UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
Western Division

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

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, as amended, the Defendants had until December 31, 2007 to complete Project One and until November 30, 2008 to complete Project Two and Project Four. Project Three has been divided into several completion dates. The Defendants had until June 30, 2009 to complete Project Three with respect to Intensive Care Coordination Services, Family Support and Training ("Family Partners") and Mobile Crisis Intervention, until October 1, 2009 with respect to Therapeutic Mentoring and In-Home Behavioral services, until November 1,

2009 with respect to In-Home Therapy services and until December 30, 2009 with respect to Crisis Stabilization Services.

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 CommonHealth) and their families about the availability of EPSDT services (including services focused on the needs of children with SED) and the enhanced availability of screening services and Intensive Care Coordination as soon as the EPSDT-eligible child is enrolled in MassHealth.*

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, as well as the availability of the new behavioral health 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.

As previously reported, the notices were first revised in June 2007 to inform members that behavioral health screens would be included as part of routine well-child care visits and revised again in February 2008 to include additional information about the standardized behavioral health screening tools. The notices were updated in January 2009 to provide members with more detailed information about the standardized behavioral health assessment process using the Child and Adolescent Needs and Strengths (CANS) tool. Finally, the Defendants have revised the notices to include information about the availability of the remedy services and will begin distributing these notices in the Fall of 2009.

***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

As previously reported, the Defendants executed a contract amendment with MassHealth's customer services contractor in December, 2007. Pursuant to the terms of this amendment, since the November 30, 2009 Court report, the customer services contractor:

- Conducted trainings for all CSRs on remedy services. The trainings included information on each of the new behavioral health services, how eligible members may access these new services, and the dates the services will become available. In addition, the trainings included information on the enrollment of MassHealth Standard and CommonHealth fee-for-service members into the MassHealth behavioral health managed care plan. An introductory training took place between April 13 and 17, 2009 and a more detailed training took place between July 6 and 10, 2009.
- 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.
- 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, the standardized behavioral health assessment process using the CANS tool, and the new behavioral health services.
- Revised the voice menu that directs members and providers with questions about services for children to CSRs trained to answer questions about EPSDT.

MassHealth required each of its contracted Managed Care Entities to provide intensive training for their CSRs about when, where and how members may obtain: standardized behavioral health screening in primary care, standardized behavioral health assessments using the CANS tool, and the new behavioral health remedy services, including information on when the remedy services will be available and how eligible members may access those services as they are implemented. MassHealth managed its MCE's to ensure compliance with these contract provisions by June 30, 2009.

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

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

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

See the response to paragraph 3 above.

Special Notices

Prior to June 30, 2009, the Defendants mailed an updated member notice to every household that included a MassHealth member under the age of 21. This notice, revised from a previous version mailed in December 2007, described the remedy services and provided information on how to access these services. The notice also contained information on the Child and Adolescent Needs and Strengths (CANS) tool, as well as helpful information on how to access remedy services through MassHealth CommonHealth.

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 MassHealth Managed Care Enrollment Guide, revised in January, 2008, and November, 2008 to describe program improvements, has been further revised to include information about the new remedy services, including information on how to access these services. The Defendants plan to distribute this revised Guide in late October 2009, after the completion of the MassHealth Managed Care Organization procurement and contracting process.

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 upon request for enrolled members.

The Handbook was initially updated in January, 2008 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 Defendants further revised the Handbook in June 2009 to include information about the standardized behavioral health assessment process

using the Child and Adolescent Needs and Strengths (CANS) tool and the new remedy services, including how to access these services.

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)). The Handbook went into use for the first time in December, 2007. 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.

At the direction of the Defendants, MBHP further revised the MBHP Member Handbook to include information about the standardized behavioral health assessment process using the Child and Adolescent Needs and Strengths (CANS) tool and the new remedy services, including how to access these services, in June 2009.

4. MCO Member Handbooks

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

Each MCO updated its Member Handbooks in February, 2008 to include more detailed information on EPSDT services, including standardized BH screening in primary care.

At the direction of the Defendant, each MCO further revised its handbooks in June, 2009 to include information on the standardized behavioral health assessment process using

the Child and Adolescent Needs and Strengths (CANS) tool and the new remedy services, including how to access these services.

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

There is no need for amendments to Member regulations at this time.

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 13, 2009 Interim Report on Implementation, the Defendants' Compliance Coordinator or her Assistant Director has held or participated in the following forums and meetings:

Health Law Advocates, Boston, June 12, 2009

Massachusetts Health Care Training Forum Meetings

Formerly known as the MassHealth Training Forum, these meetings are held once a quarter in five locations around the state. They bring together representatives of over 100 provider, consumer and advocacy organizations for briefings and trainings on a variety of MassHealth-related topics. The forums are intended to provide timely information to these organizations to support both service delivery and member outreach activities.

