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

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

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

This paragraph is introductory; see detailed response below.

***Paragraph 3**: The Defendants will inform all EPSDT-eligible MassHealth Members (Members under age 21 enrolled in MassHealth Standard or CommmonHealth) and their families about the availability of EPSDT services (including services focused on the needs of children with SED) and the enhanced availability of screening services and Intensive Care Coordination as soon as the EPSDT-eligible child is enrolled in MassHealth.*

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

These notices were first updated in June 2007 to specifically inform members that behavioral health screens are included as part of routine well-child care visits.

These notices have since been further updated to include a specific reference to the standardized behavioral health screening tools. This further revised version will be available in December 2007.

The Defendants plan to revise these notices again (i) to provide more detailed information about the standardized assessment process using the Child and Adolescent Strengths and Needs (CANS) tool, when that process has been developed; and (ii) to describe Intensive Care Coordination (ICC) and the new services focused on the needs of children with SED, including how to access those services, when those services are implemented.

***Paragraph 4**: The Defendants will take steps to publicize the program improvements they are required to take under the terms of this Judgment to eligible MassHealth Members (including newly-eligible MassHealth Members), MassHealth providers, and the general public. As part of this effort, the Defendants will take the actions described below and will also provide intensive training to MassHealth customer service representatives, including updating scripts used by such representatives to facilitate timely and accurate responses to inquiries about the program improvements described in this Judgment.*

The Defendants have developed final contract amendment language with MassHealth's customer services contractor. This amendment specifically requires the customer services contractor to:

- Train new Customer Service Representatives (CSRs) as they are hired and provide ongoing trainings for existing CSRs about (i) EPSDT services, including information

about the standardized behavioral health screens; (ii) the CANS tool once the tool has been implemented; and (iii) ICC and the new services focused on the needs of children with SED, including how to access those services, once those services are implemented. The Defendants must review and approve the training curriculum used by the contractor.

- Update the customer services contractor's Knowledge Center, which is the library of materials accessed by CSRs, to include information about (i) EPSDT services, including information about the standardized behavioral health screens; (ii) the CANS tool, once the tool has been implemented; and (iii) ICC and the new services focused on the needs of children with SED, including how to access those services, once they are implemented.
- Revise the voice menu that directs members and providers with questions about services for children to CSRs trained to answer questions about EPSDT.

Also, the Defendants have executed contract amendments with MassHealth's behavioral health services contractor, the Massachusetts Behavioral Health Partnership (MBHP), and its MassHealth contracted Managed Care Organizations (MCOs), specifically requiring these contractors to establish a schedule of intensive training for newly-hired and current CSRs about (i) when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services; and (ii) the Rosie D. lawsuit. The Defendants will review and approve the training curricula used by the contractors.

The Defendants will manage all of these contracts to assure that the new procedures will be implemented by December 31, 2007.

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

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

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

See the response to paragraph 3 above.

Also, the Defendants have finalized a new member notice that will be distributed to every household that includes a MassHealth member under the age of 21 to inform these members about the program improvements described in the Judgment. The notice will be mailed over a period of weeks in December, 2007.

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 are in the process of updating and distributing the following (or, where applicable, arranging for contractors to update and distribute the following):

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

   The Guide has been updated to include more detailed information on EPSDT services, including the fact that primary care providers will offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The updated Guide is currently being printed and the Defendants anticipate that it will be available beginning December 31, 2007.

   The Defendants plan to further revise the Guide to include information about the CANS tool, ICC, and services for children with SED, including information about how to access those services, when those services are implemented.

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

   The Handbook has been updated to include more detailed information on EPSDT services, including the fact that primary care providers will offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The updated Handbook is currently being printed and the Defendants anticipate that it will be available beginning December 31, 2007.

   The Defendants plan to further revise the Handbook to include information about the CANS tool, ICC, and services for children with SED, including information about how to access those services, when those services are implemented.

3. MBHP Member Handbook
   The Defendants have executed an amendment to EOHHS's contract with MBHP to specifically require MBHP to publish, update, and distribute an MBHP Member Handbook for members who are enrolled with MBHP but not the PCC Plan (children in the care and custody of the Departments of Social Services or Youth Services).

   The Handbook has been created and includes detailed information on EPSDT services, including the fact that primary care providers will offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The Handbook will be available beginning in December 2007.

   The Defendants plan to direct MBHP to further revise this Handbook to include information about the CANS tool, ICC, and services for children with SED, including information about how to access those services, when those services are implemented.

4. MCO Member Handbooks
   The Defendants have executed contract amendments with each MCO to specifically require them to update their materials that describe EPSDT services.

   The Defendants are working with each MCO on finalizing updates to their Handbooks that will include more detailed information on EPSDT services, including the fact that primary care providers will offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. Beginning December 31, 2007, the updated Handbooks will be available upon request, and sent to each newly-enrolled MCO member.

   The Defendants plan to direct each MCO to further revise these handbooks to include information about the CANS tool, ICC, and services for children with SED, including information about how to access those services, when those services are implemented.

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

The Defendants are in the process of revising relevant portions of MassHealth's All Provider regulations (130 CMR 450.000) to describe program improvements. The public comment period on the regulations has ended and the planned effective date is December 31, 2007. This version of the regulations does not describe ICC and the new services focused on the needs of children with SED. The Defendants plan to further revise MassHealth regulations as needed to describe these services, including how to access them, when those services are implemented. For more information about these regulations, see the response to paragraph 6.a. below.

