UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

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

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.

The most recent update to the notices to describe the new behavioral health services are scheduled for distribution in January.

***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 July 17, 2009 Court report, the customer services contractor:

- Continues to train new customer service representatives (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.

- Is, in consultation with MassHealth, currently reviewing and revising the training and Knowledge Center materials to ensure that the CSRs have the information they need to respond to the range of inquiries currently being received.

As previously reported, MassHealth required each of its contracted Managed Care Entities (MCEs)[1] 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.

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.

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 updated the following materials to include more detailed information on EPSDT services, including standardized behavioral health screening in primary care, the standardized behavioral health assessment process using the CANS tool and the new remedy services, including how to access these services:

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.

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[1] Managed Care Organization (MCO) is used to refer to the four MassHealth contracted Managed Care Organizations which are Boston Medical Center Healthnet Plan (BMCHP), Fallon Community Health Plan (FCHP), Neighborhood Health Plan (NHP), and Network Health. The term Managed Care Entity (MCE) is more comprehensive and used to refer to the four MCOs and the PCC plan behavioral health carve-out vendor, the Massachusetts Behavioral Health Partnership (MBHP). Beacon Health strategies is the behavioral health subcontractor for FCHP and NHP.

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.

MBHP Member Handbook - The MBHP member handbook is for members who are enrolled with MBHP but not the PCC Plan.

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.

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 July 17, 2009 Report on Implementation, the Compliance Coordinator or her Assistant Director has held or participated in the following forums and meetings:

June 3, 2009 – Presentation to Department of Mental Health (DMH) Forensic Services Annual Meeting (Adult and Juvenile Court Clinic staff)

August 6, 2009 – Meeting at the Louis D. Brown Peace Institute in Boston. (This organization assists families and friends of homicide victims and has contact with large numbers of at-risk youth in Boston.)

August 16, 2009 – Presentation on CBHI[2] Implementation to MassHealth Training Forum, Tewksbury (for provider staff who assist families with MassHealth enrollment)

September 16, 2009 – Meeting of the Supporting Families Involved with DCF Coalition sponsored by Rosie's Place

September 17, 2009 – CBHI Implementation Update to Boston Youth Services Network (for providers other than behavioral health services providers serving high-risk youth in Boston area)

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[2] 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.

September 21, 22 and 23, 2009 – Series of four meetings across the state with staff of Vroon, VanDenBerg, LLP (to familiarize community stakeholders (parents, providers and state agency staff) with the principles of Wraparound)

September 21, 2009 – Presentation on CBHI implementation to the Children's League of Massachusetts

September 22, 2009 – Presentation to the Board of Directors and Senior Staff of the Walker School

October 7, 2009 – CBHI Education Briefing held at the South Shore Educational Collaborative in Quincy

October 8, 2009 – Meeting with senior staff of the Office of the Commissioner of Probation

October 9, 2009 – CBHI Implementation Update to inpatient providers, sponsored by Massachusetts Association of Behavioral Health Systems

October 15, 2009 – CBHI Implementation Update to DPH statewide conference on Understanding Services for Children with Special Needs – Quincy

October 16, 2009 – Keynote presentation to the annual conference of the Massachusetts Association of School Psychologists.

October 16, 2009 – CBHI Implementation Update to quarterly meeting of deans of schools of social work (sponsored by MA chapter of National Association of Social Workers)

October 23, 2009 – CBHI Implementation Briefing to the System Integration Committee, of the Children's Behavioral Health Advisory Council

October 24, 2009 – Workshop presentation at the Annual Conference of the Massachusetts Chapter of the National Alliance for the Mentally Ill, Springfield, MA

October 29, 2009 – CBHI Implementation Briefing to the Workforce Development Committee of the Children's Behavioral Health Advisory Council

October 30, 2009 - CBHI Implementation Briefing to the Outcomes Committee of the Children's Behavioral Health Advisory Council

November 3, 2009 – CBHI Implementation Update to the Children's Mental Health Task Force of the Massachusetts Chapter of the American Academy of Pediatrics

November 4, 2009 – CBHI Implementation Update at Annual Conference of Federation for Children with Special Needs, "Joining Family Voices", Shrewsbury

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

November 11, 2009 – CBHI Presentation to the Department of Developmental Pediatrics at the Floating Hospital, Tufts/New England Medical Center