Presentations have and will be made at all five of the Training Forum meetings held this July. Staff will present on the new system enhancements being made by MassHealth in accordance with the Order, including the new community-based MassHealth behavioral health services, as well as how to help children, youth and families access the services.

<u>Paragraph 6</u>: 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 the MassHealth regulations to require the use of the Child and Adolescent Needs and Strengths (CANS) tool in behavioral health assessments and in discharge planning from twenty-four hour levels of care on December 26, 2008.

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.

In collaboration with the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) and a panel of pediatric behavioral health screening experts, the Defendants have reviewed the menu of approved screening tools and the schedule for behavioral health screenings in Appendix W. Pursuant to the recommendation of the expert panel, the Defendants plan to publish a revised version of the menu of approved behavioral health screening tools in summer 2009. 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.

The Defendants are producing an updated version of the Fact Sheet and a provider brochure for distribution starting in July 2009. These publications describe standardized behavioral health screening in primary care, standardized behavioral health assessments using the CANS, the remedy services and how to help MassHealth members 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 standardized behavioral health screening in primary care, standardized behavioral health assessment using the CANS tool and the new remedy services and how to access them:

1. PCC Plan Provider Newsletters – The PCC Plan Provider Newsletter is the provider newsletter for PCC Plan providers. The PCC Plan included an article describing the new Mobile Crisis services in the summer 2009 issue of the Newsletter.

2. MassHealth's Managed Care Organization's (MCO's) Newsletters – Each MassHealth MCO has published articles in their respective provider newsletters regarding program improvements. Between March and June of 2009, the MCO's published newsletter articles about the availability of the new behavioral health services.

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

As previously reported, the Defendants have established 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 the general public about EPSDT generally and the program improvements that the Defendants are makings in response to the Judgment.

Materials continue to be added to the website. Recent additions include:

- Updated EPSDT member notices described in paragraph 3;
- Updated Member notice described in paragraph 5.a;
- Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative (CBHI)
- Department of Public Health Toolkit for the CRAFFT
- Updated CANS Frequently Asked Questions reference
- CANS member consent forms (available in several languages);
- Remedy services descriptions and performance specifications; and
- Medical necessity criteria for remedy services.

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

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

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

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[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.

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

Development of the Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative (CBHI)

This toolkit was developed by the Screening Tool Consultants, experts in pediatric and adolescent behavioral health screening who work as consultants to MBHP providing technical assistance to primary care providers on behavioral health screening. The consultants conceived of the Toolkit out of their experience providing one-on-one support to primary care providers. It is a comprehensive guide to behavioral health screening in primary care, focusing the four most commonly used tools. The Toolkit covers topics such as "how to get started using standardized BH screening tools in your office" and guidance on clinical issues related to screening, such as how to manage the screening within the visit and how to respond to BH risks identified through screening. The Toolkits were introduced to, and well-received by, providers at Primary Care Clinician Forums held in March and April, 2009, as described below.

Primary Care Clinician Forums Regarding Standardized Behavioral Health Screening

Since the November, 2008 court report, the Defendants have conducted provider education forums to introduce the Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative (CBHI).

The forums were held on March 26, 27, 30 and April 1, 2009 in Sturbridge, Westport, Waltham, and Andover. The locations were selected based upon lower billing rates among primary care providers in the area.

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

Since the November, 2008 court report, a CANS Birth-4 User Support group was convened in February, 2009 to provide input on the CANS Birth-4 tool and reference guide**.** Subsequently, four CANS Birth-4 Training sessions were held on April 2 and June 10, 15, 30, 2009 in Mansfield, Boston (2), and Peabody. (Locations based on volume of clinician interest.)

EOHHS interagency staff and graduate clinical training program faculty from the CBHI Higher Education Workgroup met with CANS developer John Lyons in meetings held June 9th and 10th 2009

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

The MassHealth Office of Behavioral Health holds regular meetings with relevant provider trade associations.

Meetings with selected Providers of Intensive Care Coordination, Family Support and Training and Mobile Crisis Intervention – see response to Paragraph 38.

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. The Defendants are closely monitoring their contractors to ensure compliance with these contract requirements.

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 created a Children's Behavioral Health Initiative (CBHI) webpage that is available on the EOHHS website. Additionally, as more fully described in paragraph 39.b, the Defendants developed a web-based distance learning model (DLM) and certification application to facilitate CANS training and certification for behavioral health clinicians, and have developed a web-based CANS application that is 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.

As previously reported, the Defendants have conveyed copies of 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.

Fact Sheets

As previously reported, 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. Two versions of these two Fact Sheets were widely distributed in December 2007 and October 2008.

