospitals, and psychiatric inpatient hospitals.

The Defendants are requiring that MBHP and the MCOs require the use of the CANS for members under the age of 21 as part of the discharge planning process from psychiatric inpatient hospitalizations and from community-based acute treatment (CBAT) settings, including intensive community-based acute treatment (ICBAT) settings.

Effective November 1, 2008, the Department of Mental Health implemented the use of the CANS as part of the discharge process from intensive residential and continuing care programs for all DMH clients under the age of 21.

***Paragraph 17: Deleted.***

***Paragraph 18: Deleted.***

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

This paragraph is introductory; see detailed response below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

***Paragraph 27:*** ***The care and treatment planning process will be undertaken pursuant to guidelines and standards developed by EOHHS, which will ensure that the process is methodologically consistent and appropriately individualized to meet the needs of the child and family. EOHHS, in consultation with DMH, will develop an operational manual that includes these guidelines and standards for the use of the care planning teams.***

The Defendants will develop an operations manual for providers of Intensive Care Coordination during the Spring of 2009.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

***Paragraph 30:*** ***Intensive care coordination services are particularly critical for children who are receiving services from EOHHS agencies in addition to MassHealth. In order to assure the success of the care planning team process and the individualized care plan for a child with***

***multiple agency involvement, EOHHS will ensure that a representative of each such EOHHS agency will be a part of the child's care planning team. Operating pursuant to protocols developed by EOHHS, EOHHS agency representatives will coordinate any agency-specific planning process or the content of an agency-specific treatment plan as members of the care planning team. EOHHS will develop a conflict-resolution process for resolving disagreements among members of the team.***

The Defendants are in the process of developing policies and protocols with each of EOHHS' child-serving agencies covering referral to remedy services, participation by state agency staff on care planning teams and coordination of agency-specific planning processes with the ICC care planning process.

***Paragraph 31:*** ***For MassHealth Members entitled to EPSDT services, the Defendants will cover the following services for Members who have SED when such services are medically necessary, subject to the availability of Federal Financial Participation ("FFP") under 42 U.S.C. § 1396d(a) and other requisite federal approvals: assessments, including the CANS described in Section I.B above, the Intensive Care Coordination and Treatment Planning described in Section I.C above, and the services described in more detail below in this Section I.D. More detailed service descriptions will be developed later to assist in establishing billing codes, procedures and rates, and may be necessary or advisable for the process of seeking CMS approval of these services. EOHHS, in consultation with DMH, will collaborate with interested stakeholders (including clinical experts, child and family advocates, and managed care partners) in the development of clinical criteria for each of the covered services below.***

See response to paragraph 38 below.

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

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

   ***FN Text: Where provider qualifications appear in the description of the services in this section of the Judgment, the following applies: 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 clinical services within a particular scope as***

***defined by the applicable licensing authority or statute, including, but not necessarily limited 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.***

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

***(i) Behavior management therapy is provided by a trained professional, who assesses, treats, supervises, and coordinates interventions to address specific behavioral objectives or performance. Behavior management therapy addresses challenging behaviors which interfere with the child's successful functioning. The therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, that are incorporated into the child's treatment plan. The***

***therapist may also provide short-term counseling and assistance, depending on the child's performance and the level of intervention required. Behavior management therapy is provided by qualified licensed clinicians.***

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

See response to paragraph 38 below.

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

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

***(ii) Ongoing therapeutic training and support to the child/adolescent to enhance social and communication skills in a variety of community settings, including the home, school, recreational, and vocational environments. All services must be directly related to the child's treatment plan and address the child's emotional/social needs, including family issues related to the promotion of healthy functioning and feedback to the family. This service is provided by a qualified paraprofessional who is supervised by the qualified licensed clinician. This paraprofessional may also provide behavior monitoring as described above.***

See response to paragraph 38 below.

***c. Mentor Services – Mentor services include:***

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

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

See response to paragraph 38 below.

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

This paragraph is introductory; see detailed response below.

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

This paragraph is introductory; see detailed response below.

