

# Implementing the *Rosie D.* Remedy: The Opportunities and Challenges of Restructuring a System of Care for Children’s Mental Health in Massachusetts

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Issue Brief

September 2007

## Executive Summary

### Introduction

The recent district court ruling in *Rosie D. v. Romney* found that Medicaid-eligible children with serious emotional disturbances (SED) in Massachusetts were not receiving appropriate mental health screenings, service coordination, and home-based treatment services. The decision has far-reaching implications. It entitles children to extensive home and community-based services and calls for the creation of a new mental health infrastructure, which promises to improve upon the existing fragmented public mental health delivery system for children.

This issue brief explores the implications and potential effects of the case and the resulting proposed remedy on the MassHealth program, other state programs, the behavioral health and social service delivery systems, and affected children and their families. It provides a broad portrait of what stakeholders currently understand about the case and affords the opportunity to consider successes and failures as the state begins to implement the remedial plan.

### Summary of the Judgment

Following its ruling, the court requested plaintiffs and defendants to attempt to negotiate a remedial plan. Since the parties were unable to agree, each side presented a separate remedial plan for children with SED. In July 2007, the presiding judge issued his final judgment, in which he accepted the state’s plan (summarized below) with some modifications. Specifically, the court

- defined the term “serious emotional disturbance,” effectively establishing the size of the plaintiff class at 15,000 children;
- ruled that the state must provide home-based services to Medicaid-eligible children with SED who request and need them;
- established aggressive implementation timelines; and
- ruled that the provisions of the remedy are enforceable by law and cannot be modified without a court order, and that the state is bound to the terms of the judgment, even if it goes beyond what is explicitly required in the federal Medicaid Act.

### **Summary of the Remedial Plan**

The remedy ordered by the court and being implemented by the state proposed to coordinate many of the disparate pieces of the existing mental health delivery system for children and integrate them with some new processes and services to create a coherent system of care.

### **Notification of EPSDT Services and Outreach**

The state is required to improve its outreach and education to MassHealth members eligible for EPSDT (Early and Periodic Screening, Diagnosis, and Treatment, the Medicaid benefit plan for children) and their families, as well as to MassHealth mental health providers. EOHHS will disseminate this information to its provider networks and will conduct training for staff at each of the state agencies that serves children with mental health needs.

### **Behavioral Health Screening and Identification**

Primary care providers (PCPs) and pediatricians must perform EPSDT screens during well-child and follow-up healthcare visits, using a standardized behavioral health screening instrument, and refer children for treatment when those screens reveal issues. State agencies that identify children as needing a behavioral health screen will refer the children to pediatricians for screenings.

### **Assessment and Diagnosis**

Clinicians will rely on clinical assessments and the Child and Adolescent Needs and Strengths (CANS) survey to make an SED assessment and diagnosis. Following a behavioral health assessment, children who demonstrate a medical need for intensive care coordination (ICC) will be referred to an intensive care manager, who will take the lead in developing and coordinating treatment services.

**Intensive Care Coordination (ICC) and Treatment Planning**

The child's care manager and care planning team (comprised of the child, family members and other relevant support people, and representatives from other EOHHS agencies with which that child is associated) will develop a treatment plan.

**Intensive Home and Community-Based Support Services**

The development of intensive home and community-based services will allow children to return to their homes more quickly from restrictive treatment settings, and will allow more children to receive treatment in their homes, schools, and communities. The state will augment certain existing services - mobile crisis intervention and stabilization services for children facing an immediate mental health crisis - and create new services for children with SED:

- In-Home Behavioral Services (which include behavior management therapy and behavior management monitoring)
- In-Home Therapy Services (which include therapeutic clinical intervention and therapeutic training and support)
- Mentor Services (to improve a child's daily coping, social and communication skills)

**Service Delivery Network**

MassHealth, in collaboration with the Department of Mental Health (DMH), will establish a statewide service delivery network, using community service agencies (CSAs) to coordinate home-based care. MassHealth's managed care behavioral health contractor, the Massachusetts Behavioral Health Partnership (MBHP), will select the CSAs, which will include providers in MassHealth's managed care or fee-for-service network, and will assist them in coordinating service delivery.

**Data Collection**

EOHHS will create a comprehensive data collection system and design and develop an automated web-based information technology system, which will include a mental health tracking component to assist with identifying, monitoring and tracking children with SED.

**Direction and Oversight**

EOHHS appointed a compliance coordinator to oversee the state's implementation of the remedy. A court monitor also has been appointed to oversee implementation of the remedy by both parties and to ensure that the state fully complies with the judgment.

## **Implementation Issues**

### *Potential opportunities/benefits*

Stakeholders are optimistic about the opportunities that implementation of the *Rosie D.* remedy could bring, and feel it ultimately will create a better system of care for children with SED. The significant benefits that are expected to accrue as a result of implementation are:

### *Improved EPSDT Screening and Treatment*

Early identification leads to early intervention, which may, in turn, lead to more successful and possibly less expensive treatments. Through effective screening, families and physicians are able to identify potential mental health issues, which may help to ameliorate future problems.

### *Improved Service Delivery*

The new system will be integrated across multiple child-serving agencies and will offer a single point of entry, significantly improving access for children. Treatment plans and services will be specifically tailored to fit the needs of each child and family.

### *Shift from Institutionalized/Residential Care to Community-Based Care*

Children with SED will receive care in less restrictive settings that are more conducive to treatment and familiar and comfortable to them, such as their homes, schools, and child care centers.

### *Improved Outcomes Measurement*

A new data collection system will ensure better monitoring and tracking to prevent children from getting “lost” in the system and falling through the cracks, and ultimately will improve quality of care.

## **Potential Challenges**

The *Rosie D.* ruling affords a critical opportunity to transform an unworkable system for children and their families. The remedial plan represents an ambitious undertaking, however, and there are a number of significant implementation challenges that the state will likely face:

### *Workforce shortages and provider capacity issues*

Massachusetts faces a shortage of qualified “child-trained” providers, such as psychologists and social workers, as well as an inadequate number of bilingual and multi-cultural providers. Existing providers also are not spread out evenly across the state, making access a problem in many areas. One of the state’s biggest challenges will be to engage more qualified providers and train them in the new delivery structure, which is vastly different from the existing model of care that most clinicians are used to.

### *Lack of Detail in Certain Components of the Remedy*

The court remedy leaves many details to be developed further as the state implements the plan. Specifically, the state must decide how to negotiate the new provider contracts, set billing rates for new services, define utilization standards, and establish provider qualification and training standards. The state also must decide which entities will serve as CSAs and how they will be selected.

### *State and Federal Approval*

Federal approval for the new services proposed in the plan is required in order for the state to receive federal matching funds for those services. If CMS determines that this federal financial participation (FFP) is not available for a particular service in the remedy, the state is not obligated to provide that service exclusively at state cost. As a result, FFP approval is a critical milestone to successful implementation of the remedy. Other elements of the remedy, such as information system technology design and state funding, also require state legislative approval.

### **Annual Programmatic and Administrative Costs**

Perhaps one of the most important aspects of *Rosie D.* implementation deals with costs. The state has estimated that it will cost approximately \$459 million (in gross dollars, which includes the federal match) to cover the 15,000 children with SED who are expected to be identified through the new screening process and require treatment. This estimate is heavily dependent on the number of children that enter the system as a result of the *Rosie D.* ruling. If MassHealth caseloads increase significantly beyond the estimated 15,000 children, the costs could rise accordingly.

### *Current MassHealth Expenditures*

In FY 2005, the state's behavioral health expenditures for Medicaid-enrolled children under age 21 totaled \$202 million. The state's estimate of \$459 Million for *Rosie D.* implementation is more than twice that number. Some of the \$202 million is included in the state's \$459 million estimate because it is currently being spent on the SED population (in the form of therapy, certain home-based services and medications), so net new spending could be less than the full \$459 million.

### *Funding Sources*

MassHealth will be responsible for the majority of spending to implement the remedy. Funding for implementation is expected to come from a combination of appropriations from the legislature, savings offsets, and cost avoidance. It is hoped that a proportion of the costs will be offset by a decrease in acute care psychiatric hospital use among children with SED. MassHealth and its Managed Care Organizations (MCOs) also plan to incorporate utilization

management techniques, such as prior authorization, outlier standards (including pre-or post-payment reviews and service-by-service reviews) and will be setting clinical standards for its providers to reduce costs. Even when all of these factors—cost avoidance, offsets, and utilization management mechanisms—are taken into account, it is clear that the remedy will require significant new funding.

### **Potential Implications for Involved Parties**

#### *Impact on MassHealth Budget Neutrality and the Relationship With Health Care Reform*

MassHealth operates under a federal waiver as a “Section 1115 Demonstration Project,” which allows the state to operate its program differently from the requirements of Title XIX, the federal Medicaid statute. One important requirement of such a waiver is “budget neutrality”; over the life of the waiver, the federal government will not reimburse more state spending than it would have in the absence of a waiver. This means that all expansion spending—either non-Title XIX populations or non-Title XIX services—must be offset by savings in the “traditional” or “base” population.

Spending for *Rosie D.* implementation could put further pressure on budget neutrality (the terms of which are due for renegotiation when the MassHealth waiver is renewed next year). Since the *Rosie D.* remedy represents additional Title XIX costs for the demonstration’s base population, it is essential that the Commonwealth work with CMS to modify the budget neutrality limit to reflect these costs. It is possible, though far from certain, that CMS will consider the fact that these new financial burdens are the result of a court order and raise the state’s budget neutrality ceiling accordingly.

The relationship of *Rosie D.* implementation costs to Massachusetts’ newly enacted Health Care Reform Law, Chapter 58, is also an important concern. Chapter 58 provides several key coverage expansions and creates a mandate that all Massachusetts residents obtain health insurance if an affordable plan is available. While this will have a positive effect on reducing the number of uninsured throughout the state, it also promises to present an additional financial burden on available resources, and the challenge to the state will be to implement the *Rosie D.* remedy without compromising core elements of its other programs.

#### *Impact on Other EOHHS organizations*

Although the brunt of the responsibility for implementing *Rosie D.* ultimately will fall upon MassHealth, interagency collaboration is a critical component of the *Rosie D.* remedy. Other agencies that play an important role in providing services to children with SED—such as the DMH and the Departments of Social Services (DSS) and Youth Services (DYS)—will be affected as well. DMH staff will work with MassHealth to establish a delivery network and will assist in the design and development of an operating manual for the care planning teams.

Because each agency has its own way of operating, EOHHS must be wary of creating further “silos of care.” The CSA model could afford the opportunity to achieve a more streamlined system of care, provided that the CSAs contract with providers who are affiliated with MBHP or the MCOs and maintain the same geographic base as the existing mental health providers. Stakeholders stress the importance of coordinating the system with significant input from each of the main child-serving agencies, while relying primarily on one lead agency, with one entry point, to oversee service delivery.

#### *Impact on Existing Service Delivery System*

While most mental health providers and administrators welcome the court’s decision, they are concerned about many of the workforce, training and capacity issues described earlier. They worry that in an effort to fortify the new delivery system, staff might be recruited from existing outpatient programs, which may, in turn, create longer waiting lists for outpatient clinics. This could have the unintended consequence of undermining the outpatient system. There also is concern in the provider community about the capacity of the system to handle a large influx of new patients; many providers worry that the creation of a single “gate” in each region for referrals and behavioral health screenings and evaluations (through the CSAs) could create a bottleneck and overwhelm the providers.

#### *Impact on Children with SED and their Families*

The *Rosie D.* remedy will embody a considerable difference in the way children with SED are identified and are able to access and receive home and community-based services. However, it is not yet clear how children and their families will react to the system-wide changes. While a focus on community-based care will likely be viewed as a positive change, families may be reluctant to fully cooperate with the new system, and may find this new model of care intrusive rather than helpful. A fear of compromising privacy also may be a barrier that deters some families. The system must be designed carefully, with significant input from families and parents, to ensure that children who are receiving services in the community receive a high level of care coordination and that the burden of care does not disproportionately fall upon parents and families.

There is a powerful need to maintain the integrity of continuity of care for *all* children—those served by MassHealth as well as the uninsured and underinsured children with SED who are not eligible for Medicaid but still receive mental health services through DMH, DSS and DYS. Some children may cycle on and off of Medicaid frequently, such as when a parent switches jobs and loses employer-sponsored coverage, or when family income changes. A loss of Medicaid benefits often can result in abrupt changes and regression, significant events for this very fragile and unstable group of children. A challenge for state officials and advocates

will be to address this issue of continuity of care on a broader scale, so that all of the state's children who need treatment actually receive it.

## Conclusion

The *Rosie D.* decision and remedy have the potential to create a positive and lasting change and could transform the entire infrastructure of children's mental health. The challenges and opportunities of implementing the *Rosie D.* remedy are significant. At this early juncture, it is difficult to predict how implementation of the remedy will affect the children and families it

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is intended to assist. Even more uncertain is exactly how it will affect the providers, existing mental health centers, and agencies within EOHHS. EOHHS (and MassHealth and DMH, in particular) will be put to the task of maintaining the integrity of their existing programs, while simultaneously working to construct and implement a new system of mental health care for children. Providers and community mental health agencies will face the challenge of meeting capacity benchmarks while continuing to deliver a high level of quality care. And, perhaps most importantly, MassHealth-enrolled children with SED and their families will need to

adjust and learn to navigate this new system. When the plan is fully implemented, though, Medicaid-eligible children with SED can expect to be identified more quickly and to have much less difficulty accessing behavioral health services, which they will be able to receive more readily in their homes and communities.