The Defendants are in the process of developing updated Fact Sheets 1 and 2 will distribute them beginning in August. Distribution lists will include, at a minimum, the organizations and agencies to whom previous versions of the Fact Sheets have been distributed, including all child-serving state agencies.

Brochures

The Defendants have developed a brochure for MassHealth parents and one for MassHealth providers, describing the new MassHealth remedy services and how to access them. These brochures will become available in August, 2009 and the Defendants will work with providers, parent organizations and advocates to distribute them.

Articles

The Defendants are in the process of developing articles suitable for community newspapers and will be working over the next several months to place them.

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.

Protocols for the Departments of Children and Families and Mental Health were completed in June 2009. Protocols for the Department of Youth Services have been made available to staff in draft form, and are going through a third round of revision between EOHHS and DYS, considering a second set of comments that have been provided by the Plaintiffs. In accordance with paragraphs 12 and 30 of the Order, the protocols establish policies and procedures for agencies to make referrals to remedy services and to coordinate

agency specific service planning processes with ICC. Protocols are under development for the remaining EOHHS child-serving agencies, along with planning for staff training sessions.

The Defendants implemented ten agency-specific trainings for supervisors and managers of DCF, DMH and DYS, throughout the month of June. The trainings consisted of an orientation to "High-fidelity Wraparound", conducted by experienced wraparound practitioners and family partners, and training by senior agency managers on the agency's protocols.

In addition, since the November 30, 2008 Court Report the following briefings have been held:

Simmons College School of Social Work Faculty, Boston, February 2, 2009

DMR Regional Children's Meeting, Monson, April 6, 2009

Juvenile Court Clinic Directors, Worcester, April 8, 2009

Worcester Mental Health Network, Worcester, May 13, 2009

DMR Regional Children's Meeting, Danvers, May 19, 2009

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 will continue to coordinate with the associations for the above provider types to ensure that updated versions of 'Fact Sheet 1' are made available to the public at provider sites. The Defendants additionally plan to coordinate with the associations to ensure their members are notified and aware of the availability of CBHI brochures targeted to providers and to families.

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

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

On May 15, 2009, the Commissioner of DEEC sent a letter to all DEEC-licensed childcare providers in the Commonwealth to inform them about the new remedy services, dates of implementation and alerting them to upcoming training sessions to be held in September and October, 2009.

One the updated Fact Sheets are available, the Defendants will distribute them electronically to DEEC for distribution to all licensed childcare providers. 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 the new remedy services.

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 Defendants, in partnership with the Executive Office of Education and the Departments of Early Education and Care (DEEC) and Elementary and Secondary Education (DESE), convened a CBHI Pre K-12 Advisory committee in March 2009 to advise CBHI staff regarding communication strategies with public schools. Based on the recommendations of this group, Commissioner Mitchell Chester of the Department of Elementary and Secondary Education, wrote a letter addressed to all school districts providing an overview of CBHI and the role that school personnel will play in connecting children and youth to the new MassHealth behavioral health services. In partnership with the Department of

Elementary and Secondary Education, the Defendants plan to hold a series of briefings across the state for public school personnel in late September-early October 2009.

The Compliance Coordinator presented, for the third time, at the semi-annual conference of Administrators for Special Education on June 12, 2009 on the program improvements, including the new remedy services and how to help families and youth access them.

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 previously reported, 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 described in paragraph 6.b., the menu of tools has recently been reviewed in collaboration with the Massachusetts Chapter of the American Academy of Pediatrics (MCAAP) and a panel of pediatric behavioral health screening experts and, pursuant to the recommendation of the expert panel, the Defendants plan to publish a revised version of the menu of approved behavioral health screening tools in Summer 2009.

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

See response to Paragraph 8.

<u>Paragraph 10:</u> 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 held a series of provider training forums in March and April 2009 to introduce the new Primary Care Behavioral Health Screening Toolkit for the MassHealth Children's Behavioral Health Initiative. The Toolkit, along with the Department of Public Health's CRAFFT Toolkit, provide information on how to implement behavioral health screening in the primary care setting, how to use five of the frequently utilized MassHealth-approved screening tools (CRAFFT, M-CHAT, PEDS, PSC, and PHQ-9), and what to do when a screen indicates a member has a potential behavioral health services need.

The PCC Plan also held provider forums on June 10 and 16, 2009 in West Springfield and Waltham to introduce primary care providers to the new remedy services Intensive Care Coordination, Mobile Crisis Intervention, and Family Support and Training and describe how providers can help members access these services.

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:

- Mailing quarterly letters to all primary care providers in the Primary Care Clinician plan who have submitted at least one paid claim for a well child visit to MassHealth. The letters include provider-specific data on the number of paid claims for well child care

visits and the number of claims for behavioral health screens. The letters also identify resources available to providers to learn more about behavioral health screening and to help them increase their rate of screening.

