

MassHealth Chapter 171
Annual Plan for Family Support – FY - 09
Annette Shea, Office of Medicaid

MassHealth is pleased to submit a Family Support Plan as required in Chapter 171 of the Legislative Act of 2005. A set of questions and focus areas were offered as a template for the report. Those questions and focus areas were useful in gathering and organizing the material for the plan. However, for the MassHealth plan the decision was made to respond to the focus areas in a more narrative format instead of directly responding to the suggested questions. This format seemed to be the best way to present the MassHealth plan and program improvement activities. Internal MassHealth managers contributed to the content of the plan. Also, information from the MassHealth and Children's Behavioral Health Initiative website was utilized.

The plan is lengthier than previous plans because it describes a comprehensive overview of the careful planning and service implementation steps taken over the past 2 years. Those steps include a detailed description how MassHealth has obtained substantial consultation with stakeholders and the ongoing process to continue to engage stakeholders.

In 2007 MassHealth embarked on a major initiative aimed at improving access, coordination and delivery of mental health services to MassHealth-eligible children with identified mental health needs. *The Children's Behavioral Health Initiative's* (CBHI) major provision is to improve education and outreach to MassHealth members, providers, and the public, as well as private and state agency staff who come into contact with MassHealth members related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) services. Activities include improvements in communications to members and families about the availability of behavioral health services, including intensive care coordination and behavioral health screenings in primary care settings. Key focus areas include:

- implementation of standardized behavioral-health screening as a part of EPSDT "well-child" visits;
- improved and standardized behavioral-health assessments for eligible members who use behavioral-health services, the development of an information-technology system to track assessments, treatment planning and treatment delivery – *to be implemented November 30, 2008*;
- a requirement to seek federal approval to cover several new or improved community-based services

As part of this change, behavioral health screenings are now part of well-care child visits. The standardized screenings are used by pediatricians to help determine if referral to a specialist is required. The screening requirement was implemented last December, but the use of the Child and Adolescent Strengths and Needs CANS assessment tool requirement starts November, 30, 2008. MassHealth notified members and families to provide them with information about the new standardized assessment process which uses the (CANS) tool and information about how to access services. MassHealth also notified MassHealth providers, the general public and MassHealth customer services staff about the program improvement changes.

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

Since November 30, 2007 the following public programs, panels and meetings with various stakeholders have occurred:

- Trainings for Primary Care Clinicians Regarding Standardized Behavioral Health Screening (Attendance: 100-150 per training)
- Briefings for State Agency Staff and Legislators on the Rosie D. v. Romney Case, Remedy and Remedy Implementation
- Briefing for Members and Staff of the Massachusetts State Legislature, Boston, February 14, 2008
- DMH Health Planning Council, Boston, February 29, 2008
- Senior Staff, Department of Youth Services, Dorchester, March 5, 2008
- Senior Staff, Departments of Early Care and Education and Elementary and Secondary Education, Boston, March 31, 2008 and April 15, 2008
- Department of Public Health, Bureau of Substance Abuse Services, Boston, May 1, 2008
- Four briefings for DMH, DPH, DSS, and DYS Field Managers and Supervisors Regarding the Rosie D. Remedy and Implementation of the CANS Assessment Process (Attendance: 100-200 per training)
- Four briefings for Deans and Faculty of Massachusetts' Bachelors Degree and Masters Degree Mental Health Clinician Training Programs Regarding Workforce Development.

Other relevant meetings:

- Senior Care Managers and Family Partners from the Coordinated Family Focused Care (CFFC) programs, Worcester, November 13, 2007
- Mental Health and Substance Abuse Corporations of Massachusetts, November 30, 2007, December 3, 2007, March 17, 2008, and May 30, 2008
- Dr. Katherine Grimes, M.D., Medical Director of Mental Health Services Program for Youth (MHSPY), Boston, January 8, 2008
- Senior Leadership of the Walden School, a wraparound program for deaf children and youth, Boston, January 15, 2008
- Todd Paynton, Executive Director, Black Mental Health Alliance, Boston, March 11, 2008
- Massachusetts Psychiatric Society and the New England Chapter of the American Academy of Child and Adolescent Psychiatry, Waltham, March 18, 2008
- Massachusetts Chapter of the American Academy of Pediatrics, Annual Meeting, Waltham, May 7, 2008
- The Children's League, the Massachusetts Chapter of the Child Welfare League of America, Framingham, May 19, 2008