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## I. Introduction

The recent ruling in *Rosie D. v. Romney*—a class action lawsuit which found that children and adolescents with serious emotional disturbances (SED) in Massachusetts were not receiving the mental health screening and home-based treatment services mandated under the federal Medicaid Act—has far-reaching implications. This brief explores the implications and potential effects of the case and the resulting proposed remedy on the MassHealth program, other state programs, the behavioral health and social service delivery systems for children, and affected children and their families. It provides a broad portrait of what stakeholders currently understand about the case and affords the opportunity to consider successes and failures as the state begins to implement the remedial plan. The ruling is significant because it entitles children to extensive community-based services. It calls for the creation of a new mental health infrastructure, based on a unified “System of Care”—widely considered to be the best approach to serving children with complex mental health and behavioral needs—that incorporates a team of providers, parents and other family members, teachers and other stakeholders from across various child-serving agencies to develop and manage a treatment plan in a community setting.

## II. Overview

### History of the Issue

For the past two decades, children with SED in Massachusetts have faced significant challenges in navigating the public mental health system, due to multiple entry points and fragmented service delivery. Although national data show that this is not unique to the Commonwealth, it is frustrating given that the state has one of the strongest public insurance programs in the country. MassHealth, Massachusetts’ Medicaid program, serves more than 460,000 children each year; of those, a large percentage requires some type of mental health treatment. Children with severe mental health needs who qualify for MassHealth may receive care from a patchwork of providers, including state and private agencies, public schools and the courts. Massachusetts’ Executive Office of Health and Human Services (EOHHS) oversees many of the state agencies that provide mental health services to children and adults, including the Office of Medicaid, which administers MassHealth, and the Departments of Mental Health (DMH), Youth Services (DYS), Social Services (DSS), and Mental Retardation (DMR). Each agency has its own method of delivering services, and the methods of funding these services vary greatly. The issue of a fragmented delivery system and “stuck kids”—where children who are well enough to be moved to community settings

are left waiting in general and private psychiatric hospitals and residential acute-care facilities because adequate services are not available—is symptomatic of the problem. At any given time, between 125 and 140 children are “stuck” in Massachusetts’ child-serving public system.

Those who do receive needed services within their communities often are faced with an array of confusing requirements, varied points of entry, and inadequate support services, which further adds to the frustration of acquiring services. A November 2006 report issued by the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) and Children’s Hospital in Boston addresses the issue in detail.<sup>1</sup> The problem is exacerbated for children and adolescents with a serious emotional disturbance (SED)—mental, behavioral, or emotional disorders that include anxiety disorders, attention-deficit disorders, mood disorders, psychotic disorders, somatoform disorders, and eating disorders.<sup>2</sup> Children with SED suffer from the most severe forms of mental disorders and typically require the most intensive treatments, ranging from hospital and institutional-based care to intensive community-based services.

The difficulties children with SED face in navigating this disjointed system were illuminated in October 2001 in the case of *Rosie D. v. Romney*, a class action lawsuit filed against the state of Massachusetts on behalf of eight families with children with serious psychiatric disabilities who were hospitalized or at risk of hospitalization.<sup>3</sup>

Attorneys for the plaintiffs charged the state with violating several key provisions of the Medicaid Act, including failure to provide intensive home-based services for Medicaid-eligible children with SED. Specifically, plaintiffs argued that the state failed to meet the requirements of Medicaid’s EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) program, which requires states to inform children and their families of existing screening and treatment services and to pay for these services when they are provided to a child with a medical need.

### **The EPSDT Program**

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid’s benefit plan for children and adolescents up to age 21. Since its inception under the Medicaid Act in 1967, EPSDT has been the principal source of well-baby and well-child care for low-income children in the United States. The comprehensive screening services under EPSDT include developmental and behavioral health assessments, physical exams and developmental history, age-appropriate immunizations, laboratory tests, lead screening, and health education. EPSDT screens are intended to help physicians and families identify—and ultimately diagnose—potential developmental and health problems. The EPSDT statute *expressly* requires states to screen, diagnose and treat all Medicaid-eligible children for mental health disorders. Each state develops a schedule for practitioners (in consultation with recognized medical and dental organizations involved with child health care) that dictates how often and

when children should receive well-child screens, including vision, dental and hearing services. It also calls for interperiodic screens, as needed.<sup>4</sup> These guidelines are detailed in each state's Medicaid regulations.

EPSDT was strengthened significantly by the Omnibus Budget Reconciliation Act of 1989 (OBRA-89).<sup>5</sup> Although EPSDT previously was limited to services specifically listed in a state's Medicaid plan, OBRA-89 required states to provide *any* treatment service authorized and reimbursable under federal law, as long as it is "medically necessary."<sup>6</sup> The Medicaid Act allows states to develop their own criteria for determining medical necessity.<sup>7</sup> In Massachusetts, a service is "medically necessary" if it is "(1) reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness and infirmity; and (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth Agency..."<sup>8</sup>

The federal government has set broad guidelines that each state is required to follow when establishing and administering its EPSDT program, and leaves much of the details of EPSDT program development, such as the use of screening tools and tracking mechanisms, largely up to the states. Although this flexibility is an inherent part of the federal-state Medicaid program, it also represents one of the major problems with EPSDT. Essentially 50 different EPSDT programs exist, which translate to 50 different ways of interpreting and implementing screening and treatment guidelines. Such state-to-state variation can sometimes present its own set of issues. Massachusetts was one of only seven states in FY 2003 to meet the federal government's EPSDT performance benchmark for screening (set at 80 percent of children through age 3), but it fell short with diagnosis and treatment.<sup>9</sup> When screening detected a problem for the same age group, fewer than half of these children were actually referred for diagnosis or treatment.<sup>10</sup>

Like all states, Massachusetts is required to inform all Medicaid-eligible children of these services and to provide EPSDT screens; when these screens uncover physical or mental medical problems, states are obligated to follow-up with diagnosis and necessary treatment. These two requirements of EPSDT—informing and providing treatment for services identified in the screening process—are at the core of the *Rosie D.* lawsuit.

### **Current Mental Health Service Delivery Structure for Children in MassHealth**

MassHealth serves as the “approver” and “payer” for mental health services and provides many of the mental health services to children in the state.<sup>11</sup> Most children enrolled in MassHealth are required to enroll in managed care.<sup>12</sup> Mental health benefits for these children are provided either through one of four Managed Care Organizations (MCOs) or through the Primary Care Clinician (PCC) Plan.<sup>13</sup> Those enrolled in the PCC Plan receive mental health services through a managed care “carve out” vendor, the Massachusetts Behavioral Health Partnership (MBHP).<sup>14</sup> MBHP, which has served as the state’s behavioral health carve out since 1996, serves approximately half of all children enrolled in MassHealth. The MBHP contract is managed jointly by MassHealth and DMH. MBHP and each MCO manage care and handle claims for MassHealth enrollees, and each maintains its own network of mental health providers, although there is considerable overlap across these networks.

Children can receive mental health treatment through a number of child-serving agencies in Massachusetts in addition to MassHealth— DMH, DYS, DSS, and DMR.<sup>15</sup> **(See Table 1).** As the state mental health authority, DMH provides non-acute mental health services to children, including specialized services for children and adolescents with SED. Although it provides case management services directly, DMH contracts out all other children’s mental health services through independent providers.<sup>16</sup> DMH is organized into six geographic areas across the state, each of which is further divided into multiple “local services sites”. Each site oversees the state’s mental health services, which are provided through state hospitals, community mental health centers, residential treatment programs and community-based care.<sup>17</sup>

**Table 1: Current Structure of Service Delivery Across State Agencies**

State Agency	Medicaid-Eligible Children and Adolescents with SED Served	Organizational Structure	Delivery Structure for Medicaid-Eligible Children with SED	Initial Point of Contact	Mental Health Services Provided
<b>Office of Medicaid (MassHealth)</b>	<ul style="list-style-type: none"> <li>• Children up to age 21</li> </ul>	<ul style="list-style-type: none"> <li>• 4 Managed Care Organizations (MCOs)<sup>1</sup></li> <li>• 1 Primary Care Clinician Plan (PCCP)</li> </ul>	Enrolled children receive services through: <ul style="list-style-type: none"> <li>• Public and private hospitals</li> <li>• Community mental health centers</li> <li>• Schools</li> <li>• Other EOHHS agencies</li> </ul> MBHP maintains own network of licensed mental health providers	<ul style="list-style-type: none"> <li>• Primary Care Provider (or Pediatrician)</li> <li>• Other EOHHS agency</li> <li>• School</li> <li>• Hospital</li> <li>• Community health or mental health providers</li> </ul>	<ul style="list-style-type: none"> <li>• Acute care</li> <li>• Inpatient psychiatric care and day treatment</li> <li>• Outpatient hospital physician services</li> <li>• EPSDT services</li> <li>• Mental health center services</li> <li>• Targeted Case Management</li> </ul>
<b>Department of Mental Health</b>	<ul style="list-style-type: none"> <li>• Children and adolescents up to age 19 who do not have access to mental health services through other state agencies; individuals age 19-21 are served through DMH's adult system</li> </ul>	<ul style="list-style-type: none"> <li>• 6 geographic areas, divided into 31 Local Service Sites (LSS)</li> <li>• Each LSS provides case management and oversees mental health services</li> </ul>	Contracted services provided by: <sup>2</sup> <ul style="list-style-type: none"> <li>• Residential treatment programs</li> <li>• Community-based services</li> <li>• Adolescent inpatient units</li> <li>• Schools</li> <li>• After school and parent support services</li> <li>• Other EOHHS agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Eligibility Determination Specialist or case manager</li> </ul>	<ul style="list-style-type: none"> <li>• Extended stay/continuing care services</li> <li>• Intensive residential treatment</li> <li>• Day/home treatment</li> <li>• Case management</li> <li>• Individual and family support services</li> <li>• After-school programs</li> <li>• Skills training/support services</li> <li>• Community-based continuing care services</li> </ul>
<b>Department of Youth Services (Juvenile Justice)</b>	<ul style="list-style-type: none"> <li>• Children up to age 18 who are:               <ul style="list-style-type: none"> <li>• arrested on criminal charges in pretrial detention</li> <li>• found to be an adjudicated delinquent<sup>3</sup></li> <li>• referred by the court through a CHINS proceeding<sup>4</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 4 geographic areas</li> </ul>	State-operated and contracted services provided by: <ul style="list-style-type: none"> <li>• Hospitals and health care agencies in each geographic area</li> <li>• Residential settings (group homes or residential schools)</li> <li>• Community Reentry Centers</li> </ul>	<ul style="list-style-type: none"> <li>• DYS licensed clinician who contracts with behavioral health providers or Juvenile Court Clinicians<sup>5</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Acute care<sup>6</sup> (Juvenciles receive mental health evaluations within 24-hours of admission)</li> </ul>
<b>Department of Social Services (Child Welfare)</b>	<ul style="list-style-type: none"> <li>• Children through age 18<sup>7</sup> who:               <ul style="list-style-type: none"> <li>• are removed from home due to abuse or neglect and placed in DSS custody</li> <li>• voluntarily seek care through DSS<sup>8</sup></li> <li>• are referred by the court through a CHINS proceeding</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 29 Area Offices, divided into Lead Area Agencies (nonprofit organizations that contract with DSS to coordinate services in those areas)</li> <li>• Each Area Office provides case management</li> <li>• 6 Regional Resource Centers support Lead Area Agencies</li> </ul>	Contracted services provided by: <ul style="list-style-type: none"> <li>• Group homes</li> <li>• Intensive foster care settings</li> <li>• Behavioral treatment residences</li> <li>• Residential schools</li> </ul>	<ul style="list-style-type: none"> <li>• DSS licensed clinician or MBHP-contracted physician<sup>9</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Acute care<sup>10</sup> (Children in DSS care or custody receive mental health evaluations within 30 days of entering system)</li> </ul>

<sup>1</sup> Neighborhood Health Plan, Fallon Community Health Plan, Network Health and Boston Medical Center HealthNet.

<sup>2</sup> For individuals age 19-21, DMH provides services directly through its community mental health centers and state-operated inpatient units.

<sup>3</sup> Juvenciles in DYS detention facilities are not eligible for Medicaid, but when they are moved into DYS community placement, they may then be referred for EPSDT screening.

<sup>4</sup> A CHINS (Child in Need of Services) petition is filed in juvenile court, usually by a parent, school, or law enforcement official, in an attempt to prevent a youth from perpetuating harmful behaviors (such as truancy or delinquency).

<sup>5</sup> Mental health workers who provide evaluations and mental health treatment services to adjudicated delinquents.

<sup>6</sup> Acute care includes EPSDT services.

<sup>7</sup> Medicaid-eligible children who "age out" of DSS custody at age 19 are now eligible to continue receiving MassHealth services through age 21.

<sup>8</sup> DSS must provide EPSDT services for children in DSS custody, however; DSS can assist (but is not required to provide) those services to children who voluntarily seek assistance through DSS.

<sup>9</sup> Medicaid-eligible children in DSS care or custody receive mental health services through MBHP.

<sup>10</sup> Acute care includes EPSDT services.

Sources: EOHHS; Boston Bar Association and Children's Hospital Boston: *The Parents Guide to Children's Mental Health Services in Massachusetts* (Boston: BBA and Children's Hospital, 2007); Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) and *Children's Hospital Boston, Children's Mental Health in the Commonwealth: The Time is Now* (Boston: MSPCC and Children's Hospital Boston, November 2006).

