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PLAINTIFFS' FINAL REMEDIAL PLAN

August 18, 2006

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SECTION 1: SCOPE AND PRINCIPLES

I. Purpose and Scope of the Plan

A. Purpose and Goals of the Plan

This Remedial Plan (the Plan) describes the needed programmatic and operational improvements set forth in the Court's January 26, 2006 Memorandum of Decision, including the in-home support services and a method for accessing, providing, and evaluating those services, as required by that Decision. The purpose of the Plan is to describe in detail how the Commonwealth will meet its responsibilities under the EPSDT provisions of the federal Medicaid Act for the class of Medicaid eligible children with serious emotional disturbance (SED) under the age of 21 who need in-home support services. In particular, the Plan recognizes and provides for comprehensive assessments, service coordination, in-home supports, and all medically necessary services. These services will be developed with the involvement of families, and delivered through an integrated treatment planning process that includes all relevant state and local agency representatives.

The goal of this Plan is to assure that medically necessary in-home support services are available both to assist children with SED to remain in their home, in school, and in the community, as well as to reduce, to the extent reasonably possible, the likelihood that such children will be removed from their homes and home communities because of their mental health needs. The Plan also recognizes that many Medicaid-eligible children with SED are served by state and local health, human services and education agencies in addition to Medicaid, and is designed to coordinate the roles and resources of these agencies, to the extent permissible by law, in a manner that assures that medically necessary EPSDT services are available to eligible children with SED.

B. Scope of the Plan

The Court certified a plaintiff class in this case that includes: "all current or future Medicaid-eligible residents of Massachusetts under the age of twenty-one who are or may be eligible for, but are not receiving, intensive home-based services, including professionally acceptable assessments, special therapeutic aides, crisis intervention, and case management services."

Throughout the Court's January 26, 2006 Memorandum Decision, it consistently refers to the children in this case as "children with SED." Memorandum at 5. It specifically notes that these children include individuals with various DSM IV diagnoses, including autism. Memorandum at 31-32. Therefore, this Plan focuses on Medicaid-eligible children with serious emotional disturbance (SED), as defined in federal law, including autism and other pervasive developmental disorders (PDD). SED children have a mental health diagnosis that is contained in the Diagnostic and Statistical Manual, Version IV (DSM IV), and a functional impairment that substantially interferes or limits a child's role in the family, school, social relationships, or community, or that

substantially interferes with or limits a child or adolescent from achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. In-home support services, as referenced by the Court, are necessary and appropriate for children with SED who need more than outpatient services to treat their conditions. Memorandum at 23.

The Governor, as the lead defendant and chief state official for the Commonwealth, is ultimately responsible for implementing this Plan. EOHHS, as the single state Medicaid agency, is primarily responsible for taking the actions necessary to implement this Plan. DMH, as the state agency responsible for providing mental health services to citizens of the Commonwealth, is the lead agency within EOHHS responsible for implementing this Plan.

The Plan shall be implemented and interpreted consistent with the requirements of the Medicaid Act, 42 U.S.C. § 1396a.

II. Principles

The development, implementation, and evaluation of the system of in-home support services described in this Plan will be consistent with the following principles[1]:

1. Collaboration with the child and family: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process and in the planning, delivery and evaluation of in-home support services.

2. Functional outcomes: In-home support services are designed and implemented to aid children to achieve success in school, to remain with their families, to avoid delinquency, and to become stable and productive adults. Implementation of the Individual Service Plan (ISP) stabilizes the child=s condition and minimizes safety risks.

3. Collaboration with others: When children have multi-agency, multi-system involvement, a comprehensive assessment is developed and an ISP is collaboratively implemented. The Child and Family team plans and delivers needed services. Each child=s team includes the child and parents and any foster parents, and any individual important in the child=s life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, relevant service providers, the child=s teacher, the child=s DSS, DYS, DMH, or DMR case manager or worker, the child=s probation officer. The team develops an ISP, monitors implementation of the plan, and makes adjustments in the plan if it is not succeeding.

[1] These principles are incorporated in the court-approved settlement in a similar EPSDT lawsuit, *J.K. v. Eden.*

4. Accessible services: Children have access to a comprehensive array of in-home support and other behavioral health services, sufficient to ensure that they receive medically necessary treatment. Care management is provided for all SED children who have a pattern of need for more than clinic-based outpatient treatment. The ISP identifies transportation the parents and child need to access in-home support services and how transportation assistance will be provided. In-home support services are adapted or created when they are needed but not available.

