

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

ROSIE D. et al.,

Plaintiffs,

v.

01-CV-30199-MAP

MITT ROMNEY et al.,

Defendants.

**DEFENDANTS' MEMORANDUM IN SUPPORT OF THEIR
AUGUST 29, 2006 REMEDIAL PLAN PROPOSAL**

INTRODUCTION

By Memorandum of Decision dated January 26, 2006, 410 F. Supp. 2d 18, this Court found “two types of violations of the Medicaid Act: (1) inadequate or non-existent medical assessments and coordination of needed services for children with serious emotional disturbances, and (2) inadequate or non-existent in-home behavioral health support services for the same group.” 410 F. Supp. 2d at 23 and 52-53. The parties devoted six months following issuance of the Decision to development and negotiation of remedial plan proposals to address those violations, reserving their rights to appeal. Defendants filed their Remedial Plan Proposal on August 29, 2006 (Docket No. 339), and on September 13, 2006, this Court established a briefing schedule for submission of memoranda concerning that Proposal.

In determining whether to adopt defendants' Remedial Plan Proposal, the standard this Court should apply is whether that Proposal will cure the violations of the Medicaid Act identified in the January 26, 2006 Decision (Point I of this Memorandum). Defendants' Proposal

will cure those violations by providing coverage for comprehensive assessments, service coordination, and in-home behavioral support services to children with serious emotional disturbances (“SED”) in a manner consistent with the requirements of the Medicaid Act as interpreted by this Court and designed to address the Court’s criticisms of existing programs (Point II). Finally, since defendants’ Proposal fully addresses the Medicaid Act violations found by the Court, and plaintiffs cannot point to any violation of the Medicaid Act identified in the Court’s Decision but not addressed in the Proposal, plaintiffs’ objections to the Proposal are irrelevant and the Court may not reject the Proposal based on those objections (Point III).

ARGUMENT

I. THE STANDARD FOR THE COURT’S REMEDY DECISION IS WHETHER DEFENDANTS’ PROPOSAL WILL CURE THE MEDICAID ACT VIOLATIONS IDENTIFIED BY THE COURT.

At the September 13, 2006 status conference this Court asked the parties to address the standard applicable to the remedy in this case. The applicable standard is that the Court should adopt the remedy defendants propose in the August 29, 2006 Remedial Plan Proposal if the Court determines that the Proposal will cure the Medicaid Act violations identified by this Court in its January 26, 2006 Memorandum of Decision.

In general, federal court remedial orders against state and local governments must be tailored to curing an adjudicated violation of federal law. Rufo v. Inmates of the Suffolk County Jail, 502 U.S. 367, 389 (1992); Milliken v. Bradley, 433 U.S. 267, 280 (1977); Hills v. Gautreaux, 425 U.S. 284, 293-294 (1976); Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1, 16 (1971). The “nature and scope of the remedy are to be determined by the violation”; for that reason, federal court decrees “exceed appropriate limits if they are aimed at

eliminating” conditions that do not violate federal law. Milliken, supra, 433 U.S. at 281-282. A proposed remedy is acceptable where the defendants are acting in good faith and their plan has “real prospects” for curing the federal law violation “at the earliest practicable date.” Green v. County School Board of New Kent County, 391 U.S. 430, 439 (1968). Where a defendant proposes a remedy that is “a permissible means of effectuating compliance with the statute,” the district court should not adopt its own remedy in place of that proposed by the defendant. Cohen v. Brown University, 101 F.3d 155, (1st Cir. 1996), cert. den. 520 U.S. 1186 (1997).

These principles -- that the scope of the remedy may not exceed the scope of the violation, and that defendants should have the initial opportunity to tailor the remedy to the violation -- help to ensure that the remedy remains within permissible bounds, and are specifically applicable to cases involving violations of rights secured by federal spending programs. In such cases, the district court “should announce what is necessary to comply with the federal program and then allow an appropriate period of time for the state to decide whether it preferred to forego federal funds. If the state decides to retain funding it must propose a plan for achieving compliance which would then be subject to court approval.” Lynch v. Dukakis, 719 F.2e 504, 513 (1st Cir. 1983), citing Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 30 n. 23 (1981) and Rosado v. Wyman, 397 U.S. 397, 421 (1970); Emily Q. v. Bonta, 208 F. Supp. 2d 1078, 1096-97 (C.D. Cal. 2001) (after finding EPSDT notices insufficient, court directed parties to confer but final determination would be made by state, subject to court review).

Applying these principles here, the nature of the remedy is determined by the Court’s finding of two violations of the Medicaid Act, namely “inadequate or non-existent medical

assessments and coordination of needed services for children with serious emotional disturbances,” and “inadequate or non-existent in-home behavioral support services for the same group.” The question this Court must decide, therefore, is whether defendants’ Remedial Plan Proposal will cure these violations by providing medical assistance to class members including medically necessary comprehensive assessments, coordination of needed services, and in-home behavioral support services, provided that each such service is within the scope of 42 U.S.C. 1396d(a) and eligible for federal financial participation (“FFP”). As discussed below, defendants’ Proposal will do so, and should therefore be adopted by the Court.

II. DEFENDANTS’ PROPOSAL WILL CURE THE MEDICAID ACT VIOLATIONS IDENTIFIED BY THE COURT BY PROVIDING MEDICAL ASSISTANCE, INCLUDING COMPREHENSIVE ASSESSMENTS, SERVICE COORDINATION, AND IN-HOME BEHAVIORAL SUPPORT SERVICES, TO CHILDREN WITH SED WHO HAVE A MEDICAL NEED FOR SUCH SERVICES.