Two other agencies within EOHHS—DSS and DYS—also provide mental health services for children with SED, although each has very different rules that govern access to the services. Mental health care for a child receiving services through DSS, Massachusetts’ child welfare agency, depends upon whether the child is voluntarily receiving services from DSS or whether he or she has been placed in DSS custody due to reports of abuse or neglect, or for care and protection.<sup>18</sup> When a child is placed in DSS custody, DSS caseworkers are responsible for ensuring that the child receives an EPSDT screen and subsequent assessment and treatment, if necessary. However, if a child’s DSS placement is voluntary, DSS can assist (but is not required to ensure) the child and his or her family in initiating the screening, assessment and treatment process.<sup>19</sup> Children in the DSS system who are eligible for MassHealth receive services through MBHP. DSS also contracts with multiple providers across the state to provide intensive foster care, group homes, behavioral treatment residences, and residential schools for children with SED in the DSS system.<sup>20</sup>

DYS— Massachusetts’ juvenile justice agency— is not considered a “voluntary” agency, and therefore is in a somewhat different position from the other agencies involved in caring for children with SED. Children are placed in the DYS system after they are adjudicated to be delinquent or during pre-trial detention. DYS contracts with behavioral health care providers to provide mental health services during the intake process to those children who require them.<sup>21</sup> As with DSS, DYS staff can refer children who have sought their services for EPSDT screening and subsequent care, usually after they have been moved into community placement. Juveniles who are released from DYS detention facilities typically are required to report to a “Community Reentry Center” or are placed in a group home. It is here that these children could benefit most from the *Rosie D.* ruling.<sup>22</sup>

Each of these agencies works together in various situations to provide mental health services for children. The Collaborative Agreement Program (CAP), for example, is a program that blends funds from DSS and DMH<sup>23</sup> to provide specific services for children with SED who are at risk for placement outside of the home.<sup>24</sup> CAP is available to children and families who do not have any current or prior DMH or DSS involvement, and assists in determining which state agency services are most appropriate to meet the needs of the family. Examples of other interagency agreements include the “Safety First Initiative,” a collaboration between DMH, DYS and DPH to provide improved safety and health care services to children in secure residential DYS programs,<sup>25</sup> as well as the Mental Health Services Program for Youth (MHSPY) and Coordinated Family Focused Care (CFFC) program, two community-based initiatives aimed at combining physical and mental health treatment with family supports for children with SED. These programs are jointly funded by the Office of Medicaid, DMH, DSS and DOE (and, in the case of MHSPY, DYS as well).<sup>26</sup> The Massachusetts Department

of Early Education and Care (EEC) also combines funds with the Office of Medicaid to provide on-site mental health consultation to teachers in child care settings.

### III. Background of The *Rosie D.* Case

While several other EPSDT lawsuits involving children with mental health disabilities have been brought against a number of states in recent years, *Rosie D. v. Romney* is the first of this magnitude to be litigated in the Commonwealth.<sup>27</sup> The case went to trial in April 2005. Following a six-week trial that included lengthy testimony by both plaintiffs and defendants, U.S. District Judge Michael A. Ponsor ruled in January 2006 that the state failed to comply with EPSDT provisions. Specifically, he cited two violations of the Medicaid Act:

- Insufficient behavioral health screenings, assessments, and treatment service coordination for as many as 15,000 children in Massachusetts with serious emotional disturbances (SED)
- Insufficient home-based behavioral support services for children with SED

In his ruling, Judge Ponsor noted that for many of these children with SED, “treatment occurs haphazardly with no single entity providing oversight; there is overlapping care and little or no coordination.”<sup>28</sup> Following its ruling, the court requested plaintiffs and defendants to attempt to negotiate a remedial plan. Since the parties were unable to agree, each side presented a separate remedial plan for children with SED. In July 2007, Judge Ponsor issued his final judgment, in which he accepted the state’s plan (referred to hereafter as “the remedy”), with certain key stipulations.<sup>29</sup> The main components of the proposed remedy are examined more closely in the following section.

“TREATMENT OCCURS HAPHAZARDLY WITH NO SINGLE ENTITY PROVIDING OVERSIGHT; THERE IS OVERLAPPING CARE AND LITTLE OR NO COORDINATION.”



## IV. Summary of the Final Judgment and Remedial Plan<sup>30</sup>

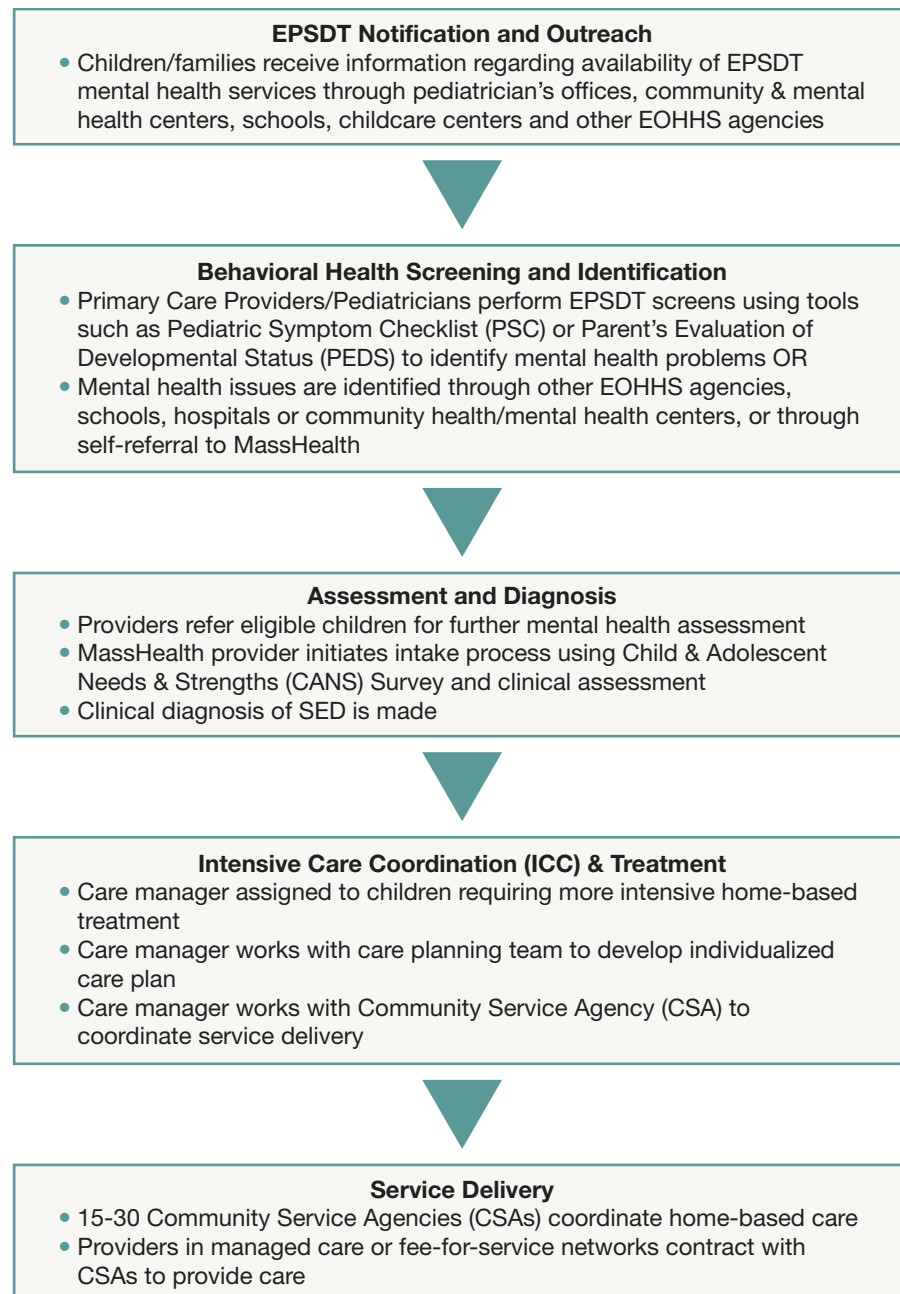
The state's plan was essentially adopted intact, with some key changes. Perhaps most importantly, the court defined the term "serious emotional disturbance" (SED), which is not defined in the Medicaid Act. Judge Ponsor used the criteria for SED set forth by the Individuals with Disabilities Education Act (IDEA)<sup>31</sup> and the Substance Abuse and Mental Health Services Administration (SAMHSA) to define SED and effectively established the plaintiff class of 15,000 children.<sup>32</sup> According to the court, all Medicaid-eligible children who meet the criteria for SED used by IDEA and/or SAMHSA will be eligible for medically necessary mental health treatment services through EPSDT.<sup>33</sup> In addition to this important change, the judge established more aggressive implementation timelines than the state had proposed and ruled that the provisions of the remedy are enforceable by law and cannot be modified without a court order. Under these new terms, certain provisions of the reform must be implemented by the end of 2007, and all must be fully implemented by June 2009.

There are five main components to the resulting remedial plan:<sup>34</sup> (See **Figure 1**).

### 1. Notification of EPSDT Services and Outreach

An important first step in moving forward with *Rosie D.* implementation requires improving education and outreach efforts to MassHealth members eligible for EPSDT and their families, as well as to MassHealth mental health providers. Outreach to families, providers and EOHHS agencies that typically come into contact with children with SED will be significantly boosted. First, the state will revise existing EPSDT notices and member handbooks to include information about available behavioral health screening and treatment services and how to access those services. MassHealth also will include updated EPSDT regulations in its MassHealth Provider Manual, and will amend its managed care contracts to ensure that network providers are aware of all updates and changes. MassHealth will conduct training for staff at DMH, DSS, DYS, DMR, as well as the Department of Transitional Assistance (DTA) and the Office for Refugees and Immigrants, explaining how children with SED can access EPSDT services. Outreach materials will be made available in primary care settings, as well as community health and mental health centers. MassHealth also will work with Department of Early Education and Care and the Departments of Education and Public Health, to educate school nurses, preschools, childcare centers, and Head Start programs about how to access behavioral health screenings and services for children enrolled in MassHealth. (See **Appendix A** for a status report of the state's progress to date on implementation of the notification and outreach component of the remedy).

**Figure 1. Pathway of EPSDT Services and Treatment for Medicaid-Eligible Children Under the Rosie D. Remedy**



## **2. Behavioral Health Screening and Identification**

A second component of implementation requires instituting improvements to existing EPSDT screening services. Under the new system, responsibility for periodic and inter-periodic screening will lie with primary care providers (PCPs) or pediatricians. Primary care providers will be required to utilize a standardized behavioral health screening instrument, such as the Pediatric Symptom Checklist (PSC) or the Parent's Evaluation of Developmental

Status (PEDS), a questionnaire for parents that inquires about a child's behavioral and emotional problems. The use of a universal screening tool is expected to improve screening practices and create a more uniform system of identifying and reaching children.<sup>35</sup> To ensure access through multiple entry points, children with SED who have already entered the mental health system through another venue (such as other EOHHS agencies, schools, hospitals or community health and mental health providers) will not be required to undergo formal screening. State agencies that identify children as needing to be screened, however, will refer the children to pediatricians for screenings. Children can self-refer and parents also may contact a MassHealth provider to request a behavioral health screening and subsequent assessment.

### **3. Assessment and Diagnosis**

Once a child has been referred for a behavioral health assessment (either through a PCP, through one of the other above mentioned pathways, or upon discharge from a hospital or intensive residential setting)<sup>36</sup>, he or she can go to a MassHealth-participating mental health provider where the assessment intake process will be initiated. All clinicians must be trained to use the Child and Adolescent Needs and Strengths (CANS) survey, an instrument used in conjunction with the clinical assessment to organize information and assist with the assessment and diagnosis.<sup>37</sup> Once a child has undergone an initial assessment, a licensed clinician will make a diagnosis and initiate a treatment plan. (While this is occurring, crisis services and short-term home-based services will be available to all children who require them immediately).

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

After undergoing a behavioral health assessment, children who demonstrate a medical need for intensive care coordination (ICC, which will likely be most children with SED) will be referred to an intensive care manager. Care managers will take the lead in providing services using the wraparound care planning process within a System of Care model<sup>38</sup> and must either be a licensed mental health professional or work directly under the supervision of such a professional. The care manager will be part of a larger care planning team, which will include the child, family members, providers, teachers, clergy, and other relevant support people, as well as a member of any other EOHHS agency with which that child is associated. The care manager will work with this team to develop an individualized care plan for the child, and is responsible for coordinating the child's entire treatment plan. In addition, the care manager will work with MassHealth and other agencies within EOHSS to coordinate service delivery. Information gathered through the child's clinical assessment and the CANS assessment will be used to develop the care plan. Each plan will outline specific treatment

goals and objectives, list the specific services the child will receive (including frequency and intensity of each service), integrate the child’s crisis plan, and identify appropriate service providers.<sup>39</sup> Care managers will be required to review the care plan each month, and the entire care planning team must review each plan on a quarterly basis.

