

Rosie D. v. Romney  
Defendants' 8/29/06 Remedial Plan Proposal

**I. Introduction and Principles**

This document presents the Commonwealth's Remedial Plan (the Plan) to address the needed programmatic and operational improvements required by the Court's January 26, 2006 Memorandum of Decision. It describes how the Commonwealth will meet its obligations under the Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) and reasonable promptness provisions of the federal Medicaid Act, as they pertain to the class of children eligible for EPSDT with serious emotional disturbance (SED).<sup>1</sup> In particular, the Plan recognizes and provides for medically necessary comprehensive assessments, service coordination, and in-home supports for children with SED.

The actions proposed in this Plan will be taken as the result of the Court's January 26, 2006 ruling against the Commonwealth on liability. While defendants appreciate having been given the opportunity to propose a remedy to cure the deficiencies found by the Court, the actions proposed herein are compelled by the Court's adverse ruling on liability rather than voluntary. Defendants' proposal of this Plan is not an expression of consent to this Plan, and this plan is not a consent decree, settlement agreement, or other contractually negotiated agreement. Defendants respectfully request an opportunity to submit a proposed form of judgment consistent with this Plan.

Fundamentally, the goal of this Plan is to assure that the Commonwealth's Medicaid Program (MassHealth) pays for medical services that fall within the scope of medical assistance as defined in federal law and that are medically necessary services for individual members of the class. The Plan describes the efforts the Commonwealth will make to establish or strengthen processes by which children with SED are screened, assessed, and appropriately referred to a network of service providers that will provide intensive care coordination and intensive home-based services, where those services are medically necessary. The Plan also recognizes that many MassHealth-eligible children with SED are served by state and local health, human services, and education agencies in addition to MassHealth. In particular, the constituent agencies of the Executive Office of Health and Human Services (EOHHS) that provide services to children with SED have independent state and federal responsibilities and mandates, which should be provided in a manner that is coordinated with MassHealth services. The Plan also recognizes the importance of family and community involvement in the appropriate treatment of children with SED, and ensures that responsible family members or other caretakers will be involved in the service planning and care coordination process.

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<sup>1</sup> Depending on applicable eligibility criteria, MassHealth Members are determined eligible for one of seven different benefit plans or "coverage types" including: MassHealth Standard, CommonHealth, Family Assistance, Basic, Essential, Prenatal, and Limited. 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.

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Under this Plan, MassHealth will make improvements to methods of notifying Medicaid Members, Medicaid providers, child-serving agencies, and other interested parties of the availability of behavioral health services, including remedy-related services and behavioral health screenings in primary care settings (Section II). The Plan ensures that EPSDT services include a standardized clinical assessment process for eligible children who may need behavioral health services, and describes the method for connecting those assessments to a treatment planning process (Section III). The Plan provides a detailed description of intensive care coordination and an individualized planning team for children with intensive needs (Section IV). The Plan describes the remedy-related services that MassHealth will cover when medically necessary (Section V). Finally, the Plan describes a systematic approach to the execution of the program improvements described in this proposal, including a defined scheme for monitoring success (Section VI). Appendix A is a visual representation of the programmatic aspects of the Plan and demonstrates the progress of a child through the Medicaid primary care and behavioral health care system. Appendices B and C provide further information regarding the legal authority of other child-serving EOHHS agencies with respect to Medicaid-eligible children.

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

### **A. Education and Outreach**

The Plan recognizes that effective informing of families about the availability of EPSDT services for SED children (as for all EPSDT-eligible children) begins as soon as a Member is enrolled in MassHealth. This section of the Plan describes proactive efforts to inform MassHealth enrollees and their families about the availability of EPSDT services, particularly focused on the needs of children with SED, and about the enhanced availability of screening, intensive care coordination, and services.

The Commonwealth will take steps to ensure that the program improvements described in this Plan are publicized to providers, eligible Medicaid Members (including newly eligible Medicaid Members), and the general public. As part of this effort, Defendants will prepare materials listed below for public distribution describing those improvements. Defendants 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 Plan.

#### **1. MassHealth Members**

For purposes of educating MassHealth Members about the program improvements described in the Plan, the Commonwealth will actively communicate with Members. Defendants will take the following actions to educate Members about these program improvements:

- 1) 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 Plan.
- 2) Updating and distributing 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. Defendants anticipate that these updated materials will be distributed to Members in the normal course of communications with Members.
- 3) Amending Member regulations, as necessary, to describe new services and other program improvements.
- 4) 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 Medicaid-eligible children and families.<sup>2</sup>

#### **2. Medicaid Providers**

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<sup>2</sup> See 42 C.F.R. § 441.45; Medicaid Manual, §5121.

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For purposes of educating providers about the program improvements described in the Plan, the Plan provides for communicating these improvements by amending provider regulations, as necessary, and by drafting and distributing provider bulletins, other updates, and provider education materials. The Defendants will take the following actions to educate providers about these program improvements:

- 1) Updating EPSDT regulations to reflect the program improvements described in this Plan.
- 2) Updating Appendix W of the MassHealth Provider Manual, which describes medical protocols and periodicity schedules for EPSDT services, to reflect the program improvements described in this Plan.
- 3) Drafting and distributing special provider communications related to the program improvements described in this Plan, including how to assist Members to access home-based services.
- 4) Updating and distributing existing provider education materials to reflect the program improvements described in this Plan.
- 5) Expanding distribution points of existing materials regarding EPSDT generally, including the program improvements described in this Plan.
- 6) Implementing any other operational changes required to implement the program improvements described in this Plan.
- 7) Holding special forums for providers to encourage clinical performance activities consistent with the principles and goals of the Plan.
- 8) Amending MassHealth's managed care contracts to assure that all such entities educate the providers in their network about the program improvements described in the Plan as described in paragraphs 1-7 above.
- 9) 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.