November 18, 2009 – CBHI Education Briefing held at the Lower Pioneer Valley Educational Collaborative in West Springfield

November 19, 2009 - CBHI Education Briefing held at the North River Educational Collaborative in Rockland

November 20, 2009 - CBHI Education Briefing held at the Joseph Keefe Technical School in Framingham

November 20, 2009 - CBHI Education Briefing held at the Boston School Department's Campbell Resource Center in Dorchester

November 23, 2009 - CBHI Education Briefing held at the Assabet Valley Collaborative in Marlborough

November 23, 2009 - CBHI Education Briefing held at New Bedford High School

November 30, 2009 - CBHI Education Briefing held at the Shore Collaborative in Chelsea

November 30, 2009 - CBHI Implementation Update at school mental health conference sponsored by MetroWest Community HealthCare Foundation, Ashland

December 2, 2009 - CBHI Education Briefing held at the E.N Rodgers Middle School in Lowell

December 2, 2009 - CBHI Implementation Update at Annual Breakfast Of Child Protection Council, Fall River

Five more CBHI Education Briefings will be held in January and February, in Essex County, in Barre, at a location to be determined on Cape Cod, in Northampton and in Pittsfield.

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

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

Effective December 26, 2008, 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.

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.

MassHealth, with the assistance of our screening tool consultants, performed its first annual review of the menu of screening tools. As a result of this review, effective November 1, 2009, MassHealth is amending the list of approved behavioral health screening tools to delete the Achenbach System Child Behavior Checklist (CBCL), Youth Self-Report (YSR), and Adult Self-Report (ASR) and add a newly-developed tool, the Strengths and Difficulties Questionnaire (SDQ). The CBCL, YSR, and ASR were removed because they are diagnostic tools rather than screening tools. Additionally, they are lengthy, proprietary (and, therefore, expensive), and time consuming to score. The SDQ has been added to the list because it is supported by the American Academy of Pediatrics and has been supported in numerous publications as a mental health screening tool, is appropriate for children ages 3 through 16, is available for free, and is available in over 65 languages. An updated Screening Toolkit will be made available to providers in January, 2010.

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 have developed a brochure for parents or other caregivers of children and youth on MassHealth, describing the new home and community based services and how to access them. The Plaintiffs have reviewed and commented on the text. The brochure is currently in production and will be available for distribution in January 2010. There will be five regional versions of the brochure, each containing provider contact information specific to that region. Specifically, the brochures will list the Mobile Crisis Intervention access numbers for the communities in the region, the region's In-Home Therapy and Intensive Care Coordination providers and instructions for using the MCEs' customer service departments for help finding outpatient providers.

In addition, the Defendants are also in the process of producing a guide for school personnel, health center staff, Primary Care Clinicians, Court staff, child care providers, Early Intervention programs, behavioral health providers and family organizations that is designed to be a companion piece to the brochure. This guide is based on the text of EOHHS agency-specific CBHI protocols (see Paragraph 7(c) below) which the Plaintiffs have extensively reviewed and commented upon. It is intended to give the wide range of staff who come into contact with MassHealth Members or prospective MassHealth Members the information they need to inform caregivers of the new remedy services and how to access them.

The Defendants and MassHealth's MCEs will make available the staff guide and provide ordering information for the brochure to an extensive list of provider organizations, associations, organizations and networks. The Defendants intend to reach large numbers of school personnel, health centers, Primary Care Clinicians, Court staff, child care providers, Early Intervention programs, behavioral health providers and family organizations. Printed copies of the brochure will be shipped free of charge to anyone placing an order.

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. Since the July 17, 2009 Court report, the PCC Plan has included an article titled "Helping Families Access New Behavioral Health Services" in the Fall 2009 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. Each MCO maintains a website that includes relevant information on CBHI for their providers. Since the July 17, 2009 Court report, Beacon Health Strategies, as the behavioral health partner for Fallon and Neighborhood Health Plan, posted on article on October 29 in their online provider newsletter, The Lighthouse Times, titled: Children's Behavioral Health Initiative: Providers Offering In-Home Behavioral Services, In-Home Therapy, and Therapeutic Mentoring.

d. 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) 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.

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

See the response to Paragraph 6(c), above.

e. Implementing any other operational changes required to implement the program improvements described in this Judgement.