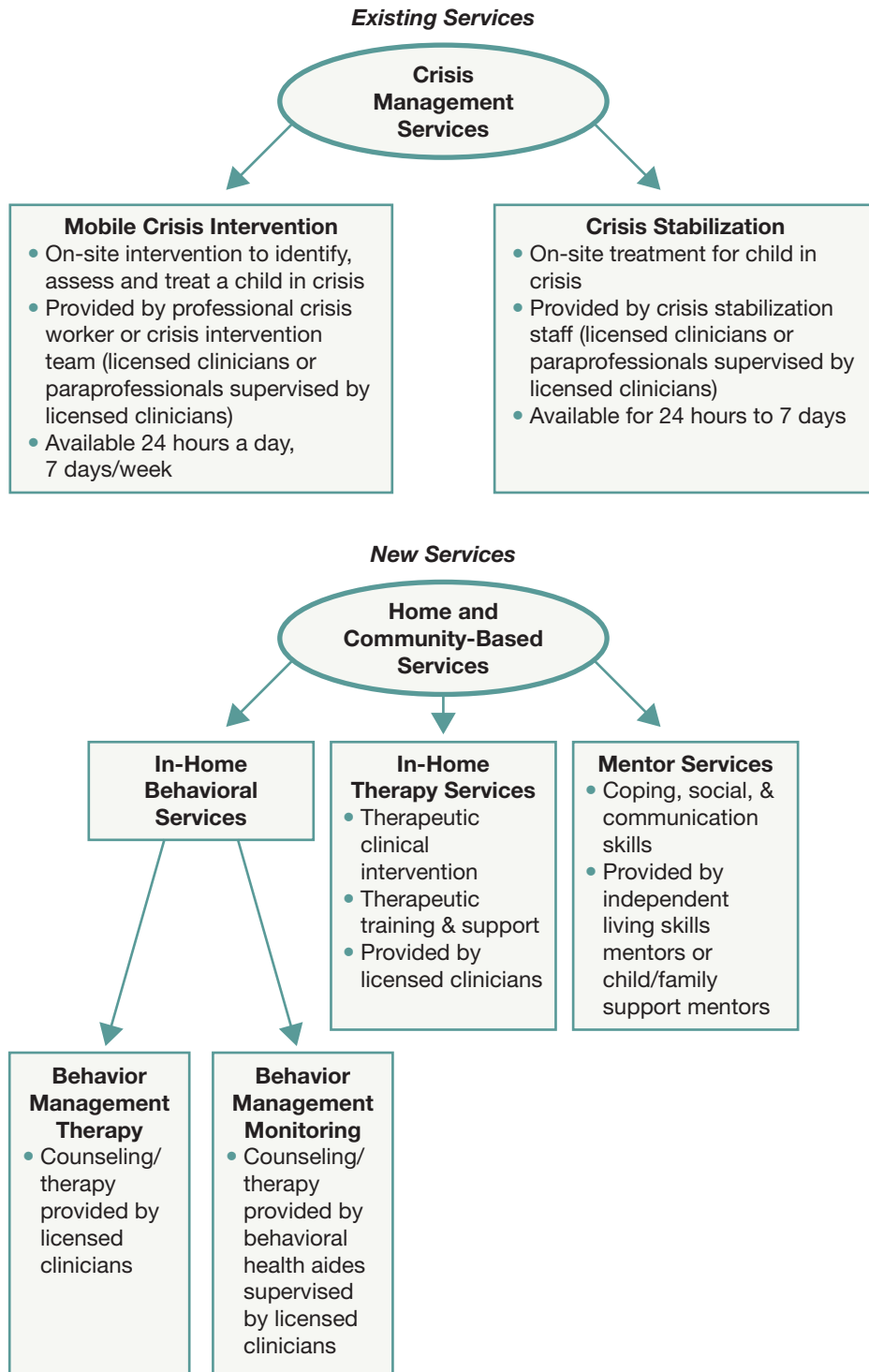
The development of *intensive home and community-based services* (**See Figure 2**) is one of the key elements of the entire *Rosie D.* remedy. The ultimate goal of such services is to prevent a child’s removal from the home and subsequent placement in residential care or hospital. These services either will be administered in the child’s home (birth, adoptive or foster), or in the child’s community, in settings such as childcare centers or respite homes. They are intended to allow children to return to their homes more quickly from more restrictive treatment settings, and to sustain a child’s tenure in their home, school, and community. Certain existing services, such as crisis services, will be augmented. For a child and family facing an immediate mental health crisis, mobile services –crisis intervention and crisis stabilization—will be available and will be provided either by a professional crisis worker or by a team. These mobile services are intended to help a child avoid admittance into the emergency room during a mental health crisis, because crisis services will be dispatched directly to the child. Crisis intervention will be available on a 24-hour basis and crisis stabilization will be available for up to seven days, if necessary.

In addition to these existing home and community-based services, three new services will be available to children who need them.<sup>40</sup> These include In-Home Behavioral Services, In-Home Therapy Services, and Mentor Services. In-Home Behavioral Services comprise behavior management therapy (provided by licensed therapists) and behavior management monitoring (provided by behavioral health aides under the supervision of licensed clinicians). In-Home Therapy Services include therapeutic clinical intervention and therapeutic training and support, and will ensure access and provide enhanced quality by serving a child in his or her natural environment. Mentor Services are designed to help improve the child’s daily coping, social, and communication skills, and are provided by independent living skills mentors or child and family support mentors.<sup>41</sup>

## 5. Service Delivery Network

The design and implementation of a comprehensive service delivery network is one of the larger and more complex components of the *Rosie D.* remedy. Mental health service delivery will remain under the purview of MassHealth, with significant input from the Department of Mental Health (DMH). DMH will work closely with MassHealth to establish a delivery network. The agencies will build a statewide network of community service agencies (CSAs), which will be “responsible for coordinating and providing or arranging” home-based care.<sup>42</sup> Each CSA will be located in one of 15-30 predetermined geographic areas across the state.<sup>43</sup>

Figure 2. Home and Community-Based *Rosie D.* Remedy Services



MassHealth's managed care behavioral health contractor, the Massachusetts Behavioral Health Partnership (MBHP), will select the CSAs, based on standards established by MassHealth and DMH, and will assist the CSAs in coordinating service delivery. MassHealth and DMH will establish qualifications, standards and performance measures for each CSA. Behavioral health providers who already are part of MassHealth's managed care or fee-for-service network will provide care through contracts with CSAs. <sup>44</sup>

## **Other Plan Components**

### **Data Collection**

To expedite the identification of SED children in need of services and to streamline service delivery monitoring and tracking, EOHHS is required to create a comprehensive data collection system. The state will employ existing mechanisms that are used to capture utilization and spending data from MassHealth claims reimbursement forms, such as the Medicaid Management Information System (MMIS)<sup>45</sup> and data collection mechanisms used by the MCOs and MBHP. EOHHS also will design and develop an automated web-based technology system, which will include a mental health tracking component. This information technology component will record more comprehensive access and utilization data such as number of EPSDT screens and assessments, number of referrals and home-based assessments, and utilization of intensive care coordination services and home-based support services. It also will provide data to measure health outcomes and member satisfaction.

### **Direction and Oversight**

To fulfill the requirement of appointing a compliance coordinator for the plan, EOHHS created a new position as part of its Interagency Initiatives effort.<sup>46</sup> The compliance coordinator is responsible for overseeing the state's implementation of the remedy, and will assist MassHealth and the other agencies within EOHHS as they work through the plan's development and execution. Judge Ponsor also appointed a court monitor (agreed to by both the plaintiffs and defendants) to oversee implementation of the remedy by both parties and to ensure that the state fully complies with the judgment.<sup>47</sup>

## V. How It Could Work

### Potential opportunities/benefits

Stakeholders are optimistic about the opportunities that implementation of the *Rosie D.* remedy could bring. Both state officials and advocates agree that the remedy is a move in

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the right direction for Medicaid-eligible children and adolescents with SED, and that it will serve as a good case management model, which will be instrumental in getting all of the relevant child-serving agencies on board. Marylou Sudders, former Massachusetts Commissioner of Mental Health and current President and CEO of the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) has called the plan a “deliberative and thoughtful response to the court order,” and applauds the state in its efforts to improve community outreach.<sup>48</sup> Judge Ponsor also stated that the “plan holds a ‘real prospect’ for curing the Medicaid violations found by the

court.”<sup>49</sup> Inarguably, the remedy will create a better system to monitor the care of children. The most significant benefits that are expected to accrue as a result of implementation are:

#### 1. Improved EPSDT Screening and Treatment

Early screening and treatment for children enrolled in the Medicaid program are correlated with improved health outcomes.<sup>50</sup> Through effective screening, families and physicians are able to identify potential mental health issues, which may help to ameliorate future problems. Early identification leads to early intervention, which may, in turn, lead to more successful and possibly less expensive treatments further down the road.

#### 2. Improved Service Delivery

The *Rosie D.* remedy affords a critical opportunity to transform an unworkable system for children and their families, and represents a strict departure from the current fragmented service delivery system. The intended result would be an improved and streamlined arrangement that is integrated across multiple child-serving agencies. Treatment plans and services will be specifically tailored to fit the needs of each child and family they are intended to serve. This is particularly important, as children’s mental health problems do not occur in isolation and often need to be addressed in the context of the child’s family unit. The remedy also will likely create a delivery system in which services are more clearly defined, with more consistent provider rates.

### **3. Shift from Institutionalized/Residential Care to Community-Based Care**

The *Rosie D.* remedy represents a paradigm shift from institutionalization and residential school placements to community-based care. The benefit is that these services are relatively portable, and children with SED will receive care in settings that are familiar and comfortable to them, such as their homes, schools, and child care centers. A growing body of research has evidenced the benefits of home and community-based care over institutionalization and residential school care.<sup>51</sup> Federal and state agencies (including Massachusetts DMH) have recognized that providing care in the least restrictive setting (where a child can be integrated into the community, rather than segregated from it) is more beneficial to children with SED, and have been working toward achieving that goal in recent years.

### **4. Improved Outcomes Measurement**

The information gathered by the new data collection system ultimately can be used to improve quality of care for children with SED. The monitoring contingencies that will be put in place also promise to ensure a better method of tracking families to prevent children from getting “lost” in the system and falling through the cracks.<sup>52</sup> Improved data collection mechanisms also offer an opportunity for EOHHS to make programmatic improvements whenever necessary.

The new administration’s recent decision to appoint Assistant Secretaries at EOHHS, who do not also serve as Commissioner of an agency, to oversee certain agencies could also help to realize the preceding benefits. There is a sense within EOHHS that the organizational changes will bring a greater degree of collaboration among child-serving agencies. Several new appointments to key agencies seem to reflect Governor Patrick’s commitment to increasing interagency collaboration. The Office of Children, Youth, and Families Services has taken on a slightly enhanced role, in that it will have more administrative oversight for DSS and DYS, which could set the tone for these agencies to work together more closely.<sup>53</sup> In addition, several of the new appointees promise to bring significant insight and experience to the issues surrounding *Rosie D.* implementation.

## **Potential Challenges**

In essence, the remedy calls for the implementation of a statewide system of care model, which will, by its very nature, present many challenges and obstacles. A few of the most significant challenges that key stakeholders anticipate are outlined below.

### **1. Workforce Shortages and Provider Capacity Issues**

As have many other states, Massachusetts has faced a provider shortage in recent years; this is particularly acute in pediatric settings, where there is a shortage of “child-trained” providers



such as psychologists and social workers. Low Medicaid and private insurance payment rates, high staff turnover due to low pay and high rates of “burnout,” and disincentives in child psychiatrist training programs are driving these shortages. Adding to this problem is the need for outpatient providers to do significant unpaid collateral work in order to provide effective services. (For example, providers often need to speak with the teachers, family members and others close to the child to get a clearer understanding of how to diagnose and treat).<sup>54</sup> In addition to a shortage of pediatric psychiatrists, there also appears to be a shortage of community settings in which to provide mental health care.

Other barriers to access include an uneven distribution of providers throughout the state, as well as an inadequate number of bilingual and multi-cultural providers to administer culturally competent care to diverse populations of children with SED. All of these factors could have resounding implications for the *Rosie D.* outcome, as the state struggles to engage more qualified providers and train them in the new delivery structure. This, in turn, points to another issue—licensure. Currently, many clinicians involved in providing various aspects of mental health care to children with SED (particularly those who serve bilingual populations) have earned Master’s degrees but are not licensed. While these providers qualify for Medicaid reimbursement under current protocols, the remedy calls for such licensure (or supervision by a licensed provider), which could further restrict the existing pool of providers.<sup>55,56</sup>

Implementation of the community-based model of care represents a shift in service delivery and also is expected to present a unique set of challenges to providers, who will be required to change their existing patterns of care. Under the traditional model of care, most therapists and psychiatrists meet with their clients in an office setting and are accustomed to providing discrete levels of care. Some providers may be reluctant to leave their offices to provide care and may resist going out into the communities to deliver care. It will be challenging to teach these clinicians (many of whom have not been trained in the wraparound approach to care) to be part of a care management team in the home, and to teach them to build community support.<sup>57</sup> Those closely involved with existing methods of service delivery speak to the need for a “philosophical change” in the way the system will work.

Some stakeholders argue that provider capacity is an even more persistent problem than provider shortages.<sup>58</sup> This goes back to the issue of “stuck kids,” although it is not always a simple case of *whether* kids are being detained in hospitals and residential facilities once they are diagnosed as stable enough to be released. Instead, it is more often a question of *where* these children will go once they are released, since a reliable infrastructure of home-based care is currently not available. The community supports and home-based services that are available exist only in “pockets” and on a short-term basis. While one of the main goals of the *Rosie D.* remedy is to address this problem, advocates worry that it may be difficult to

develop the capacity to provide in-home wrap-around services, such as planning, training, and implementation; especially since this was not clearly addressed in either the final plan or the plaintiff’s proposed plan.<sup>59</sup> As *Rosie D.* compliance coordinator Emily Sherwood acknowledges, “Building the infrastructure and the statewide capacity for delivery systems will be one of the biggest challenges to implementation.”<sup>60</sup>

“BUILDING THE INFRASTRUCTURE AND THE STATEWIDE CAPACITY FOR DELIVERY SYSTEMS WILL BE ONE OF THE BIGGEST CHALLENGES TO IMPLEMENTATION.”

