UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

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

JUDGMENT

This Judgment and the remedies ordered herein address the findings and rulings contained in the Court's Memorandum of Decision dated January 26, 2006 ("Decision"). As detailed in the Decision, the Court found the Defendants in violation of two provisions of the Medicaid statute: the provision mandating "early and periodic screening, diagnostic, and treatment services ("EPSDT"), 42 U.S.C. §§1396a(a)(10)(A) and (a)(43), §§1396d(r)(5) and (a)(4)(B) (2005), and the "reasonable promptness provision," 42 U.S.C. §1396a(a)(8) (2005).

As part of the Decision, the Court ordered the parties to confer and develop a joint remedial plan. When the parties were unable to reach an agreement, they submitted separate proposed remedial plans. The parties submitted memoranda thereafter detailing the areas of disagreement. The Court heard argument on December 12, 2006.

On February 22, 2007, the Court issued a Memorandum and Order Regarding Remedy that adopted the Defendants' proposed remedial plan ("Defendants' Plan") "as its remedial order . . . subject to four provisos." See February 22, 2007, Memorandum

and Order on Remedy ("Remedy Order") at 4. The Court also ordered the Defendants to submit a proposed form of judgment embodying the remedial plan adopted by the Court.

Having reviewed the Defendants' submission, the Court now orders as follows:

I. DEFENDANTS' PLAN

1. The Defendants shall take the steps described in below with respect to the class of children who are eligible for EPSDT[1] and who have "serious emotional disturbance" ("SED"), subject to the following provisos:

a. Since the Medicaid Act (Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq.) itself does not define a child suffering from SED, the governing definition for an eligible SED child under this Judgment will be the definition set forth in the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §1401(3)(A)(i), and its implementing regulations or the definition set forth in the regulations governing the Substance Abuse and Mental Health Services Administration ("SAMHSA") of the United States Department of Health and Human Services, 58 Fed. Reg. 29422-02 (May 10, 1993). Any child satisfying the SED criteria used in the IDEA or by SAHMSA, or both, will be eligible for services. While Defendants will be free to make clinical decisions based on the needs of the individual children, no language below that appears to categorically narrow the definition of class of children eligible for services will have any force and effect.

b. Timelines for implementation of the Judgment are set forth in Section I.E.1 below. These timelines constitute a portion of this Judgment and will be subject to enforcement by the Court. They are, however, subject to modification for good cause upon application by any party.

c. As an order of the Court, the substantive terms of this Judgment are mandatory and may not be modified unilaterally at the discretion of the Defendants. Absent a modification agreed to by the parties, or permitted for good cause by the Court, as further described in Section II below, the Judgment is to be implemented according to its terms.

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[1] Currently, MassHealth Standard and CommonHealth Members are eligible for EPSDT. See MassHealth Special Terms and Conditions, MassHealth Medicaid Section 1115 Demonstration Waiver (11-W-00030/1) Attachment D —§§ 3.1.1.2 and 3.1.4.2.

d. This Judgment embodies the Defendants' Plan as a final order of judgment, subject to the Court's exercise of ongoing jurisdiction to insure implementation as further described in Section IV below.

The terms of this Judgment constitute an order of the court and do not constitute a consent decree, settlement agreement, or any other agreement or consensual act of the parties.

A. Informing Families, Providers, and Others of EPSDT Services for SED Children -- Education and Outreach and Screening

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.

1. Education and Outreach

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.

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.

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.

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.

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

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.

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.

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.

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.

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

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

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

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

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.

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

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.

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

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.

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.

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

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.

2. ***Screening for Behavioral Health***

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.

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.

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).

3. ***Identification of Behavioral Health Needs – The Role of Other EOHHS Agencies, and other Public and Private Agencies***

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

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.

B. Assessment and Diagnosis

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:

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.

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.

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

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

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

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

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

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

[Sections 17 and 18 deleted]

C. Intensive Care Coordination and Treatment Planning

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

1. The Care Manager

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.

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.

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.

2. The Care Planning Team

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.

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.

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.

3. ***Individualized Care Plan***

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.

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.

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.

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.

4. Intensive Care Coordination for Children with Multiple EOHHS Agency Involvement

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.

D. Covered Services

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.

1. Crisis Management

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.[2]

[2] Where provider qualifications appear in the descriptions of the services in this section of the Judgment, the following applies:

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.

2. Home and Community-Based Services

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

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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.

(including foster homes and therapeutic foster homes), child-care centers, respite settings, and other community settings. These services may be provided as a bundled service by a team or as a discrete clinical intervention depending upon the service needs of the child.

a. *In-home Behavioral Services* - Behavioral services usually include a combination of behavior management therapy and behavior management monitoring, as follows:
   i) Behavior management therapy is provided by a trained professional, who assesses, treats, supervises, and coordinates interventions to address specific behavioral objectives or performance. Behavior management therapy addresses challenging behaviors which interfere with the child's successful functioning. The therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, that are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and the level of intervention required. Behavior management therapy is provided by qualified licensed clinicians.
   ii) Behavior management monitoring is provided by a trained behavioral aide, who implements and monitors specific behavioral objectives and interventions developed by the behavior management therapist. The aide may also monitor the child's 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.

b. *In-home Therapy Services* - Therapy services include a therapeutic clinical intervention and ongoing training and therapeutic support, as follows:
   i) A structured, consistent, therapeutic relationship between a licensed clinician and the family and/or child for the purpose of meeting specific emotional or social relationship issues. The licensed clinician, in conjunction with the care planning team, develops and implements therapy goals and objectives which are incorporated into the child's treatment plan. Clinical services are provided by a qualified licensed clinician who will often work in a team that includes a qualified paraprofessional who is supervised by the qualified licensed clinician.
   ii) Ongoing therapeutic training and support to the child/adolescent to enhance social and communication skills in a variety of community settings, including the home, school, recreational, and vocational environments. All services must be directly related to the child's

treatment plan and address the child's emotional/social needs, including family issues related to the promotion of healthy functioning and feedback to the family. This service is provided by a qualified paraprofessional who is supervised by the qualified licensed clinician. This paraprofessional may also provide behavior monitoring as described above.

c. *Mentor Services* – Mentor services include:

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

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

E. Implementation

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.