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

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

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

The Defendants continue to meet with providers in person and by conference call to reinforce use of the CANS. Beginning in September, 2009, the Defendants initiated a series of conference calls and face-to-face meetings designed to facilitate a provider Community of CANS Practice, by sharing best practices identified by the Commonwealth as well as by providers. A kickoff call was held on September 18, followed by meetings in October and November. Other meetings and calls are planned in December 2009 and January 2010, and it is anticipated that further calls and meetings will be scheduled throughout 2010. Best practices identified through these calls and meetings are being documented by the UMass CANS Training Program and will be disseminated to CANS assessors.

The Office of the Compliance Coordinator also provided training for CSA supervisory staff on use of the CANS in wraparound practice, at the MCE-sponsored CSA statewide meeting in November 2009.

The Defendants plan to continue regular provider conference calls for technical support, to encourage effective use of the CANS tool and the CANS Application. The last such call occurred November 13, 2009, and additional calls will be scheduled in 2010.

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. This includes a monthly meeting with the Association of Behavioral Health and regularly scheduled meeting times with the National Alliance on Mental Illness (NAMI).

The MCEs have convened a monthly stakeholder group consisting of a group of providers delivering CBHI services from across the state, representatives from the Association for Behavioral Healthcare, and MassHealth. The purpose of this group is to work collaboratively to identify areas of strength and need and to brainstorm options and develop creative and mutually agreeable strategies to address issues and improve the system. The first meeting occurred on November 3 and a second meeting occurred on December 1.

Meetings with selected Providers of Intensive Care Coordination, Family Support and Training and Mobile Crisis Intervention

See response to Paragraph 38.

g. 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.

As previously reported, the Defendants executed amendments to its contracts with the MCEs to 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.

h. 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 previously reported, and as described in paragraph 6.d, the Defendants created a Children's Behavioral Health Initiative (CBHI) webpage that is available on the EOHHS website, 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. For additional information about the CBHI CANS Application, please refer to the response to Paragraph 39.b.

***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.

See the response to Paragraph 6(c), above.

In addition, the Defendants have developed the first in a series of informational articles for distribution to ethnic community newspapers and other publications. The articles target parents/caretakers of MassHealth-eligible youth under the age of 21.

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.

For each of the EOHHS child-serving state agencies, the Defendants are developing agency specific protocols for agency staff. These protocols describe the new remedy services and how to access them, as well as specific agency policies for assessing the need for behavioral health services, making referrals for assessments and/or services and coordinating with MassHealth behavioral health providers. Appendices to the protocols include medical necessity criteria and lists of provider contact information.

Once each of the agency's protocols have been developed, CBHI and state agency staff deliver trainings to appropriate central office and field staff.

Protocols have been finalized and trainings delivered for: the Department of Children and Families, the Department of Developmental Services, the Department of Mental Health, the Department of Public Health – Bureau of Substance Abuse Services, the Department of Public Health – School Based Health Centers and the Department of Youth Services.

Protocols for the Department of Public Health – Early Intervention Providers have been completed. The training is currently scheduled for January.

Protocols for the Department of Transitional Assistance, the Office for Refugees and Immigrants, the Commission for the Blind and the Commission for the Deaf and Hard of Hearing are under development.

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.

See the response to Paragraph 6(c), 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.

See the response to Paragraph 6(c), above.

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.

Based on recommendations of the CBHI Pre K-12 Advisory committee convened by the Defendants, the Executive Office of Education and the Departments of Early Education and Care (DEEC) and Elementary and Secondary Education (DESE), the Defendants have organized a series of presentations for school staff in a variety of locations around the state. These meetings have been supported by the Department of Elementary and Secondary Education and have been hosted by urban school districts and Special Education Collaboratives. At these meetings, attendees receive copies of a power point presentation describing the remedy, the new services and how children and youth can access them, as well as a list of Mobile Crisis Intervention, In-Home Therapy and Intensive Care Coordination providers specific to their region.