## 2. Lack of Detail in Certain Components of the Remedy

The court remedy leaves many details to be developed further as the state implements the plan. Specifically, the details outlined in the remedial plan regarding the structure of the service delivery system will need to be more clearly defined over time. For example, the state will need to determine how it will negotiate the new provider contracts, decide how to set billing rates for new services (and whether they will be provided at a capitated rate or through an hourly fee) and define utilization standards, provider qualification and training standards and performance measures. Also unclear is which entities will serve as CSAs and how they will be selected. Many of the details of the technology system also have yet to be decided, including whether to use an outside contractor or to design the system in-house. Keeping this in mind, Judge Ponsor in his final judgment specifically agreed that it was within EOHHS’s discretion to fill in the details as implementation of the remedy proceeds, and then, if the state is unsuccessful in its efforts, the plaintiffs can return to court. Ultimately, the court monitor will be looking at the effectiveness and feasibility of the implementation plan. One of the benefits to this approach is that the state will not be locked into a path of implementation that could turn out to be more difficult than necessary to implement the goal.

As implementation moves forward, more of these key issues will be decided. MassHealth and DMH officials will take the lead in directing implementation, with input from other agency members. The “*Rosie D.* Implementation Team,” a cross-agency collaborative, has formed internal workgroups for each of the main components of the remedy. These workgroups have been meeting regularly, and will be responsible for making many of the decisions regarding program implementation. In addition, the “*Rosie D.* Executive Team,” chaired by EOHHS Secretary Dr. JudyAnn Bigby, has convened recently. This team is composed of Commissioners of each of the agencies involved with *Rosie D.* implementation, as well as selected department heads, and will provide substantive guidance and input throughout the implementation process.

### **3. State and Federal Approval**

The Office of Medicaid has sought guidance from the Centers for Medicare and Medicaid Services (CMS) on how to proceed with *Rosie D.* implementation.<sup>61</sup> CMS approval for the new services proposed in the plan is required; without it, the state will not be eligible for federal financial participation (FFP) for those services. (The federal government matches 50 cents for every dollar that the state spends in Medicaid funding on services that are part of the state's approved Medicaid plan.) CMS has indicated that it will not approve services outside of the waiver or state plan renewal process, and it remains unclear as of this writing if CMS will approve these services. The issue is whether CMS believes the services fall within one of the categories of medical assistance listed in the Medicaid Act, and whether the agency believes the service already is provided by another legally responsible party (e.g., DSS, in the case of children in foster care). MassHealth officials remain apprehensive because certain similar services in other states have been rejected by CMS (such as care coordination assessments in California).<sup>62</sup> Ultimately, as long as the services that are offered in the community fall within the scope of services that CMS usually approves, it is quite possible that it will approve the state's request for coverage of these services. However, EOHHS also is concerned that new rehabilitation and targeted case management regulations that are forthcoming from CMS will place further constraints on the types of services that are approved and could make implementing *Rosie D.* more challenging and could further threaten the state's assurance of FFP.<sup>63,64</sup> If CMS determines that FFP is not available for a particular service in the remedy, the state is not obligated to provide that service exclusively at state cost. As a result, FFP approval is a critical milestone to successful implementation of the remedy. Several other elements of the remedy, such as the information technology system design, also require state legislative approval. And, of course, the legislature will need to authorize funding for the major plan components.

Given these potential implementation issues, it will be critical to have a cohesive mechanism in place to monitor the progress of all involved parties. While no specific plans have been established yet, the court monitor has the authority to "recommend corrective or further actions necessary to redress any problems identified in implementing the court's judgment."<sup>65</sup> The compliance coordinator and court monitor are aware of the potential implementation obstacles (such as provider shortages and capacity issues), and will be observing closely to ensure that the remedy is effectively executed.

### **Annual Programmatic and Administrative Costs**

#### **Projected Costs of Plan Implementation**

Perhaps one of the most important aspects of *Rosie D.* implementation deals with administrative costs (required for initial setup and program design and provider training) and

THE COURT ANTICIPATES THE ANNUAL PROGRAM AND OPERATING COSTS WILL BE ABOUT \$459 MILLION.

annual program and operating costs (required to fortify screening and assessments, to provide service coordination and new services, and to maintain the program). Plaintiffs' counsel and many advocates close to the case have projected cost estimates of full implementation between \$200 and \$400 million annually for these 15,000 children. The state has estimated a range of \$149-\$612 million, and the court has anticipated that costs will likely be close to the state's mid-range estimate of \$459 million (the projected cost—in gross dollars, which includes the federal match—to cover the 15,000 children with SED who are expected to be identified through the new screening process and require treatment).<sup>66</sup> MBHP also calculated a per member, per month cost estimate and found that full implementation costs would be approximately \$400 million.<sup>67</sup>

These estimates, while reasonably solid, are heavily dependent on the number of children that enter the system as a result of the *Rosie D.* ruling. If MassHealth caseloads increase significantly beyond the estimated 15,000 children, the costs could rise accordingly. An improved screening and assessment process could mean that more children will be identified and qualify for services, which will drive up costs. Cost offsets also were not taken into account in the state's estimate.

### **Current Expenditures**

MassHealth funds behavioral health services for Medicaid-eligible children. In FY 2005, the state's behavioral health expenditures for Medicaid-enrolled children under age 21 totaled \$202 million.<sup>68</sup> The state's estimate of \$459 million for *Rosie D.* implementation is more than twice that number. It is important to note, however, that some of the money required for implementation of the remedy is already being accounted for. A significant portion of the \$202 million, included in the state's \$459 million estimate, currently is being spent on the SED population (in the form of therapy, certain home-based services and medications), so net new spending could be less than the full \$459 million. For context, \$459 million represents approximately 7 percent of total MassHealth spending on services in FY 2006. Fifteen thousand children account for approximately 1.5 percent of the MassHealth caseload at a given point in time.

### **Funding Sources**

Because *Rosie D.* is a lawsuit based on Medicaid law and deals with the obligations of the state's Medicaid program, MassHealth will be responsible for the majority of spending to implement the remedy. Funding for implementation is expected to come from a combination of appropriations from the legislature, savings offsets, and some degree of cost avoidance. MassHealth is not planning to rely on blended funding from other agencies to secure its share

of the required funding. Instead, in addition to seeking state funding, the agency will depend on streamlining service coordination and in-home support services, which ultimately could help to keep costs down because efforts will not be duplicated across agencies. At the same time, many of the cost offsets that likely will be seen are expected to benefit other agencies within EOHHS and won't necessarily be realized by MassHealth. For example, a reduced reliance on residential school placements could result in a savings to local school budgets, and, to a lesser extent, DSS's budget (but not to the MassHealth budget, since residential school costs are not generally covered by MassHealth). DYS might see a savings because early detection means that fewer of those children will end up in DYS custody. (However, if there is a significant increase in the overall number of children being served through these agencies, these offsets could be relatively small.)

Other "savings" could be found in non-MassHealth spending (such as "pass-through spending" which includes Medicaid claims for DSS caseworkers who handle Medicaid-eligible children), and decreased spending for services that Medicaid typically does not cover, such as stays in group homes and DSS residential facilities. In the end, these savings will be seen by the Commonwealth but will not necessarily trickle down to the MassHealth budget.

It is hoped that a proportion of the costs will be offset by a decrease in acute care psychiatric hospital use among children with SED. The current cost per child per day for a stay at one of Massachusetts' 15 acute care psychiatric hospitals is approximately \$620, with an average length of stay of 10-12 days.<sup>69</sup> Here, children typically receive short-term acute psychiatric treatment, where the goal is to stabilize the child and see them through a mental health crisis. Because MassHealth pays 100 percent of the cost of acute hospitalization for MassHealth enrollees (subject to a 50 percent FFP), acute inpatient care represents a fairly large percentage of Medicaid mental health spending for kids with SED. If children can instead be treated with mobile services, such as crisis intervention and crisis stabilization, money likely will be saved. To further reduce costs, MassHealth plans to incorporate utilization management techniques, such as prior authorization, outlier standards (including pre-or post-payment reviews and service-by-service reviews) and also will be setting clinical standards for its providers. The MCOs and MBHP also will continue to use existing utilization management and performance improvement techniques, such as their Quality Improvement Activities (QIAs).<sup>70</sup>

However, even when all of these factors—cost avoidance, offsets, and utilization management mechanisms—are taken into account, it is clear that the remedy still will be far from "cost neutral."

## Potential Implications for Involved Parties

### Impact on MassHealth – A Closer Look at Budget Neutrality and the Relationship With Health Care Reform

A majority of the Medicaid program in Massachusetts is operated under the authority of a federal “Section 1115 Demonstration Project,” called MassHealth. This demonstration, commonly known as a waiver, is an agreement with CMS that allows the Commonwealth to operate its program differently from the requirements of Title XIX, the federal Medicaid statute. This waiver gives the state significant administrative flexibility and also allows it to offer coverage to more people than would be permitted under a traditional Medicaid program, while still receiving the federal financial participation (FFP), up to a point, to cover these services. One important requirement of a Section 1115 demonstration project is “budget neutrality”; over the life of the waiver, the federal government will not reimburse more state spending than it would have in the absence of a waiver. This means that all expansion spending—either non-Title XIX populations or non-Title XIX services—must be offset by savings in the “traditional” or “base” population.

The state must submit a budget neutrality analysis each year, and in recent years has been very close to its budget neutrality limit.<sup>71</sup> Spending for *Rosie D.* implementation could put further pressure on budget neutrality (the terms of which are due for renegotiation when the MassHealth waiver is renewed next year). Since the *Rosie D.* remedy represents additional Title XIX costs for the demonstration’s base population, it is essential that the Commonwealth work with CMS to modify the budget neutrality limit to reflect these costs. The state is planning to provide CMS with its budget neutrality requirements in the fall of 2007, and these will include a proposal to integrate *Rosie D.* spending into the budget neutrality provisions.<sup>72</sup>

To obtain CMS approval (and ultimately FFP) for its proposed services, the state will amend its state Medicaid plan in the fall of 2007. This is because the court has ruled that the services in question—EPSDT services—are mandatory, and a state cannot be compelled to request a waiver of federal laws. At the same time, all Medicaid services for children in Massachusetts are provided under the 1115 waiver— so the waiver is implicated by what the state does with *Rosie D.* services, primarily in terms of the effect of the new state plan services on how much money the state spends on Medicaid services overall. All of this, in turn, has a direct impact on budget neutrality calculations. It is possible, though far from certain, that CMS will consider the fact that these new financial burdens are the result of a court order and raise the state’s budget neutrality ceiling accordingly. In the absence of such an agreement, *Rosie D.* spending would represent a budget neutrality expansion, and squeeze against the already tight budget neutrality ceiling.

The relationship of *Rosie D.* implementation costs to Massachusetts' newly enacted Health Care Reform Law, Chapter 58, is also an important concern. Chapter 58 does several important things— it expands coverage to children up to 300 percent of the Federal Poverty Level (FPL), increases enrollment caps in MassHealth programs that have them, and restores a number of benefits for adults. Chapter 58 also creates a new health insurance program, “Commonwealth Care,” which offers subsidized coverage, on a sliding scale, to low-income individuals below 300 percent of FPL. Perhaps most importantly, Chapter 58 creates a mandate that all Massachusetts residents obtain health insurance if an affordable plan is available. All of these expansions will have a positive effect on reducing the number of uninsured throughout the state. At the same time, these factors, when combined, promise to present an additional financial burden on available resources. While it certainly can be argued that there is no inclination in the current environment to cut MassHealth services or reduce eligibility, the state still will face tough choices in the coming year. *Rosie D.* represents a remarkable departure, in many ways, from the way in which MassHealth currently provides services to children with SED, and the challenge to EOHHS will be to implement the remedy without compromising core elements of its other programs.

#### **Impact on Other EOHHS organizations**

Although the brunt of the responsibility for implementing *Rosie D.* ultimately will fall upon MassHealth, other agencies that play an important role in providing services to children with SED—such as DMH, DSS, DYS, and DMR—will be affected as well. DMH staff will work with MassHealth to establish a delivery network and will assist in the design and development of an operating manual for the care planning teams. DMH also will be responsible for handling certain aspects of care under the plan. Because the lawsuit fundamentally is about creating a comprehensive and structured System of Care, a higher level of coordination among child-serving agencies can be expected. Interagency collaboration is a critical component of *Rosie D.* implementation. This is due not only to the overlapping nature of each agency, but also because the remedy expressly calls for such collaboration. For example, when children are receiving mental health services from MassHealth as well as other agencies within EOHHS, a representative from each involved agency must be part of the child's care planning team. Stakeholders argue that it is precisely this collaboration that will be the linchpin of the *Rosie D.* remedy, and it holds the key to success in building a stronger system of care. They caution that DMH (and DSS to a certain extent) must play a central role, rather than merely a peripheral one, and work in conjunction with the Office of Medicaid to design and develop a new delivery system model.

Because each agency has its own way of operating, EOHHS must be wary of creating further “silos of care.” One of the overarching organizational questions deals with how to integrate the overlapping service delivery systems of each agency. This is something that

officials within all branches of EOHHS have raised concerns about. Another concern is that implementation of the remedy through the CSA model could create a whole separate system of care, independent of the existing framework of community-based providers, with separate lead agencies (DSS, DMH, and MassHealth) all working in isolation from each other. The CSA model could afford the opportunity to achieve a more streamlined system, as long as the CSAs contract with providers who are affiliated with MBHP or the MCOs and maintain the same geographic base as the existing mental health providers. Stakeholders stress the importance of coordinating the system with significant input from each of the main child-serving agencies, while relying primarily on one lead agency, with one entry point, to oversee service delivery. Conversely, there is a threat that *Rosie D.* will create two systems: a “*Rosie D.* system” and another system for other Medicaid and non-Medicaid eligible children (who still need support from other public agencies), which will only further fragment an already fragmented system. Advocates also worry that because DMH funds services for many children with SED who are not Medicaid-eligible, these services could be eliminated due to a lack of funding and, as a result, these children could find it difficult to get the services they need.