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3. Child-Serving Agencies, the Executive and Legislature; Public Education and Outreach

To improve public information about the program improvements described in this Plan, the Plan will also be presented to public and private agencies that serve children and families, as follows:

- 1) Presenting the Plan to appropriate officials in the Executive Branch and the Legislature.
- 2) Creating new pamphlets, informational booklets, fact sheets, and other outreach materials describing these improvements.
- 3) 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.
- 4) 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.
- 5) 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.
- 6) 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.

**B. Screening for Behavioral Health**

MassHealth is required to cover EPSDT screenings for eligible children, which include a comprehensive health and developmental history, a comprehensive unclothed physical exam, immunizations, laboratory tests and health education.<sup>3</sup> The purpose of the screenings is to identify the need for further corrective treatment including “necessary health care, diagnostic services, treatment and other measures described in [42 U.S.C. § 1396d(a) of the Medicaid Act] ... needed to correct or ameliorate defects and physical and mental illnesses and conditions ...”<sup>4</sup> MassHealth relies principally on the primary care system to identify children -- through periodic and medically necessary interperiodic screening -- who are in need of further diagnosis and treatment with respect to all their various health needs, including children with SED who need behavioral health services. Emphasizing primary care settings for EPSDT screenings assures that appropriate clinical judgment is used to evaluate the screening results and that all the child’s medical and behavioral needs are identified and addressed, and allows MassHealth to better track and monitor screenings. At the same time, MassHealth allows “open” access to all behavioral

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<sup>3</sup> See 42 U.S.C. §1396d(r)(1).

<sup>4</sup> Medicaid Manual, §5122; 42 U.S.C. §§ 1396d(r)(1)(B) and (5); 42 U.S.C. § 1396a(a)(43); 42 U.S.C. §1396d(r)(B).

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health services. MassHealth does not require Members to obtain an EPSDT screening as a prerequisite to accessing medically necessary behavioral health services.

The goal of improving EPSDT behavioral health screening is to increase the likelihood that administered screenings identify children in need of behavioral health services. Therefore, the Plan requires that primary care providers 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)<sup>5</sup>. Where additional screening tools may be needed, for instance to screen for autistic conditions, depression or substance abuse, it is MassHealth's expectation that primary care providers will use their best clinical judgment to determine which of the approved tools are appropriate for use.

MassHealth's provider agreements with Primary Care Clinicians (PCCs) expressly require PCCs to provide periodic and inter-periodic EPSDT screens. MassHealth's managed care organization (MCO) contracts also require the MCOs to impose this requirement on their primary care physicians. Under this Plan, the Defendants will amend MassHealth provider regulations to clarify that this existing requirement applies to all primary care providers, whether they are paid through the managed care or the fee-for-service system. There will be a renewed emphasis on screening, combined with on-going 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<sup>6</sup>. 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 using 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 VI).

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<sup>5</sup> See Medicaid Manual, §5123.2.b (No list of specified tests and instruments is prescribed for identifying developmental problems because of the large number of such instruments, development of new approaches, the number of children and the complexity of developmental problems which occur, and to avoid any connotation that only certain tests or instruments satisfy Federal requirements.)

<sup>6</sup> In this regard, it is important to note that the Medicaid Manual cautions against labeling or premature diagnosis of a child. "Providers should report only that a condition was referred or that a type of diagnosis or treatment service is needed." Medicaid Manual, §5123.2.

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

Even with an effective plan for screening EPSDT-eligible children for behavioral health needs through primary care, the Plan recognizes and addresses the need for multiple “entry points” for MassHealth behavioral health services. MassHealth-eligible children with SED come in contact with other EOHHS agencies, state agencies, public schools, community health centers, hospitals and community mental health providers. These contacts may be the first event that leads a child to be identified as being in need of mental health care. For this reason, a primary care visit or EPSDT screening is not a prerequisite for an eligible child to receive MassHealth behavioral health services. MassHealth-eligible children and eligible family members can be referred for Medicaid services by these other entities at any time. While families play the central role in identifying and requesting Medicaid services for their children, state and local agencies and providers are partners, working with families to assist eligible children to gain access to needed services.

For this reason, the Plan provides for information, outreach and training activities, focused on these agencies and providers. In addition, EOHHS will develop and distribute written guidance that establishes protocols for referrals for behavioral health EPSDT screenings, assessments, and services, including home-based services, 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.

This is particularly important in those instances when EOHHS agencies assume responsibility for the care or custody of children. Appendix B sets out in detail the legal authorities and roles of the Departments of Social Services, Youth Services, Mental Health, and Mental Retardation with respect to referrals, describes the manner in which they work with families on medical decision-making, and identifies those situations where an agency providing substitute care may make medical decisions in the best interests of a child.