October 7, 2009 – CBHI Education Briefing held at the South Shore Educational Collaborative in Quincy

November 18, 2009 – CBHI Education Briefing held at the Lower Pioneer Valley Educational Collaborative in West Springfield

November 19, 2009 - CBHI Education Briefing held at the North River Educational Collaborative in Rockland

November 20, 2009 - CBHI Education Briefing held at the Joseph Keefe Technical School in Framingham

November 20, 2009 - CBHI Education Briefing held at the Boston School Department's Campbell Resource Center in Dorchester

November 23, 2009 - CBHI Education Briefing held at the Assabet Valley Collaborative in Marlborough

November 23, 2009 - CBHI Education Briefing held at New Bedford High School

November 30, 2009 - CBHI Education Briefing held at the Shore Collaborative in Chelsea

December 2, 2009 - CBHI Education Briefing held at the E.N. Rodgers Middle School in Lowell

Five more CBHI Education Briefings will be held in January and February, in Essex, in Barre, at a location to be determined on Cape Cod, in Northampton and in Pittsfield.

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 approved behavioral health screening tools has recently been updated, adding a new tool and removing a lengthy behavioral health clinical assessment tool seldom used by primary care clinicians.

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.

Paragraph 10: ***There will be a renewed emphasis on screening, combined with ongoing training opportunities for providers and quality improvement initiatives directed at informing primary care providers about the most effective use of approved screening tools, how to evaluate behavioral health information gathered in the screening, and most particularly how and where to make referrals for follow-up behavioral health clinical assessment. Additional quality improvement initiatives will include improved tracking of delivered screenings and of utilization of services delivered by pediatricians or other medical providers or behavioral health providers following a screening and use of data collected to help improve delivery of EPSDT screening, including assuring that providers offer behavioral health screenings according to the State's periodicity schedule and more often as requested (described in Section I.E.2).***

Clinical Topic Review: Behavioral Health Screening at Well Visits

The Center for Health Policy and Research (CHPR) at UMass Medical School periodically performs "Clinical Topic Reviews" (CTRs) on behalf of MassHealth. CTRs provide MassHealth with in-depth information on a quality improvement area. MassHealth requested CHPR to

conduct the State Fiscal Year (SFY) 2008 CTR on behavioral health screening for children with well visits during SFY2007 (July 1, 2006 - June 30, 2007). The purpose of the CTR was to assess the baseline of behavioral health screening *prior* to the December 31, 2007 implementation of the new requirement to use standardized behavioral health screening tools as a part of well visits for children and youth under the age of 21. Specifically, the CTR assessed the percentage of paid well visits for children and adolescents that included a screening for behavioral health conditions and collected information about the use of formal screening tools at well visits, the percent of children identified with a behavioral health condition, the percent of those children referred for behavioral health services and the rates of behavioral health service utilization by those children. The Defendants plan to provide a copy of this report to the Court Monitor.

Screening Data

The latest available screening data is from the second quarter of calendar year (CY) 2009, April 1 through June 30. Data is only available for providers who are part of the Primary Care Clinician (PCC) Plan and for providers who bill MassHealth on a Fee For Service (FFS) basis is available. We expect to have MCO data dating back to April 1, 2009 available in January.

For the period April 1 through June 30, 2009 the number of well child visits, behavioral health screens and the percentage of positive screens for providers who are part of the Primary Care Clinician (PCC) Plan and for providers who bill MassHealth on a Fee For Service (FFS) were:

Quarter	# of well-child visits	# of standardized screens	% of children identified w/ behavioral health need
Q1 1/1/09 – 3/31/09	119,209	65,887	9.2%
Q2 4/1/09 – 6/30/09	45,293	25,799	10.7%

The lower number of visits and screens in the second quarter reflects the fact that this data only includes FFS and PCC plan data, while the previous quarter reports MCO data as well.

For the period April 1 through June 30, 2009 the number of behavioral health screens as a percentage of the number of well-child visits and other visits in which screens occurred are as follows (1st quarter data given for comparison):

MassHealth Plan	Jan. 1 – Mar. 31, 2009	Apr. 1 – June 30, 2009
Fee For Service	39.7%	43.8%
Primary Care Clinician	56.2%	62.1%
TOTAL ACROSS PLANS	53.8%	54.6%

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

Age Group	Jan. 1 – Mar. 31, 2009	Apr. 1 – June 30, 2009

< 6 months	29.7%	26.9%
6 months through 2 years	59.3%	61.3%
3 through 6 years	64.5%	67.4%
7 through 12 years	65.6%	69.1%
13 through 17 years	58.6%	61.8%
18 through 20 years	27.4%	28.8%

The rates of screening correlate with anecdotal reports from Primary Care Clinicians that 1) they are not satisfied with the current instruments available for screening children under one year of age and 2) as children reach school age, their annual visits have fewer mandatory elements, making it easier on the provider to conduct the behavioral health screen. We suspect the low rates of screening for youth aged 18 through 20 reflect the fact that these MassHealth members likely see providers serving adults only, who may be less aware of the screening requirements.