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

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

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

***b. Tasks performed will include:***

***(i) Developing and announcing a standardized list of behavioral health screening tools.***
***(ii) Drafting managed-care or provider contract amendments and regulatory changes to conform to the new requirements.***

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

For a response to subparagraph i.), see in the response to paragraphs 6 and 8 above.

For a response to subparagraph ii.), see the response to paragraphs 4, 5(b), 6(d),(g), and (h) above.

For a response to subparagraph iii.), see the response to paragraph 3 above.

***c. Timelines for implementation:***

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

The Defendants submitted a report dated June 27, 2007, that fulfilled the requirement in subpart i. The Defendants took the steps described in paragraphs 2-12 above to complete this project.

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

***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.***

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

***b. Task performed will include:***

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

See the response to paragraphs 15-16 above.

***c. Timelines for implementation:***

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

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

As described in paragraphs 14-16, the Defendants will substantially complete this project by November 30, 2008, as required by subpart ii. The Defendants have amended managed care entity contracts to require the provision of assessments including the CANS effective November 30, 2008. The proposed regulations for fee-for-service providers were published and the public comment period for these regulations ended on November 21, 2008. Final regulations will be published accordingly. Fee-for-service providers, including mental health centers and psychiatrists, can begin to claim an enhanced rate for assessments that include the CANS provided on or after November 30, 2008.

***Paragraph 38:*** ***Development of a Service Delivery Network***

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

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

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

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

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

***CSAs will operate in service areas that will be defined by EOHHS, and DMH, with the following objectives in mind: that CSA service areas be generally consistent with DMH***

***sites; that they promote consistency with DSS Family Networks provider areas; that they promote consistency, capacity, and efficiency; that they reflect linguistic or cultural characteristics, as appropriate; and that they reflect natural service areas. The current expectation is that there will be one CSA in each area so 21 defined, and that in total there will be no fewer than 15, and may be as many as 30, CSA service areas. The Defendants will consider defining regions for certain functions.***

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

Subject to CMS approval, discussed more completely in Section c.iv, below, MassHealth is taking the following the following steps to implement delivery of services described in the Order:

Selection of Community Service Agencies: Delivery of Intensive Care Coordination and Parent/Caregiver Peer-to-Peer Support

The Massachusetts Behavioral Health Partnership (MBHP) issued a request for responses (RFR) for Community Service Agencies (CSAs) on October 24, 2008. The RFR was developed in accordance with service specifications required by EOHHS, which consulted with DMH and received input from the CBHI Advisory Council, the Plaintiffs, the Monitor and the Monitor's consultants.

Bidders have until January 6, 2009 to respond to the RFR. MBHP, in collaboration with the MCOs, will select the CSAs by the end of February 2009. MassHealth will require all MCOs to offer to contract with the selected CSAs.

There will be one CSA selected for each of the 29 Department of Children and Families (DCF) service areas. In addition, MBHP may select up to three additional culturally- or linguistically-focused CSAs who will be allowed to focus on certain populations and enroll children and youth from an areas beyond the service area in which they are located.

The Defendants will directly provide initial training and one year of Wraparound coaching to each of the CSAs.

MassHealth is requiring its managed care entities to provide Intensive Care Coordination and Parent/Caregiver Peer-to-Peer Support Services through the CSAs as of June 30, 2009, provided that CMS has approved the Defendants' State Plan Amendment.

Selection of Mobile Crisis Intervention Providers

MassHealth has decided to utilize Emergency Services Providers (ESPs) to provide Mobile Crisis Intervention services and, for youths ages 18 through 20, Crisis Stabilization services. MBHP has been directed to re-procure its network of ESP providers and incorporate the requirements of the Judgment for Mobile Crisis Intervention Services and Crisis Stabilization Services. ESPs will be selected by MBHP, using provider qualifications established by DMH and MassHealth. MassHealth is requiring the MCOs to contract with MBHP's selected network of ESPs.