### **III. Assessment and Diagnosis**

The Plan seeks to improve the consistency and quality of clinical assessments that are provided to eligible children with SED, recognizing that comprehensive assessment is crucial to appropriate treatment. Under this Plan, the Defendants will require a clinical behavioral health assessment in the circumstances described below by licensed clinicians and other appropriately trained and credentialed professionals. In addition to the clinical assessment, the standardized clinical information collection tool known as the Child and Adolescent Needs and Strengths (CANS) will be used as an information integration and decision support tool which can be used by clinicians and other staff in collaboration with families to help identify and assess a child's behavioral health needs. Information obtained through the CANS process provides a profile of the child which is used in conjunction with the clinical judgment and expertise of the trained clinician to inform treatment planning and to ensure that treatment addresses identified needs.

#### **A. The Assessment Process**

- 1) 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.
- 2) 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.
- 3) 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.
- 4) As described in more detail in Section IV below, the Plan envisions that, 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. Because the intensive care coordination process is a linchpin of the



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Plan, the Plan specifically enumerates the clinical eligibility standards for accessing intensive care coordination.<sup>7</sup>

The Plan's emphasis on consistent assessment procedures is intended to ensure the consistent identification of children with SED who may suffer from a chronic disabling condition and a complex set of problems that require coordination among service providers to assure effective treatment. Defendants also recognize that members in certain settings may be more likely to need intensive services. For this reason, the assessment process described here, including the use of the CANS where appropriate, and in all cases designed to assess a child's need for the services described in this Plan, 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.

**B. Clinical Criteria for Intensive Care Coordination**

The Plan establishes clinical criteria that will serve as a guide to determine whether referral to intensive care coordination is medically necessary for the child. The clinical criteria are intended to assure that this remedial Plan is appropriately focused on children who are diagnosed with serious emotional disturbance that is causing substantial functional impairment whose condition is, or is at risk of becoming, chronic.

- 1) Presence of a DSM IV Diagnosis: Individuals who currently have or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Axis 1 of the DSM IV, other than "V" codes, substance abuse disorders, or developmental disorders (including mental retardation) which are excluded unless they co-occur with another diagnosable serious emotional disturbance, and
- 2) Functional Impairment: The disorder directly results in functional impairment that substantially interferes with the child's role or functioning, as described below, and
- 3) Duration: The duration of the disability is expected to persist for a year or longer, and
- 4) Appropriate Level of Intervention: As determined by the clinical assessment, less intensive levels of intervention, such as outpatient treatment, or more intensive levels of intervention, such as inpatient treatment, are inappropriate to address the child's behavioral health needs.

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<sup>7</sup> Some System of Care models, and the Plaintiffs' proposal, envision first a preliminary assessment, followed by a second comprehensive assessment for home-based services in advance of determining eligibility for care management.

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In this context, Functional Impairment describes difficulties that substantially interfere with the child's role or functioning. Children who would have met functional impairment criteria, but for the fact that they were already receiving intensive treatment or support services, are included in this definition. Functional impairments of episodic, recurrent, or continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Functional Impairment must be present in at least two of the following three environments:

- 1) Family;
- 2) School; and
- 3) Community.

The Functional Impairment must also be present in at least one of the following capacities:

- 1) Self care. Impairment in self care is manifested by a person's consistent inability to take age appropriate care of personal grooming, hygiene, clothes and/or meeting of nutritional needs.
- 2) Interpersonal relationships. Impairment in interpersonal relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with family, peers, and other adults.
- 3) Learning. Impairment in learning is manifested by the consistent inability to achieve academic and social educational goals in an expected time-frame despite appropriate instructional strategies or support services.

#### **IV. Intensive Care Coordination and Treatment Planning**

Children who qualify for Intensive Care Coordination, based on the criteria set forth in Section III, will have the option of having services coordinated through a Care Manager. The Intensive Care Coordination service and process is described in detail in this section. The Care Manager will be responsible for coordinating the care planning process and for facilitating the child-centered, family focused care planning team.

##### **A. The Care Manager**

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.

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

##### **B. The Care Planning Team**

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),

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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 a CANS standardized instrument, in conjunction with a comprehensive psychosocial assessment, as well as other clinical diagnosis, 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<sup>8</sup>, and the obligation of all direct service providers to assure that the services they deliver are medically necessary.

**C. Individualized Care Plan**

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 objectives, including moving to less intensive levels of services; (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.

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<sup>8</sup> See 42 U.S.C. §1396a(a)(30)(A); 42 C.F.R. § 440.230; Medicaid Manual, § 5123. See also 130 C.M.R. § 450.204.

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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.

**D. Intensive Care Coordination for Children with Multiple EOHHS Agency Involvement**

The Plan recognizes that 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 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.<sup>9</sup> EOHHS will develop a conflict resolution process for resolving disagreements amongst members of the team.

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<sup>9</sup> All EOHHS agencies will retain authority to determine eligibility for agency services, including eligibility for participation in special agency programs or collaborations and to determine the amount, frequency and duration of non-Medicaid services provided by the agency. Appendix C is a list of circumstances in which the Departments of Social Services and Youth Services retain sole and exclusive authority. The list is not intended to inhibit the centrality or the decision-making authority of the care planning team, but rather to ensure that all members of the team are clearly informed about the decisions over which certain state agencies, based on their mission and statutory obligations, must exercise control.