Program Improvement Implementation Management Structure

MassHealth has reconfigured their implementation management structure to reflect the accelerating shift from behavioral health policy development to program implementation. Therefore, the following workgroups and executive structure now exist:

Children's Behavioral Health Initiative (CBHI) Executive Committee

Convened by: Barbara Leadholm, Commissioner of the Department of Mental Health

Members: Marilyn Chase, Assistant Secretary of the Executive Office of Health and Human Services for Children, Youth and Families; Tom Dehner, Director of the Office of Medicaid; Angelo McClain, Commissioner of the Department of Social Services; Jane Tewksbury, Commissioner of the Department of Youth Services; and Sally Fogerty, designee of John Auerbach, Commissioner of the Department of Public Health.

Interagency Implementation Team

Members: Senior staff from the Departments of Mental Health, Mental Retardation, Public Health, Social Services and Youth Services, staff from the MassHealth Behavioral Health Unit and the Office of the Compliance Coordinator.

Focus: Oversight and coordination of activities to:

- inform EOHHS child-serving state agency staff about the Rosie D. remedy and remedy services, including how to access services for children enrolled in MassHealth
- develop proposed policies and procedures to ensure participation by representatives of involved state agencies on care planning teams for children enrolled in Intensive Care Coordination (ICC).
- develop proposed protocols to ensure coordination between any agency-specific planning process or the content of an agency-specific treatment plan through the care planning team process for children enrolled in Intensive Care Coordination.
- develop a proposed conflict resolution process for resolving disagreements among care planning team members

MassHealth Implementation Team

Members: Representatives of all involved business units within MassHealth, senior staff from the Departments of Mental Health, Social Services and Youth Services and staff from the Office of the Compliance Coordinator

Focus: Oversight and coordination of all MassHealth implementation activities.

Managed Care Entity (MCE) Workgroup

Sharon Hanson, MPH, Director, MassHealth Managed Care Program

Members: MassHealth Staff, Compliance Coordinator's Assistant Director, and the Behavioral Health Directors from each of MassHealth's MCOs and MBHP

Focus: Implementation of the Rosie D. remedy.

Expert and Stakeholder Consultation Processes

MassHealth convened a workgroup, which met regularly in 2006 and 2007 with John Lyons, Ph.D., developer of the CANS tool. The group included 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. The workgroup developed a Massachusetts CANS tool in two forms: one form for children under the age of five and another form for children and adolescents ages five to 21.

MassHealth presented draft versions of the Massachusetts CANS tool to providers, families and the Rosie D. Plaintiffs to gather their input. Both forms of the CANS tool are now complete.

In addition, EOHHS developed a cover sheet to accompany both forms of the CANS tool, that requires the clinician to identify whether the member has a serious emotional disturbance.

The Children's Behavioral Health Initiative Executive Committee has established a Children's Behavioral Health Advisory Council, which met for the first time on March 3, 2008. The Council is chaired by Barbara Leadholm, Commissioner of the DMH, and consists of 29 members representing a broad range of stakeholders including families, youth with mental health needs, mental health providers and guilds. Senior staff from EOHHS child-serving agencies, the Director of Special Education for the Department of Elementary and Secondary Education, and representatives from the MCOs and MBHP attend Advisory Council Meetings as observers.

The purpose of the Advisory Council is to advise the Governor, the General Court, the Secretary of Health and Human Services and EOHHS agencies on matters concerning children's behavioral health.

MassHealth will develop sampling methods and tools to measure Member satisfaction of services covered under the Rosie D. Judgment. Member satisfaction will be measured for the purpose of program improvement. MassHealth plans to conduct member satisfaction surveys based on a random sample of members who have had some experience with behavioral health services. MassHealth intends to contract with a vendor to develop these surveys.