MassHealth is requiring its managed care entities to provide Mobile Crisis Intervention Services and, for youths ages 18 through 20, Crisis Stabilization Services as of June 30, 2009, provided that CMS has approved the Defendants' State Plan Amendment.

Network Development for All Other Remedy Services

MBHP and the MCOs will be required to provide In-Home Behavioral Services, In-Home Therapy Services, Crisis Stabilization Services for children and youth ages 0 through 17, and Therapeutic Mentor Services, provided CMS has approved the Defendants' State Plan Amendment.

Service Definitions and Specifications for All Remedy Services

MassHealth requires managed care entities to provide MassHealth covered services, including Remedy Services in accordance with service definitions and specifications that MassHealth establishes. The Defendants completed service definitions and specifications for all of the remedy services were completed in September 2008. They were developed with extensive input from the Plaintiffs and the Monitor's consultants. MassHealth will amend the managed care entity contracts to incorporate the required service definitions and specifications.

Utilization Management, Quality Management and Network Management

MassHealth currently requires its managed care entities to provide all services in accordance with MassHealth's medical necessity regulation (130 CMR 450.204). In addition, MassHealth intends to require its managed care entities to utilize common Medical Necessity Criteria (MNC) for the remedy services. Final MNC guide providers as they determine the medical necessity of a remedy service for a child or youth on MassHealth and are used by MBHP and the MCOs to review providers' determinations of medical necessity as a part of utilization management activities. MassHealth has developed proposed MNC for each of the remedy services with extensive input from the Plaintiffs and the Monitor's consultants. The Defendants have asked for a child psychiatrist with System of Care experience to be added to the Monitor's consultants. In addition, the Defendants will be reviewing the proposed MNC with clinicians practicing in the community settings. Both the child psychiatrist and the community clinicians will help the Defendants to evaluate the accuracy of the MNC in describing children and youth with a medical need for the specific remedy services.

The Defendants hope to complete work on the MNC by the end of February 2009. MassHealth will work with the MCOs and MBHP throughout the Winter of 2008/2009 to amend contracts in order to require coordinated approaches to utilization management, quality management and network management.

***c. Tasks performed will include:***

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

As described in paragraph 6.g and in paragraph 38.c.ii, the Defendants have met with providers in a variety of venues to discuss many delivery system design issues, including those related to access such as service specifications and provider and staff qualifications. At the beginning of the design process, the Defendants issued a Request for Information, soliciting stakeholder input on a number of delivery system design issues. The design has been developed paying careful attention to the issues of access and availability of providers. Responses received through the RFI validated the basic design approach. Workforce availability remains a great concern for providers, advocates and purchasers, including MassHealth. See the response to Paragraph 38.c.iii below.

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

The Defendants continue to rely on the Children's Behavioral Health Advisory Council, a large multi-stakeholder group chaired by the Commissioner of the Department of Mental Health, for advice and counsel on critical design issues. The Council also has two sub-committees, a Clinical Sub-Committee and an Outcomes Sub-Committee.

The Defendants also have held meetings with provider organizations and with families and family organizations, as described in paragraphs 5.d and 6.g, to get input on service design.

***iii) Planning concerning anticipated need and provider availability.***

<u>Start-up training</u>

The Defendants will be providing initial group training and twelve months of staff coaching to providers of Intensive Care Coordination, In-Home Therapy and Mobile Crisis Intervention. On November 21, 2008, the Defendants released a new Request for Information regarding training. The Defendants currently plan to issue a Request for Responses (RFR) soliciting bids for portions or all of the training contract in late December.