Defendants’ Proposal was developed to cure the Medicaid Act violations identified by this Court by providing medical assistance including assessments, service coordination, and in-home behavioral support services to children with SED who have a medical need for such services in a manner consistent with the requirements of the Medicaid Act.¹ Significant features of the Proposal are a more uniform assessment process with specific clinical criteria designed to aid in identifying children with SED as early as possible; intensive care coordination to assure that treatment plans reflect children’s assessed needs and that children receive needed therapeutic treatment, including as their needs change over time; and the addition of a variety of new in-home support services as covered services.

¹ State Plans for medical assistance must “provide . . . for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title” 42 U.S.C. 1396a(a)(10)(A). The term “medical assistance” is defined to mean “payment of part or all of the cost of . . . early

Initially, defendants note that their Proposal is contingent upon the availability of federal financial participation, FFP, in the costs of the remedy. The Medicaid Act requires states to include in their state plans provision for “corrective treatment the need for which is disclosed by such child health screening services,” 42 U.S.C. 1396a(a)(43)(C). Such “corrective treatment” includes only “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services,” 42 U.S.C. 1396d(r)(5). The Proposal provides medical assistance for the assessments, service coordination, and in-home behavioral supports identified by the Court in its Decision, but also recognizes that defendants can only be required to provide services under the Medicaid Act for which FFP is available. S.D. ex rel. Dickson v. Hood, *supra*, 391 F. 3d at 590 (legislative history of EPSDT indicates that states are required to provide “any service that a state is allowed to cover with Federal matching funds under Medicaid”); Preterm Inc. v. Dukakis, 591 F. 2d 121, 128 (1st Cir. 1979) (imposing cost of medical services on state where FFP not available “not consonant with the basic policy of the Medicaid system under which the federal government participates in the funding of medical services provided by the states”).

The Medicaid Act and implementing regulations establish a process for determining the availability of FFP for state expenditures: the state must submit for federal approval a proposed state plan for medical assistance that contains all the information necessary for approval by CMS, the federal agency responsible for Medicaid, *see* 42 C.F.R. 430.12-18. Submittal of a proposed state plan and subsequent federal approval of that plan is the only way to ensure the

and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals

eligibility of FFP for state expenditures for medical assistance, 42 C.F.R. 430.10. As a first step towards determining whether the services described in the Proposal are eligible for FFP, defendants have sought guidance from CMS on that question; once that guidance is received and this Court has approved a remedial plan, defendants will submit a state plan amendment to obtain federal approval for any allowable services and assure the availability of FFP for claimed services. Affirmation of Michael Norton dated October 25, 2006, Paras. 3-5.

Defendants also note that the Proposal contains numerous features not required by the Medicaid Act. Defendants propose to adopt these features of their Proposal as an exercise of their administrative discretion under the Act; by doing so, they do not waive their authority to continue to exercise that discretion consistent with the Act, and to modify provisions of the Proposal in the exercise of that discretion.

Subsections A, B, and C of this Point will describe the steps that defendants propose (assuming the availability of FFP) with respect to these and other improvements contemplated by the Proposal; Subsection D will discuss implementation of the Proposal.

A. Comprehensive Assessments

This Court held that “compliance with Medicaid’s EPSDT mandate for children with a serious emotional disturbance requires that Defendants provide, at a minimum, reasonably comprehensive medical assessments,” 410 F. Supp. 2d at 23, 32, 52. Such assessments, this Court stated, are essential to “(a) identify promptly a child suffering from a serious emotional disturbance, (b) assess comprehensively the nature of the child’s disability, [and] (c) develop an overarching treatment plan for the child,” 410 F. Supp. 2d at 23. The Court further described the

who are eligible under the plan and are under the age of 21.” 42 U.S.C. 1396d(a)(4)(B).

assessments required by the Medicaid Act for children with SED as “comprehensive and in depth”; “performed by a trained professional, and more often by a team of professionals and knowledgeable lay persons, including family members”; and “available to the agency actually providing treatment.” 410 F. Supp. 2d at 35.

The Court identified three respects in which the Commonwealth’s approach to assessing children with SED was deficient. “First, no feature of the Commonwealth’s Medicaid system assures that SED children will necessarily receive these pediatric assessments at any particular time or in any consistent form,” and as a result “thousands of SED children in Massachusetts get no comprehensive assessments at all.” 410 F. Supp. 2d at 34. “Second, no agency or individual is responsible for insuring that these initial assessments, if they occur, are passed on to the agencies who will ultimately be responsible for treating the child”; as a result, “it is uncertain that the pediatric assessment will be incorporated into any detailed plan to address an SED child’s complex needs.” “Third, many if not most of the assessments that are performed lack depth and comprehensiveness.” *Id.* at 34 and 52.

Defendants’ Proposal sets forth improvements to the Commonwealth’s assessment system that address the specific deficiencies in assessment found by the Court and that will help to assure that eligible children enrolled in the Commonwealth’s Medicaid program access medically necessary comprehensive assessments. These improvements are described below.

1. Prompt identification of children with SED

The Medicaid Act requires the periodic screening of all Medicaid-eligible children who request such screening, 42 U.S.C. 1396a(a)(43)(B). Screening services must be provided “at intervals which meet reasonable standards of medical and dental practice, as determined by the

State after consultation with recognized medical and dental organizations . . . [and] at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions,” 42 U.S.C. 1396d(r)(1)(A) and 42 C.F.R. 441.56(b)(1) and (2). If a need for corrective treatment is disclosed as the result of a child health screening, state plans for medical assistance must arrange for corrective treatment that falls within the scope of medical assistance as defined in federal law, 42 U.S.C. 1396a(a)(43)(C), 1396a(a)(1), 1396d(a), 1396d(r)(5). Sections II and VI of Defendants’ Proposal, at pp. 3-7 and 23-24, set forth the steps that defendants propose to take to improve this process as it relates specifically to children with SED.