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.

The Defendants' Compliance Coordinator has met with members of the following family organizations to discuss EPSDT, the Judgment, the remedy services, the implementation process, the stakeholder consultation process and strategies to inform parents of MassHealth-enrolled children of the remedy services. Activities to date have included group meetings in various locations around the state, a statewide conference call, meetings with leadership and will shortly include electronic dissemination of written material, including 'Fact Sheet 1' (described in paragraph 7.b below):

1. Adoptive Families Together (AFT) – The Compliance Coordinator met with the Executive Director of AFT on July 13, 2007. AFT helped to publicize the first statewide meeting of parents interested in the implementation of the Judgment, which was held on Monday evening, August 27, 2007 meeting in Natick, MA and has agreed to disseminate 'Fact Sheet 1' and other materials as they become available to members.

2. Federation For Parents of Children with Special Needs (the "Federation") – The Compliance Coordinator met with Massachusetts Federation Leadership on July 12, 2007, including staff in charge of the Family Voices and Family Connections programs. The Compliance Coordinator participated in a statewide conference call with Family Voices members on October 4, 2007. The Federation and its constituent projects have agreed to disseminate 'Fact Sheet 1' and other materials as they become available to members.

3. National Alliance for the Mentally Ill (NAMI), Massachusetts Chapter – the Executive Director, Laurie Martinelli, participated in the August 27, 2007 meeting in Natick. At Ms. Martinelli's suggestion, the Western Massachusetts Chapter of NAMI invited the Compliance Coordinator to speak to members at an October 17, 2007 meeting held in Springfield. NAMI has agreed to disseminate 'Fact Sheet 1' and other materials as they become available to members.

4. Parent /Professional Advocacy League (PAL) – The Compliance Coordinator met with Lisa Lambert, the Executive Director of The Parent/Professional Advocacy League, on several occasions (May 9, July 24, October 17, and November 27) and also conducted additional phone conversations with Ms. Lambert. Ms. Lambert invited the Compliance Coordinator to speak to a meeting of statewide PAL stakeholders on May 30, 2007. PAL helped to organize and publicize the August 27, 2007 meeting in Natick, MA and has agreed to disseminate 'Fact Sheet 1' and other materials as they become available to members.

The Compliance Coordinator also has participated in the following public forums to discuss EPSDT, the Judgment, the remedy services, the implementation process and the stakeholder consultation process:

1. Massachusetts Medicaid Policy Institute Forum (MMPI) – On October 12, 2007, the Compliance Officer participated on a panel discussing MMPI's report on the Rosie D. case and remedy.

2. Mental Health Task Force of the Massachusetts Chapter of the Academy of Pediatrics The Compliance Coordinator regularly attends Task Force meetings to report on implementation activities and to get feedback from this broad group of stakeholders.

The Compliance Coordinator has met with the following stakeholder and advocacy groups to discuss EPSDT, the Judgment, the remedy services, the implementation process, the stakeholder consultation process and strategies to inform parents of MassHealth-enrolled children of the remedy services:

1. Massachusetts Association for Mental Health (MAMH) – on October 4, 2007, the Compliance Coordinator met with the Executive Director, Bernie Carey, and the Policy Director, Tim O'Leary.

2. Professional Advisory Committee (PAC) – on August 27, 2007 and October 11, 2007, the Compliance Coordinator participated in PAC meetings. PAC is an ad hoc committee of mental health advocates and providers that has met for over 30 years.

3. Representative Ruth Balser, House Chair of the Joint Committee on Mental Health and Substance Abuse – at the invitation of Chairwoman Balser, the Compliance Coordinator met with the Chairwoman and Chief of Staff on July 25, 2007, to report on the status of the implementation activities and future plans.

Finally, the Compliance Coordinator has met with the following state agency contacts to discuss EPSDT, the Judgment, the remedy services, the implementation process, and to develop plans to train agency staff who come into contact with MassHealth-enrolled children and families about these topics and how to help families get regular behavioral health screenings:

1. Anne Sheetz, RN, Director of the School of Health Services, Department of Public Health (DPH) - The Compliance Coordinator met with Ms. Sheetz on July 18, 2007 and conducted subsequent phone calls. A plan has been developed to disseminate electronically 'Fact Sheet 2' (described in paragraph 7.b. below) in December 2007 to all school nurses and to train a smaller group of school nurse leaders (managers who work with DPH to implement new policies and procedures), on December 5, 2007 about the screening requirements and how to help parents access behavioral health screens for their MassHealth-enrolled children.

2. Kate Roper, Program Director, Massachusetts Early Childhood Comprehensive Systems (MECCS) Project, Department of Public Health (DPH) - The Compliance Coordinator has met with Ms. Roper to coordinate Rosie D. implementation activities with the activities of the Massachusetts Early Childhood Comprehensive Systems (MECCS) project. The goal of the MECCS project is to coordinate the activities of member agencies that relate to early childhood education.

3. Department of Mental Health (DMH) - At the request of Commissioner Barbara Leadholm, the Compliance Coordinator met senior leaders at DMH October 9, 2007 to brief the leadership team on the Judgment, the remedy services and implementation plan, with an emphasis on issues of relevance to DMH.

4. Massachusetts Administrators for Special Education (ACES) - The Compliance Coordinator addressed the ACES, one of two state professional associations for Special Education Administrators, at their semi-annual meeting on October 26, 2007, to inform them of the Judgment, the remedy services and implementation plan, with an emphasis on issues of relevance to educators.