<u>Workforce Development</u>

Given that staffing the current behavioral health system is an ongoing challenge for behavioral health provider agencies, the Defendants know that workforce availability is key to successful implementation of the remedy services. There are a number of initiatives that have take place since the last court report to address this issue, including:

- On November 14, 2008. the Defendants convened a one-day intercollegiate Faculty Retreat whose goals were: (1) to provide an overview of the significant change process underway in the public children's behavioral health system in Massachusetts; (2) to provide an in-depth introduction to the research base and "best practices" for Systems of Care and Wraparound Practice; and (3) to facilitate exploration of the potential implications for clinical education, informed by models and resources from other states. Over 20 schools, representing clinical preparation programs in social work, psychology, nursing, education and medicine, attended the retreat. The Defendants used the retreat to propose a Higher Education Curriculum Initiative, in which the state would partner with clinical programs in order to integrate into clinical education both research and best practices in Systems of care for youth with emotional disorders and their families, Wraparound practice, and the reduction of health care disparities. 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. The Defendants will host a follow up meeting with faculty in January 2009 and will convene a conference in April 2009 for both students and faculty. At this later conference, faculty and students will be introduced to career opportunities within the CBHI and child-serving state agencies, and will participate in experiential learning workshops on such topics as conducting a strengths-based assessment, exploring cultural identity, and facilitating a Wraparound team. The spring conference will also feature tracks for faculty in order to continue the work from the November 2008 faculty retreat.
- In May 2008 the Defendants entered into an Interdepartmental Service Agreement with the Commonwealth Corporation (CC), a quasi-public entity that works closely with the Commonwealth's Executive Office of Labor and Workforce Development. Through this ISA, CC is facilitating the development of a curriculum designed to train paraprofessionals who will be qualified, as members of a team lead by a clinician, to deliver In-Home Behavioral Services, In-Home Therapy Services, Caregiver Peer to Peer Support, and Therapeutic Mentoring. CC has been researching and defining competencies in consultation with a working group of consumers, providers, and educators. The result of this group will be a written set of competencies to guide the development of curriculum at the community college level that would count toward Associate's and Bachelor's degree credits. Meanwhile, CC has identified a core group of community colleges interested in collaborating in the creation of courses and/or certificates that would prepare individual to work in the above services. These potential partners offer Associate's degrees in concentrations,

such as human services, early childhood development and early intervention, in which the proposed courses and/or certificates could easily fit. The proposed outcomes of this collaboration are: (1) the creation of career pathways for individuals entering the behavioral health workforce at the entry level in a professional role; (2) the adequate preparation of a workforce who will be able to deliver services in a strength-based, family-driven system of care; and (3) the diversification of the behavioral health workforce.

- MBHP is holding informational meetings around the state for prospective Family Partners (who deliver "Peer-to-Peer Caregiver Support"). MBHP is working with the Parent/Professional Advocacy League (PAL) to conduct these meetings. The purpose of these meetings is to educate parents of children with behavioral health needs about: the potential increase in employment opportunities for Family Partners through the remedy's Family/Caregiver Peer-to-Peer Support service; the required competencies; and opportunities for training. In addition, it is currently anticipated that PAL will be contacting community organizations in minority communities to partner with them to explore the possibilities for Family Partners in these communities.

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

On March 24, 2008, the Defendants submitted two State Plan Amendments (SPAs) for review and approval by the Centers of Medicare and Medicaid Services (CMS). One SPA proposes to amend the Targeted Case Management (TCM) portion of the State Plan (the TCM SPA) and the other proposes to amend the State Plan to add the Remedy services other than ICC as "EPSDT" services (the EPSDT SPA).

Prior to submission, MassHealth requested a meeting with CMS Central Office and Regional Office staff to brief them on this case, the Judgment and the proposed State Plan Amendments.

On June 17 and 18, CMS issued Requests for Additional Information (RAIs) on both the TCM SPA and the EPSDT SPA. The RAIs focused on clarifying exactly what activities would be performed in each of the services and who would be qualified to perform them.

The Defendants submitted written responses to the RAIs by the deadline of September 15 , 2008. The RAI responses were reviewed by the Plaintiffs and Monitor's consultants prior to submission.

The Defendants and CMS have had two phone calls and have additional calls scheduled. The calls continue to explore details of service activities, qualifications of providers and rate methodologies for both SPAs.

The Defendants have responded to CMS' clarifying questions regarding our written response to CMS' RAI on the TCM SPA. We have also submitted a rate methodology

for the TCM service. This SPA is on track for a decision within the prescribed timeframe of 90 days from CMS' receipt of the Defendants RAI response.