First, as part of their response to the Court’s criticism that the Commonwealth’s assessments are inconsistent in form and insufficient in depth and comprehensiveness, defendants will require that primary care providers who perform behavioral health screenings do so in a more uniform way that provides more specific information about particular children’s disabilities, by selecting from a menu of standardized behavioral health screening tools that will include the Pediatric Symptom Checklist (“PSC”) and the Parents’ Evaluation of Developmental Status (“PEDS”), and other, more specialized screening tools appropriate to the identification of particular conditions such as autistic conditions, depression, or substance abuse, Proposal p. 6.²

Second, defendants will amend their provider regulations and managed care organization

² The Proposal provides for choice from a menu of standardized screening tools, rather than use of a particular tool, because the State Medicaid Manual, at 5123.2.b, recommends against specification of particular tools for identifying developmental problems given the large number of such tools, development of new approaches, number of children and complexity of problems which occur, and to avoid any connotation that only certain tools meet federal requirements. The State Medicaid Manual is the official medium by which the Centers for Medicare and Medicaid Services (“CMS”), the federal agency charged with responsibility for administering the Medicaid Act, communicates with states concerning Medicaid policy, and as such is entitled to “respectful consideration,” S.D. ex rel. Dickson v. Hood, 391 F. 3d 581, 590 n. 6 (5th Cir. 2004). An electronic copy of the portions of the State Medicaid Manual cited

contracts to clarify and reemphasize the requirement that all Medicaid primary care physicians must offer children who present for treatment both periodic and inter-periodic EPSDT screenings (that is, screenings at the ages of one to two weeks, one month, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, and then every year until the child's 21st birthday, as well as more frequent screenings as medically necessary) and that those screenings must include behavioral health screening using the menu of standardized behavioral health screening tools described above, Proposal p. 6.

Third, as part of their response to the Court's observation that assessments must be performed by trained professionals, defendants will organize on-going training opportunities 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 during screening, and how and where to make referrals for follow-up behavioral health assessments, Proposal p. 6. Primary care providers will conduct behavioral health screens because such screens are required to be conducted "by, or under the supervision, of a certified Medicaid physician, dentist, or other provider qualified under State law to furnish primary medical and health services," State Medicaid Manual, 5123.1(C). Ensuring that primary care providers know how to perform behavioral health screenings and refer their patients for follow-up behavioral health assessments is part of defendants' response to the Court's criticism that at present no one is responsible for ensuring that initial assessments are passed along to those ultimately responsible for treating the child.

Fourth, as part of their response to the Court's criticism that "thousands of SED children

in this Memorandum, obtained from the CMS website at www.cms.hhs.gov/Manuals/PBM (Publication No. 45) on

in Massachusetts get no comprehensive assessments at all,” defendants will plan to increase the amount and quality of the data that they collect concerning EPSDT screenings so that defendants are better able to enforce the requirement that providers offer behavioral health screenings as described above and make necessary follow-up arrangements as required, Proposal pp. 6 and 23-24. Defendants plan to track, among other things, the number of EPSDT visits, well-child visits, and other primary care visits; the number of EPSDT behavioral health screens provided; and the subsequent utilization of intensive care coordination and in-home support services. Collecting this information will help defendants to monitor providers who offer behavioral health screenings, and track whether children found to have a positive behavioral health screen are referred for further assessment.

Fifth, defendants will engage in numerous activities related to education and outreach, listed in Proposal pp. 3-5 and 7, to ensure that Medicaid members, Medicaid providers, child-serving agencies, and the public generally are aware of the program improvements being made as the result of this case, and in particular the enhanced availability of screening, intensive care coordination, and services. The goal of these steps is to educate persons most likely to come into contact with children with SED about the availability of behavioral health screenings, assessments, and services.

Sixth, the Proposal recognizes that children with SED and their families may come in contact with other state agencies, public schools, community health centers, hospitals, and community mental health providers, and that these contacts may be the first event that leads to identification of a child as in need of mental health care. Any of these entities can refer an

October 25, 2006, is attached.

eligible child for further assessment by Medicaid behavioral health providers and services; screening is not a prerequisite. The Proposal provides for information, outreach, and training activities directed at these entities to enhance their ability to play this role, Proposal p. 7. In addition, defendants will create protocols for state agency referrals of children for behavioral health screenings, assessments, and services, and will work with state 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.

Overall, the steps described above will ensure that consistent behavioral health screening designed to identify children who should be referred for further diagnosis or treatment is available at regular intervals, and more frequently as requested, to all of the Medicaid-eligible children of Massachusetts who are entitled to EPSDT services.

2. Comprehensive assessment of children's disabilities

The Court determined that the Medicaid Act requires defendants to “assess comprehensively the nature of the child’s disability,” 410 F. Supp. 2d at 23. Section III of defendants’ Proposal, at pp. 8-10, describes the assessment system that defendants will create to provide medical assistance, including diagnostic services, for EPSDT eligible children enrolled in Medicaid. Assuming the availability of FFP, defendants will address the Court’s concerns as follows:

First, as part of defendants’ response to the Court’s criticism that thousands of SED children “get no comprehensive assessments at all,” there will be multiple pathways into the assessment process, Proposal p. 8. In many cases the assessment process will be initiated when a child presents for treatment to a Medicaid behavioral health provider following referral by the

child's primary care provider based on the results of a behavioral health screening, as described above. Such a referral is not, however, a prerequisite to assessment. Children can also be referred for assessment and services by parents, providers, state agencies, and schools that identify potential behavioral health needs.

Second, as part of defendants' response to the Court's criticism that nothing at present requires that SED children will receive assessments at any particular time, defendants will require trained Medicaid behavioral health providers to offer a clinical assessment to each Medicaid-eligible child who appears for treatment based on a referral by a primary care provider following a screening or the other pathways described above, Proposal p. 8. In other words, each time a child presents for behavioral health treatment, he or she will be offered further clinical assessment, if such assessment is medically necessary for the child.