**V. Covered Services**

**A. In General**

The Plan recognizes that Medicaid-eligible children with SED are entitled only to those medically-necessary services “. . . to correct or ameliorate . . . physical or mental illnesses or conditions,” for which federal financial participation (FFP) is available under 42 U.S.C. § 1396d(a). This section provides service descriptions in two general categories of services that will be offered under the Plan, subject to the availability of FFP under Section 1396d(a). This list of covered services is not intended to be a comprehensive description of all the services that will be available to MassHealth-eligible children once the Plan is implemented. Rather, the list is an elaboration of two service categories, crisis management and home and community-based services, which the Court found were insufficient and which Defendants intend to cover for children with SED when the services are medically necessary. The components of two other service categories, clinical assessments and intensive care coordination, and the processes through which those services are covered, are outlined in Section III and IV above.

Because of uncertainty about whether certain of the proposed covered services fall outside the scope of Section 1396d(a), Defendants will submit a list of proposed covered services to the CMS for its review. 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 and 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. Pending the results of that process, the following covered services are expected to be provided to children with SED under this Plan, but this depends on the availability of FFP and all required federal approvals.

**B. Crisis Management**

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

**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, seven days a week. Phone contact and consultation may be provided as part of the intervention. Providers are qualified,

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licensed clinicians or, in limited circumstances, qualified paraprofessionals supervised by qualified, licensed clinicians.<sup>10</sup>

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 care taker 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 seven 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.

**C. Home and Community-based Services**

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.

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<sup>10</sup> Where provider qualifications appear in the descriptions of the remedy-related services in this section of the Plan, the following applies:

As used in this plan, 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.

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In-home Behavioral Services

Behavioral services usually include a combination of behavior management therapy and behavior management monitoring, as follows:

(1) 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.

(2) 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.

In-home Therapy Services

Therapy services include a therapeutic clinical intervention and ongoing training and therapeutic support, as follows:

(1) 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.

(2) 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 client'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.



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Mentor Services

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.

Child/Family Support Mentors provides 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 mentors are qualified paraprofessionals and are supervised by a licensed, qualified clinician.

## **VI. Implementation**

### **A. Implementation Considerations**

The Court correctly noted in its January 26, 2006 Memorandum of Decision that States “retain substantial discretion in implementing their [Medicaid] plans,” 410 F. Supp.2d 18, 24 (D. Mass. 2006). The Medicaid Act does not dictate the manner in which EOHHS organizes the delivery of Medicaid services, so long as those services are delivered in a manner that comports with its obligations under EPSDT to assure that Medicaid-eligible children with SED receive medically necessary services. For that reason, the description below of Defendants’ preliminary plans for implementing this Plan is a statement of Defendants’ present intention, but is subject to change over the course of implementation of the Plan in accordance with Section VI, Subsections E and F of the Plan. By providing this description of implementation projects and details of a possible delivery system, Defendants do not in any way cede their responsibility and discretion to make changes to the implementation projects, including the possible delivery system, that they determine are necessary or appropriate during the course of implementation.

### **B. Implementation Project Planning**

A full and successful implementation of a program of the scope and complexity described in this Plan will, of necessity, need to take place over a number of years. The Plan anticipates 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 Plan.

It is important to note that there are significant interdependencies between components of each of these four projects. Moreover, certain elements of each project are subject to external factors that are not fully within the control of EOHHS. To put it simply, this is a complicated endeavor, and no organizational structure, timetable, or task list can make it otherwise. Defendants are nevertheless dedicated to a successful implementation.

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

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

Tasks performed will include:

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

Expected Timeframe: 6-12 months

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

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.

Tasks performed will include:

- 1) Developing a Massachusetts-specific short and long form CANS in conjunction with Developer John Lyons
- 2) Training behavioral health providers to complete and use the CANS tool, including EOHHS-required data gathering techniques
- 3) Drafting managed care and provider contract amendments and regulatory changes to conform with the new requirements

Timeframe: 12-24 months for initial phase; full implementation more than 36 months

Note: Because of the number of behavioral health providers who perform assessments, deploying the CANS statewide is necessarily a long-range project. It will be most successful if done in phases, defined geographically or by provider type.

**3. Project 3: Development of a Service Delivery Network**

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

Defendants recognize that the basic goal of network development is to ensure access to the medically necessary services Members require. It is also important to devise a network arrangement that encourages a coordinated service planning approach. Specifically, Defendants recognize the need to minimize the risk of fragmentation in service delivery, and that provider-level coordination is critical to successful outcomes for children in need of intensive care coordination. An appropriate solution, in Defendants' view, is a process of network design and development that is directed and managed by EOHHS and DMH with the goal of 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 and DMH. EOHHS and DMH will establish standards for

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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 MCOs and the managed care behavioral health contractor, will offer to contract with the same entities as CSAs, subject to successful negotiations and EOHHS's determination that such entities have the capacity to serve the managed care entities' expected MassHealth enrollment.<sup>11</sup> Defendants' current expectation is that the Medicaid fee-for-service population will have access to the same providers as the Medicaid managed care population, but that assumption will need to be tested.<sup>12</sup>

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. Defendants anticipate that there will be one CSA in each area so defined, and that in total there will be no less than 15, and may be as many as 30, CSA service areas. Defendants will also consider defining regions for certain functions.