Regarding the screening instruments for children under a year old, we await the release of a new instrument currently being tested for this population. Regarding youth ages 18 through 21, we plan to develop quality improvement activities this year to address the low rate of screening in this population.

Quality Improvement Activities

In September 2009, MassHealth's Primary Care Clinician Plan mailed MassHealth provider-specific screening performance data to primary care providers who had one or more claims paid for well child care visits.

The PCC Plan introduced two new reports for PCCs in October 2009. The Pediatric Behavioral Health Profile Report includes a measure that provides three rates related to the behavioral health of members under the age of 21 on the PCC's panel. These include the rate of behavioral health screening at the time of the most recent well-child care visit, the rate of potential behavioral health need identified at the time of the screen, and the rate of follow up for a potential behavioral health need. The reports are mailed to PCCs with more than 180 members on their panel.

Additionally, all PCCs receive a Pediatric Behavioral Health Reminder Report. The Reminder Report informs PCCs which members under the age of 21 in their panel received a behavioral health screen that identified a potential behavioral health need at their most recent well-child care visits but who did not receive follow-up care for that potential need.

The MCOs are all required to track and submit quarterly reports of the rates at which providers are using a standardized behavioral health screening tool for enrollees up to the age of 21 as part of their well child EPSDT visits.

The contracted MCOs undertake various quality improvement activities including: (1) conducting an internal, structured review for oversight of behavioral health screening rates by primary care providers (PCPs) during well child visits; (2) developing provider profiler reports that include behavioral health screening rates for tracking and improving screening rates of low-

performing PCPs; (3) continuing global outreach to PCPs to raise awareness of the behavioral health screening requirement; and (4) organizing cross-functional activities for sharing best practices around behavioral health screenings.

As previously reported, MassHealth has been working closely with the Court Monitor to support a series of fourteen visits to Primary Care practices across the state by Christina Crowe, a clinical consultant working with the Court Monitor. The sites were selected to include offices with high, average and low rates of screening. The purpose of the visits is to learn about best practices and barriers to implementing and sustaining high rates of behavioral health screening. MassHealth looks forward to receiving the report of these visits to inform our quality improvement activities.

Referral Information for PCCs

The CBHI Family brochure, brochure ordering information and the Guide for Staff, described in Paragraph 6.d, will be electronically distributed to PCCs through the MCEs and various medical associations and guilds. They will also be placed on the CBHI and MCE websites.

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

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 services. This information is included in the Defendants' written educational materials and 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 paragraphs 6(c) and 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 the MCEs 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 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. As described in response to Paragraph 39, the Commonwealth has engaged in multiple, ongoing efforts to provide technical assistance to providers in order to ensure that providers are informed of the CANS requirement, know how to obtain training and certification, understand how to use the CANS in practice, and are capable of using the CBHI CANS Application for recording CANS data.

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. In consultation with Dr. Lyons, the UMass CANS Training team has redesigned the CANS online training and the CANS certification examination, with the goal of increasing the effectiveness of the training and the accuracy of the examination. These changes will be in place by May 2010, in time for recertification of currently certified clinicians.

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 the MCEs 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.

The Compliance Coordinator or her staff has contacted the Massachusetts Hospital Association and the Massachusetts Association of Behavioral Healthcare Systems to offer outreach visits t to inpatient units treating MassHealth members under 21. These visits, which will occur in 2010, will provide technical assistance on use of the CANS and the CBHI application on the Virtual Gateway.

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.***

As previously reported, 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 have worked closely with the Departments of Children and Families (DCF), Developmental Services (DDS), Mental Health (DMH), Public Health (DPH) 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 requiring 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.

The Defendants are in the process of developing protocols with other child serving agencies in EOHHS including the Department of Transitional Assistance, 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.

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.

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

(i) Behavior management therapy is provided by a trained professional, who assesses, treats, supervises, and coordinates interventions to address specific behavioral objectives or performance. Behavior management therapy addresses challenging behaviors which interfere with the child's successful functioning. The therapist develops and monitors specific behavioral objectives and interventions, including a crisis-response strategy, that are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and the level of intervention required. Behavior management therapy is provided by qualified licensed clinicians.