Third, the clinical assessment will include a diagnostic evaluation from a licensed clinician able to make a clinical diagnosis of the child, Proposal p. 8.

Fourth, as part of defendants' response to the Court's criticism of the present assessment system as lacking consistency, depth, and comprehensiveness, defendants will require the use of a standardized clinical information collection tool, the Child and Adolescent Needs and Strengths ("CANS"), 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. Medicaid providers will be required to use the CANS as a standardized tool to gather and organize information as part of a clinical intake process in connection with each assessment, Proposal p. 8, increasing the depth and consistency of that process.

Fifth, in response to the Court's observation that proper assessments must be performed

by trained professionals, clinical behavioral health assessments will be carried out by licensed clinicians and other appropriately trained and credentialed professionals, Proposal p. 8.

Sixth, in further response to the Court's criticism that the existing system lacks consistency, defendants have developed clinical criteria to be used during the clinical assessment process to identify children with SED.³ To ensure that the Medicaid assessment process results in reliable identification of children with SED who have a medical need for specific services including intensive care coordination, defendants' Proposal defines the diagnoses, degree of functional impairment, and expected duration of impairment that indicate a need for such referral (Proposal pp. 9-10).⁴

Seventh, this assessment process will be available when medically necessary not only for children entering the system through screening and the other pathways described above, but also as part of discharge planning for children who have been identified as having behavioral health problems and who are being discharged from acute inpatient hospitals, community based acute treatment settings, and Department of Mental health intensive residential settings and continuing care programs, Proposal p. 9. This will ensure that the program improvements created by the Proposal are available to children currently enrolled in Medicaid and receiving mental health services and not just to new enrollees.

Eighth, the assessment process just described will lead to treatment planning, described

³ As this Court is aware, "SED" is not a defined term in the Medicaid Act, but originated in a different federal statute, the Individuals with Disabilities Education Act ("IDEA"), 410 F. Supp. 2d at 32, n. 5. For purposes of IDEA, children with SED have been diagnosed with a mental illness and suffer a significant functional impairment in multiple settings for a period lasting at least one year. 410 F. Supp. 2d at 32. Because this case asserts causes of action only under the Medicaid Act, the IDEA is not directly relevant; defendants' clinical criteria are nonetheless consistent with the IDEA and the practice of federal agencies that deal with mental illness, as discussed in more detail below at pp. 27-28.

below, if such services are medically necessary, Proposal p. 8. The Commonwealth will provide payment for medically necessary services provided to the child pending completion of the assessment process and development of the treatment plan.

Overall, the steps described above will improve the consistency and quality of clinical assessments in order to ensure consistent identification and comprehensive assessment of children with SED who have a medical need for services to enable effective treatment planning.

3. Development of treatment plans

Although the third element of a Medicaid Act-compliant assessment system identified by the Court is the requirement to “develop an overarching treatment plan for the child,” 410 F. Supp. 2d at 23, neither treatment planning nor service coordination are specifically identified within any category of services described in 42 U.S.C. 1396d(a), although either may arguably fall within the scope of services included as targeted case management services under 42 U.S.C. 1396d(a)(19) and 1396n(g)(2). The latter statute was recently amended (by section 6052 of the Deficit Reduction Act of 2005, Pub. L. 109-171), and now more completely describes those services that are permissible case management services and for which FFP is available, and those that are not (compare 1396n[g][2][A][ii] and [iii]). In addition to statutory language expressly limiting the activities that can be provided as case management, the Medicaid Act now states expressly that FFP is available for case management services or targeted case management services only if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, or other educational program. 42 U.S.C. 1396n(g)(4)(A).

⁴ Defendants are not only authorized to establish medical necessity criteria, 42 C.F.R. 440.230(d), but required to

Although the recent act required CMS to promulgate emergency implementing regulations, CMS has not yet done so. These changes, and the lack of implementing regulations, create great uncertainty about the circumstances under which FFP is available for case management services. As stated above, defendants are seeking guidance from CMS to assure that FFP is available for the treatment planning and service coordination services for children with SED described in the Proposal. Assuming the availability of FFP, treatment planning for children with SED will follow directly from the assessment process just described, addressing the Court's criticism that under the present system there is no certainty that assessment results will be incorporated in treatment plans, 410 F. Supp. 2d at 34. The treatment planning process proposed by defendants, which is described in Section III and IV of defendants' Proposal, pp. 8-9 and 11-13, has the following features:

First, children with SED who are identified as meeting the clinical criteria set forth in defendants' Proposal will be referred to the intensive care coordination process, Proposal p. 9.

Second, children who present for intensive care coordination will receive an intensive, home-based assessment and treatment planning process, organized by a care manager. A care planning team comprised of the child's family and other community supports will be involved in the process, although there is no provision of the targeted case management statute or other applicable Medicaid Act provisions that impose any such requirement.

Third, responding to the Court's criticism that in the present system no one is responsible for ensuring that assessments are passed on to treating agencies, and that therefore "it is uncertain that the pediatric assessment will be incorporated into any detailed plan to address an

safeguard against unnecessary utilization of services, 42 U.S.C. 1396a(a)(30)(A).

SED child's complex needs," 410 F. Supp. 2d at 34, under the Proposal responsibility for ensuring that the assessment is incorporated into a detailed treatment plan will rest with the care manager, who will either be a licensed mental health professional or will be under the supervision of a licensed mental health professional. Specifically, the care manager will be responsible for the following tasks related to treatment planning: (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; and (6) preparing, monitoring, and modifying the individualized care plan in concert with the care planning team. In other words, the care manager must collect the pertinent information about the child and make sure that it is reflected in the plan.