CSAs may deliver the clinical assessment services described above in Section III of this Plan and the intensive care coordination services described above in Section IV of this Plan. CSAs will either deliver or, as a component of intensive care coordination, assist Members to access the services described above in section V of this Plan. CSAs will be responsible for assisting Members to access to all Plan services that they do not themselves provide.

Tasks performed to establish the service delivery network will include:

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<sup>11</sup> 42 U.S.C. §1396u-2 ("each Medicaid managed care organization must provide the State and the Secretary with adequate assurances.... That the organization ... has the capacity to serve the expected enrollment in the service area").

<sup>12</sup> Unlike MassHealth-contracted managed care entities, which are permitted under federal law to selectively contract for their provider networks, MassHealth is permitted to establish reasonable provider qualifications but is required to contract with all willing providers who are qualified. Accordingly, fee-for-service providers could be different from managed care-contracted providers, depending on the number (more or less) of qualified providers who are willing to participate. See 42 U.S.C. §1396a(a)(23) ("[The State Plan must] provide that any individual eligible for medical assistance may obtain such assistance from any, institution, agency, ... or person, qualified to perform the service or services required ... who undertakes to provide him such services").

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- 1) Designing delivery system approaches that maximize access to services, taking into consideration the availability and willingness of providers to provide the services
- 2) Engaging in a public process to involve stakeholders in the development of the network and services
- 3) Planning concerning anticipated need and provider availability
- 4) Working with CMS to obtain approval of services to be offered and of managed care contracting documents
- 5) Defining CSA Service Areas
- 6) Defining standards with respect to provider qualifications, service delivery standards, training requirements, documentation requirements, utilization management standards, and performance measures
- 7) For each Plan service, 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)
- 8) Drafting contract and procurement documents, including the production of a detailed data set for contractors and the creation of detailed performance standards for contractors and providers
- 9) Negotiating contracts, setting rates for new services, and arranging for appropriate federal claiming protocols
- 10) Performing reviews of new service providers to assure readiness to perform contract requirements
- 11) Designing strategies to educate providers, Members, and the general public about the new services offered
- 12) 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

Timeframe: 24 months for initial phase; full implementation more than 36 months

Note: Like Project 2, Defendants anticipate a phased-in implementation of the service delivery system. Design decisions about those phases must be coordinated with implementation phases in Project 2.

**4. Project 4: Information Technology System Design and Development**

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.

Tasks performed will include:

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- 1) Defining existing system capacities
- 2) Gathering requirements for new functionality, including assessing whether development should be in-house or outsourced
- 3) Obtaining legislative authorization and funding
- 4) Drafting contract and procurement documents, including detailed architectural standards, privacy standards, and performance standards
- 5) Working with CMS to obtain necessary federal approvals of contracting documents
- 6) Issuing an RFR, reviewing responses, and selecting bidder(s)
- 7) Negotiating contract(s)
- 8) Confirming business requirements and technical specifications
- 9) Performing construction, testing, and provider training

Timeframe: 24 months from legislative authorization and funding approval

**C. Data Collection**

**1. Background**

There are multiple sources of data available to the Medicaid agency and multiple methods for data collection. This Plan 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 serious emotional disturbance. Some of the data points outlined here are presently available or easily accessible, while others are not.

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 of this Plan, as detailed below. Notably, MMIS does not ordinarily collect information 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 (NewMMIS), currently anticipated for implementation in August 2007.

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 claims 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.

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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.

For collecting and managing all of the data points associated with this Plan, EOHHS will need to develop a new information technology (IT) application. Although none of this data collection is required by the Federal Medicaid Act, EOHHS believes that the data will assist us to assess our performance of the requirements of the Plan and to reassure the Court of our 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 collection 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 to 24 months from the time that legislative authorization and appropriation is received, and often include multiple roll-outs of advancing sophistication and breadth to assure that providers can successfully use the application and that the data collected is accurate and timely.

With these considerations in mind, the Plan proposes the following as a preliminary data collection strategy to assess Member access to and utilization of 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. Defendants also propose collecting data with regard to children's behavioral health outcomes and Member satisfaction.

2. *Potential Tracking Measures*

a. *EPSDT Behavioral Health Screening*

- 1) Number of EPSDT visits or well-child visits and other primary care visits.
- 2) Number of EPSDT behavioral health screens provided. An EPSDT behavioral health screen is defined as a screen delivered by a qualified MassHealth primary care provider.
- 3) Number of positive EPSDT behavioral health screens. A positive screen is defined as one in which the provider administering the screen, in their professional judgment, identifies a child with a potential behavioral health services need.

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b. Clinical Assessment

- 1) 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 Member for the purposes of determining a behavioral health diagnosis and the need for treatment.
- 2) Number of clinical assessments that meet SED clinical criteria and indicate that the Member could benefit from intensive care coordination services.

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

- 1) 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.
- 2) Number of Members who receive ongoing intensive care coordination services.

d. Intensive Home-Based Services Treatment

- 1) Member-level utilization of services as prescribed under an individualized care plan, including the type, duration, frequency, and intensity of home-based services.
- 2) Provider- and system-level utilization and cost trends of intensive home-based services.

e. Child and System Outcome Measures

Member-level outcome measures will be established to track the behavioral health of an EPSDT 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 of the Plan.

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.

f. Member Satisfaction Measures

Defendants will develop sampling methods and tools to measure Member satisfaction of services covered under this Plan. 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.