- As previously reported, the Defendants and the MCOs convened a Joint Quality Improvement Workgroup regarding screening. This group continues to meet to share successful practices, facilitate discussion, and generate ideas and suggestions related to quality improvement activities.
- The Defendants have begun working with the Court Monitor, Ms. Snyder, to schedule meetings with selected primary care providers to discuss the experience of implementing behavioral health screening in primary care The Defendants plan to use the information gained during meetings with these providers to identify additional quality improvement strategies and opportunities to support the implementation of behavioral health screening in primary care.

The Defendants are tracking the number of claims for well-child visits, the number of claims for behavioral health screens, and the number of claims for a behavioral health screen with modifiers indicating a possible behavioral health need. This data allows the Defendants to measure the number of well-child visits delivered as a percentage of the total number of visits required by the periodicity schedule. The Defendants are currently working with the Court Monitor on specifications for a report of behavioral health service utilization by children and youth identified as having a possible behavioral health need through behavioral health screening in primary care.

<u>Paragraph 11:</u> MassHealth will continue the practice of not requiring a primary care visit or EPSDT screening as a prerequisite for an eligible child to receive MassHealth behavioral health services. MassHealth-eligible children and eligible family members can be referred or

can self-refer for Medicaid services at any time by other, including other EOHHS agencies, state agencies, public schools, community health centers, hospitals and community mental health providers.

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

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

See response to paragraph 7.c. above.

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

This paragraph is introductory; see detailed response below.

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

As previously reported, MassHealth executed contract amendments with MBHP and the MCOs requiring them to require their behavioral health clinicians treating MassHealth-enrolled children and youth under the age of 21 to use the CANS tool as part of the clinical assessment process by November 30, 2008. Additionally, MassHealth promulgated regulations on December 26, 2008, which required behavioral health clinicians who serve MassHealth-enrolled children and youth under the age of 21 on a fee-for-service basis to use the CANS tool as part of the

clinical assessment process. The use of the CANS during a clinical assessment is required 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.

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.***

As previously reported, the Defendants worked closely with John Lyons, Ph.D., developer of the CANS tool, and with in-state experts and stakeholders to develop 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. In addition, the Defendants 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.

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.

See response to Paragraph 14, above.

As previously reported, providers have been informed of this requirement through multiple channels, including Network Alerts from MBHP and the MCOs, provider forums, and CBHI mass emails. MassHealth also sent a transmittal letter explaining these requirements to MassHealth fee-for-service providers when the CANS regulations became effective on December 26, 2008.

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.

See response to Paragraph 14, above.

As previously reported, MassHealth-contracted providers of behavioral health services are also required to ensure that behavioral health clinicians who use the CANS are certified in the use of the CANS tool. To be certified, clinicians are required to pass a certification examination that has been approved by John Lyons, PhD. 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 John Lyons, Ph.D. The training program includes both in-person trainings and a web-based distance learning model (DLM) with continuing education unit (CEU) credits.

The Defendants started providing the in-person trainings in May, 2008. The web-based training became available in July, 2008. In person trainings were offered multiple times per week, including weekends, at locations across the state through January, 2009. In-person trainings continue to be offered once a week or when there is sufficient registration. Total in-person training sessions to date are 295, including 201 sessions at provider locations and 94 sessions at public locations. 5,282 people have been trained through in-person trainings and 2,849 have been trained through the web-based training, for a total of 8,131. 7,622 have been certified.

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 are 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 are required to 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.

As previously reported, the Defendants have required MassHealth fee-for-service providers to 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 have also required 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 developed, and have distributed to ICC providers, an ICC Operations Manual for providers of Intensive Care Coordination. The Operations Manual was reviewed and commented on by the plaintiffs and by staff of the Department of Mental Health.

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.***

As described in paragraph 7, the Defendants worked closely with the Departments of Children and Families (DCF), Mental Health (DMH) and Youth Services (DYS), to develop agency-specific protocols and train supervisory and program management staff in their use. These agencies are the largest providers of children's services within the Executive Office of Health and Human Services. The protocols include, among other provisions, language describing state agency participation on Care Planning Teams for children and youth they serve and protocols for coordinating state agency care planning processes with ICC care planning. Protocols for the Departments of Children and Families and Mental Health were completed in June 2009. Protocols for the Department of Youth Services have been made available to staff in draft form, and are going through a third round of revision between EOHHS and DYS, considering a second set of comments that have been provided by the Plaintiffs.

The Defendants are in the process of developing protocols with other child serving agencies in EOHHS including the Departments of Disability Services, Public Health and Transitional Assistance, as well as the Office for Refugees and Immigrants, the Commission for the Blind and the Commission for the Deaf and Hard of Hearing.