In follow-up telephone conferences following the Defendants' RAI response on the EPSDT SPA, CMS raised a number of questions and concerns about the services described. In general, CMS has stated that the services appear to overlap each other and they have requested further explanation from the Defendants about how the services are different from each other. In particular, CMS has raised concerns about whether federal financial participation is available for the Parent/Caregiver Peer-to-Peer Support Service and the Crisis Stabilization Service In addition, the Defendants' response to the RAI on the EPSDT SPA did not include rate methodologies for the EPSDT services because the rate development could not be completed until the service specifications were complete. CMS asked MassHealth to withdraw its written responses to the RAI, in order to "stop the clock" to avoid a denial of the EPSDT SPA so that discussions about both the services and rate methods could continue. Accordingly, MassHealth withdrew its RAI response on October 21, 2008. MassHealth will re-submit the RAI response once the discussions with CMS have concluded. It is unknown at this time whether CMS will approve all of the services described in the EPSDT SPA.

Senior staff responsible for the relationship between EOHHS' Office of Medicaid and CMS are supporting this process, as well as the Monitor's consultants.

***v) Defining CSA Service Areas.***

See the response to Paragraph 38.b above.

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

See the response to Paragraph 38.b above.

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

See paragraph 38.b above

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

See paragraph 38.b above.

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

Work is well underway with the Commonwealth's rate setting agency, the Division of Health Care Finance and Policy (DHCFP), to develop fee for service (FFS) rates for the remedy services. These rates will be one of the resources used to develop MassHealth's capitation payment to its MCOs and MBHP.

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

This will be performed by MBHP and the MCOs pursuant to the contract amendments negotiated and executed in 2008.

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

As described in paragraphs 2-7 above, the first phase of this work -- educating providers, members, and the general public about standardized behavioral health screening -- is now complete.

The Defendants will revise all relevant communication materials, and use all of the communication channels, referenced in these paragraphs as each phase of the remedy is implemented. Updated materials will be disseminated prior to implementation of the remedy services, as described in paragraphs 2-7 above.

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

The design work is underway by the MassHealth Implementation Team. See the response to Paragraph 38.b above for additional detail.

***d. Timeline for implementation:***

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

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

The Defendants submitted a report dated November 30, 2007 that fulfilled the requirement in subpart i. The Defendants are taking the steps described in paragraphs 19-33 above to complete this project by June 30, 2009, as required by subpart ii.

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

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

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

***b. Tasks performed will include:***

***i) Defining existing system capacities.***

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

***iii) Obtaining legislative authorization and funding.***

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

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

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

***vii) Negotiating contract(s).***

***viii) Confirming business requirements and technical specifications.***

***ix) Performing construction and testing based upon the Unified Process***

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

EOHHS has initiated development of two web-based applications to support the use of the CANS tool and to assist the Defendants to meet reporting requirements with respect to the CANS. The steps that the Defendants will take with respect to all other reporting requirements are described in Paragraph 46.

The first CANS application is the CANS Certified Assessor Training and Certification Application, which will: (1) permit clinicians to register for face-to-face Certified Assessor Training; (2) provide web-based Certified Assessor Training for those that choose not to take

the face-to-face training, and (3) administer the Certified Assessor Examination, and issue credentials to clinicians who pass the examination.

The second application is the CANS Application, which will allow clinicians to enter client CANS and SED determination information into a secure EOHHS database, subject to necessary consent, and provide the Defendants data needed for court reporting, and for other clinical and administrative purposes.

Thus far, the Defendants have taken the following steps with respect to the design and release of the two systems:

**CANS Certified Assessor Training and Certification Application**

The CANS Certified Assessor Training and Certification Application was developed and is currently being hosted through an interagency service agreement with the University of Massachusetts.

The training registration function for face-to-face Certified Assessor Training and the Certified Assessor Examination began on May 12, 2008. The web-based Certified Assessor Training began in June 2008.