#### **Impact on Existing Service Delivery System**

While some providers and administrators who oversee existing community-based mental health centers do not anticipate much of a change from the “status quo” with the implementation of the remedy, many welcome the court’s decision but are concerned about the implementation issues, particularly with respect to workforce issues, training and the current capacity of providers to respond appropriately. They also worry that in an effort to fortify the new delivery system, staff might be recruited from existing outpatient programs, which may, in turn, create longer waiting lists for outpatient clinics. As a result of that, “lower level” mental health issues, if left untreated for too long, could eventually escalate into true SED cases. This could have the unintended consequence of undermining the outpatient system, if the existing structure is not adequately supported. Providers and administrators caution that merely supplementing the salary of care managers to attract them will only serve to draw staff out of the existing outpatient system—a system that already faces challenges in staffing its clinics. Efforts should be made to avoid building a new system at the expense of the old system, and the focus should instead be on adding on to the existing system’s strengths.

As mentioned earlier, there also is concern in the provider community about the capacity of the system to handle a large influx of new patients. Community-based mental health providers worry that the creation of a single “gate” in each region for referrals and behavioral health screenings and evaluations (through the CSAs) could create a bottleneck and overwhelm the providers.



### Impact on Children with SED and Their Families

The *Rosie D.* case and subsequent ruling represent critical changes for children with SED and their families. In his ruling Judge Ponsor opined, “the plan will represent a new day for this population of underserved, disabled children.”<sup>73</sup> The resulting remedial plan represents an ambitious undertaking. If successfully implemented, it will embody a considerable difference in the way children with SED are identified and are able to access and receive behavioral health services, particularly home-based services. With this in mind, it is not yet possible to determine how children and their families will react to the system-wide changes that will occur. While a focus on community-based care likely will be viewed as a positive change, there has been some speculation that families may be reluctant to fully cooperate with the new system. Children and their families may find this new model of care intrusive rather than helpful, and may need specific guidance and reassurance as they move to a community-based model of care. A 2002 survey conducted to examine families’ experiences in obtaining mental health care for their children found that families tend to be unhappy when they do not know what to expect from mental health encounters.<sup>74</sup> Finally, a fear of compromising privacy may be a barrier that deters some families. At the same time, many of the families directly involved with the case have voiced their frustrations at the barriers to care they have encountered, and are optimistic that the community-based model is a better alternative than the fragmented care they have been receiving.

Stakeholders also caution that the system must be designed carefully, with significant input from families and parents, to ensure a high level of care coordination for children who are receiving services in the community. Under the current structure, services for children in residential programs are coordinated by existing staff, and the same thought and planning must go into creating a new community-based system, to ensure that this level of coordination is maintained and that the burden of care does not disproportionately fall upon parents and families

State officials and advocates alike seem confident that once the system is firmly in place, children with SED who qualify for Medicaid will receive the care that they require. At the

THE CHALLENGE TO STATE OFFICIALS AND ADVOCATES IS TO ASSURE CONTINUITY OF CARE FOR ALL OF THE STATE’S CHILDREN WHO NEED TREATMENT.

same time, there is a powerful need to maintain the integrity of continuity of care for *all* children—those served by MassHealth as well as the uninsured and underinsured children with SED who are not eligible for Medicaid but still receive mental health services through DMH, DSS and DYS. Some children may cycle on and off of Medicaid frequently, such as when a parent switches jobs and loses employer-sponsored coverage, or when family income changes. A loss of Medicaid benefits often can result in abrupt changes and regression, significant events for

this very fragile and unstable group of children. Some officials caution that the state could be in complete compliance with the *Rosie D.* ruling and still not be providing good, quality care to this other important group of children. The challenge to all state officials and advocates, then, will be to address this issue of continuity of care on a broader scale, so that all of the state's children who need treatment actually receive it.

## VI. Current Models

As an example of how an effective community-based system of care can successfully be developed and implemented, Judge Ponsor pointed to several existing wrap-around programs under EOHHS that fully comply with EPSDT requirements—Coordinated Family Focused Care program (CFFC), Mental Health Services Program for Youth (MHSPY), and Worcester Communities of Care (WCC). He noted that these are proven programs that work well for children with SED in Massachusetts, and that they seem to be cost effective. Specifically, he stated, “the adequate provision of necessary medical services for children with SED is not beyond the Commonwealth’s expertise, nor is it any more costly than the current, inadequate programming.”<sup>75</sup>

CFFC is a wraparound program for SED children at risk of being removed from community care, which serves two hundred fifty children at a time, fifty in each of five cities: Springfield, New Bedford, Brockton, Lawrence and Worcester. Services are paid for through a blended funding approach, with funds from Office of Medicaid, DMH, DSS, and the Department of Education. MHSPY is a community-based program that serves approximately fifty children with SED in five communities (Cambridge, Somerville, Malden, Medford, and Everett) who are at risk of being placed out of the home. It also works across multiple child-serving agencies, such as the Office of Medicaid, DMH, DYS, DSS, and DOE, to provide care. The WCC federal pilot program serves children with more extreme impairment than the other two programs. It was initiated in 1999 as a pilot program and became a part of the CFFC program four years later. Funding for all three programs is coordinated through MBHP and each program employs many of the same community-based treatments and services that are called for in the *Rosie D.* remedy. MHSPY, for example, utilizes case managers to coordinate intensive behavioral health services, which range from traditional services (such as medication, therapy and hospitalization) to less traditional services (such as respite care, tutoring, transportation and mentor services).<sup>76</sup> Each of these programs has been effective in their own niche. Children enrolled in several of the MHSPY sites, for example, were found to have a significant reduction in hospitalizations, residential care, and foster care. Most importantly, they showed significant functional improvement upon leaving the program.<sup>77</sup>

The obvious question, then, is are these programs viable models that the state could consider expanding upon? If so, how might they serve as models to inform *Rosie D.* implementation? Undoubtedly, there are elements of these programs that work well, and EOHHS could take those particular elements and reproduce them on a larger scale. For example, the CFFC program relies on a “family partner” to represent the parents’ needs and act as a liaison between the parents and service providers. Family partners help to ease the families’ transition to community-based care by helping to prepare families, providing peer-to-peer outreach, and handling other aspects of care management. This could be one way to help families feel more comfortable with and vested in the new service delivery structure. MHSPY providers also have found that that family engagement has been vital to the success of their program. Another key lesson these programs can teach is the importance of including physical health providers on the care team, to ensure that the integral relationships between physical and mental health for children with SED are fully understood.<sup>78</sup>

While there do seem to be elements of these programs that can provide valuable lessons in establishing a successful *Rosie D.* model, state officials and advocates agree that it is not simply a matter of taking these existing models and duplicating them across the state. These programs serve relatively small numbers of children and it would be very difficult to replicate them to provide services for 15,000 children. The costs of reproducing either MHSPY or CFFC on a scale of the magnitude needed to comply with *Rosie D.* requirements are prohibitive; the economies of scale that might be expected simply do not exist at such a widespread level. Intensive (and costly) education would be required for each staff member. CFFC also works in part because of its blended funding approach across agencies (relying on funding and service coordination from the Office of Medicaid, DMH, DSS, DYS and DOE), and it is unlikely that the Office of Medicaid will attempt to fund its *Rosie D.* initiative in this way.

## VII. Conclusion

The *Rosie D.* decision and remedy have the potential to create a positive and lasting change in the entire infrastructure of children’s mental health in Massachusetts. The challenges and opportunities of implementing the *Rosie D.* remedy are significant. At this early juncture, it is difficult to predict how implementation of the remedy will affect the children and families it is intended to assist. Even more uncertain is exactly how it will affect the providers, existing mental health centers, and agencies within EOHHS. EOHHS (and MassHealth and DMH, in particular) will be put to the task of maintaining the integrity of its existing programs, while simultaneously working to construct and implement a new mental health system of care for children. Providers and community mental health agencies will face the challenge of meeting capacity benchmarks while continuing to deliver a high level of quality care. And, perhaps most importantly, MassHealth-enrolled children with SED and their families will need to adjust and learn to navigate this new system. When the plan is fully implemented, Medicaid-eligible children with SED can expect to be identified more quickly and to have much less difficulty accessing behavioral health services, which they will be able to receive more readily in their homes and communities.

There are many concurrent existing factors that could create a climate that is particularly amenable to ensuring the success of *Rosie D.* implementation. An increased momentum in the state legislature to reform the children’s mental health system and strong support from advocates and families to address the problems inherent in the delivery of mental health care to children with SED, as well as the recent passage of comprehensive health reform in Massachusetts, all point to a climate that is ripe for change.

At the same time, stakeholders caution that we should not view the *Rosie D.* ruling through “rose-colored glasses” and note that it will not provide a “one size fits all” fix for the system. It is possible that the outcome of the remedy will actually turn out to be very different from what the advocates, families, and state agencies were expecting and hoping to achieve. As *Rosie D.* implementation moves forward in the coming months, stakeholders will need to continue to monitor, strategize, and evaluate their progress at each step along the way to ensure a successful outcome.

## Appendix A

### Progress Report on State's Implementation of Outreach and Screening Component of *Rosie D.* Remedy

The Court's Proposed Judgment in the *Rosie D.* case issued specific timelines by which the state must submit interim progress reports and reach final implementation of each phase of the Remedy. (See Appendix B).

In fulfillment of this requirement, EOHHS submitted its first implementation report to the Court at the end of June 2007. The report outlines the progress that the state has made to date toward the first components of the *Rosie D.* remedy— EPSDT Services Notification and Outreach Improvements and Behavioral Health Screening and Identification Improvements. The following is a brief summary of the state's report.<sup>1</sup>

#### I. EPSDT Services Notification and Outreach Improvements

##### For MassHealth Enrollees

- Updated its EPSDT Member Notices to indicate that mental health screening is part of routine well-child visits. The state began mailing these notices to MassHealth members in June 2007
- Drafted language, which updates its contract with EOHHS' customer services vendor, MAXIMUS, Inc. to require the training of customer service representatives on EPSDT services (specifically with regard to behavioral health screening), the use of the CANS screening tool, and the creation and availability of new ICC services for children with SED. This language also will be included in MassHealth's MCO enrollment guide, and the MBHP and MCO contracts
- Began updating its Member Handbooks to include the above information regarding availability and use of the EPSDT services, to be included in:
  - PCC Plan Member Handbooks (expected to be available in September 2007)
  - MBHP Member Handbook (EOHHS has required MBHP to create a handbook for its members, which is expected to be available in September 2007)

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<sup>1</sup> This summary includes information on specific progress that the state has made as of June 2007, when the report was submitted. For additional information regarding outreach and screening activities that the state has planned, see *Rosie D. et al. v. Mitt Romney et al: Defendants' Report on Implementation of Project One*. United States District Court. District of Massachusetts, Western Division. June 27, 2007.

- MCO Member Handbooks (expected to be available before December 31, 2007)
- Began collaborating with various advocacy organizations on outreach efforts. Specifically, the Compliance Coordinator has:
  - Met with The Parent/Professional Advocacy League (PAL) to discuss ways to notify families about EPSDT screenings, assessments and treatment services
  - Met with the Massachusetts’ Chapter of the AAP’s Mental Health Task Force to discuss the state’s efforts to implement EPSDT screenings, assessments and treatment services
  - Scheduled meetings with the Federation for Parents of Children with Special Needs and Adoptive Families Together to discuss EPSDT outreach efforts

**For MassHealth Providers**

- Drafted amendments to its Provider regulations (CMR 450.140-150), which specifically state that during well-child care visits, primary care providers (PCPs) must screen MassHealth-enrolled children for behavioral health issues and refer children for treatment when those screens reveal issues (expected to become effective by December 31, 2007)
- Began updating the newsletters it publishes for its PCC Plan and MCO providers, its EPDST billing guidelines brochure, and its PCC Plan provider contract and handbook to include information on the requirement for PCPs to use standardized screening tools (expected to be completed by December 31, 2007)
- Began to identify changes needed to the Medicaid Management Information System (MMIS) to assist with tracking provider utilization rates of behavioral screening tools
- Drafted language for its MBHP and MCO contracts, which requires them to disseminate information on EPSDT improvements to their provider networks, and to conduct annual behavioral health screening and referral forums for PCPs (expected to become effective around July 1, 2007 and August 15, 2007, respectively)
- Began exploring ways to connect EOHHS’ existing web-based enrollment system (“Virtual Gateway”) with *Rosie D.* implementation efforts

**For Public and Private Agencies That Serve Children and Families**

- Informed key officials in related agencies (EOHHS, Executive Office of Administration and Finance, Office of Medicaid, DMH, DMR, DPH, DSS and DYS, and the state legislature) of the *Rosie D.* remedy
- Included funding requests in its budget request to the Legislature for:

- A Communications Coordinator (to develop the outreach component of the remedy, which will include the production of new pamphlets and fact sheets)
- Liaison staff for MassHealth, DMH, DSS and DYS (to develop and foster the interagency collaborations required for the remedy)

## **II. Behavioral Health Screening and Identification Improvements**

### **For Primary Care Providers**

- Drafted a list of screening tools (including PSC, PEDS and other tools) to be submitted to the Massachusetts' Chapter of the AAP and the Massachusetts Medical Society for review

### **For MassHealth Providers**

- Drafted language for its MCO contracts requiring them to develop and implement quality improvement activities for network providers (expected to become effective around August 15, 2007)
- Began developing a plan to track the number of EPSDT screens given by PCPs, and to track service utilization that results from such screenings

Source:

*Rosie D. et al. v. Mitt Romney et al: Defendants' Report on Implementation of Project One.* United States District Court. District of Massachusetts, Western Division. June 27, 2007.