Fourth, although neither the targeted case management statute or any other provisions of the Medicaid Act so requires, treatment planning will be the product of the efforts not just of the care manager but also of a care planning team, consistent with the Court's observation that a proper assessment "must be performed, at a minimum, by a trained professional, and more often by a team of professionals and knowledgeable lay persons, including family members," 410 F. Supp. 2d at 35. Care planning teams under defendants' Proposal will be family-centered and include a variety of interested persons and entities, as appropriate, including family members (whether biological, kinship, foster, and/or adoptive), providers, case managers from other state agencies when a child has such involvement, and natural supports such as neighbors, friends, and

clergy, Proposal pp. 11-12.

Fifth, as a further aspect of defendants' response to the Court's criticism that the current system lacks any locus of responsibility for ensuring that assessed needs become part of a treatment plan, 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, Proposal p. 12. In other words, having the team carry out any additional necessary assessments as well as develop a treatment plan assures that the group that creates the child's treatment plan has her most recent assessments and all other pertinent information provided by the care manager. Defendants will develop an operational manual to guide the operations of the team and ensure methodological consistency.

Sixth, 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) in response to the Court's criticism that the present system fails to coordinate crisis services with existing treatment plans, 410 F. Supp. 2d at 35-36, incorporate the child and family's crisis plan; and (5) identify the providers of services, Proposal p. 12.

Seventh, the care planning team will have the authority to identify and arrange for all medically-necessary services needed by the eligible child with SED. This authority will be exercised in a manner consistent with defendants' overall authority 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, Proposal p. 12.

Eighth, the plan of care will be reviewed periodically and will be updated, as needed, to reflect the changing needs of the child. Such review will occur when there is a change in another state agency's plan for the child, but at least monthly by the care manager, and at least quarterly by the care planning team. 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. Responsibility for monitoring and modifying the plan of care will rest with the care manager and the care planning team.

Ninth, the care plan will include transition or discharge plans specific to the child's needs.

Overall, the steps described above will ensure that the assessed needs of each child identified with SED are taken into consideration in the development of an individualized treatment plan that addresses the child's medical needs.

B. Service Coordination

Turning now from assessments to service coordination, this Court concluded that "compliance with Medicaid's EPSDT mandate for children with a serious emotional disturbance" requires, in addition to assessments, "ongoing clinical oversight of the services being provided." Such coordination should "oversee implementation of this plan [i.e., the child's treatment plan] (typically by multiple medical providers) as the needs of the child evolve," 410 F. Supp. 2d at 23. Specifically, there should be "a trained individual who (1) meets

regularly with the child and his or her family, (2) coordinates necessary diagnostic efforts to ensure that the child's disability is understood, (3) oversees the formulation of a plan to address the child's needs, and (4) takes primary responsibility to ensure that the plan is carried out (by whatever state or private contract agencies may be involved) and appropriately modified as the child's needs evolve." 410 F. Supp. 2d at 38. This Court concluded that service coordination for children with SED under the present system is generally of insufficient duration and availability, and, even at its best, falls short of the requisite standard because case managers rarely meet with the children whose care they coordinate, oversee formulation of treatment plans, or take responsibility for implementation and modification of treatment plans. 410 F. Supp. 2d at 38-39 and 53.

Defendants' Proposal as it relates to service coordination, see Proposal Section IV, pp. 11-13, is subject to the comments above concerning the need for FFP and current uncertainty about federal law with respect to case management. With those caveats, the Proposal incorporates the features identified as requisite by the Court and seeks to eliminate the defects identified by the Court, as follows:

First, care managers (described above at pp. 15-16) will have the responsibilities identified by the Court as requisite for coordination of services for SED children, 410 F. Supp. 2d at 38. In addition to their responsibility for treatment planning and related diagnostic efforts, as described above, which specifically includes the responsibility to work directly with the child and family, care managers are also responsible for ensuring that treatment plans are carried out by coordinating the delivery of available services, collaborating with other caregivers on the child and family's behalf, and facilitating transition planning, including planning for aftercare or

alternative supports when in-home support services are no longer needed, Proposal p. 11.

Second, responding to the Court's criticism that existing service coordination is of insufficient duration, intensive care coordination will be available under the Proposal for as long as the child meets the clinical criteria set forth in the Proposal, Proposal p. 11. As explained above, those criteria are intended to identify children who have been diagnosed with a mental illness and suffer a significant functional impairment in multiple settings expected to last more than a year, consistent with the Court's definition of the children for whom a remedy is necessary, 410 F. Supp. 2d at 32. The duration of intensive care coordination under the Proposal will thus match the need for such coordination. The expectation is that intensive care coordination under the Proposal will meet the medical needs for care coordination for the children who meet the criteria.

Third, responding to the Court's criticism that under the existing system too few children with SED receive service coordination, under the Proposal defendants will provide medical assistance for intensive care coordination to every child who presents for such services and meets the criteria for intensive care coordination for as long as they continue to meet the criteria, Proposal p. 11. The availability of service coordination will thus match the need for such coordination.

Fourth, despite the limitations on case management activities under present law⁵, subject to the availability of FFP the Proposal goes beyond the requirements of the Medicaid Act and recognizes that the need for service coordination is particularly critical for children involved

⁵ The case management statute, 42 U.S.C. 1396n(g)(2)(A)(ii)(II) and (III), now expressly limits case management activities to "Development of a specific care plan . . . that specifies the goals and actions to address the medical, social, educational, and other services needed . . . [such as] ensuring the active participation of the eligible individual

with multiple state agencies, for instance, Medicaid-eligible children who are also involved with the Department of Social Services, Department of Mental Health, Department of Youth Services, or Department of Mental Retardation. Where practicable and necessary, where a child has multiple state agency involvement, a representative from each such agency will be a part of the child's care planning team, and in that role will coordinate any agency-specific planning process or treatment plan. Defendants will also develop a mechanism for resolving disputes among agencies in this situation, Proposal p. 13.