The Defendants have developed a conflict-resolution process for resolving disagreements among members of ICC care planning teams. Plaintiffs have commented twice on the document and the Defendants are currently revising the process document.

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.

<u>Paragraph 37:</u> Project 2: CANS Development, Training and Development

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

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

2. Task performed will include:

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

See the response to paragraphs 15-16 above.

3. Timelines for implementation:

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

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

As described in paragraphs 14-16, the Defendants substantially completed this project by November 30, 2008, as required by subpart ii. The Defendants amended managed care entity contracts to require the provision of assessments including the CANS effective November

30, 2008. The regulations for fee-for-service providers were published on December 26, 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.

The Service Design Process

As previously reported, the Defendants worked closely with the Departments of Mental Health, Children and Families, Public Health and Youth Services, and consulted broadly with provider and advocacy organizations to make the foundational design decisions for the remedy services. This process included issuing a "Request for Information."

Starting in the early Spring of 2008, the parties and the Monitor's consultants worked on definitions and specifications for each of the seven remedy services. The parties completed that work in September, 2008, just in time to inform the State Plan Amendment process with the Centers for Medicare and Medicaid Services, and just in time for MBHP and the MCO's to use the definitions and specifications to begin provider selection activities.

The parties completed work on the Medical Necessity Criteria (MNC) for the services prior to June 30, 2009.

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

MassHealth required its managed care entities to provide Intensive Care Coordination and Parent/Caregiver Peer-to-Peer Support Services through the CSAs to children and youth under the age of 21 enrolled in MassHealth Standard and CommonHealth with a medical need for the service as of June 30, 2009. MassHealth has very closely managed its contractors to ensure compliance with these obligations.

As previously reported, in March 2009, MBHP, in collaboration with the MCOs, announced the selection of 32 CSAs. Of these, 29 were selected, one for each of the 29 Department of Children and Families (DCF) service areas. The remaining three selections represent culturally- or linguistically-focused CSAs who will focus on certain populations and enroll children and youth from areas beyond the service area in which they are located.

Prior to June 30, 2009, all MassHealth MCEs executed contracts with all 29 geographic CSAs and the three specialized CSA. On June 30, 2009, 31 CSAs had met all readiness criteria and were "open for business". One CSA had not met the readiness criteria and was not allowed to begin operating. To ensure access while the CSA worked to meet readiness criteria, nearby CSAs were alerted to the situation and referrals were routed to these providers. In addition, the area covered by this CSA is also covered by one of the contracted specialized CSAs. In any event, following intensive technical assistance provided by the MCEs, this provider has been able to get a solid staff team in place and meet the readiness criteria. The MCEs have cleared the provider to start accepting referrals as of July 20, 2009.

Selection of Mobile Crisis Intervention Providers

As previously reported, MassHealth required its managed care entities to provide Mobile Crisis Intervention Services for MassHealth-enrolled children and youth under the age of 21 with a medical need for the service as of June 30, 2009. Emergency Services Providers were selected by MBHP in March 2009, using provider qualifications established by DMH and MassHealth. MassHealth required the MCOs to contract with MBHP's selected network of ESPs.

As of June 30, 2009, one MCE had executed new contracts with all 17 ESPs. Two MCEs had signed new contracts with 15 ESP providers, and two MCEs had signed new contracts with 8 ESP providers. For those MCEs that are still negotiating new ESP contracts, the MCEs have

assured MassHealth that the ESP providers have agreed to continue honor existing ESP contracts and/or negotiate single case agreements so that MassHealth members are able to access MCI services, while negotiations are ongoing.

Authorization Processes

The MCEs were contractually obligated to develop and implement service authorization procedures in advance of June 30, 2009. MassHealth has worked closely with the MCEs to ensure their compliance with these contract provisions.

By June 30, 2009, all MCEs had drafted internal authorization policy and procedure documents to assist their staff in acting on requests for authorizations for ICC and FS & T. The plans had conducted initial internal trainings and developed workflows as a further aid to their clinical staff. The MCEs recognize that ongoing trainings will be required post June 30th to incorporate feedback on the process from the provider community.

While the MCEs arrived at a common set of utilization parameters for ICC and FS & T, they are using different methods of utilization management and different administrative processes for handling authorization requests. The MCEs are using a variety of methods to inform and assist the CSA provider network with the authorization procedures for ICC and FS & T, including in-person trainings, email communication, network alerts, in-person meetings with CSA providers, website postings, and addendums to provider manuals (Note: prior authorization is not required for MCI.). The Defendants are closely monitoring the implementation of these processes by:

- Reviewing and monitoring monthly MCE authorization reports to identify trends or areas of concern. These reports include the number of authorizations requested, approved, and

denied by plan and will allow MassHealth to compare service "penetration rates" across plans.