5. Training liaisons from the Departments of Mental Health, Public Health, Social Services, Transitional Assistance, Youth Services, Mental Retardation and the Office for Refugees and Immigrants (ORI) - On November 14, 2007, the Compliance Coordinator participated in a meeting with liaisons from DMH, DPH, DSS, DTA,

DYS, DMR and ORI to discuss methods for training their staff who come into contact with MassHealth-enrolled children under the age of 21 about the Judgment.

6. Executive Office of Health and Human Services General Counsels - In June and on November 8, 2007, the Compliance Coordinator participated in regular meetings of the EOHHS General Counsels to review the Judgment, the remedy services and implementation plan with an emphasis on activities the other EOHHS agencies need to undertake to support implementation of the Judgment, such as staff training activities.

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

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

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

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

The Defendants are in the process of updating Appendix W to include a list of MassHealth-approved standardized behavioral health screening tools, from which primary care providers must select a tool when administering behavioral health screens for MassHealth enrolled children. On July 25, 2007, the Defendants shared the list of proposed behavioral health screening tools with representatives of the Massachusetts Chapter of the American Academy of Pediatrics, the Massachusetts Medical Society, the Massachusetts Association of Family Practitioners, the Massachusetts League of Community Health Centers, and the Massachusetts Association of Health Plans, all of which support the list of approved tools. The Defendants will publish the updated Appendix W along with the updated EPSDT regulations described in subparagraph a. above. The effective date will be December 31, 2007.

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.

The Defendants plan to develop a new, stand-alone guide for MassHealth providers on how to access behavioral health services for children enrolled in MassHealth, but not enrolled in the PCC Plan or in a MassHealth-contracted MCO, which will be updated as remedy screenings, assessments and services become available.

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

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

1. PCC Plan Provider Newsletters – The PCC Plan included articles in the Fall and Winter issues of its provider newsletter that include information on the requirement for PCCs to use standardized behavioral health screening tools.

2. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Preventive Pediatric Health-care Screening and Diagnosis (PPHSD) Services Billing Guidelines for MassHealth Physicians and Mid-level Providers – The Defendants have updated this Guide for providers who bill MassHealth directly for EPSDT and PPHSD screening services. The Defendants anticipate that the updated Guide will be available by December 31, 2007.

3. PCC Plan Provider Contract – The Defendants have drafted updates to the contract, and these updates have been approved by the Centers for Medicare and Medicaid Services (CMS). The updated PCC contract will be mailed to all enrolled PCCs in December 2007.

4. PCC Plan Provider Handbook – The Defendants have drafted updates to this Handbook for providers who are enrolled as PCCs. The updated Handbook will be mailed to all enrolled PCCs with the updated PCC Plan provider contract.

5. MCO newsletters – MassHealth-contracted MCOs are developing articles to be included in each MCO's provider newsletter to inform providers about the requirement for using standardized behavioral health screening tools. These newsletters will be published by December 31, 2007.

6. MassHealth "Update" article – MassHealth will include an article containing information for providers about using standardized behavioral health screening tools in MassHealth "Update", which is MassHealth's online newsletter to all MassHealth providers.

In subsequent phases, the Defendants will assess which of the above materials, or additional materials that are distributed to providers, need to be updated to inform providers about the standardized assessment process using the CANS tool, and about ICC and the new services

focused on the needs of children with SED, including how to access those services once those services are implemented.

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

The Defendants will consider how to expand distribution points for the materials described in subparagraph d. above as updates to those documents are implemented. Also, the Defendants will be posting materials, including the "Update" article, on the EOHHS/MassHealth website.

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

The Defendants have identified changes that must be made to the Medicaid Management Information System (MMIS) to allow MassHealth providers to be reimbursed for the administration and scoring of the standardized behavioral health screening tools, and that will allow the Defendants to track the rate at which providers are utilizing a standardized behavioral health screening tool when administering behavioral health screens. The Defendants will make such changes to MMIS in a timeframe that will allow MMIS to reimburse providers for the services provided on or after December 31, 2007. Also, the Defendants will implement other operational changes that are identified as necessary to implement the projects described in the Judgment.

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

The Defendants have executed amendments to its contracts with MBHP and the MCOs to specifically require each of them to conduct at least one forum per year for primary care providers to educate these providers about the importance of behavioral health screenings and appropriate referrals to behavioral health providers (MBHP will perform forums for PCCs). For the current year, these forums took place on November 6, 8, 13 and 15, in Taunton, Springfield, Waltham and Worcester.

Additionally, the Defendants have executed amendments to its contracts with MBHP and the MCOs to specifically require them to implement at least one quality forum per year for behavioral health providers to encourage clinical performance activities consistent with the principles and goals of the Judgment. EOHHS will provide further direction about the details of these forums, which will take place in the second half of State Fiscal Year 2008.

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

The Defendants have executed amendments to its contracts with MBHP and the MCOs to specifically require them to educate their network providers about the program

improvements described in sections a. through g. of this paragraph. In addition, the Defendants, including the Compliance Coordinator, have met with MBHP and the MCOs regarding implementation of Project 1.