Overall, the steps described above will ensure that treatment services for children with SED are provided in a coordinated manner in accordance with each child's changing needs, again with the goal of addressing the child's medical needs.

C. In-Home Behavioral Support Services

The remaining Medicaid Act violation found by the Court is "inadequate or non-existent in-home behavioral support services," 410 F. Supp. 2d at 23. "In-home behavioral support services" are not specifically identified within any category of services described in 42 U.S.C. 1396d(a). Nevertheless, such services, the Court concluded, are "a medical necessity for many SED children," particularly those who suffer "extreme functional impairment," *id.* The Court emphasized that such services must be provided on a long-term basis in order to address chronic medical needs, 410 F. Supp. 2d at 32. Describing the type of services required, the Court stated that the "regular, long-term presence of a clinician or trained para-professional in the home on a regular basis – forming a relationship with the child, modifying problematic behaviors, taking the child on outings, offering support in school, relieving the parents or guardians during

(or the individual's authorized health care representative) and others to develop such goals," and providing

evenings or weekends – is a critical part of the treatment plan of many SED children.” 410 F. Supp. 2d at 36.

The Court found the current system of in-home support services for children with SED deficient in two general respects: time limitations, and lack of coordination with other programs. With respect to duration, the Court found that the Commonwealth’s programs were designed to be “short-term interventions during acute episodes,” and were not “designed to serve children with chronic conditions who require varying levels of service over long periods, often through their entire childhood and adolescence.” The Court also found that these services were not “adequately coordinated with the other treatment children may be receiving.” 410 F. Supp. 2d at 36-38 and 53.

This Court also found that one necessary aspect of in-home supports is “prompt crisis intervention,” 410 F. Supp. 2d at 31, 32. Crisis services “must foresee crises and address the proper clinical response to them ahead of time, as part of the child’s treatment planning.” 410 F. Supp. 2d at 35. As with the Commonwealth’s other in-home supports, this Court found the Commonwealth’s crisis services deficient with respect to duration and coordination with other services. 410 F. Supp. 2d at 36.

Subject to the availability of FFP⁶, the Proposal provides for a variety of in-home behavioral support services consistent with the Court’s description and intended to address the deficiencies found by the Court, described in Section V of the Proposal, pp. 14-17, as follows:

First, responding to the Court’s criticism of existing crisis services for children with

“[r]eferral and other related activities to help an individual obtain needed services”

⁶ The Court should be aware that CMS recently indicated, in a letter sent on August 16, 2006 to the Director of California’s Medicaid program, that FFP is not available for services that are not “independently recognized” under section 1905(a) of the Social Security Act (that is, 42 U.S.C. 1396d[a]). Norton Aff., Ex. 2.

SED, the Proposal provides for mobile crisis intervention (that is, professionally trained crisis workers who can travel to a child experiencing a mental health crisis to assess and treat the child and stabilize the situation) available in community settings (including the child's home) and crisis stabilization services. The duration for which crisis stabilization services may be available has been extended to up to seven days, Proposal pp. 14-15. Coordination with the child's overall treatment plan is assured by the required inclusion of the child and family's crisis plan in the overall treatment plan, as mentioned above.

Second, responding to the Court's criticism of existing in-home support services as "inadequate or non-existent," the Proposal creates three new categories of such services: in-home behavioral services, consisting of behavior management therapy and behavior management monitoring; in-home therapy services; and mentor services (independent skills living mentors and child/family support mentors). Each of these services involves a clinician or qualified paraprofessional going to the home or other community setting to provide behavioral, therapy, or mentor services to modify problematic behaviors, see Proposal, pp. 16-17.

Third, responding to the Court's criticism that the duration of existing in-home support services is too limited, under the Proposal treatment teams will have the authority to arrange for all medically-necessary services needed by an eligible child with SED consistent with reasonable medical necessity criteria and standards for prior authorization.

Overall, the steps described above will ensure that a variety of in-home behavioral health services including crisis services are available to children with SED for whom they are medically necessary.

D. Implementation of Defendants' Proposal

Recognizing their obligation to satisfy this Court that their Proposal has “real prospects” of eliminating the Medicaid Act violations found by the Court “at the earliest practicable date,” Green v. County School Board of New Kent County, *supra*, 391 U.S. at 439, Section VI of the Proposal describes defendants’ present preliminary plans with respect to implementation of the Proposal, specifying the particular projects into which the implementation will be organized, the tasks to be performed within each project, the estimated timeframe for completion, and any contingencies relevant to that project. One respect in which defendants have begun work to eliminate these contingencies is by seeking CMS guidance concerning whether FFP will be available for the services described in the proposal, as noted above, Norton Aff., Paras. 3-5.

In addition, as part of planning for implementation of the Proposal, and to understand the Proposal’s broader impact on the Massachusetts Medicaid program, defendants have begun preparation of a preliminary estimate of the annual program and operating costs of the Proposal. While preliminary estimates are available for only some portions of the proposal, it is already clear that the cost of implementation will be substantial. Defendants currently estimate the annual cost of providing service coordination and in-home support services as set forth in the Proposal to 5,000 children to be approximately \$153 million; to 10,000 children to be approximately \$306 million; to 15,000 children, approximately \$459 million; to 20,000 children, approximately \$612 million. These estimated additional expenses could represent a doubling, and perhaps substantially more, of current Medicaid expenditures for behavioral health services in Massachusetts for children, which are approximately \$200 million. Norton Aff., Paras. 2, 6-12.