- Reviewing denials of services requested by a care planning teams for youth in ICC.
- Meeting with MCE representatives weekly to address issues or concerns regarding access.
- Meeting with representatives from Parent Professional Advocacy League (PPAL) monthly to hear if there are any concerns regarding access to CBHI for families.
- Meeting with representatives from the Mental Health and Substance Abuse Corporations of Massachusetts monthly to hear concerns from the provider community.
- Negotiating MCE contract provisions that require MCEs to obtain MassHealth prior review of all proposed changes to MCE authorization parameters or procedures.
- Working with MHSACM to distribute a survey at the end of July and the end of August to providers inquiring about MCE interface, timeliness of decisions, clarity of process to obtain authorizations, problems/issues, as well as things working well that we can share with MCEs. These surveys will be returned directly to MassHealth.

Claims Payment Systems

All the plans have the CPT codes used for billing for all the remedy services. Prior to June 30, 2009, the MCEs finalized their claims systems for ICC and FS&T and MCI and assured the Defendants of their readiness to start paying claims on the first three remedy services as of June 30, 2009.

The MCE claims systems do not include an SED identifier. The MCEs are able to identify members who have been determined to have an SED through the CANs feed from the

Virtual Gateway. The MCEs also receive an eligibility feed from MassHealth that contains information on the child's state agency affiliation, if any.

Network Management for CSA and MCI services

The MCEs are contractually obligated to develop and implement network development and management activities for ICC, FST and MCI services. MassHealth is working closely with the MCEs to ensure their compliance with these contract provisions.

The MCEs conducted a series of statewide meetings for CSA providers (April 24, May 8, May 29 and June 26.) Post-implementation, monthly statewide meetings have been scheduled with the CSA providers to continue to disseminate information, share best-practices, engage in mutual problem solving, and generally assist providers with questions and concerns.

The MCEs engaged and are engaging in a series of co-led individual network management meetings with individual provider organizations to assess readiness for 6/30 and to assist providers with barriers and challenges they face. MBHP has a regional network manager who serves as a liaison to each CSA and who works closely with the identified MCO "co-manager" to provide timely assistance and feedback on performance to each CSA. A structured CSA readiness assessment tool was used by all of the MCEs to evaluate each CSA's implementation readiness. MBHP coordinated this effort but all plans shared in the responsibility for ensuring that the provider network was ready for the "go-live" on 6/30.

Beginning in June, 2009, the MCEs began meeting together monthly to review region-specific CSA and MCI readiness and to prioritize needed interventions to ensure readiness as well as to discuss and plan for any necessary remedial actions necessary to improve early implementation.

MBHP and the other MCEs met in May to coordinate around various ESP issues including the MCI service.

MBHP spoke at an MCE monthly meeting with the CSAs in May about the integration of ESP/MCI and the importance of communication, collaboration, and referral relationships between these two services.

On June 26, 2009 the MCEs, ESP/MCI providers and CSAs heard from a nationally recognized consultant who will further address integration and collaboration between these providers.

MBHP is informing, training and communicating with all ESPs about MCI policies and procedures for MBHP members as well as all the other payer populations included in the scope of ESP services (e.g. this includes all MassHealth plans). This is being accomplished through formal trainings with ESP CEOs, ESP Directors, MCI managers, MCI clinicians and MCI paraprofessionals during May and June.

Each ESP/MCI provider is receiving technical assistance/readiness assessment visits throughout June, as well as additional face to face, phone and email communication as needed. A structured MCI readiness assessment tool was completed on every ESP's MCI implementation.

MCE Staffing and Training

The MCEs are required by contract to perform a wide range of network management and quality management activities for the remedy services. The Defendants are closely monitoring MCE preparation and readiness to perform these new functions.

The MCEs are using a variety of strategies to ensure that they are prepared to respond to the increased demands on their staff at all levels. Strategies include:

- Use of web-based and Interactive Voice Response (IVR) technologies to receive authorization requests
- Hiring of dedicated CBHI clinical and/or network management staff
- Re-deployment of existing staff to CBHI specific responsibilities
- Cross-training of staff in different clinical departments

Regarding network management, the MCE's have developed a plan to co-manage network management activities with each CSA. Each MCO has assigned personnel to be responsible for network management activities for every CSA, and to work in tandem with the assigned MBHP personnel to oversee each CSA.

Regarding quality management, each MCE has identified an initial approach to managing quality through their network management personnel and their clinical personnel. Each has indicated plans to identify additional quality activities and/or personnel once data reporting and quality management standards have been established.