Behavioral Health clinicians are currently using the Certified Assessor Application to register for face-to-face training and to take the Certified Assessor Examination after completion of that training. As described in paragraph 16.b, at the current rate, the Defendants will have trained close to 7,000 clinicians and certified over 5,000 clinicians before November 30, 2008.

**CANS Application**

*Defining Existing System Capacities*

During January through March 2007, the Defendants 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, it was determined that the ESM system would not have the required functional capacity. As a result, the Defendants decided to develop a web-based CANS Application that, subject to consent from the child or the child's parent, guardian, or custodian, can collect CANS data from MassHealth behavioral health providers and providers in the network of MBHP or one of the MCOs over the EOHHS Virtual Gateway and share it with the child's MCO or MBHP, if applicable.

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.

*System Production*
The CANS Application will be produced in two releases. The first release, which is currently expected to be in December, 2008, will allow users to develop familiarity with the application and will ask them to document certain member demographic information and to answer the questions that determine whether a child has a Serious Emotional Disturbance (SED). The second release, which is expected in the Spring of 2009, will add the rest of the assessment questions from the two versions of the CANS tool. The second release will include full reporting functionality for the Defendants and will allow EOHHS to export records to clinicians who have performed the CANS and the member's managed care plan, if applicable. Consent from the member, the member's custodial parent, or another authorized individual will be required to add any information other than demographic information and the SED determination into the application.

*Virtual Gateway Enrollment*
In order to access the new CANS Application, providers must be enrolled with the Virtual Gateway. VG personnel are currently contacting provider organizations to help them understand VG enrollment procedures. This process includes having the provider organization designate a staff person who can assign and maintain appropriate VG security roles.

*Authorization and Funding*
The Defendants have developed a budget for system implementation and obtained the necessary funding.

*Procurement and Contracting*
The Defendants are addressing the system design and development by leveraging and building on existing information technology resources, including existing information technology systems within EOHHS. The Defendants do not anticipate procuring a vendor to perform the activities described in this part of the Judgment.

*User Training and Support*
The Defendants are developing materials to assist providers in using the CANS Application. These materials will be made available to providers through a number of pathways, including through the CBHI website. In addition, VG personnel will provide technical user support.

*System Security*
The Virtual Gateway provides a secure, reliable platform that is accessible to people with disabilities.

***c. Timelines for implementation***

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

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

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

The Defendants are taking the steps described in paragraphs 39-46 to complete this project by November 30, 2008, as required by subpart ii. At this time, the defendants anticipate that the CANS Application will be produced in two releases as described in paragraph 39.b. The first release, which will allow the Defendants to report on the number of CANS assessments performed and the number of SED determinations, is currently expected to be available in December, 2008.

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

This paragraph is introductory; see response to paragraph 39 above.

***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.***

This paragraph is introductory; see response to paragraph 39 above.

***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.***

This paragraph is introductory; see response to paragraph 39 above.

***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.***

This paragraph is introductory; see response to paragraph 39 above.

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

Provider organizations have been notified to set up their Virtual Gateway accounts and to set security roles that will provide access to the CANS Application for appropriate end users. A support structure has been developed to support the providers during this crucial setup phase.

***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, 25 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.***

Wherever possible, the Defendants plan to use claims data from MMIS and encounter data from the MCOs and MBHP. Encounter data is client- and service-specific data reported by the MCOs and MBHP to MassHealth. Claims data is data from the claims that providers who service MassHealth members on a fee for service basis submit to MassHealth for reimbursement.

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

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

***a. EPSDT Behavioral Health Screening***

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

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

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

The Defendants will use MMIS claims data and encounter data to report on all three of these measures. There is a lag in time between service provision and claims payment, and also in the submission of MCO data to EOHHS; therefore, it is expected that the Defendants will have data to test the reporting function in May 2008, and will have a full data set to report to the Court Monitor by November 30, 2008.

More detailed information about each of the three measures follows.

MassHealth expanded upon an existing report on EPSDT (or well-child) visits and other primary care visits provided by primary care providers and added a new programming specification to incorporate MCO encounter data in the report.