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3. Current State & Feasibility

As noted, considerable thought should be put into implementing a tracking system or systems of the size and scope described herein. Certain data collection elements and reports can occur on a shorter timeframe while other data elements will take longer to collect due to systems limitations.

a. Claims Data: Utilization and Spending

The Commonwealth's MMIS is able to track Member-level utilization and spending data. Reports can be generated that measure any "billable" event, including numbers of screenings, numbers of assessments and unduplicated Member utilization of home-based services including the duration and type of service.

b. Other Data: Screening Results, Assessment Scores, and Outcome Measures

MMIS is a claims-based system and is not equipped for producing all of the data elements contemplated. For example, MMIS is not built to track the results of EPSDT screens or clinical assessments. It is likely that a separate IT system would need to be developed that collects Member-level data regarding screening results, standardized assessment scores, and child outcomes. A successful system would likely be web-based and simple to use, but Defendants intend to proceed cautiously with this effort, in part based on concerns that efforts to require additional data entry from MassHealth providers will discourage provider program participation.

c. Member Satisfaction Measures

Currently, certain MassHealth providers and managed care plans conduct Member satisfaction surveys regarding various levels of care (e.g. inpatient, outpatient, day treatment). Defendants will need time to review current provider practices, assess industry standards, and determine what appropriate satisfaction measures need to be collected. Defendants will need to develop contract amendments with their providers such that providers collect and report uniform satisfaction measures.

4. Quality Improvement

Defendants will use the data collected as described above to improve the quality of Medicaid behavioral health services for children.

**D. Reporting and Monitoring**

**1. Compliance Coordinator**

The Defendants shall designate an individual to serve as their Compliance Coordinator. The Coordinator shall have the necessary authority to review, evaluate, and design and implement strategies to facilitate compliance with this Plan by the Defendants, their

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agencies, agents, and employees. The Coordinator shall identify any obstacles to timely compliance and have the authority to implement actions that effectively address such obstacles.

*A. Compliance Meetings*

The Plaintiffs will meet quarterly with the Defendants and Defendants' Compliance Coordinator to discuss the implementation of this Plan and any obstacles to its full and timely implementation for at least 18 months from the date of approval of a remedial plan.

*B. Compliance Reports*

The Compliance Coordinator shall develop semi-annual reports that describe the Defendants' actions to address each provision or section of this Plan. The report also shall identify any obstacles that have impeded compliance with these provisions.

**2. Court Monitor**

The Court shall appoint a Monitor acceptable to both Defendants and Plaintiffs to oversee the implementation of this Plan. The Monitor shall serve at the discretion of the Court, and shall undertake those tasks described herein.

The Monitor shall have the authority to: (1) receive information relevant to the Defendants' obligations under this Plan; (2) coordinate and facilitate meetings between the parties; (3) independently review the Defendants' compliance with this Plan; (4) respond to complaints concerning compliance or other actions of the Defendants; (5) recommend corrective or further actions necessary to redress any problems identified in implementing this Plan; (6) mediate disputes between the parties; and (7) take whatever actions are useful to facilitate the timely implementation of this Plan.

The Monitor shall have relevant expertise in behavioral health, health care or Medicaid program administration.

The Monitor shall have access to all data, reports, records or related documentation in the possession of the Defendants, their agents, contractors, evaluators, and providers that is necessary to perform the above functions.

The Monitor shall be compensated by the Defendants at a rate established by the Court. The Monitor shall prepare an annual budget for approval by the Court. The parties shall be afforded an opportunity to review and comment on the budget prior to its submission to the Court.

The Plaintiffs and Defendants shall attempt to agree on a Monitor with relevant experience; in the event that they are unable to reach agreement, they will attempt to agree on candidates for Monitor and shall submit the list of candidates to the Court for

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selection. In the event that the Monitor resigns or otherwise is unable to continue to serve, the same process shall be used to select a replacement.

**E. Modifications to the Plan**

Nothing shall require the Defendants to perform any aspect of this Plan that is not a requirement of the EPSDT or reasonable promptness provisions of the Federal Medicaid Act. The applicable provisions are: 42 U.S.C. §§1396a(a)(10)(A), 1396a(a)(10) (B)(4), 1396d(a), 1396d(r), 1396a(a)(43), and 1396a(a)(8). Nothing contained in this Plan shall require the Defendants to take any action or pay for any service or otherwise perform any aspect of this Plan unless Federal Financial Participation is available in accordance with all applicable federal requirements.

**F. Modifications to Actions Taken to Implement Plan**

Implementation of this Plan, as described in Section VI, depends on the availability of FFP and all required federal approvals, obtaining all required Massachusetts legislative authorization and funding, compliance with all applicable state and federal laws, Defendants' determination that the proposed approach to the delivery of services maximizes access to services for Members given the availability in the Commonwealth of willing, trained, qualified providers of remedy-related services, and successful negotiation with managed care entities as required. Nothing contained in this Plan shall preclude Defendants from modifying actions that they have taken or may take to implement this Plan. This provision will not relieve Defendants of their obligations under the Medicaid Act and the Court's January 26, 2006 decision.