5. Best practices: In-home support services are provided by competent individuals who are adequately trained and supervised. In-home support services are delivered in accordance with guidelines that incorporate evidence-based Abest practice.@ The ISP identifies and appropriately addresses behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders and other similar traumatic or frightening circumstances. The ISP also addresses mental health conditions, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled or who have maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the promotion of permanency in the child's life, especially for children in foster care. In-home support services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. Most appropriate setting**:** Children are provided in-home support and other behavioral health services in their home and community to the extent possible. In-home support and other behavioral health services are provided in the most integrated setting appropriate to the child=s needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child=s needs. Levels of restrictiveness should be reviewed regularly to ensure that they are clinically necessary and appropriate.

7. Timeliness**:** Children identified as needing in-home support services are assessed and served promptly.

8. Services tailored to the child and family**:** The unique strengths and needs of children and their families dictate the type, mix, and intensity of in-home support and other behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and the services they believe are required to meet these goals.

9. Stability**:** The Child and Family team uses the ISP to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. The Child and Family team anticipates crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the ISP incorporates all appropriate in-home support and other behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. The ISP anticipates and

appropriately plans for transitions in children=s lives, including transitions to new schools and new placements, and transitions to adult services.

10. Respect for the child and family=s unique cultural heritage: In-home support services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. Independence**:** In-home support services include support and training for parents in meeting their child=s behavioral health needs and support and training for children in self-management. The ISP identifies parents= and children=s need for training and support to participate as partners in the assessment process, and in the planning, delivery and evaluation of services, and provides that training and support, including transportation assistance and assistance in understanding written materials.

12. Connection to natural supports**:** The ISP identifies and appropriately utilizes natural supports available from the child and parents= own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

SECTION 2: THE PATHWAY TO IN-HOME SUPPORT SERVICES

III. Entry Points

There are multiple entry points to the pathway to in-home support services. These portals reflect both the different agencies and systems that serve children, as well as the different conditions and reasons why children enter those systems. At a minimum, these entry points include:

1. Mental health

    a. DMH eligibility and ISP process
    b. DMH facilities and inpatient units
    c. DMH community programs
    d. DMH Area Offices
    e. DMH crisis programs
    f. Community mental health practitioners
    g. Community mental health centers and clinics
    h. Private psychiatric hospitals or psychiatric units in general hospitals

2. Mental retardation

    a. DMR eligibility and ISP process
    b. DMR facilities
    c. DMR community programs
    d. DMR local service centers and Area Offices

3. Child welfare

    a. DSS assessment and service planning process
    b. DSS inpatient (BIRT) units
    c. DSS community programs
    d. DSS lead agencies and staff
    e. DSS Area Offices and social workers

4. Juvenile justice

    a. Juvenile court clinics
    b. Juvenile detention facilities
    c. Juvenile residential and community treatment programs
    d. Probation and parole officers
    e. DYS offices and staff

5. Health/MassHealth

   a. Emergency rooms
   b. Pediatric and psychiatric units
   c. Community health centers
   d. Pediatricians
   e. Family practitioners
   f. HMO/MBHP care managers
   g. HMO/MBHP mental health programs (FST, CSP, ART, CBAT)
   h. Early intervention programs and staff

6. Child care

   a. Day care centers and professional staff
   b. OCCS lead agencies and staff

7. Education

   a. school nurses, counselors, social workers, and psychologists
   b. IEP process

8. Family and Community Supports

IV. Screening

A. EPSDT Screening by Health Care Professionals

MassHealth is required to provide for EPSDT screenings to eligible children. The purpose of the screenings is to identify the need for further corrective treatment including "necessary health care, diagnostic services, treatment and other measures described in 42 USC [1396d]a [of the Medicaid Act] … needed to correct or ameliorate defects and physical and mental illnesses and conditions…."[2] The goal of improving EPSDT behavioral health and developmental screening is to increase the likelihood that administered screenings identify children in need of Medicaid mental health services. To achieve this goal, there must be enhanced emphasis on screening, combined with outreach and education efforts directed at informing health care professionals about the approved screening tools, how to evaluate behavioral health information gathered in the screening, and how and where to make referrals for follow-up behavioral health assessment.