Overall, the Proposal provides for a comprehensive, system-wide reform of the Medicaid

behavioral health system for children in Massachusetts. Defendants' plan for implementation of that proposal is a reasonable approach to a complex, far-reaching, and expensive endeavor.

III. PLAINTIFFS' CRITICISMS OF DEFENDANTS' PROPOSAL ARE WITHOUT MERIT BECAUSE THEY DO NOT ESTABLISH THAT THERE IS ANY MEDICAID ACT VIOLATION LEFT UNADDRESSED BY THE PROPOSAL.

Plaintiffs' Report to the Court and Final Remedial Plan, filed August 28, 2006 (Docket No. 338), identified (at pp. 10-14) nine disputed issues. Defendants assume that plaintiffs will criticize the Proposal on these same nine grounds, and therefore respond briefly to those criticisms here.

A general theme of plaintiffs' criticisms of the Proposal is that it is unreasonable to the extent that it contains any limits, such as limits on the children served by the Proposal, limits on the services covered by the Proposal, or limits on who may perform behavioral health screenings. However, as explained in subpart A of this point, the Medicaid Act authorizes and at times requires defendants to place reasonable limits on the services it provides. Furthermore, plaintiffs' criticisms of the Proposal rest not on any Medicaid Act violation found by the Court left unaddressed by defendants' Proposal -- there are none -- but rather, apparently, on plaintiffs' views of desirable policy; for that reason, plaintiffs' criticisms are not reasons for the Court to reject the Proposal (subpart B of this point).

A. The Medicaid Act Authorizes Defendants to Place Reasonable Limits on the Scope of Services Based on Medical Necessity and by Establishing Clinical Criteria.

The Medicaid Act does not contemplate limitless expenditure by states; to the contrary, states are allowed to place reasonable limits on the Medicaid services they will provide. The Act makes federal appropriations available "for the purpose of enabling each State, as far as

practicable under the conditions in such State, to furnish” medical assistance and rehabilitation and other services, 42 U.S.C. 1396 (emphasis supplied). States are required to establish “methods and procedures . . . necessary to safeguard against unnecessary utilization of such care and services,” 42 U.S.C. 1396a(a)(30)(A), and may place appropriate limits on a service based on criteria such as medical necessity or utilization control procedures, 42 C.F.R. 440.230(d).

The EPSDT provisions of the Medicaid Act do not abrogate states’ authority and obligation to safeguard against unnecessary utilization. Specifically, Section 5122.F of the State Medicaid Manual advises states with respect to their EPSDT obligations that “You [the agency] make the determination as to whether the service is medically necessary. You are not required to provide any items or services which you determine are not safe and effective or which are considered experimental. 42 C.F.R. 440.230 allows you to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 21). You may define the service as long as the definition comports with the requirements of the statute”

Defendants are thus authorized by the Medicaid Act to impose reasonable limits on EPSDT services. The Proposal contemplates a substantial increase in state expenditures, but it is defendants’ obligation to ensure that that increase is not limitless, and in particular that unnecessary utilization is prevented and that only medically necessary services are provided. Defendants are both entitled and obligated to impose reasonable limits on remedy services to avoid squandering scarce resources. This is the context in which plaintiffs’ specific criticisms of the Proposal must be considered.

B. Plaintiffs' Specific Criticisms Are Not Based on Adjudicated Medicaid Act Violations.

First, plaintiffs criticize defendants' clinical criteria for intensive care coordination (Proposal, pp. 9-10) as overly restrictive and "not consistent with or required by federal law." See Plaintiffs' August 28, 2006 Report, p. 10. There are three points in response.

a. The clinical criteria are closely based on this Court's definition of children with SED, 410 F. Supp. 2d at 32, the group as to which this Court found Medicaid Act violations, 410 F. Supp. 2d at 23 (identifying "two types of violations of the Medicaid Act: (1) inadequate or non-existent medical assessments and coordination of needed service for children with serious emotional disturbances, and (2) inadequate or non-existent in-home behavioral support services for the same group.") In particular, the Court stated that children with SED "have been diagnosed with a mental illness (e.g., bipolar disorder or autism) and suffer from a significant functional impairment in multiple settings (e.g., home and or school) for a period lasting at least one year." 410 F. Supp. 2d at 32. The clinical criteria track this definition, see Proposal pp. 9-10 (specifying diagnoses, degree of functional impairment, and expected duration required for intensive care coordination). Thus, the clinical criteria are an important part of defendants' effort to address the Medicaid Act violations found by the Court.

b. Plaintiffs' real dispute with the clinical criteria appears to lie in the fact that the criteria, in specifying the diagnoses that determine whether intensive care coordination is medically necessary, exclude some diagnoses. Specifically, the Proposal provides that individuals are eligible for intensive care coordination if they 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.” In particular, plaintiffs object to the exclusion of autism from the clinical criteria (Plaintiffs’ Report, p. 10).

Far from being inconsistent with federal law, the exclusion of certain diagnoses stated in the Proposal’s clinical criteria are consistent not only with regulations implementing the IDEA, which defines emotional disturbance separately from autism and mental retardation, but also with the practice of the federal agency which deals with mentally ill children, the Substance Abuse and Mental Health Services Administration of the United States Department of Health and Human Services (“SAMHSA”). SAMHSA has defined “serious emotional disturbance” for the purpose of making state mental health block grants, and that definition excludes substance abuse disorders, developmental disorders including autism, and “V” codes. See 58 FR 294220-02, 1993 WL 167366 (F.R.) Thus, defendants’ clinical criteria are consistent with the practice of the federal agencies responsible for dealing with mental illness with respect to the definition of children with SED.

c. The clinical criteria are a reasonable exercise of defendants’ authority to place reasonable limits on EPSDT services, as discussed above. The clinical criteria defendants have established for care coordination are reasonable (confirmed by the fact that they are consistent with IDEA regulations and SAMSHA practice) and well designed to assure that those children with the greatest need for care coordination meet the clinical criteria. As such, the criteria are well within the scope of defendants’ authority under the Medicaid Act.