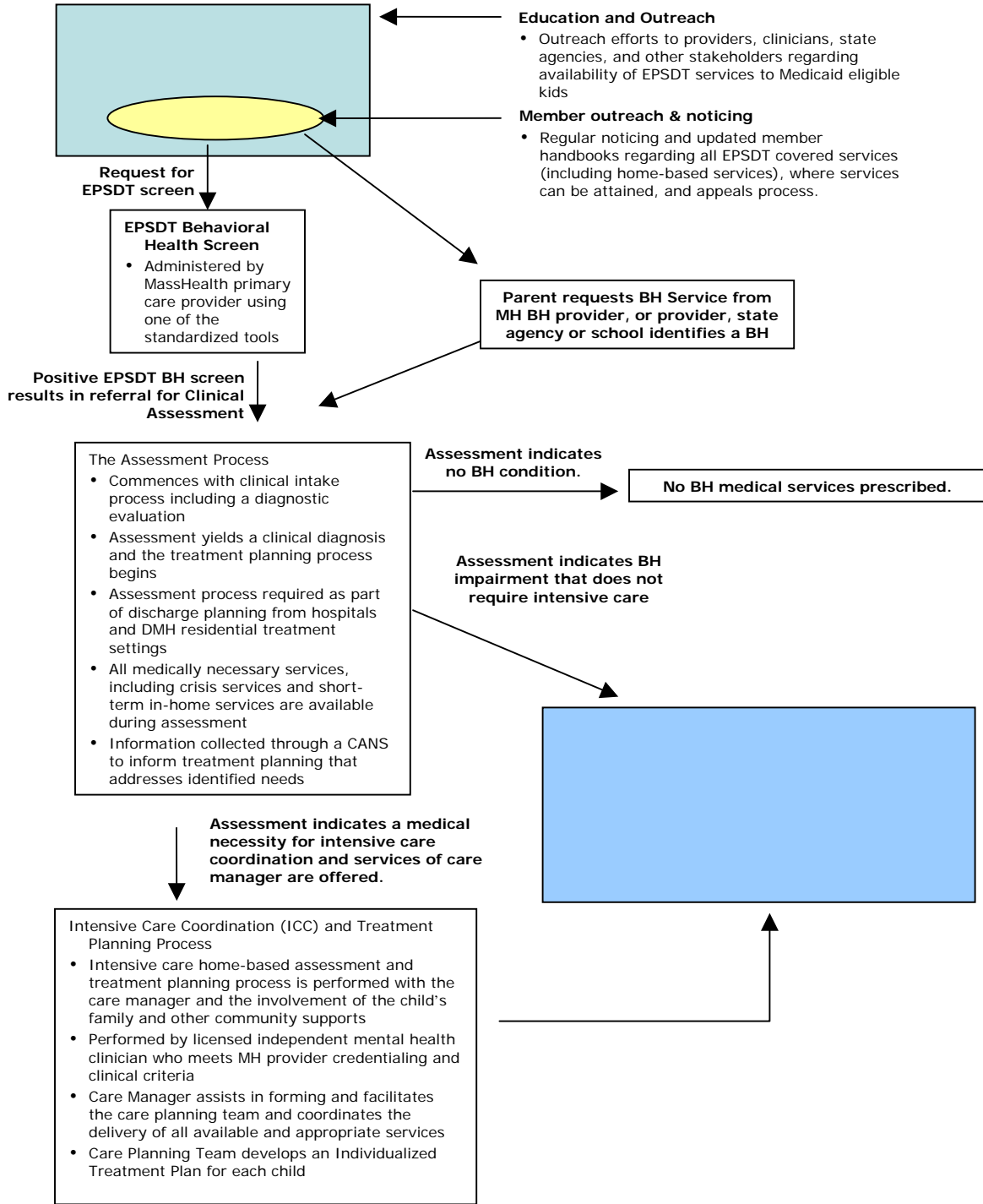
**G. Resolution of Disputes Between the Parties**

The preferred mechanism for resolution of disputes between the parties is by complaint to the Court Monitor, mediation of the dispute by the Monitor, and a recommendation by the Monitor with respect to such dispute as set forth in Section VI (D)(2) of this Plan. If either party is dissatisfied with the Monitor's recommended solution of the dispute it may bring the matter to the Court's attention by motion for review of the Monitor's recommended solution.

**H. Completion of Implementation and Conclusion of Reporting and Monitoring**

The Reporting and Monitoring requirements set forth above will terminate five years after the date of the order approving this Plan.

# APPENDIX A: EPSDT Behavioral Health Decision Tree



## **APPENDIX B – LEGAL AUTHORITY OF STATE HUMAN SERVICES AGENCIES WITH RESPECT TO MEDICAID ELIGIBLE CHILDREN**

This subsection is intended to clarify the authority of EOHHS agencies with respect to their clients who are also Medicaid-eligible.

- a. DSS: DSS is both a voluntary and an involuntary agency, depending on the circumstances. Children are referred to DSS in several ways: (1) a report of abuse or neglect (a “51A”) is filed on behalf of a child; (2) a family or child is referred by the court through a Child in Need of Services (CHINS) proceeding, either through a voluntary application for services or by a child being placed in DSS custody; (3) a family applies for voluntary services with DSS.

DSS knows the MassHealth enrollment status of children in its care and custody. For those not in its care or custody DSS may ask the child/family to self identify their MassHealth enrollment, but does not always do so.