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

The Defendants are developing a strategy and implementation plan for using the Virtual Gateway/EOHHS website to inform MassHealth providers, the broader community of human services providers, and members of the public, about Rosie D. remedy services and how to obtain them. The Defendants are in the process of developing a list of materials concerning well-child screening that can be posted on the Commonwealth's website by December 31, 2007. The Defendants plan to post information about the CANS tool, ICC, and new services focused on the needs of children with SED when those services are implemented.

***Paragraph 7: The Public - To improve public information about the program improvements the Defendants are required to take under the terms of this Judgment, the Defendants will take the following actions to present the terms of this Judgment to public and private agencies that serve children and families*:**

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

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

- the Executive Office of Administration and Finance,
- the Executive Office of Health and Human Services,
- the Office of Medicaid, and
- the Departments of Mental Health, Mental Retardation, Public Health, Social Services and Youth Services.

A copy of the Judgment will be included with a copy of this report, and sent to:

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

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

The Defendants have drafted two notices, in the form of 'fact sheets' for the purposes of outreach. 'Fact Sheet 1' is for the general public. 'Fact Sheet 2' is for agencies/groups that work with children and whose staff are likely to help parents learn about and access needed screenings, assessments and services for their children. Both Fact Sheets contain information about EPSDT services available to children enrolled in MassHealth. The Defendants plan to update these Fact Sheets in the future to provide more information about the CANS tool, ICC, and services focused on the needs of children with SED and ICC, when those services are implemented.

The Defendants are in the process of developing methods for distributing 'Fact Sheet 1' to primary care providers, Community Health Centers and Community Mental Health Centers, and for distributing 'Fact Sheet 2' to staff working with the agencies/groups noted above. The Defendants will begin implementing these distribution plans by December 31, 2007.

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

The Defendants are developing materials that will be used to train line workers at the Departments of Mental Health, Social Services, Youth Services, Mental Retardation, Transitional Assistance, and the Office for Refugees and Immigrants about MassHealth services, including the new services required by the Judgment. The Defendants are working with representatives from these agencies to develop a plan to provide educational materials to these agencies for use in training their line staff.

d. Distributing outreach materials in primary care settings, community health centers, and community mental health centers and posting electronic materials on the EOHHS

Virtual Gateway that are designed to provide information to MassHealth Members and to public and private agencies that come in contact with or serve children with SED or their families.

The Defendants will coordinate with the associations for these provider types to ensure that 'Fact Sheet 1' (described in subparagraph b. above) is made available to the public at provider sites.

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

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

The Defendants will coordinate with the agencies/groups that work with children and whose staff are likely to help parents learn about and access needed screenings, assessments and services for their children, including the Department of Early Education and Care, to disseminate 'Fact Sheet 2' (described in subparagraph b. 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.

Similarly, the Defendants will coordinate with the Department of Education, the Department of Public Health, and the Public School Districts to disseminate 'Fact Sheet 2' (described in subparagraph b. above).

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

As explained in response to paragraph 6.a. above, the Defendants have drafted updates to 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. The public comment period on the regulations has ended and the planned effective date is December 31, 2007.

As explained in paragraph 6.b. above, the Defendants have finalized a menu of screening tools, which includes the Pediatric Symptom Checklist (PSC) and the Parents' Evaluation of Developmental Status (PEDS), as well as other tools to screen for autistic conditions, depression

or substance abuse. The menu of tools will appear in Appendix W of the MassHealth Provider Manual and will be effective December 31, 2007.

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

As explained in paragraph 6.a. above, the Defendants have drafted updates to MassHealth regulations governing the EPSDT program (130 CMR 450.140-150) to clarify that all primary care providers are required to provide periodic and medically necessary inter-periodic screens. The public comment period on the regulations has ended and the planned effective date is December 31, 2007.

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).***

The Defendants are using the vehicle of the provider training forums held on November 6, 8, 13, and 15, to inform primary care providers about the most effective use of the approved screening tools, to educate them on how to evaluate behavioral health information gathered during the screening, and to provide information on how and where they can refer members needing further behavioral health clinical assessment.

Also, the Defendants have executed amendments to its contracts with the MCOs to require them to develop and implement quality improvement activities for providers in their networks.

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

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

state agencies, public schools, community health centers, hospitals and community mental health providers.

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

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

As described in the response to paragraph 7 above, the Defendants plan to develop and distribute written guidance that establishes protocols for referrals for screenings, assessments and services, including home-based services, and to work closely with the child-serving state and private agencies to enhance the capacity of staff to connect children with SED and their families to these screenings, assessments and services.

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 of November 31, 2008, MassHealth will require clinicians who are enrolled as providers in MassHealth's fee-for-service network, or who participate in an MCO or MBHP's network, to provide a comprehensive clinical evaluation, including referrals for any medically necessary tests, such as neuro-psych testing or developmental testing. The comprehensive clinical evaluation will include a diagnosis and referral, if indicated. The clinician also will be required to determine if the youth meets either the SAMHSA or IDEA definition of SED, or both.

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

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

The Defendants have convened a workgroup, which has been meeting regularly since March of 2006, comprised of representatives from MassHealth, the Department of Mental Health (DMH), the Department of Youth Services (DYS), the Department of Social Services (DSS), the Office of Clinical Affairs (OCA), the Commonwealth Medicine Division of the University of Massachusetts Medical School, the Department of Public Health (DPH), and a child psychiatrist.

This workgroup is consulting with John Lyons to develop a CANS tool to implement the terms of the Judgment. The workgroup met with John Lyons on multiple occasions. The workgroup has reviewed the CANS document currently used by DSS. Representatives from the workgroup have attended two CANS conferences (one in April 2006 and one in October 2007).