MassHealth has met with and in many cases established an ongoing dialogue with the following advocates and family youth groups:

- Massachusetts Coalition for Infant and Early Childhood Mental Health, Marlborough, November 9, 2007
- Lisa Lambert, Executive Director, Parent/Professional Advocacy League, Boston, November 27, 2007, April 7, 2008, and April 29, 2008
- Advocates for "Medical Homes" for children and youth with behavioral health needs, Worcester, December 20, 2007
- Full Service Schools Roundtable, Boston, January 17, 2008
- Brighton Early Childhood Mental Health System of Care, Brighton, February 4, 2008
- Committee for Children's Mental Health (Director David Keller), Worcester, February 12, 2008

- Judge Baker Center, Boston, program with Terry Cline, Ph.D., Administrator of the U.S. Substance Abuse and Mental Health Services Administration, “Child and Adolescent Mental Health Services: What the U.S. Needs”, April 2, 2008
- Panel Discussion, Children’s Mental Health Task Force of the Massachusetts Chapter of the American Academy of Pediatrics, Waltham, April 8, 2008
- “Partnering for Recovery”, the Annual Rehabilitation and Recovery Conference, sponsored by the MBHP. Co-presented a workshop on implementation of the Remedy with Lisa Lambert, Executive Director of the Parent/Professional Advocacy League, April 30, 2008
- Department of Mental Health Statewide Youth Advisory Council, Westborough, May 20, 2008
- On March 28, 2008, MassHealth convened a second briefing for representatives from schools of social work, professional psychology, and nursing who could not attend the November 28, 2007 briefing. An extremely well-attended working meeting was held on April 18, 2008 to discuss both short and long term strategies for training and education of the existing and future clinical workforce. A follow up meeting is planned for occurred on June 17th. The April meeting resulted in the formation of a smaller workgroup that will assist MassHealth in planning a one day clinical workforce conference designed to introduce students and faculty to Wraparound approaches and the larger system changes in children’s mental health in Massachusetts.
- MassHealth is in the process of executing an Interdepartmental Service Agreement with the Commonwealth Corporation (CC), a quasi-public entity that works closely with the Commonwealth’s Executive Office of Labor and Workforce Development. Through this ISA, CC will facilitate the development of a curriculum designed to train paraprofessionals who will be qualified, as members of a team lead by a clinician, to deliver the remedy’s in-home services (in-home behavioral services and in-home therapy services). CC will research and define competencies, consult with providers and explore partnerships with community colleges as a venue for delivering this training with the hopes that such a training would count toward Associate’s and Bachelor’s degree credits.
- MassHealth is exploring opportunities and potential methods for working with family organizations to educate parents of children with behavioral health needs about the potential increase in employment opportunities for Family Partners through the remedy’s Family/Caregiver Peer-to-Peer Support service, the required competencies, and opportunities for training.
- MassHealth will also consult with non-academic training agencies.
- MassHealth included questions regarding workforce issues in the RFI and these responses have been summarized into briefs and shared with all three of the main CBHI workgroups.

Delivery System Design and Implementation of Program Improvements

MassHealth amended the contract with its customer service contactor to ensure that staff would be properly trained on EPSDT services, including behavioral health screens. One of the critical improvements included revising the voice menu which directs members and providers

with questions about services for children to Customer Service Representatives (CSRs) trained to answer questions about EPSDT.

As part of the program improvement activities, MassHealth's behavioral health services contractor, the Massachusetts Behavioral Health Partnership (MBHP), and MassHealth's contracted Managed Care Organizations (MCOs), have completed intensive training for their CSRs about when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services, and have established a schedule for refresher trainings on updates to the behavioral health screens. Both MBHP and the contracted MCOs will ensure that all new CSRs will be trained about (i) when, where and how members may obtain EPSDT screenings, diagnosis, and treatment services and (ii) the CANS tool, once the tool has been implemented; and (iii) the Rosie D. remedy services, including how to access those services, once they are implemented.

Further steps that EOHHS will take to publicize the program improvements to eligible MassHealth members, providers, and the general public include updating and distributing EPSDT notices to specifically refer to the availability of behavioral health screening and services and to describe other behavioral health program improvements.

In December 2007, MassHealth mailed a new member notice to every household that included a MassHealth member under the age of 21 to inform those members about the program improvements in the behavioral health system. This member notice also is being included in each distributed copy of the PCC Plan' member handbook, each MCO's member handbook, and MBHP's member handbook. The Handbooks have been updated to include more detailed information on EPSDT services, including the fact that primary care providers must offer to conduct behavioral health screens using a standardized behavioral health screening tool during preventive care visits. The updated Handbook went into use in January, 2008. MassHealth plans to further revise the Handbook to include information about the CANS tool and the other new services, including information about how to access those services, when those services are implemented.

MassHealth updated and distributed (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 home-based services.