## Appendix B

### Timelines for Progress Reports and Implementation of *Rosie D. Remedy*

Project/Phase	Deadline for Preliminary Status Report to Court	Deadline for Full Implementation
Direction and Oversight (Appointment of Court Monitor)	March 23, 2007	April 6, 2007
EPSDT Notification and Outreach Improvements	June 30, 2007	December 31, 2007
Behavioral Health Screening and Identification Improvements	June 30, 2007	December 31, 2007
Assessment and Diagnosis Improvements (Includes CANS Development, Training and Deployment <sup>1</sup> )	November 30, 2007	November 30, 2008
Design and Development of Information Technology System	November 30, 2007	November 30, 2008
Service Delivery Network Development	November 30, 2007 <sup>2</sup>	June 30, 2009

<sup>1</sup> CANS (Child and Adolescent Needs and Strengths) is the national standardized clinical information collection tool that the state will be developing.

<sup>2</sup> In his memorandum, Judge Ponsor noted that more than one status report might be required for the development of a service delivery network.

Source: *Rosie D. et al. v. Deval L. Patrick, et al: Final Judgment*. United States District Court. District of Massachusetts, Western Division. July 16, 2007.



## Appendix C

### Glossary of Acronyms and Definitions

<b>AAP</b>	American Academy of Pediatrics
<b>CANS</b>	Child and Adolescent Needs and Strengths Survey, an instrument clinicians will use under the <i>Rosie D.</i> remedy to assist with SED assessment and diagnosis
<b>CAP</b>	The Collaborative Agreement Program, a state program that blends funds from DSS and DMH to provide services for children with SED who are at risk for placement outside of the home
<b>CASSP</b>	The Child and Adolescent Service System Program, a federal program created to assist states in developing a comprehensive System of Care for children and adolescents with mental health needs; fundamental principles include care that is served in a setting that is child-centered, family-focused, community-based, multi-systemic, culturally competent, and least restrictive
<b>CBATS</b>	Community-Based Acute Treatment Settings
<b>CFFC</b>	Coordinated Family Focused Care, a community-based wraparound program in Massachusetts for children and adolescents with SED who are at risk of being placed outside of the home; managed by MBHP and jointly funded by the Office of Medicaid, DMH, DSS, and DOE
<b>CHINS</b>	Child in Need of Services, a petition filed in juvenile court, usually by a parent, school, or law enforcement official, in an attempt to prevent a youth from perpetuating harmful behaviors (such as truancy or delinquency)
<b>CMS</b>	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
<b>CSA</b>	Community Service Agencies, the basis of the new statewide network of behavioral health providers that will coordinate and provide or arrange for home-based care to children with SED
<b>CSP</b>	Community Support Program, a MassHealth program (managed by MBHP) that provides intensive short-term case management to children and adolescents with SED who are at risk of being removed from their communities
<b>DOE</b>	Department of Education, Commonwealth of Massachusetts
<b>DMH</b>	Department of Mental Health, Executive Office of Health and Human Services, Commonwealth of Massachusetts
<b>DMR</b>	Department of Mental Retardation, Executive Office of Health and Human Services, Commonwealth of Massachusetts
<b>DSM</b>	The Diagnostic and Statistical Manual of Mental Disorders, a handbook for clinicians published by the American Psychiatric Association that lists categories of mental disorders and the criteria for diagnosing them
<b>DSS</b>	Department of Social Services, Executive Office of Health and Human Services, Commonwealth of Massachusetts
<b>DTA</b>	Department of Transitional Assistance, Executive Office of Health and Human Services, Commonwealth of Massachusetts
<b>DYS</b>	Department of Youth Services, Executive Office of Health and Human Services, Commonwealth of Massachusetts
<b>EEC</b>	Department of Early Education and Care, Commonwealth of Massachusetts
<b>EOHHS</b>	Executive Office of Health and Human Services, Commonwealth of Massachusetts
<b>EPSDT</b>	The Early and Periodic Screening, Diagnosis, and Treatment program, Medicaid's benefit plan for children and adolescents up to age 21
<b>FFP</b>	Federal Financial Participation, rate at which the federal government reimburses MassHealth expenditures that are part of the state's approved Medicaid plan
<b>FPL</b>	Federal Poverty Level, federal poverty income guidelines issued annually by U.S. Department of Health and Human Services

<b>FST</b>	Family Stabilization Team, a MassHealth service that provides short-term intensive therapeutic home-based services to children with SED facing immediate mental health crises
<b>FY</b>	Fiscal Year
<b>ICC</b>	Intensive Care Coordination, term used to describe the coordination of home-based services under the <i>Rosie D.</i> remedy for children with SED
<b>IDEA</b>	Individuals with Disabilities Education Act, U.S. federal law that governs how states and school districts provide special education and services to children with disabilities
<b>MassHealth</b>	The Massachusetts Medicaid program
<b>MCO</b>	Managed Care Organization
<b>MBHP</b>	Massachusetts Behavioral Health Partnership, Massachusetts' behavioral health carve out for MassHealth enrollees
<b>MHSPY</b>	Mental Health Services Program for Youth, a community-based wraparound program in Massachusetts that serves children with SED who are at risk of being placed out of the home; managed by MBHP and jointly funded by the Office of Medicaid, DMH, DYS, DSS, and DOE
<b>MMIS</b>	Medicaid Management Information System, automated claims processing and information technology system for MassHealth
<b>MSPCC</b>	Massachusetts Society for the Prevention of Cruelty to Children
<b>OBRA-89</b>	The Omnibus Budget Reconciliation Act of 1989
<b>PAL</b>	Parent/Professional Advocacy League
<b>PCC Plan</b>	Primary Care Clinician Plan, a primary care management program for MassHealth
<b>PCP</b>	Primary Care Provider
<b>PEDS</b>	Parents' Evaluation of Developmental Status, questionnaire for parents that inquires about a child's behavioral and emotional problems and one of the standardized behavioral health screening instruments that PCPs may choose from when performing EPSDT screens
<b>PSC</b>	Pediatric Symptom Checklist, one of the standardized behavioral health screening instruments that PCPs may choose when performing EPSDT screens
<b>QIAs</b>	Quality Improvement Activities, performance management and quality measurement techniques used by MCOs and MBHP
<b>SAMHSA</b>	The Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
<b>SEDs</b>	Serious Emotional Disturbances, mental, behavioral or emotional disorders that include anxiety disorders, attention-deficit disorders, mood disorders, psychotic disorders, somatoform disorders, and eating disorders
<b>WCC</b>	Worcester Communities of Care, a community-based wraparound pilot program in Massachusetts that serves children with SED who are at risk of being placed out of the home; managed by MBHP and jointly funded by the Office of Medicaid, DMH, DSS, DYS and DOE

## **Acknowledgments**

The author thanks the state officials, mental health providers, advocates and researchers who granted interviews and provided insightful comments and feedback on early drafts. Without their valuable input this report would not have been possible:

Tom Dehner, Emily Sherwood, Ben Walker, Joan Mikula, and Robert Turillo of the Massachusetts Executive Office of Health and Human Services; Suzanne Fields, John Strauss, and Scott Taberner of the Massachusetts Behavioral Health Partnership; Irvin Rich and Gloria Nagel of the Centers for Medicare and Medicaid Services; Karen Braunwald of Westwood Lodge; Betty Funk of the Mental Health and Substance Abuse Corporations of Massachusetts, Inc.; Josh Greenberg of Children’s Hospital Boston; Lisa Lambert of The Parent/Professional Advocacy League; Celeste Lee of the Blue Cross Blue Shield of Massachusetts Foundation; David Matteodo of Massachusetts Association of Behavioral Health Systems; Bonnie Saulnier of Wayside Youth and Family Support Network; Marylou Sudders of the Massachusetts Society for the Prevention of Cruelty to Children; Beth Waldman of Bailit Health Purchasing, LLC; and Katherine Wilson and Steven Winn of Behavioral Health Network, Inc.

The author also wishes to thank MMPI’s Board of Directors and Robert Seifert, Executive Director of the Massachusetts Medicaid Policy Institute, for their support and guidance in producing this report.

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### **About the Massachusetts Medicaid Policy Institute**

The Massachusetts Medicaid Policy Institute (MMPI) is an independent and nonpartisan source for information and analysis about the Massachusetts Medicaid program, “MassHealth.” MMPI promotes broader understanding of MassHealth and its interrelatedness with other health care programs for low income people, and a more rigorous and thoughtful public discussion of the program’s successes and the challenges ahead.

## Endnotes

<sup>1</sup> Massachusetts Society for the Prevention of Cruelty to Children (MSPCC) and Children's Hospital Boston, *Children's Mental Health in the Commonwealth: The Time is Now* (Boston: MSPCC and Children's Hospital Boston, November 2006).

<sup>2</sup> For a discussion of the definition of SED that was adopted by the *Rosie D.* Court, see Section IV.

<sup>3</sup> The original lawsuit was filed as *Rosie D. v. Swift*, 310 F.3d 230 (1st Cir. 2002); when the suit went to trial in 2005, a new administration had taken office. Defendants named in the 2005 lawsuit included then-Governor Mitt Romney, the Secretary of EOHHS, the Secretary of the Executive Office of Administration and Finance, and the director of the Massachusetts Office of Medicaid. Plaintiffs included *Rosie D.* and seven other named children, as well as a broader class of approximately 15,000 children. Section IV contains additional information about the specific plaintiff class, as defined by the Court.

<sup>4</sup> Centers for Medicare and Medicaid Services (CMS) Web Site, [http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrnrn/02\\_Benefits.asp](http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrnrn/02_Benefits.asp)

<sup>5</sup> The Omnibus Budget Reconciliation Act of 1989, P.L. 101-239.

<sup>6</sup> See 42 U.S.C. § 1396d(r)(5); 42 U.S.C. § 1396d(a).

<sup>7</sup> See, for example, 42 U.S.C. § 1396a(a)(30)(A); 42 CFR 440.230(d); State Medicaid Manual 5122 F EPSDT Services.

<sup>8</sup> 130 C.M.R. §450.204(A)

<sup>9</sup> This is the most recent EPSDT screening data from CMS. (It also is important to note that the background research for the *Rosie D.* initiative began in 2000, making this 2003 EPSDT data relevant to the case at that time).

<sup>10</sup> National Center for Children in Poverty, *Maximizing the Use of EPSDT to Improve the Health and Development of Young Children* (New York: Columbia University, Mailman School of Public Health, 2006).

<sup>11</sup> MassHealth Standard and MassHealth Commonwealth are the two MassHealth programs that provide EPSDT services to children.

<sup>12</sup> Children with third-party liability (e.g. secondary forms of insurance such as private health insurance or Medicare) can receive additional wraparound mental health benefits on a fee-for-service basis.

<sup>13</sup> The four MCOs are Neighborhood Health Plan, Fallon Community Health Plan, Network Health and Boston Medical Center HealthNet.

<sup>14</sup> Neighborhood Health Plan also provides mental health services through a carve out, Beacon Health Strategies.

<sup>15</sup> DMR is the state agency for adults and children with mental retardation and developmental disabilities. Because it deals primarily with mental retardation and not mental or behavioral disorders, DMR does not play as large a role as the other child-serving agencies in *Rosie D.* implementation.

<sup>16</sup> For individuals age 19-21, DMH provides services directly through its community mental health centers and state-operated inpatient units. (Information provided by The Massachusetts Department of Mental Health, July 2007).

<sup>17</sup> Massachusetts Department of Mental Health, *Fiscal Years 2005-2007 State Mental Health Plan* (Boston: EOHHS, September 2004).

<sup>18</sup> DSS is primarily an “involuntary” agency. Many children also enter the DSS system through a Child in Need of Services (CHINS) petition and custody. A significant number of the children who appear before the courts via the CHINS pathway have significant mental health needs. For more information on CHINS, see Appendix C.

<sup>19</sup> *Rosie D. et al. v. Romney et al., Defendants' Remedial Plan Submitted to Court*. August 29, 2006. Appendix B (Referred to hereafter as “Remedial Plan”).

<sup>20</sup> Massachusetts Department of Social Services, *Info. For Educators* Newsletter: Spring 2006 v. 1, issue 2.

<sup>21</sup> Generally, children detained in DYS detention facilities are not eligible for Medicaid. However, the state may claim federal Medicaid reimbursement for certain services to children in DYS facilities. (Information provided by The Massachusetts Department of Youth Services, May 2007, and Massachusetts Office of Medicaid, July 2007).

<sup>22</sup> Information provided by The Massachusetts Department of Youth Services, May 2007.

<sup>23</sup> Blended funding can allow an agency to provide a broader array of services without having to secure additional funding, and can promote interagency collaboration. On the other hand, it typically places greater restraints on state agencies and may interfere with administrative oversight. (For more information on blended funding, See Bazelon Center for Mental Health Law, *Blending or Braiding Federal Funds*. <http://www.bazelon.org/issues/children/publications/mixmatch/blendbraid.htm>)

<sup>24</sup> Boston Bar Association and Children's Hospital Boston: *The Parents Guide to Children's Mental Health Services in Massachusetts* (Boston: BBA and Children's Hospital, 2007).

<sup>25</sup> Massachusetts EOHHS, *Department of Social Services 2005 Annual Report* (Boston: EOHHS, March 2007).

<sup>26</sup> See Section VI for a more detailed discussion of MHSPY and CFFC.

<sup>27</sup> See *Collins v. Hamilton*, 349 F.3d 371,375 (7<sup>th</sup> Cir. 2003); *Pediatric Specialty Care v. Arkansas Dep't of Human Servs*, 293 F.3d 472 (8<sup>th</sup> Cir. 2002); *Chisholm v. Hood*, 133 F. Supp. 2d 894 (E.D. La. 2001); and *Katie A. v. Los Angeles County*, 481 F.3d 1150 (9<sup>th</sup> Cir. 2007).