The Defendants are reporting on the number of EPSDT behavioral health screens provided by implementing a specific code that all primary care providers, including those in an MCO network, are using when they bill for behavioral health screens. MassHealth has made changes to its own systems and has required MCOs to make system changes necessary to report this code. The Defendants have developed the programming for the report from MMIS and MCO encounter data.

The Defendants are reporting on the number of screens identifying a child with a potential behavioral health services need through the use of specific "modifiers" that all primary care providers, may use when billing the code for the behavioral health screen. MassHealth has amended its MCO contracts to require MCOs to utilize this billing code as well. These modifiers indicate both the type of provider that performed the screen, as well as whether the screening was positive or not. MassHealth has made changes to its own systems and has required the MCOs to make system changes necessary to report this code as well. The Defendants have developed the programming for the report from MMIS and MCO encounter data.

***b. Clinical Assessment***

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

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

The Defendants plan to approach reporting on clinical assessments in two ways.

The Defendants will first report on the number of assessments through MMIS and encounter data. Through work with the Division of Health Care Financing and Policy (DHCFP), the MCOs, and MBHP, the Defendants identified a coding strategy for billing and reporting on clinical assessments. The Defendants anticipate being able to report on the number of assessments using the CANS using claims and encounter data in the Spring of 2009. Because the deadline for implementing the clinical assessments is also November 30, 2008, the first reports from claims with any substantial amount of data will be produced later.

In addition to reporting based on claims and encounter data, the Defendants plan to report on these measures through the online CANS Application described in paragraph 39.b. This will allow behavioral health providers to enter SED determination data and CANS data online. The capability to report on the number of assessments performed, and on the number of assessments where the child met SED criteria, are built into the CANS Application. Due to delays (described above) in implementation of the CANS Application system, Defendants anticipate that information on the number of assessments and SED determinations will begin to be available by the end of December, 2009.

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

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

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

The Defendants will report on ICC services delivered to new members in a given time period, as well as the total number of members who are receiving ongoing ICC services. The Defendants plan to report on both of these measures using claims and encounter data by using specific codes and modifiers which have been identified by DHCFP.

Additionally, the Defendants plan to use the data collected using the online CANS Application described in paragraph 46.b above to report on the number of assessments completed by the ICC team. The Defendants currently are developing these requirements.

The Defendants plan to have the operational capacity to report on ICC services by the Spring of 2009. However, data about ICC will not be available from claims until after the Remedy Services have been implemented.

***d. Intensive Home-Based Services Treatment***

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

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

The Defendants are working with the managed care entities to develop the capacity to report on the member-level utilization of services as prescribed under an individualized care plan by linking claims and encounter data to managed care entity service authorization data, which will include the ICC Care Plan for youth enrolled in ICC.

The Defendants anticipate that the approach developed to meet this requirement will be ready for use by the time ICC and in-home services are implemented in June 2009.

Since members will begin utilizing services only after their initial care plans are developed, it is likely that the first reports to contain a significant amount of actual data on utilization of services as prescribed, will be ready approximately six months after services are substantially implemented.

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

The Defendants currently are researching potential member-level outcome measures. The Defendants will consult with the Children's Behavioral Health Advisory Council, the Monitor and the Plaintiffs as they identify these measures.

In addition, the Defendants are researching appropriate tools to measure the fidelity of clinical practice to the wraparound model. Measuring outcomes without measuring the service delivered limits the ability to evaluate the program.

Because ICC is a long-term, rather than an acute care service, meaningful outcome measurement will require members to receive ICC for at least six months before there is any initial data on outcomes. Therefore, while the Defendants anticipate having a system in place to collect outcome data at the time that the new services for children with SED are implemented in June 2009, the first reports on outcomes will not be available for at least six months afterwards.

***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 Defendants plan to conduct member satisfaction surveys based on a random sample of members who have had some experience with the services covered under the Judgment. The Defendants intend to contract with a vendor to develop these surveys.

RESPECTFULLY SUBMITTED,

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

/s/ Daniel J. Hammond
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