As a result of this work, the workgroup has produced a draft Massachusetts CANS tool for use with MassHealth-enrolled members aged 5 to 21 to record the comprehensive assessment of the member's behavioral health needs. The draft tool includes a cover sheet that requires the clinician to identify whether the member has a serious emotional disturbance either under SAMHSA or IDEA definition, or both. A draft of this tool was provided to the Plaintiffs for review and comment. The workgroup also plans to produce a draft CANS tool for use with MassHealth-enrolled members under the age of 5. The Plaintiffs will have an opportunity to review and comment on this tool as well.

The Defendants plan to present the proposed version of the Massachusetts CANS tool to providers and families to gather their input. Based on this stakeholder input, modifications to the draft version of the Massachusetts CANS may be made.

If a member is referred to Intensive Care Coordination, the Massachusetts CANS tool will be reviewed and modified by the ICC team, as needed, as part of the ICC assessment.

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

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

also be referred for assessment and services by a provider, a state agency, or a school that comes into contact with a child and identifies a potential behavioral health need.

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

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.

The Defendants are developing a plan to offer CANS training in 2008 to MassHealth fee for service and managed care network behavioral health providers. The Defendants will also offer CANS training to select employees of the Commonwealth's child-serving state agencies.

The Defendants have negotiated an Interdepartmental Service Agreement (ISA) with the Commonwealth Medicine Division of the University of Massachusetts to assist in developing the training program, in collaboration and consultation with John Lyons. This ISA should be executed by the time this Report is filed, or shortly thereafter. The training program will include both in-person trainings with continuing education unit (CEU) credits and also a web-based training opportunity. These trainings will be free of charge to the clinicians or state agency personnel who participate.

MassHealth clinicians who are required to use the CANS tool will be required to be trained and certified on the use of the CANS tool. To be certified, they will be required to pass a certification examination that has been approved by John Lyons. Clinicians who fail to attain a passing score will have opportunities to retake the certification examination.

The Defendants will amend MassHealth regulations, provider contracts, and interagency service agreements, as necessary, to require that appropriate clinicians use the Massachusetts CANS tool as described in this Judgment. As noted in paragraph 15 above, the Defendants will require that clinical assessments include a diagnostic evaluation and the cover sheet of the Massachusetts CANS tool will provide a space for them to record the results of this evaluation.

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

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

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

The Massachusetts CANS will be reviewed 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 described in response to paragraph 15 above, the assessment process, including the use of the CANS, will be part of discharge planning at an acute inpatient hospital or CBAT setting if the child has been determined to have SED using the SAMHSA and/or IDEA definition. The CANS will also be completed as part of a discharge process whenever a youth is leaving a DMH intensive residential setting or a continuing care program.

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.***

See response to paragraph 38 below.

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.

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

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

   FN Text: Where provider qualifications appear in the description of the services in this section of the Judgment, the following applies: As used in this Judgment, the terms "qualified, licensed clinician" and "qualified paraprofessional" refer to individuals with specific licensure, education, training, and/or experience, as will be set forth in standards to be established by the Defendants. Such individuals will be authorized to provide specific services referred to herein. A licensed clinician is an individual licensed by the Commonwealth to provide clinical services within a particular scope as defined by the applicable licensing authority or statute, including, but not necessarily limited to, physicians, psychiatrists, licensed clinical psychologists, licensed

independent clinical social workers, licensed clinical social workers, and licensed mental health counselors. A paraprofessional is an individual who, by virtue of certification, education, training, or experience is qualified to provide therapeutic services under the supervision of a licensed clinician.

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

See response to paragraph 38 below.

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

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

child's performance and the level of intervention required. Behavior management therapy is provided by qualified licensed clinicians.

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

See response to paragraph 38 below.

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

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

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

See response to paragraph 38 below.

c. Mentor Services – Mentor services include:

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

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

See response to paragraph 38 below.

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

This paragraph is introductory; see detailed response below.

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

This paragraph is introductory; see detailed response below.

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

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

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

b. Tasks performed will include:

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

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

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

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

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

c. Timelines for implementation:

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

The Defendants submitted a report dated June 27, 2007, that fulfilled the requirement in subpart i. The Defendants are taking the steps described in paragraphs 2-12 above to complete this project by December 31, 2007, as required by subpart ii.

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

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

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

b. Task performed will include:

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

See the response to paragraphs 15-16 above.

c. Timelines for implementation:

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

The submission of this Report is intended to fulfill the requirement in subpart i. The Defendants are taking the steps described in paragraphs 13-16 above to complete this project by November 30, 2008, as required by subpart ii.

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

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

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

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

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

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

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

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

The Defendants have created an interagency Network Development Workgroup to undertake the process of network design and development. The Chair of the Workgroup is the Assistant Commissioner for Child and Adolescent Services for the Department of Mental Health (DMH). Members of the Workgroup include the Compliance Coordinator, Senior Central Office Managers from the Departments of Social Services and Youth Services, top field clinical managers from DSS and DMH, and managerial and line staff from MassHealth and DMH.

The Workgroup has been meeting for weekly two-hour planning sessions since July 2007. Since September, 2007, at the Defendants' request, MBHP has supplied staff involved with overseeing the Coordinated Family-Focused Care as resources to the Workgroup.

