UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS, WESTERN DIVISION

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

JUDGMENT

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

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

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

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

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

I. DEFENDANTS' PLAN

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

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

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

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

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

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

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

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

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

1. Education and Outreach

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

4. The Defendants will take steps to publicize the program improvements they are required to take under the terms of this Judgment to eligible MassHealth Members (including newly-eligible MassHealth Members), MassHealth providers, and the general public. As part of this effort, the Defendants will take the actions described below and will also provide intensive training to MassHealth customer service representatives,

including updating scripts used by such representatives to facilitate timely and accurate responses to inquiries about the program improvements described in this Judgment.

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

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

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

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

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

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

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

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

c. Drafting and distributing special provider communications related to the program improvements described in this Judgment, including how to assist

MassHealth Members to access the home-based services described in Section I.D.

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Screening for Behavioral Health

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

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

10. There will be a renewed emphasis on screening, combined with ongoing training opportunities for providers and quality improvement initiatives directed at informing primary care providers about the most effective use of approved screening tools, how to

evaluate behavioral health information gathered in the screening, and most particularly how and where to make referrals for follow-up behavioral health clinical assessment. Additional quality improvement initiatives will include improved tracking of delivered screenings and of utilization of services delivered by pediatricians or other medical providers or behavioral health providers following a screening and use of data collected to help improve delivery of EPSDT screening, including assuring that providers offer behavioral health screenings according to the State's periodicity schedule and more often as requested (described in Section I.E.2).

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

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

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

B. Assessment and Diagnosis

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

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

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

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

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

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

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

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

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

[Sections 17 and 18 deleted]

C. Intensive Care Coordination and Treatment Planning

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

1. The Care Manager

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

21. The basic responsibilities of Care Managers are: (1) assisting in the identification of other members of the care planning team; (2) facilitating the care planning team in identifying the strengths of the child and family, as well as any community supports and other resources; (3) convening, coordinating, and communicating with the care planning team; (4) working directly with the child and family; (5) collecting background information and plans from other agencies, subject to the need to obtained informed consent; (6) preparing, monitoring, and modifying the individualized care plan in concert with the care planning team; (7) coordinating the delivery of available services; (8)

collaborating with other caregivers on the child and family's behalf; and (9) facilitating transition planning, including planning for aftercare or alternative supports when in-home support services are no longer needed.

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

2. The Care Planning Team

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

24. The care planning team will use multiple tools, including a CANS standardized instrument, in conjunction with a comprehensive psychosocial assessment, as well as other clinical diagnoses, to organize and guide the development of an individualized plan

of care that most effectively meets the child's needs. This plan of care will be reviewed periodically and will be updated, as needed, to reflect the changing needs of the child. As part of this process, further assessments, including re-assessments using the CANS or other tools, may be conducted so that the changing needs of the child can be identified.

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

3. Individualized Care Plan

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

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

manual that includes these guidelines and standards for the use of the care planning teams.

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

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

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

30. Intensive care coordination services are particularly critical for children who are receiving services from EOHHS agencies in addition to MassHealth. In order to assure the success of the care planning team process and the individualized care plan for a child with multiple agency involvement, EOHHS will ensure that a representative of each such EOHHS agency will be a part of the child's care planning team. Operating pursuant to protocols developed by EOHHS, EOHHS agency representatives will coordinate any agency-specific planning process or the content of an agency-specific treatment plan as members of the care planning team. EOHHS will develop a conflict-resolution process for resolving disagreements among members of the team.

D. Covered Services

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

1. Crisis Management

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

a. *Mobile Crisis Intervention* - A mobile, on-site, face-to-face therapeutic response to a child experiencing a mental health crisis for the purpose of identifying, assessing, treating, and stabilizing the situation in community settings (including the child's home) and reducing the immediate risk of danger to the child or others. Mobile crisis services may be provided by a single professional crisis worker or by a team of professionals trained in crisis intervention. Services are available 24 hours a day, 7 days a week. Phone contact and consultation may be provided as part of the intervention. Providers are qualified licensed clinicians or, in limited circumstances, qualified paraprofessionals supervised by qualified, licensed clinicians.[2]

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

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

2. ***Home and Community-Based Services***

33. The components of this service category are In-Home Behavioral Services (including behavior management therapy and behavior management monitoring), In-Home Therapy Services (including a therapeutic clinical intervention and ongoing training and therapeutic support), and Mentor Services (including independent living skills mentors and child/family support mentors). While the services in this category may be provided where clinically appropriate, it is intended that they be provided in any setting where the child is naturally located, including, but not limited to, the home

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As used in this Judgment, the terms "qualified, licensed clinician" and "qualified paraprofessional" refer to individuals with specific licensure, education, training, and/or experience, as will be set forth in standards to be established by the Defendants. Such individuals will be authorized to provide specific services referred to herein.

A licensed clinician is an individual licensed by the Commonwealth to provide clinical services within a particular scope as defined by the applicable licensing authority or statute, including, but not necessarily limited to, physicians, psychiatrists, licensed clinical psychologists, licensed independent clinical social workers, licensed clinical social workers, and licensed mental health counselors.

A paraprofessional is an individual who, by virtue of certification, education, training, or experience is qualified to provide therapeutic services under the supervision of a licensed clinician.

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

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

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

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

c. *Mentor Services* – Mentor services include:

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

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

E. Implementation

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

1. Implementation Project Planning

35. The Defendants will implement this Judgment as a dynamic process involving multiple concurrent work efforts. Those efforts will be organized into four main projects, described below, which encompass all aspects of the program improvements contained in

this Judgment. This Judgment assigns a timelines for implementing each project, which are subject to modification for good cause upon application of either party. It is important to note that certain elements of each project are subject to external factors that are not fully within the control of EOHHS.

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

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

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

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

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

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

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

c. *Timelines for implementation:*