MassHealth plans to amend Member regulations, as necessary, to describe the behavioral health services in more detail. MassHealth also plans to expand distribution points of existing materials regarding EPSDT generally, including the behavioral health program improvements. MassHealth created a website for the Children's Behavioral Health Initiative (CBHI) which is available on the EOHHS website to provide information to MassHealth members, MassHealth providers, the broader community of human service providers, and members of the general public about EPSDT and the program improvements that MassHealth is making.

The CBHI webpage became available in December 2007. To date, MassHealth has posted on this website many of the materials that describe the requirement for primary care providers to use standardized behavioral health screening tools. The site is updated regularly, as new materials are developed, reports filed and updates written. The site offers visitors the opportunity to provide feedback or make suggestions about the site.

MassHealth is tracking the number of delivered behavioral health screenings and is developing a plan for updating existing systems and methods to allow MassHealth to track the utilization of services following a screening. MassHealth plans 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.

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

Assessment and Intensive Care Coordination

The assessment process, 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.

MassHealth is continuing to develop its approach to the assessment process in acute inpatient hospitals, community based acute treatment settings, DMH intensive residential settings and DMH continuing care programs, to ensure the use of the CANS to support discharge planning is appropriate, effective and reliable. MassHealth is engaged in discussions with John Lyons, other experts, providers, including state agencies, acute inpatient hospitals, other providers of MassHealth reimbursed twenty-four hour services and the Rosie D. Plaintiffs in its implementation of these changes.

MassHealth will provide Intensive Care Coordination to children who qualify and who choose to have Intensive Care Coordination including a Care Manager, who facilitates an individualized, child-centered, family focused care planning team. 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.

Care Management and Care Planning Team

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 obtain 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.

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 that care provision is strength-based, individualized, child-centered, family-focused, community-based, multi-system, and culturally competent.

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.

The care planning team will use multiple tools, including the 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.

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.

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.

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.

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.

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.

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.

Behavioral Health Services

In 2006 MassHealth expanded coverage of EPSDT to include children enrolled in the CommonHealth benefit plan. For MassHealth Members entitled to EPSDT services, MassHealth will cover the following services for Members who have Serious Emotional Disorders (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 above, Intensive Care Coordination and Treatment Planning. 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.

Mobile Crisis Intervention and Crisis Stabilization

In-Home Behavioral Services:

In Home Behavioral Services (including behavior management therapy and behavior management monitoring) are 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.

- 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 which is 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.

Outreach and Communication

MassHealth distributed fact sheets to the Massachusetts Medical Society, the Massachusetts League of Community Health Centers, the Massachusetts Chapter of the American Academy of Pediatrics, the Massachusetts Association of Family Practitioners, and the Mental Health and Substance Abuse Corporation of Massachusetts in December 2007, requesting each organization make the materials available to their provider networks and to encourage their provider networks to circulate the materials to their patients and families.

MassHealth distributed fact sheets to staff working with the following agencies/groups in December 2007, requesting that each agency/group distribute fact sheets to their respective staff/provider groups and encourage their staff/provider groups to circulate member fact sheets to their clients:

- Department of Social Services
- Department of Youth Services
- Department of Mental Health
- Department of Transitional Assistance
- Office for Refugees and Immigrants
- Department of Early Education and Care
- Department of Public Health
- Department of Education

MassHealth developed and implemented 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 Serious Emotional Disorder (SED).

MassHealth distributed outreach materials in primary care settings, community health centers, and community mental health centers and posted electronic materials on the EOHHS Virtual Gateway 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.

MassHealth will continue to coordinate with the associations for these provider types to ensure that updated information is made available to the public at provider sites.

The Department of Early Education and Care (DEEC) distributed fact sheets to all childcare providers in the Commonwealth. MassHealth will continue to work with DEEC on strategies to inform childcare providers and the families and children they serve about behavioral health screenings, CANS assessments and services for their children.

MassHealth held three meetings with the Departments of Early Education and Care (DEEC) and Elementary and Secondary Education (DESE). This has resulted in the creation of a staff planning group which will develop and implement strategies for communicating necessary information about the Rosie D. remedy, the remedy services and how to access them to child care providers and school personnel, including Superintendents, Special Education Directors, School Counselors and School Nurses.

Effective December 31, 2007, MassHealth requires 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) as well as other tools to screen for autistic conditions, depression or substance abuse listed in Appendix W of the MassHealth Provider Manual, which became effective December 31, 2007. 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.