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

See response to paragraph 38 below.

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

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

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

See response to paragraph 38 below.

c. Mentor Services – Mentor services include:

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

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

See response to paragraph 38 below.

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

This paragraph is introductory; see detailed response below.

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

This paragraph is introductory; see detailed response below.

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

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

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

b. Tasks performed will include:

(i) Developing and announcing a standardized list of behavioral health screening tools.
(ii) Drafting managed-care or provider contract amendments and regulatory changes to conform to the new requirements.
(iii) Improving EPSDT Member notices concerning the availability of behavioral health and other EPSDT screening, and the availability of behavioral health services.

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

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

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

c. Timelines for implementation:

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

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

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

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 MCE 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.

Services Implementation Update:

Per the amended court order, MassHealth was required to ensure that it and its contracted MCEs began providing payment for medically necessary In-Home Behavioral Services (IHBS) and Therapeutic Mentoring services by October 1, 2009. The tables below indicate the number of providers per region for each of the aforementioned services[3].

REGION	NUMBER OF IN-HOME BEHAVIORAL SERVICES PROVIDERS AS OF 10-31-09
Northeast	3
Boston/Metro	4
Southeast	3
Central	5
Western	6

REGION	NUMBER OF THERAPEUTIC MENTORING PROVIDERS AS OF 11-23-09
Northeast	10
Boston/Metro	17
Southeast	16
Central	10
Western	13

Per the amended court order In-Home Therapy (IHT) MassHealth was required to ensure that it its contracted MCEs began providing payment for medically necessary In-Home Therapy

[3] The number of providers in each region reflects providers in the MCE "common network" as well as providers "in network" for MBHP only.

services by November 1, 2009. The tables below indicate the number of IHT providers per region.

REGION	NUMBER OF IN-HOME THERAPY PROVIDERS AS OF 11-1-09
Northeast	10
Boston/Metro	17
Southeast	16
Central	10
Western	13

The MCEs held a "kick-off" meeting for providers of these three services on September 9th in Worcester. This meeting included presentations by three national experts on each of the services, a review of the performance specifications for the services, a question and answers session, as well as distribution of MCE service authorization processes and parameters. Prior to the "go-live" dates for the services, the MCEs also conducted site visits with every IHBS provider and providers of IHT and Therapeutic Mentoring new to delivering home-based behavioral health services and/or Medicaid reimbursable services via managed care.

In an effort to streamline and encourage consistency, the MCEs agreed to common service authorization parameters for IHBS, Therapeutic Mentoring and IHT. The MCEs are also using a common set of clinical review questions for use when interfacing with providers to complete initial and concurrent service authorization requests.

The MCEs are also in the process of implementing a series of regional meetings which began in December 2009 with all the IHBS, Therapeutic Mentoring, and IHT providers. These meetings will focus on the following activities:

- Providing technical assistance to providers on implementation;
- Monitoring and discussing regional access and availability, identifying barriers, and developing strategies to mitigate barriers;
- Identifying the need for further integration and relationship building with stakeholders, community providers and community based organizations
- Inviting stakeholders, providers from various levels of care to; discuss access, integration and other issues pertaining to the interface between CBHI and other levels of care, as well as stakeholders;
- Reviewing and discussing contract compliance, program fidelity and quality;
- Ensuring providers are included in regional network management meetings with other behavioral health levels of care to facilitate continuity of care and integration into the continuum of care;
- Collaborating regarding on-going quality improvement; and
- Monitoring and discussing regional staffing.

The MCEs continue to hold statewide meetings with the thirty two Community Service Agency providers. Meetings dates with selected topics are outlined below:

MEETING DATE	TOPIC(S)
August 21	• Partnering for Change Presentation: The Key Role of Parents, Youth and Family Organizations (Lisa Lambert, Executive Director, PAL; Chantell Albert, Multicultural Outreach Coordinator; and Stephany Melton, Education and Communications Coordinator) • Regional break-out sessions focusing on access issues and intake procedures
September 25	• MassHealth Eligibility and Operations (Bob Guerino, MassHealth Member Education Unit) • Presentations by specialized CSA providers • MCE updates
October 30	• Coordination and collaboration meeting between ICC, MCI, and providers of 24-hour levels of care (i.e. inpatient units, Community Based Acute Treatment, crisis stabilization) • MCE updates
November 20	• CANS in Clinical Practice (Jack Simons, Assistant Director Children's Behavioral Health Interagency Initiatives) • DCF Presentation (Bob Wentworth, Assistant Commissioner Planning and Program Development) • Group discussion focusing on access issues and System of Care Committees
December 18	• CommonHealth Disability Determination Process (Kathleen Nichols, Customer Service Manager UMass Disability Determination Unit) • Additional topics TBD