Recommendations prepared by the Workgroup are presented to an Executive Committee, which consists of the Assistant Secretary of Health and Human Services for Children and Families, the Director of the Office of Medicaid, the Commissioners of DMH, DSS, DYS, and the senior agency staff from the Workgroup.

The Workgroup and the Executive Committee are preparing a "Request for Information" or "RFI." RFIs are used to solicit information and recommendations from policy stakeholders and potential providers of new or re-designed services. The RFI will describe the Defendants' system design work to date: preliminary plans for the service areas, the Community Service Agencies, the clinical model for Intensive Care Coordination, and descriptions of the other services and how they will be delivered as part of a coherent system of services. It will also solicit input by asking questions about particular aspects of the design and specifications.

The current plan is to issue the RFI in early January. Following analysis of the information obtained through the RFI, the Workgroup and Executive Committee will make final design and specification decisions, which will be implemented through amendments to MassHealth's with MBHP and the MCOs.

Through these contract amendments, MassHealth will direct MBHP and the MCOs to contract with one network of Community Services Agencies, will establish medical necessity criteria for the remedy services, and will require specific approaches to utilization and quality management. The Defendants anticipate that MBHP and the MCOs will select, contract with, and develop a management process for the network throughout the remainder of 2008.

The Defendants anticipate that, during the first six months of 2009, MBHP, the MCOs, and the selected providers will undertake organizational and staff development activities. The Defendants anticipate that the services will become operational by June 30, 2009. This may include providing certain services in advance of June 30, 2009, if that is feasible.

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 above, the Network Development Workgroup involves people familiar with the current array of behavioral health providers in Massachusetts. The draft design has been developed paying careful attention to the issues of access and availability of providers. The RFI will be a critical tool for "testing" those design assumptions with the provider community and with current service consumers (through family organizations and advocacy organizations).

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

Through the design process to date, the Workgroup and the Compliance Coordinator have consulted with a number of experts to inform deliberations. These include family members, professional "Family Partners" (paraprofessionals who are themselves parents or guardians of children with SED who coach and mentor other caregivers of children with SED), family organizations, clinical managers from the five Coordinated Family-Focused Care sites, provider organizations such as the Children's League of Massachusetts and the Mental Health and Substance Abuse Corporations of Massachusetts, Judge Baker Children's Center, the Massachusetts Infant and Early Childhood Mental Health Coalition, and the Massachusetts Early Childhood Comprehensive Systems project (MECCS).

The RFI described above will give the Workgroup the opportunity to obtain input from a comprehensive array of stakeholders. During this period the Workgroup will also be consulting with Legislators and their staff. As part of the consultation process, the Workgroup expects to have additional group meetings with groups of providers, family members, and other stakeholders.

iii) Planning concerning anticipated need and provider availability.

Given that staffing the current behavioral health system is an ongoing challenge for behavioral health provider agencies, the Defendants know that workforce availability is key to successful implementation of the remedy services. There are a number of initiatives underway and in the planning stages to address this issue, including:

- Assistant Secretary Marilyn Chase and the Compliance Coordinator held a meeting on November 28, 2007, for leaders from academic programs in Massachusetts in the fields of Social Work, Psychology and Counseling, to discuss the need for professional and paraprofessional staff in the new behavioral system. A number of specific, actionable steps were suggested at this meeting. Follow-up meetings have been scheduled to further develop the suggested next steps.
- Assistant Secretary Chase will be meeting with leadership of the Commonwealth's Executive Office of Labor and Workforce Development to explore how they might support development of the clinical and paraprofessional workforce.
- The Defendants will also consult with non-academic training agencies.
- The Defendants will include questions regarding workforce issues in the RFI.

As mentioned above, the Workgroup has devoted considerable resources to conceptualizing the remedy services and staffing models in order to support high-quality and sustainable services.

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

The Defendants are nearing the end of a several-months-long process of developing draft State Plan Amendments (SPAs) for review and approval by the Centers of Medicare and Medicaid Services (CMS). Senior staff responsible for the relationship between EOHHS's Office of Medicaid and CMS supported this process and the Court Monitor provided to the Plaintiffs and Defendants consultants with recent experience in helping other states file similar plans. This consultation has been extremely valuable. The proposed SPAs will be filed with CMS very shortly.

CMS review of SPAs such as these typically includes a set or series of written questions from CMS, to be answered by the Office of Medicaid. In anticipation of this process, appropriate Office of Medicaid senior staff have been assigned to support the Compliance Coordinator and the program and budget units in their development of responses to these questions. The Defendants will also share the questions and answers with the Monitor and the Plaintiffs.

v) Defining CSA Service Areas.

The Executive Committee has adopted a preliminary recommendation by the Network Development Workgroup to use the 29 DSS service areas as the CSA Service Areas. The Executive Committee adopted this preliminary recommendation because the size of the DSS Area strikes a good balance between being small enough that the Community Service Agencies (CSAs) can be well-integrated into their communities, while not leading to so many CSAs that establishing and maintaining statewide standards and quality becomes nearly impossible.

This recommendation is "preliminary" because it will be included in the RFI and the Workgroup and the Executive Committee will consider stakeholder recommendations and the recommendations of the Plaintiffs before making a final decision.

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

All of these are currently under development.

MBHP staff is currently preparing a second draft of service specifications, provider specifications and medical necessity criteria, based on work done over the summer by MassHealth, DMH, MBHP, and MCO staff and on revisions recommended by the Workgroup. Input received through the RFI process will be incorporated into final specifications.