Recently, Provider Forums Co-Sponsored by the MCOs and MBHP were held. These two-hour forums featured presentations by the Compliance Coordinator or her Assistant Director and senior staff from Wayside Youth and Family Support Network and The Walker Home and School, both of whom currently use the CANS.

MassHealth updated 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. MassHealth published the updated Appendix W along with the updated EPSDT regulations described in subparagraph a. above with an effective date of December 31, 2007. MassHealth plans to review the menu of approved screening tools and the schedule for behavioral health screenings

periodically, in collaboration with the Massachusetts Chapter of the American Academy of Pediatrics.

MassHealth plans to evaluate the need 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.

MassHealth has updated (or has required the contractor responsible for their publications 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 December, 2007 and March, 2008 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 – MassHealth have updated this guide for providers who bill MassHealth directly for EPSDT and PPHSD screening services. The updated guide became available in December, 2007
3. PCC Plan Provider Contract – MassHealth updated this contract and mailed the updated contract to enrolled Primary Care Clinicians in January, 2008.
4. PCC Plan Provider Handbook – MassHealth updated this Handbook for providers who are enrolled as PCCs. The updated Handbook was mailed to all enrolled PCCs with the updated PCC Plan provider contract.
5. MCO newsletters – Each MassHealth-contracted MCO included articles in their respective MCO provider newsletters to inform providers about the requirement for using standardized behavioral health screening tools. These newsletters were published between November, 2007 and January, 2008.
6. MassHealth “Update” article – MassHealth included articles containing information for providers about using standardized behavioral health screening tools in MassHealth “Update”, which is MassHealth’s online newsletter to all MassHealth providers. These articles were published in December, 2007, and February, 2008.

MassHealth will assess which materials need to be updated to inform providers about the behavioral health services, including how to access those services once those services are implemented.

MassHealth implemented changes to the Medicaid Management Information System (MMIS) to allow MassHealth primary care providers to be reimbursed for the administration and scoring of the standardized behavioral health screening tools, and to allow the MassHealth to

track the rate at which providers are utilizing a standardized behavioral health screening tool when administering behavioral health screens.

- MassHealth will hold special forums for providers to encourage clinical performance activities consistent with the principles and goals of these programmatic changes.

MassHealth conducted four forums, in both November 2007 and June 2008, for primary care providers to educate these providers about the appropriate requirements when screening children for behavioral health issues.

MassHealth also has made expert consultation available, free of charge, to primary care providers who have clinical or administrative questions regarding use of the standardized behavioral health screening instruments in their practices, through the Massachusetts Child Psychiatry Access Program that is administered for EOHHS by MBHP.

Designing Utilization Management, Quality Management, Network Development and Network Management Approaches

MassHealth will work with the MCOs and MBHP throughout the Summer of 2008 to develop coordinated approaches to developing their networks of behavioral health providers, including providers of the Rosie D. remedy services, as well as coordinated approaches to utilization management, quality management and network management.

MassHealth submitted State Plan Amendments (SPAs) for review and approval by the Centers of Medicare and Medicaid Services (CMS) on March 24, 2008. Prior to submission, MassHealth requested a pre-submission meeting with Central Office and Regional Office CMS staff to brief them on the Rosie D. case, the Judgment and the proposed State Plan Amendments. MassHealth expects the next step in the process will be to respond to questions from CMS regarding the SPAs.

Defining Existing System Capacities

During January through March 2007, MassHealth 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 Rosie D. 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, MassHealth decided to sequence the IT approach in two phases. The first phase will be to develop an IT solution that, subject to consent from the child or the child's parent, guardian, or custodian, can collect CANS data from MassHealth behavioral health providers and share it with the child's MCO or MBHP, if applicable (the CANS IT Application). The second phase will be to develop a solution that can collect data from the intensive care management 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. 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, MassHealth has decided to take this system as the starting point for developing the IT platform for the CANS tool.

Outcome measurements

MassHealth is 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 managed care companies for members in care management programs. MassHealth currently is 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. Currently it appears that managed care organizations have the most complete infrastructure for recording data on care plans and being able to link those plans with actual services provided.

MassHealth anticipates that the approach developed to meet this requirement will be ready for use by the time Intensive Care Coordination 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.

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. MassHealth 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.

MassHealth currently is researching potential member-level outcome measures. MassHealth will consult with the Children's Behavioral Health Advisory Council, the Monitor and the Rosie D. Plaintiffs as they identify these measures.

In addition, MassHealth is 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 MassHealth anticipates 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.