The MCEs continue to conduct monthly on-site technical assistance visits with each of the CSA providers to help address any provider level problems or concerns and to offer support and assistance to providers in a variety of areas. The MCEs also conduct weekly phone check-ins with CSA providers in an effort to monitor and address any provider level issues or concerns in "real-time".

Additionally, the MCEs have convened a stakeholder group consisting of, a group of providers delivering CBHI services from across the state, representatives from the Association for Behavioral Healthcare, and MassHealth. The purpose of this group is to work collaboratively to identify areas of strength and need in areas such as communication, authorization processes, and access to care and to brainstorm options and develop creative and mutually agreeable strategies to address issues and improve the system. The first of these stakeholder meetings occurred on November 3 and a second meeting occurred on December 1.

MassHealth Survey of CSAs to Evaluate MCE Communication and Service Authorization Processes

As part of a continuous quality improvement effort, MassHealth, conducted a survey regarding MCE communication processes and service authorization processes for the new remedy services. The goal was to obtain feedback about each of the five MCEs.

All thirty two CSA providers were asked to participate in the survey. A draft report of the survey results is currently being reviewed.

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.

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

For a description of the processes by which MassHealth's contracted MCEs are working with providers of the remedy services, please see the response to Paragraph 38b, above.

In addition, as previously reported, the Defendants work closely with the Children's Behavioral Health Advisory Council, a large multi-stakeholder group chaired by the Commissioner of the Department of Mental Health, to solicit 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.

The Defendants issued a Request for Responses to solicit 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 years. John VanDenBerg, PhD, 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 began operations in August, including a series of orientation meetings for system stakeholders, and began training CSA staff in September. The Contract also requires on on-the-job coaching as a follow-up to training. The trainings are delivered by John

VanDenBerg Ph.D. or his staff and consist of four full days of training in Wraparound care coordination, divided into two segments of two days. These trainings are for all CSA direct care staff, their supervisors, and program managers. CSA-based Family Partners delivering Family Support and Training, and their supervisors, receive an additional two days of Family Partner training. Family Partner training is provided by Susan Boehrer, Executive Director of the Oklahoma Federation of Families for Youth and Children's Mental Health.

Training focuses not only on teaching of principles, but also on imparting and refining specific skills needed for implementing high-fidelity wraparound. Training involves mandatory homework and includes experiential exercises as well as expert presentations and video demonstrations. Continuing education credits are provided for participants. Training began September 16, 2009. As of the end of November, Days One and Two of the Wraparound training have been offered four times at various locations statewide, and Days Three and Four have been given twice; Days Three and Four will be given again twice in December. The two extra days of Family Partner training were given twice in November. Additional trainings will be provided, according to need, in 2010.

Because training has been shown to have much greater impact on behavior when combined with follow-up coaching, six experienced coaches from Vroon VanDenBerg have been assigned to work with the thirty-two CSAs building on skills introduced in the trainings. Each CSA has one coach, with other Vroon VanDenBerg staff available if needed for consultation on specific issues. As of the end of November, coaches are completing initial visits to their CSAs and are drafting a coaching plan for each CSA. Coaching will occur through a combination of on-site and distance consultations. John VanDenBerg will also offer a training, in collaboration with Peter Metz, MD from UMass Medical School, on the role of psychiatry and psychopharmacology in Wraparound, on December 15, 2009. This training meeting, for psychiatrists and psychiatric nurse clinical specialists attached to CSAs, will be sponsored by MassHealth's MCEs.

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 the Medicaid State Plan Amendment (SPA) 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 continuing to discuss outstanding issues regarding Crisis Stabilization Services with the State. On August 3, 2009, CMS issued a Request for Additional Information (RAI) for the new Crisis Stabilization State Plan

Amendment, which the Commonwealth had to, and did, respond to by October 30, 2009. As part of the RAI response, the Defendants submitted new rates for this service, by type of individual practitioner who may deliver the service at the Crisis Stabilization facility, as requested. CMS also requested the Commonwealth to state that no funds would be used to pay for the costs of room and board. The Commonwealth, in its response, stated that room and board costs were "essential to the efficient and effective" delivery of this service. CMS has informally indicated that they have begun the internal process for issuing a denial of Massachusetts' proposed Crisis Stabilization State Plan Amendment. The Defendants expect to receive formal notification of CMS's decision shortly.