<sup>28</sup> *Rosie D. et al. v. Mitt Romney et al: Memorandum of decision*. United States District Court. District of Massachusetts, Western Division. January 26, 2006. (Referred to hereafter as "*January 2006 Memorandum*").

<sup>29</sup> In addition to the stipulations listed in Section IV, the final judgment makes several key changes from the court's proposed judgment, which was issued in February 2007. Specifically, the judge ruled that the state must provide intensive care coordination (home-based services) to Medicaid-eligible children with SED who request and need them. The court also ruled that the state is bound to the terms of the judgment (even if this goes beyond what is explicitly required in the EPSDT provisions of the Medicaid Act), and there is no time limit on the court's authority to enforce the judgment. See *Rosie D. et al. v. Deval Patrick et al: Memorandum and Order Regarding Final Judgment*. United States District Court. District of Massachusetts, Western Division. July 16, 2007.

<sup>30</sup> While this issue brief primarily focuses on the final remedy that was adopted by the court, it is important to point out perceived deficiencies in the remedy itself. Plaintiffs and advocates argue that the remedy is too narrow. Specifically, they argued for a greater degree of accountability among agencies and maintained that schools and other providers should play a larger role in early screening and identification. They also felt that pediatricians should not be the only providers responsible for performing mental health screens, as this would limit the scope and effectiveness of the EPSDT program, and instead proposed to allow any approved Medicaid provider to conduct EPSDT screening. Finally, they proposed the inclusion of additional services (such as after-school services, therapeutic foster care and multisystemic therapy) in the range of services provided to children with SED.

<sup>31</sup> 34 C.F.R. §300.8(c)(4)(i) and 58 Fed. Reg. 29422-02 (May 10, 1993).

<sup>32</sup> This estimate of Medicaid-eligible children who suffer from SED—approximately 15,000—was derived from calculations based on existing data of all children in the Commonwealth who meet the IDEA/SAMSHA criteria for SED and the percentage of children eligible for MassHealth. National prevalence data indicated that at the time of the ruling, more than 112,000 children in Massachusetts had some level of SED. Of those, more than half (58,000) were classified as "severe" cases (i.e., SED with "extreme functional impairment"). Approximately 25% of the state's children qualify for Medicaid, which equates to between 14,000 and 15,000 children in the plaintiff class. (Center for Public Representation, *Summary of the Court's Decision in Rosie D. v. Romney*, February 2006).

<sup>33</sup> One important note regarding disorders that fall within the court's definition of SED should be made here. Although several of the children named in the *Rosie D.* case have a broad range of mental

disorders, which include pervasive developmental disorders (PDDs, a class of developmental disorder which include Autism, Asperger's Syndrome, and several other related disorders), the IDEA and SAMHSA definitions of SED do not expressly include PDD. As a result, these disorders do not fall within the plaintiff class. In an effort to provide services to some children with PDDs, DMR has submitted an application for an autism waiver to CMS. See [http://www.mass.gov/Eeohhs2/docs/dmr/asd\\_updates\\_2007winter.pdf](http://www.mass.gov/Eeohhs2/docs/dmr/asd_updates_2007winter.pdf)

<sup>34</sup> All information contained in this section was derived from the court's final judgment. For a more detailed description of the components of the remedy, see *Rosie D. et al. v. Deval Patrick et al: Final Judgment*. United States District Court. District of Massachusetts, Western Division. July 16, 2007. (Referred to hereafter as "*Final Judgment*").

<sup>35</sup> The Center for Health Policy Research (CHPR) at the University of Massachusetts Medical School is working with EOHHS to train pediatricians and primary care providers (PCPs) to use the PEDS and PSC behavioral health screening instruments. The MCOs and MBHP also will conduct provider forums to train the PCPs and pediatricians in their networks to use these tools.

<sup>36</sup> When appropriate, the assessment process will be part of the discharge planning process for children who are discharged from acute inpatient hospitals, community-based acute treatment settings (CBATS), intensive residential settings or continuing care programs. Those who require additional behavioral health services will be referred by their mental health provider for intensive care coordination services, which are discussed further in the following section. (*Final Judgment*, 9).

<sup>37</sup> The Center for Adoption Research (CAR) at the University of Massachusetts Medical School is working with the Office of Medicaid to provide CANS training to pediatricians and PCPs.

<sup>38</sup> The wraparound method of providing mental health services is one of the defining features of a system of care, an evidence-based model of mental health treatment. Wraparound describes an approach to community-based mental health care that recognizes the individual needs of the child and family. It typically encompasses an array of services, such as case management; individualized service plans; a variety of home, community, and school-based services and supports; crisis intervention; parent education and training; and family support services. (Bazelon Center for Mental Health Law, *Making Sense of Medicaid for Children with Serious Emotional Disturbance* (Washington, D.C.: Bazelon Center, 1999). A system of care is a collaborative effort that brings the child, family members, and multiple child-serving agencies together to provide a unified system of community-based services to treat children with SED. It typically is based upon core principals established by the Child and Adolescent Service System Program (CASSP), a federal program created in 1984 to assist states in developing a comprehensive System of Care for children and adolescents with mental health needs. These principles include care that is served in a setting that is child-centered, family-focused, community-based, multi-systemic, culturally competent, and least restrictive. (Center for Mental Health Services, SAMHSA's National Mental Health Information Center. <http://mentalhealth.samhsa.gov/cmhs/childrencampaign/ccmhs.asp>)

<sup>39</sup> *Final Judgment*, 14.

<sup>40</sup> While some of these services currently are available under two MassHealth programs (Family Stabilization Teams, or FSTs; and Community Support Programs, or CSPs), the remedy calls for these services (or similar services) to be offered as part of a more formalized treatment plan, and to be readily available on a regular basis to children with SED who require intensive community-based treatment services, whenever it is deemed medically necessary; and therefore these are considered "new services".

<sup>41</sup> *Final Judgment*, 14.

<sup>42</sup> *Final Judgment*, 20.

<sup>43</sup> CSA sites likely will be current DMH sites and/or DSS Family Network provider areas. (*Final Judgment*, 20). "Family Networks" is DSS' newly structured mental health service delivery system. Under Family Networks, DSS contracts with multiple mental health sites throughout Massachusetts to

provide treatment for children with SED who are in the DSS system. (Massachusetts Department of Social Services, *Info. For Educators* Newsletter: Spring 2006 v. 1, issue 2.)

<sup>44</sup> It is important to note, however, that the 4 Managed Care Organizations (MCOs) currently contracting with MassHealth cannot also serve as a CSA. (*Rosie D. et al. v. Romney et al., Plaintiffs' Memorandum Concerning the Defendants' Proposed Remedial Plan*. United States District Court. District of Massachusetts, Western Division. November 21, 2006)

<sup>45</sup> EOHHS currently is in the process of updating MMIS and expects to activate this updated version in the fall of 2007.

<sup>46</sup> Emily Sherwood, former staff director for the Massachusetts Legislature's Joint Committee on Health Care Financing, was appointed director of Children's Behavioral Health Initiatives at EOHHS in May 2007.

<sup>47</sup> Karen Snyder, former Chief of Program Operations at the Department of Children and Families in Connecticut, was selected in April 2007 and assumed this position in July 2007.

<sup>48</sup> Author's conversation with Marylou Sudders, Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), April 2007.

<sup>49</sup> *Rosie D. et al. v. Mitt Romney et al.: Memorandum of decision*. United States District Court. District of Massachusetts, Western Division. February 22, 2007, page 2. (Referred to hereafter as "*February 2007 Memorandum*").

<sup>50</sup> The Kaiser Commission on Medicaid and the Uninsured, *Impacts of Medicaid and SCHIP on Low-Income Children's Health*. (Washington, D.C.: The Henry J. Kaiser Family Foundation, May 2007). <http://www.kff.org/medicaid/upload/7645.pdf>

Ku, Leighton, *Medicaid: Improving Health, Saving Lives*. (Washington, D.C.: Center on Budget and Policy Priorities, Revised August 2005). <http://www.cbpp.org/7-19-05health.pdf>

<sup>51</sup> Koppelman, Jane, *The Provider System for Children's Mental Health: Workforce Capacity and Effective Treatment*, NHPF Issue Brief No. 801. (Washington, D.C.: National Health Policy Forum, October 2004) and U.S. Department of Health and Human Services, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* (Washington, D.C.: U.S. Department of HHS, January 2001). These are just two of many existing resources that document the benefits of community-based care.

<sup>52</sup> Data tracking is one of the areas of the plan over which plaintiffs have expressed concern; they contend that greater emphasis must be placed on outcomes evaluation and monitoring quality of care.

<sup>53</sup> Information provided by Massachusetts Office of Medicaid, May 2007.

<sup>54</sup> It should be noted MBHP does pay for outpatient collateral work. The state's FSTs and the CFFC program also have bundled rates that include compensation for collateral work.

<sup>55</sup> Information provided by the Behavioral Health Network, Inc., June 2007.

<sup>56</sup> The remedy stipulates that only "qualified licensed clinicians" and "qualified paraprofessionals" may serve as mental health providers. Licensed clinicians include professionals who have received appropriate licensure in their field, and may include physicians, psychiatrists, clinical psychologists, clinical social workers and mental health counselors. Paraprofessionals are individuals who either have been certified, or received a set level of education or training to provide services in their field. (*Final Judgment*, 16).

<sup>57</sup> Information provided by Massachusetts Behavioral Health Partnership and Mental Health and Substance Abuse Corporations of Massachusetts, Inc., May 2007.

<sup>58</sup> Although the terms *capacity* and *shortage* are often used interchangeably, from a mental health perspective, *capacity* usually means having the right number of providers with the appropriate training and skill set, while *shortage* usually means not having enough providers geographically spread across a region.

<sup>59</sup> The consulting firm Mercer H.R. was hired by the state to conduct a capacity assessment. A better sense of the state's provider capacity as it relates to *Rosie D.* will come when these findings are released.

<sup>60</sup> Author's conversation with Emily Sherwood, Children's Behavioral Health Initiatives, EOHHS, May 2007.

<sup>61</sup> Letter to CMS from Beth Waldman, Massachusetts Medicaid Director, dated December 29, 2006.

<sup>62</sup> *Ibid.*

<sup>63</sup> The proposed regulations are expected to include changes that will affect Medicaid reimbursement for rehabilitation services and targeted case management services. "Intensive community-based services" for children with SED would most likely fall into one or both of these categories of medical assistance, if they do, in fact, fall into any category of medical assistance at all. The current impetus behind restructuring existing rehabilitation regulations is to place greater limits on the types of services that are approved for Medicaid funding, and the new rules could preclude MassHealth from receiving the federal match for those services if they also are offered by another state agency. (For more information on the proposed rehabilitation regulations, see The Bazelon Center for Mental Health Law's web site: [www.bazelon.org/takeaction/archive/2005/8-18-05medicaid.htm](http://www.bazelon.org/takeaction/archive/2005/8-18-05medicaid.htm))

<sup>64</sup> EOHHS is expected to submit its list of proposed covered services for *Rosie D.* to CMS outside of the waiver process, since the legal obligations of *Rosie D.* extend only to state-plan services and not waiver services.

<sup>65</sup> *Final Judgment*, 27.

<sup>66</sup> In Massachusetts, all costs generally are discussed in terms of gross dollars. The state appropriates the full amount of the Medicaid program and CMS then reimburses the state general fund with the federal match.

<sup>67</sup> Information provided by MBHP, May 2007. An actuarial analysis provided for MassHealth by Mercer H.R. Consulting is due to be released in the fall of 2007; this is expected to shed further light on anticipated costs.

<sup>68</sup> Information provided by Massachusetts Office of Medicaid, May 2007

<sup>69</sup> Information provided by Massachusetts Association of Behavioral Health Systems, May 2007.

<sup>70</sup> For more information on QIAs, see Massachusetts EOHHS, Office of Medicaid, *9<sup>th</sup> Annual Report to CMS on the 1115 Waiver* (Boston: EOHHS, April 11, 2007).

<sup>71</sup> For an in-depth analysis of budget neutrality, see Massachusetts Medicaid Policy Institute, *The Role of MassHealth "Budget Neutrality" Requirements in Designing Policies to Expand Health Coverage* (Boston: Massachusetts Medicaid Policy Institute, January 2006).

<sup>72</sup> Information provided by EOHHS, July 2007.

<sup>73</sup> *Final Judgment*, 3.

<sup>74</sup> Health Care for All and Parent/Professional Advocacy League, *Speak Out for Access: The Experiences of Massachusetts Families in Obtaining Mental Health Care for Their Children* (Boston: HCFA and PAL, October 2002). The results discussed here were not published in the report itself, but were provided by the Parent/Professional Advocacy League (PAL) in April 2007.

<sup>75</sup> *January 2006 Memorandum*, 55.

<sup>76</sup> The Center for Public Representation, *A Report of Home-Based Services for Children in Massachusetts With Serious Emotional Disturbance* (Northampton, Massachusetts: CPR, October 2005).

<sup>77</sup> Mental Health Services Program for Youth Web Site: <http://www.mhspy.org/> and Grimes, Katherine D., and Mullin, Brian, MHSPY: *A Children's Health Initiative for Maintaining At-Risk Youth in the Community*. The Journal of Behavioral Health Services and Research 33:2, April 2006. [http://www.mhspy.org/publications/JBHS\\_final%20article.pdf](http://www.mhspy.org/publications/JBHS_final%20article.pdf)

<sup>78</sup> Stroul, Beth A., *Integrating Mental Health Services into Primary Care Settings* (Summary of the Special Forum Held at the 2006 Georgetown University Training Institutes. (Orlando: July 2006).