Training requirements will be developed once the service and provider specifications are finalized.

Preliminary work on performance measures has been done. The Network Development Workgroup will present recommendations on performance measures to the Executive Committee in late December.

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. In addition, the Defendants have taken the following steps to increase clinical resources (both staff and consultative) available to support the system design work:

- A new Director of the MassHealth Behavioral Health Unit, a licensed clinician, will be starting mid-December. Additional staff will be hired shortly thereafter.
- The Compliance Coordinator is in the process of hiring an Assistant Director who is a senior clinical psychologist who has served as Clinical Director of one of the Coordinated Family Focused Care sites. He will start in mid-January.

The Department of Mental Health and MassHealth are in the process of convening a clinical advisory committee to the Rosie D. implementation process.

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

See paragraph 38.b. above.

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

Work has begun with the Commonwealth's rate setting agency, the Division of Health Care Finance and Policy (DHCFP), to develop fee for service (FFS) rates for the remedy services. These rates will be paid to providers serving MassHealth members in our FFS program. These rates will be one of the resources used to develop MassHealth's capitation payment to its MCOs and MBHP. Preliminary development work on the MCO and MBHP capitation rates for the first year that remedy services will be provided is underway.

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

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

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

The first phase of this work -- educating providers, members, and the general public about universal standardized behavioral health screening -- is well underway, as described in paragraphs 2-7 above.

The Defendants will revise all of the communication materials, and use all of the communication channels, referenced in these paragraphs as each phase of the remedy is implemented. Updated materials will be disseminated prior to implementation of the CANS assessments and prior to implementation of the remedy services.

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

The design work is underway, with the Services Workgroup, the MassHealth Behavioral Health Program and the MassHealth Managed Care Program all contributing to this effort.

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 submission of this Report is intended to fulfill the requirement in subpart i. The Defendants are taking the steps described in paragraphs 19-33 above to complete this project by June 30, 2009, as required by subpart ii.

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

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

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

b. Tasks performed will include:

i) Defining existing system capacities.

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

iii) Obtaining legislative authorization and funding.

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

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

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

vii) Negotiating contract(s).

viii) Confirming business requirements and technical specifications.

ix) Performing construction, testing, and provider training.

The Defendants plan to address the information technology system design and development project by leveraging and building on existing information technology resources, including

existing information technology systems within EOHHS. Doing so will avoid investment in an entirely new case management system that duplicates those already in use across EOHHS. Further, this approach will minimize new data entry burden on the behavioral health provider community. Where possible, the reporting on utilization of services will be done through claims and managed care encounter data. Other clinical systems will be based on existing EOHHS systems to the extent feasible.

Thus far, the Defendants have taken the following steps:

Defining Existing System Capacities:
During January through March 2007, the Defendants worked with an outside consultant to determine whether an enterprise-wide service management (ESM) system currently under development for EOHHS would meet the requirements of the Judgment. After consulting with program managers and IT professionals from MassHealth, EOHHS IT, DSS, DYS and DMH to gather high-level system requirements, it was determined that the ESM system would not have the required functional capacity. As a result, the Defendants decided to sequence the IT approach in two phases. The first phase would be to develop an IT solution that can collect CANS data from MassHealth behavioral health providers. The second phase would be to develop a solution that can collect data from the CSAs regarding ICC and the delivery of the new services for children with SED.

EOHHS IT next conducted an internal review of existing agency data systems to determine if any of these systems could be leveraged to meet the needs of the Judgment. Systems reviewed included: the DMH Meditech system; the Medicaid Management Information System (MMIS); the existing MassHealth data warehouse system; and the DSS STARS system (which stores DSS CANS data). It was determined that none of these existing systems could meet all reporting requirements. However, it was determined that certain components of the DSS STARS system provide functionality that is similar to that which is required to administer the CANS tool. Therefore, the Defendants have decided to take this as the starting point for developing the IT platform for the CANS tool.

Gathering Requirements for New Functionality:
In addition to developing high-level requirements, as described above, the Defendants have hired 2 business analysts, and assigned an IT project manager to develop detailed requirements for the IT approach. The business analysts are following an IT methodology for developing requirements, called the “unified process,” which involves detailing how users would interact with an IT system in their day-to-day work, and documenting these processes in use cases. The development of use cases requires a detailed knowledge of both existing and new business process flows that will be occurring at EOHHS agencies, at any managed care entities under contract with MassHealth, and at the community provider level.

The business analysts have completed a formal planning document, have begun work on use cases, and currently are assisting in the development of the business processes for clinical assessments. The Defendants anticipate that the development of requirements will take several additional months.

Assessing whether a system will be built in-house or out-sourced typically occurs after detailed requirements have been developed. At this time, Defendants anticipate building many components in-house because major portions of the desired functionality exist in the DSS STARS system.

Obtaining Authorization and Funding:
Current funding only includes the funds necessary to complete the work being done to evaluate system requirements. Once the system requirements have been defined, the Defendants will develop a budget for system implementation and seek the necessary appropriation.

Contracting and Procuring:
Once the process of analyzing system requirements is complete, the Defendants will determine whether it is necessary to procure and contract for any needed functionality. In the event of a procurement, the Defendants will rely, where possible, on existing EOHHS architectural, privacy and performance standards.

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 submission of this Report is intended to fulfill the requirement in subpart i. The Defendants are taking the steps described in paragraphs 39-46 to complete this project by November 30, 2008, as required by subpart ii.