To assist the MCEs in preparing to perform all necessary Network and Quality Management activities, the Defendants designed and hosted the "CBHI Institute" in October, 2008. This was a day long meeting for MCE staff and prospective remedy service providers. All MCE leadership attended. The Defendants, with the assistance of the Court Monitor and her consultants, brought together leading practitioners of all of the proposed remedy services to present on the Wraparound model of care planning, the role of the Family Partner, and to describe and discuss the service specifications for all of the remedy services.

In addition, with the help of the Court Monitor, consultants with expertise on managed care utilization management approaches provided consultation to MassHealth MCE managers.

MCE leadership also participated in a “Wraparound 101” training conducted by Anthony Irsfeld in February 2009. Additionally the plans have hosted “Wraparound 101” trainings and CANS trainings for their clinical and network management staff members. All the plans have indicated that they have held additional trainings on the new MassHealth services, performance specifications, medical necessity criteria, and CBHI for staff who have member and/or provider contact.

Pursuant to contract requirements, the MCE’s have completed intensive training for their Customer Service Representatives (CSRs) about when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services.

Network Development for All Other Remedy Services

MBHP and the MCOs are contractually required to provide In-Home Behavioral Services and Therapeutic Mentoring services as of October 1, 2009, In-Home Therapy Services as of November 1, 2009 and Crisis Stabilization Services as of December 1, 2009 (pending CMS approval.)

The MCE's have selected a common statewide network of providers for each of the remaining remedy services, with the exception of Crisis Stabilization (which is still pending federal approval in any case). The Defendants are working closely with the MCEs to plan provider trainings and other readiness activities to support provider readiness to perform by the service implementation deadlines.

Ensuring Appropriate Levels of Care for Members

The MCEs have indicated a variety of strategies for identifying youth who might be appropriate for ICC. Strategies include:

- Reviewing youth currently enrolled in care management programs (including those currently receiving FST) for possible referral (with parent/guardian consent) for ICC.

- During clinical reviews with a child or youth's provider, discussing possible referrals to ICC and/or other remedy services.

- Reviewing the care of children and youth who appear on existing reports on high utilizers of behavioral health services.

- MCEs are working to identify additional triggers that will be used to create reports in the future.

Information System

All the MCEs have indicated that information systems are fully prepared to provide the contractually-required reports and data to MassHealth.

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. 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 Defendants also hold regular meetings with provider organizations and with family organizations.

iii) Planning concerning anticipated need and provider availability.

Start-up training

The Defendants issued a Request for Responses soliciting bids for contractors to provide training and coaching in Wraparound and Family Support and Training (Family

Partners). EOHHS selected Vroon VanDenBerg LLP to be the contractor, and has signed a twelve-month contract with options to extend for two one-year terms. John VanDenBerg, the firm's president, was a pioneer in the development of high-fidelity Wraparound and has been a leading researcher and trainer in the field for two decades. The contractor will begin operations in July, including a series of orientation meetings for system stakeholders, and will begin training CSA staff thereafter. Since experience has demonstrated that classroom training is insufficient for robust skill development in Wraparound, the contract focuses heavily on providing on-the-job coaching as a follow-up to training. Supervisors in each CSA will also be taught how to coach their own staff. The Commonwealth anticipates that the functions provided by the contractor will eventually be transferred to the CSAs, MCEs, and to a Center for Research and Training to be organized by the DMH.

Workforce Development

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:

- Following the November 14th Faculty Retreat, the Defendants hosted a follow up faculty-student conference in April 2009 for both students and faculty. At this later conference, faculty participated in workshops on teaching system of care-based competencies and breakout discussions facilitated by their peers on topics ranging from infusing existing curriculum with system of care principles and competencies to developing an interdisciplinary certificate based on system of care principles.

Students participated in interactive workshops focused on the skills required to run successful Wraparound Teams, such as conducting strength based assessments and facilitating group decision making. They were also introduced to career opportunities resulting from the new MassHealth behavioral health services: Community Service Agencies (CSA) and Emergency Service Providers (ESPs—providers of Mobile Crisis Intervention) were invited to participate in a career fair in order to meet potential job candidates.

- In April 2009 the Defendants hosted a career forum at Holy Cross College to introduce working clinicians to the career opportunities resulting from the new MassHealth behavioral health services. As with the Student-Faculty conference described above, CSAs and ESPs were invited to participate in a career fair in order to meet potential job candidates,
- MBHP is holding informational meetings around the state for prospective Family Partners (who deliver "Family Support and Training"). 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 Support and Training service; the required competencies; and opportunities for training. In addition, PAL is working with 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.***

In March, 2009 the Defendants received CMS approval for Targeted Case Management Services (Intensive Care Coordination) for Individuals Under 21 with Serious Emotional Disturbance. On June 4, 2009, the Defendants received CMS approval for Mobile Crisis Intervention, In-Home Behavioral Services, In-Home Therapy Services, Therapeutic Mentoring Services and Family Support and Training. Prior to issuing the approval letter, CMS requested that the Defendants remove Crisis Stabilization Services from the SPA and re-submit it as a separate SPA. The Defendants did as CMS requested. This allowed CMS to approve the remaining five services in the SPA, while the Defendants and CMS continue to discuss outstanding issues regarding Crisis Stabilization Services. CMS has informed us they will be issuing a Request for Additional Information (RAI) for the new Crisis Stabilization State Plan Amendment.