Second, plaintiffs complain that the Proposal should, but does not, include the following covered services: school therapeutic services, interpreter services, special therapy services, child/family training, and multi systemic therapy. The short answer to this contention is that

although the remedy must -- and does -- provide for in-home behavioral support services, the Court did not find any violation of the Medicaid Act arising from a failure to provide school therapeutic services, interpreter services, special therapy services, child/family training, and multi systemic therapy, and they are therefore outside the scope of the required remedy. Nonetheless, defendants have sought CMS guidance as to whether FFP is available for these services, see Norton Affidavit, Attachment 1.

Third, plaintiffs assert that “any health care professional in any location” should be able to perform behavioral health screenings. Again, this Court found no violation based on the identity or professional qualifications of persons performing behavioral health screenings, and the found violations determine the scope of the remedy. Defendants’ Proposal, which requires that behavioral health screenings be carried out by Medicaid primary care providers, (1) is consistent with the Court’s direction that assessments should be done by a “trained professional,” 410 F. Supp. 2d at 35, (2) is also consistent with State Medicaid Manual 5123.1(C), which provides that screenings should be performed by “a certified Medicaid physician, dentist, or other provider qualified under State law to furnish primary medical and health services” (emphasis supplied), and (3) will permit the Medicaid program to track screening data, a significant aspect of defendants’ compliance efforts, as described above.

Fourth, plaintiffs contend that the Proposal is somehow objectionable because medical necessity determinations made by the care planning team will be subject to reasonable medical necessity criteria, standards for prior authorization, and other utilization management activities required under the Medicaid Act. Again, no violation was found with respect to the Commonwealth’s medical necessity criteria, so this subject is not one that the remedy needs to

address. Moreover, as discussed above, the Medicaid Act requires defendants to conduct utilization management, 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 440.230(d), State Medicaid Manual 5122.F. A Proposal which failed to comply with that statutory mandate would be objectionable; acknowledging the existence of the mandate surely is not.

Fifth, plaintiffs assert that the Proposal should establish a maximum caseload for a care manager. Again, plaintiffs seek to impose a remedy beyond the scope of the Medicaid Act violation found by the Court and beyond the Medicaid Act itself, which does not specify any upper or lower bounds on the caseloads for care managers, 42 U.S.C. 1396n(g)(2) (as recently amended). The Court found a Medicaid Act violation based on the failure to provide service coordination that satisfies certain requirements, such as case managers able to meet with children and families individually and carry out the other functions described above. Subject to the availability of FFP, defendants' Proposal provides for case managers to carry out those functions; a remedy tailored to the found violation does not require specification of caseload ratios.

Sixth, plaintiffs point out differences between the service delivery system proposed by defendants and the service delivery system plaintiffs would prefer. This is another instance of plaintiffs demanding a remedy beyond the actual violations found by the Court, which related to the failure to provide specified services, not the service delivery system. In addition, 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 at 24. The Medicaid Act does not dictate the manner in which defendants organize the delivery of Medicaid services, so long as those services are delivered in a manner that comports with the Commonwealth's

obligation under EPSDT. Defendants included a description of their preliminary plans for implementing their Proposal so that the Court can feel assured that the Proposal has “real prospects” of success, Green v. County School Board of New Kent County, *supra*, 391 U.S. at 437, but retain discretion to alter that implementation system consistent with complying with the Medicaid Act and this Court’s decision.

Seventh, plaintiffs criticize defendants’ intentions with respect to data collection and compliance planning; plaintiffs would prefer that there be far more extensive data collection and analysis. This is yet another area where no violation was found by the Court, nor indeed could there have been given the absence of any Medicaid Act requirements with respect to data collection. Plaintiffs’ effort to expand the scope of the remedy beyond the adjudicated violations should be rejected.

Eighth, plaintiffs object to the fact that the Proposal reserves defendants’ discretion to modify the preliminary plans for implementing the Proposal set out in Section VI of the proposal. Implementation of the Proposal is an enormous, complex undertaking involving numerous contingencies, ranging from the availability of FFP and uncertainty over anticipated CMS guidance concerning permissible case management expenditures, as discussed above, to the capacity of existing managed care entities to carry out the tasks with respect to network development that the Proposal envisions they will undertake, Proposal pp. 19-20. This Court deliberately refrained from dictating that planning, service coordination, and in-home supports “be provided through these specific programs [i.e., MHSPY and CFFC], or in any particular manner.” Retention of discretion to modify the implementation plan in light of the various contingencies involved is necessary for a successful implementation.

Ninth, plaintiffs object to the possibility that implementation of some aspects of the Proposal may take longer than three years. In light of the scope and complexity of the steps set forth in the Proposal, the timelines proposed by defendants for the various implementation tasks, as set forth in Section VI of the Proposal, represent a good faith effort to achieve the earliest practicable implementation of the Proposal.

In sum, none of plaintiffs' criticisms of the Proposal amount to a reason to reject it. Defendants' Proposal addresses every aspect of the two Medicaid Act violations found by the Court, and has real prospects of eliminating them at the earliest practicable date. For that reason, defendants' Proposal should be adopted.

CONCLUSION

Defendants' Proposal should be adopted.

Respectfully submitted,

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Date: October 25, 2006

I hereby certify that a true copy of this document was served upon counsel for the plaintiffs (Mr. Schwartz, Ms. Costanzo, and Mr. Laski) by electronic mail on October 25, 2006.

/s/ Deirdre Roney