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.

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.

See the responses to Paragraphs 3 through 7, above.

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

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. As described in paragraphs 19-38 above, the Defendants completed this project by June 30, 2009, as required by subpart ii.

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

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

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

b. Tasks performed will include:

i) Defining existing system capacities.

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

iii) Obtaining legislative authorization and funding.

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

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

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

vii) Negotiating contract(s).

viii) Confirming business requirements and technical specifications.

ix) Performing construction and testing based upon the Unified Process

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

Introduction

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 process of defining system capacities, designing and building the secure CBHI CANS Application hosted on the Virtual Gateway has been described in previous reports. The steps that the Defendants will take with respect to all other reporting requirements are described in Paragraph 46.

CANS Certified Assessor Training and Certification Application

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. As previously mentioned, this application is currently being updated in consultation with Dr. John Lyons, to permit a more accurate assessment of examinees' CANS rating skills. The upgrade will be available by May 2010, in time for the first round of recertification.

CANS Application

The second application is the CANS Application on the Virtual Gateway, 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. Two releases of this software occurred in December 2008 and April 2009. Further releases are planned for February 2010, and Summer or Fall of 2010, with various technical improvements as well as user enhancements including improved gathering of race, ethnicity and language data, posting of announcements on the log-in screen, and improved export of data for analytic purposes.

Virtual Gateway (VG) Enrollment and User Activity

Provider organizations are required to set up their Virtual Gateway accounts and to set security roles that will provide access to the CANS Application for appropriate end users.

The number of organizations enrolled with the Virtual Gateway (VG) for the CANS Application continues to increase, as does the number of individuals enrolled as Certified Assessors.

The number of organizations entering CANS records has steadily risen, from 207 in September to 225 at the end of November. The number of trained and certified assessors has topped 8,000 and continues to grow, although more slowly.

User Training and Support
As previously reported, the Defendants have developed materials to assist providers in using the CANS Application. These materials, which include interactive training modules, are made available to providers through a number of pathways, including through the CBHI website. In addition, VG Help Desk personnel provide technical user support. Many questions are also fielded by the UMass CANS Program and by the Office of the Compliance Coordinator.

In addition, a CANS newsletter is being planned for electronic distribution to a variety of CANS stakeholders, including providers. The CANS newsletter will provide updates and refreshers about the CANS requirement, good practice using the CANS, and appropriate use of the CBHI CANS Application on the VG. The first issue is planned for release in January, 2010. Subsequent issues will appear at least quarterly. The newsletter will be electronically distributed to all CANS Application users.

c. Timelines for implementation

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

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

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 allowed 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 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 data and MCE encounter data. Through work with the Division of Health Care Financing and Policy (DHCFP), and the MCEs, 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.

In order to report on the number of home-based assessments that are performed as the first step in ICC, the Defendants will be relying on data in the CANS Application. The CANS Application includes an indication of whether an assessment using a CANS is an initial assessment or reassessment.

In order to monitor and report on the number of members receiving ongoing ICC, the Defendants will rely on the fact that MBHP is contracted to collect data on a weekly basis directly from CSAs about the number of members (from all the MCEs) receiving ICC.

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 will be developing a methodology to report member level utilization for children with an ICC ICP.

The Defendants are requiring the MCEs to develop claims based data reporting for system level utilization and cost trends for the new remedy services. Complete system level data on the first quarter of FY10 is due from each MCE in January, and should be combined for a system level report in February 2010.

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; and
- 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, rather than an acute care service, meaningful outcome measurement will require members to receive ICC for at least six months before there is any initial data on outcomes. As a result of this aspect of the service design, as well as the three-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.

The Wraparound Fidelity Index includes a member satisfaction questions about their experience with Wraparound in ICC. MBHP's contract requires it to hire a subcontractor to conduct this survey on a sample of ICC members, which will include members from all the MCEs. It is anticipated that these Wraparound Fidelity Index interviews will begin in January, 2010.

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Date: December 7, 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/ William W. Porter
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