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.

The Commonwealth's rate setting agency, the Division of Health Care Finance and Policy (DHCFP), developed fee for service (FFS) rates for the remedy services. Depending on the CMS RAI for Crisis Stabilization Services, the Defendants may ask DHCFP to develop a different rate setting methodology for this service.

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

This is being 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.

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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.

See the response to Paragraph 38.b above..

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. In accordance with the Judgment, as modified by the Court, this project was separated into three compliance deadlines. The Defendants had until June 30, 2009 to complete Project Three with respect to Intensive Care Coordination Services, Family Support and Training ("Family Partners") and Mobile Crisis Intervention, until October 1, 2009 with respect to Therapeutic Mentoring and In-Home Behavioral services, until November 1, 2009 with respect to In-Home Therapy services and until December 30, 2009 with respect to Crisis Stabilization Services. As described in paragraphs 19-38 above, the Defendants completed this project by June 30, 2009, to the extent required by the Amended Judgment.

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.

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

The first CANS application was the CANS Certified Assessor Training and Certification Application, which: (1) permits clinicians to register for face-to-face Certified Assessor Training; (2) provides web-based Certified Assessor Training for those that choose not to take the face-to-face training, and (3) administer the Certified Assessor Examination, and issue credentials to clinicians who pass the examination.

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

CANS Application

Defining Existing System Capacities

As previously reported, 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.

Virtual Gateway Enrollment

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. As of June 12, 2009, seven hundred and two organizations had been enrolled for the CBHI application with the VG. During the period from January through March of 2009, over 4,600 individual users were enrolled. During that quarter, the VG help desk handled over one thousand customer service calls, and ninety percent of user requests were being processed by VG Customer Service within two days.

Authorization and Funding

The Defendants developed a budget for system implementation and obtained the necessary funding.

Procurement and Contracting

The Defendants addressed the system design and development by leveraging and building on existing information technology resources, including existing information technology systems within EOHHS. The Defendants did not need to procure a vendor to perform the activities described in this part of the Judgment.

User Training and Support

The Defendants have developed materials to assist providers in using the CANS Application. These materials are made available to providers through a number of pathways, including through the CBHI website. In addition, VG personnel 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 took the steps described in paragraphs 39-46 to complete this project by November 30, 2008, as required by subpart ii. The CANS Application was produced in two releases as described in paragraph 39.b. The first release, which allows the Defendants to

report on the number of CANS assessments performed and the number of SED determinations, became available in December, 2008. The second release, which permits entry of the the full CANS with member consent, and also includes additional features, became available April 23, 2009. Further enhancements are planned for future releases.

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.***

New MMIS has been implemented.

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

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.***

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

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

As previously reported, 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 are using MMIS claims data and encounter data to report on all three of these measures.

b. Clinical Assessment

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

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

The Defendants are reporting on clinical assessments in two ways.

The Defendants count the number of assessments using MMIS claims date and MCE 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 claims data does not capture whether a child or youth meets SED clinical criteria.

The SED determination is gathered through the CANS Application. Behavioral health providers 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.

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 the number of intensive home-based assessment performed in ICC, the number of members enrolled in ICC in a given time period, as well as the total number of members who are receiving ongoing ICC services, and ICC utilization by these members. The Defendants have developed specific data specifications for the MCEs to use to report this data.

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 have developed data reporting specifications for the MCEs to use to report on provider and system level utilization and cost trends of the 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.

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 have consulted the academic literature, experts and stakeholders to inform the development of an outcome measurement plan. This plan is still under development, but will include the following elements:

- use of CANS data to measure child and youth clinical outcomes
- use of the Wraparound Fidelity Index and the Treatment Observation Measure to measure fidelity of ICC provider practice to the Wraparound model

The Defendants are coordinating their development of the outcome measurement plan with the Court Monitor as she develops her compliance monitoring plan.

Because ICC is a long-term service, meaningful outcome measurement will require members to receive ICC for at least six months before there is any initial data on outcomes. As a result of this aspect of the service design, as well as the three to four month claims lag,

the first reports on outcomes will not be available for at least nine to ten months after the service is first delivered.

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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Date: July 17, 2009

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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Assistant Attorney General