In all cases where DSS has custody of a MassHealth child and places the child out of the home, DSS assures that the child is seen by a MassHealth enrolled provider for EPSDT screenings and all other necessary medical or behavioral health services. In cases where the child is in the care of DSS through a voluntary placement agreement or CHINS custody, DSS assists the parents of Medicaid eligible children to identify the child’s medical or behavioral health needs and works with the parents to assure that the child is seen by a MassHealth enrolled provider for EPSDT screenings and all other necessary medical or behavioral health services. If the parent is unable or unwilling, DSS will assure the eligible child is seen by a MassHealth enrolled provider for EPSDT screenings and all other necessary medical or behavioral health services. For children who are not in the care or custody of DSS, DSS can, with the consent of the parent, refer a Medicaid eligible child for an EPSDT screening and all other necessary medical or behavioral health services.

DSS’ authority to make medical decisions depends on its legal relationship to the child. When DSS has court ordered custody (non-CHINS) it can make most, but not all, medical decisions. For cases where the child is not in DSS care or custody, the parent is required to sign a release of information that allows DSS to provide the parents with assistance to assure that the child’s medical or behavioral health needs are identified and treated by a MassHealth enrolled provider. In voluntary placement cases, DSS and the parent enter into a written agreement that describes the role of DSS and the role of the parent in the child’s medical care. When the child is referred to DSS through a CHINS petition and the child is in DSS custody, DSS has the authority to make routine medical decisions, but it involves the parents in the medical care. Many other medical decisions remain with the parent and DSS works with the parent to assist them to obtain services needed for the child and helps the parent to identify the services that might be needed. (See 110 CMR 12.00, et. seq.)

In any case where DSS has the legal authority to do so, DSS assures that the child receives EPSDT screenings and all other necessary medical or behavioral health services and can provide any assessments or other records in its possession to MassHealth or a MassHealth provider. In cases where DSS does not have such legal authority, it can refer Medicaid eligible children to MassHealth services and can provide any assessments or other records in its possession to MassHealth or a MassHealth provider at the direction of the child's parent or guardian.

- b. The Department of Youth Services (DYS): DYS is not a voluntary agency. Juveniles generally enter the DYS system when they are held in pre-trial detention for lack of bail or are committed to DYS by the juvenile court after an adjudication of delinquency on criminal charges. DYS does not have legal custody of juveniles, although it does have physical custody in the two situations described above.

DYS cannot make medical decisions for juveniles absent parental involvement and consent, except in an emergency. Medical decisions are made by families, guardians, court order and in certain situations by the consent of the juvenile. When juveniles are in DYS detention or secure facilities, they are considered to be inmates of public institutions and not eligible for Medicaid (even though their families may be Medicaid Members at the time). When a Medicaid eligible juvenile is moved into a DYS community placement, DYS can refer the juvenile for EPSDT screening by a provider and all other necessary medical or behavioral health services.

- c. The Department of Mental Health (DMH): DMH is a voluntary agency. Requests for DMH services come from parents or guardians. DMH does not take legal custody of children and cannot make medical decisions for children. DMH is a "payor blind" agency and as such it does not independently determine whether children who are applying for DMH services are Medicaid eligible. DMH does ask children to self identify available third-party payors, including Medicaid, at the time of the application for DMH services. DMH can refer children who self identify as Medicaid eligible for EPSDT screenings and all other necessary medical or behavioral health services.
- c. The Department of Mental Retardation (DMR): DMR is a voluntary agency. Requests for DMR services come from parents or guardians. DMR does not take legal custody of children and cannot make medical decisions for children. DMR is a "payor blind" agency and as such it does not independently determine whether children who are applying for DMR services are Medicaid eligible. DMR does ask children to self identify available third-party payors, including Medicaid at the time of the application for DMR services. DMR can refer children who self identify as Medicaid eligible for EPSDT screening and all other necessary medical or behavioral health services.

**APPENDIX C – LEGAL AUTHORITY OF DSS AND DYS IN NON-MEDICAL DECISIONS**

DSS: DSS retains the following decisions for children in its care or custody involved in Intensive Care Coordination:

- 1) The nature and extent of visitation and contact, including whether visitation must be supervised, its frequency and location;
- 2) short-term trial placements for the purpose of transitioning to a permanent family;
- 3) the provider, level of care, location and duration of all out of home placements made pursuant to its authority; and
- 4) The type, level and scope of advocacy on behalf of the child's educational needs to the extent that the educational needs are not MassHealth covered services provided pursuant to a MassHealth Municipal Medicaid contract.

DYS: DYS retains the following decisions for children involved in Intensive Care Coordination:

- 1) Whether to grant conditional liberty to allow the client to be in the community;
- 2) The revocation of the grant of conditional liberty;
- 3) The authority to issue a warrant to apprehend the client in the community;
- 4) The authority to return the client to a secure setting;
- 5) All security issues regarding the client;
- 6) The authority to search the client;
- 7) The authority to conduct random urine tests;
- 8) The authority to require electronic monitoring and reporting;
- 9) The authority to make all placement decisions that are a part of DYS-mandated condition of the client's liberty;
- 10) To determine all behavioral management issues, including the nature and type of counseling such as substance abuse, sex offender, anger management, etc., that are a part of a DYS-mandated condition of the client's liberty;
- 11) To set the frequency of DYS contact with the client;
- 12) To determine the conditions under which the client is at liberty; and
- 13) To decide whether as a condition of the client's liberty the client must be in school or employed.