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

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

Paragraph 41: ***The primary source for Medicaid data is MassHealth's claims payment system, known as the Medicaid Management Information System (MMIS). While MMIS can collect claims level data on utilization and spending, it is not a good source for much of the data required to evaluate the implementation beyond that otherwise necessary for providers to claim reimbursement from MassHealth. EOHHS is currently part way through a major multi-year project to develop a replacement MMIS (New MMIS), currently anticipated for implementation in August, 2007.***

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

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

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

Paragraph 43: ***For detailed clinical and provider performance data, MassHealth's clinical staff and contracted reviewers undertake clinical record reviews. This method of collecting data is appropriate in very limited circumstances and is time-intensive and costly.***

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

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

As explained in response to paragraph 39.a. above, the Defendants have been working with multiple EOHHS agencies to define the data needs and to implement the Judgment. As also explained above, once the system requirements have been defined, the Defendants will determine whether it is necessary to seek any additional legislative appropriation and will work with the MassHealth provider community to ensure that the envisioned data collection approach is feasible, given clinical and business processes in the provider community.

Paragraph 45: ***With these considerations in mind, the Judgment includes the following as a preliminary data collection strategy to assess Member access to, and utilization of, 25 EPSDT***

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

Wherever possible, the Defendants plan to use claims data from and MMIS and MBHP and encounter data from the MCOs. As explained in more detail in response to paragraph 46 below, there are some measures which will require the collection of new data or the combination of new data with existing claims and encounter data.

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

a. EPSDT Behavioral Health Screening

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

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

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

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

More detailed information about each of the three measures follows.

The ability to report on EPSDT or well child visits and other primary care visits already exists and is part of MassHealth's quality improvement measures. The existing report is from MMIS only, so a new programming specification is currently being developed to incorporate encounter data.

The Defendants will report on the number of EPSDT behavioral health screens provided by implementing a specific code that all primary care providers, including those in an MCO network, will use when billing for behavioral health screens. The MassHealth system requirements necessary to report this code already have been made. The MCOs will be making any system changes necessary to support this code by December 31, 2007. The Defendants are in the process of developing the programming for the report from our MMIS and encounter data.

The Defendants will report on the number of screens identifying a child with a potential behavioral health services need by implementing specific "modifiers" that all primary care providers, including those in an MCO network, will use when billing the code for the behavioral health screen. These modifiers will indicate both the type of provider that performed the screen, as well as whether the screening was positive or not. The MassHealth system requirements necessary to report this code already have been made. The MCOs will be making any system changes necessary to support this code by December 31, 2007. The Defendants are in the process of developing the programming for the report from our MMIS and encounter data.

b. Clinical Assessment

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

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

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

The Defendants will first report on the number of assessments through MMIS and encounter data. The Defendants are researching the possibility of using a modifier (similar to the modifiers being implemented for behavioral health screens) to indicate whether the child met SED clinical criteria. The Defendants currently are working with the Division of Health Care Financing and Policy (DHCFP), the MCOs, and MBHP to identify the best coding strategy for billing and reporting on clinical assessments. The Defendants plan to have the system in place to report this data from claims by November 30, 2008. Because the deadline for implementing the clinical assessments is also November 30, 2008, the first reports from claims with any substantial amount of data will be produced later.

In addition to reporting based on claims, the Defendants are considering reporting on these measures by building an online CANS interface available to all MassHealth behavioral health providers using the code that has been developed in the DSS STARS system. This would allow behavioral health providers to enter CANS data online.

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

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

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

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

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

The Defendants plan to have the coding, MMIS, and data warehouse changes as well as the on-line CANS IT system complete by November 30, 2008. However, since ICC will not be fully implemented until June 30, 2009, there will be limited data from claims to report on these indicators until after the services have been implemented.

d. Intensive Home-Based Services Treatment

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

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

The Defendants are considering reporting on the member-level utilization of services as prescribed under an individualized care plan by linking an electronic treatment planning record to actual services provided (as reported in claims). Many of the large providers have their own electronic treatment records, as do some managed care companies for members in care management programs. The Defendants currently are gathering requirements for linking care plans to the services provided, and looking at the needs of the providers and their treatment planning systems, the existing treatment plans that link to claims payment in managed care systems, and in-house, on-line treatment plan systems currently used by providers contracted with DSS.

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

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

e. Child and Outcome Measures - Member-level outcome measures will be established to track the behavioral health of an EPSDT-eligible MassHealth Member with SED who has been identified as needing intensive care coordination services over time.

Defendants will consult with providers and the academic literature and develop methods and strategies for evaluating Member-level outcomes as well as overall outcomes. Member-level outcome measures would be tracked solely for the purpose of program improvement and would not be useable as a basis for arguing that Defendants are not complying with any order of the Court.

The Defendants currently are researching potential member-level outcome measures, including the CANS tool and the Treatment Outcome Package (TOP). The Defendants will work with provider stakeholder groups to assist in making this decision.

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

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

f. Member Satisfaction Measures - Defendants will develop sampling methods and tools to measure Member satisfaction of services covered under this Judgment. Member satisfaction would be measured solely for the purpose of program improvement and would not be useable as a basis for arguing that Defendants are not complying with any order of the Court.

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

Respectfully submitted,

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Date: November 30, 2007

I hereby certify that this document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing.

____/s/ Deirdre Roney_____