1. Implementation Project Planning

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.

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.

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.

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.

37. *Project 2: CANS Development, Training and Deployment*

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

b. *Tasks performed will include:*
   i) Developing a Massachusetts-specific short and long form CANS in conjunction with Developer John Lyons.
   ii) Training behavioral health providers to complete and use the CANS tool, including EOHHS-required data gathering techniques.
   iii) Drafting managed-care and provider contract amendments and regulatory changes to conform with the new requirements.

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.

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

38. *Project 3: Development of a Service Delivery Network*

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

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

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

CSAs will be providers included in the networks of MassHealth's contracted managed care entities and its fee-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

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.

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.

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

iii) Planning concerning anticipated need and provider availability.

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

v) Defining CSA Service Areas.

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

vii) For each service described in Section 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).

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

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

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

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

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.

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.

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

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

b. *Tasks performed will include:*

i) Defining existing system capacities.

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, testing, and provider training.

c. *Timelines for implementation:*

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

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

2. *Data Collection*

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.

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.

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.

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.

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.

45. With these considerations in mind, the Judgment includes the following as a preliminary data collection strategy to assess Member access to, and utilization of,

EPSDT behavioral health screenings, clinical intake assessments, intensive care coordination, comprehensive assessments, and intensive home based services. Data points described below that are not available from MMIS are conceptual and subject to a complete inventory of the business requirements and data elements necessary for creating an appropriate tracking system or systems.

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.

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.

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.

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.

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

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.

3. Reporting and Monitoring

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

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

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

48. *Court Monitor* - According to the steps described in more detail herein, the Court shall appoint a Monitor acceptable to both Defendants and Plaintiffs to oversee the implementation of this Judgment. The Monitor shall serve at the discretion of the Court, and shall undertake those tasks described herein:

a. The Monitor shall have the authority to: (1) receive information relevant to the Defendants' obligations under this Judgment; (2) coordinate and facilitate meetings between the parties; (3) independently review the Defendants' compliance with this Judgment; (4) respond to complaints concerning compliance or other actions of the Defendants; (5) recommend corrective or further actions necessary to redress any problems identified in implementing this Judgment; (6) mediate disputes between the parties; and (7) take whatever actions are useful to facilitate the timely implementation of this Judgment.

b. The Monitor shall have relevant expertise in behavioral health, health care, or Medicaid program administration.

c. The Monitor shall have access to all data, reports, records, or related documentation in the possession of the Defendants, their agents, contractors, evaluators, and providers that is necessary to perform the above functions.

d. The Monitor shall be compensated by the Defendants at a rate established by the Court. The Monitor shall prepare an annual budget for approval by the Court. The parties shall be afforded an opportunity to review and comment on the budget prior to its submission to the Court.

e. The Plaintiffs and Defendants shall attempt to agree on a Monitor with relevant experience. The parties will report to the Court, in writing, no later than March 23, 2007, regarding their efforts to agree upon a Monitor. If they agree on a Monitor, the name of this party, along with the proposed Monitor's *curriculum vita* and a budget, will be submitted at that time. In the event that the parties are unable to agree on a Monitor, each side will submit a list of three names, along with the *curriculum vita* of each, no later than April 6, 2007. The Court will thereafter select a Monitor from the proposed names. At the time the names are submitted, the parties will also submit a proposed budget for the Monitor. In the event that the

Monitor resigns or otherwise is unable to continue to serve, the same process shall be used to select a replacement.

49. Nothing contained in this Judgment shall require the Defendants to take any action or pay for any service or otherwise perform any aspect of this Judgment unless Federal Financial Participation is available in accordance with all applicable federal requirements. Implementation of this Judgment depends on the availability of FFP and all required federal approvals, obtaining all required Massachusetts legislative authorization and funding, and compliance with all applicable state and federal laws.

II. MODIFICATIONS

50. The terms of this Judgment, including the deadlines established in Section I.E.1., are subject to modification as follows:

a. for good cause upon application to the Court by either party; or

b. by agreement of the parties.

III. DISPUTE RESOLUTION

51. During the Court's term of jurisdiction, as described in Section IV below, the parties will resolve disputes as follows:

a. The preferred mechanism for resolution of disputes between the parties is by complaint to the Court Monitor, mediation of the dispute by the Monitor, and a recommendation by the Monitor with respect to such dispute as set forth in Section I.E.3 above.

b. If either party is dissatisfied with the Monitor's recommended solution of the dispute, it may bring the matter to the Court's attention by motion for review of the Monitor's recommended solution.

c. Notwithstanding the foregoing, either party may apply to the Court immediately, with concurrent notice to other parties, if the dispute involves an emergency requiring the Court's immediate attention.

IV. RETAINED JURISDICTION

52. This Judgment constitutes a final order of judgment, subject to the Court's exercise of ongoing jurisdiction to insure implementation. The Reporting and Monitoring provisions set forth in Section I.E.3 above will terminate five years after the date of entry of this Judgment.

It is So Ordered.

7.16.07
Date

Michael A. Ponsor
MICHAEL A. PONSOR
United States District Judge