As part of a periodic and any other interperiodic EPSDT behavioral health screening, all Medicaid-eligible children routinely examined by a pediatrician, family practitioner, or other health care professional will be formally screened for behavioral health conditions using the Pediatric Symptom Checklist (PSC), M-CHAT for autistic

[2] Medicaid Manual at §5122; 42 USC 1396d(r)(1)(B) and (5); 42 USC 1396a(a)(43); 42 USC 1396d(r)(B).

conditions, CRAFFT for adolescents, and PEDS for children under five years of age, unless the parent or guardian objects.

B. Screening Responsibilities of Publicly-Funded Entities

Children in the care and custody of DSS or DYS, or children who are evaluated at any other state agency, educational, or publicly-funded entry point, will be referred for a formal screen from a medical provider or other health care professional, using the PSC, CRAFFT, M-CHAT, or PEDS, unless the child already is known to have a behavioral health condition. DMH, DMR, DSS and DYS are responsible for promptly referring the child to an appropriate medical provider and making reasonable efforts, including tracking, outreach, and assistance, to ensure that the screen is completed in a timely manner.

C. Other Methods to Identify a Mental Health Condition

As part of its regular intake and evaluation process, state agencies, schools, and child care centers are often required to assess children, and identify children who have a behavioral health condition or concern. If this assessment is undertaken by a health care professional, it constitutes an EPSDT interperiodic screen. If it is done by someone who is not a health care professional, then it is considered an identification or assessment of a mental health condition.

EOHHS and DMH will develop assessment, referral, and treatment coordination protocols with its agencies and other publicly funded entities and agencies to enhance the capacity of their staff to identify children with SED and to refer these children and their families to a preliminary assessment and medically necessary services.

V. Preliminary Assessment

A. Children Who Need a Preliminary Assessment

If the screening process indicates that the child has an emotional disturbance or mental health condition or is at risk of developing such a condition (positive score on the PSC, M-CHAT, CRAFFT, or PEDS), the child is referred to, and promptly receives, a preliminary assessment by a qualified mental health provider, clinician, or other trained evaluator, unless the parent or guardian objects. With the guardian's consent, the medical provider should provide, or arrange for, any appropriate mental health treatment pending this assessment.

Children who request or receive mental health care, on a routine or emergency basis, including all children served by DMH and those served by DMR who have a mental health condition, do not require formal mental health screening by a health care professional and shall promptly receive a preliminary assessment, unless the parent or guardian object. Children in the care or custody of DSS or DYS who are known to have, or at serious risk of developing, a mental health condition (DSM IV diagnosis) do not

require further screening and shall receive a preliminary assessment. If, as part of an intake assessment or evaluation by a state agency, educational agency, or other publicly-funded entity, including routine evaluations by DSS, DYS, DMR, local schools, or child care centers, a child is identified as having an emotional disturbance or mental health condition, the child will be referred for, and promptly receive, a preliminary assessment, unless the parent or guardian object.

B. Preliminary Assessment Process

The preliminary assessment will be done using a standardized, validated assessment instrument. The short form or a modified form of the Child and Adolescent Needs and Strengths Tool (CANS-MH) will be used, together with other relevant information concerning the child to guide the determination of whether the child needs a comprehensive assessment for in-home support services. A copy of the CANS-MH is attached is Appendix 1. When a modified form of the CANS is developed for Massachusetts, it will be substituted for the generic instrument in Appendix 1.

SECTION 3: THE CORE COMPONENTS OF IN-HOME SUPPORT SERVICES

The core components of in-home support services include a comprehensive assessment, a care manager, a single Child and Family team, an integrated treatment plan (the Individual Services Plan or ISP), which are provided through a Community Services Agency or the home-based provider for the area where the child lives.[3] These components have been well developed in MHSPY and similar programs, and can be replicated or adopted here.

VI. Comprehensive Assessments

A. Standard for a Comprehensive Assessment

If the preliminary assessment indicates that the child's mental health needs can be addressed adequately through clinic-based outpatient services, then the child is provided outpatient services with ongoing behavior monitoring from a mental health agency/ provider/clinician. An algorithm, developed by the author of the CANS-MH, will be used to determine if a child has a pattern of need that can be addressed by outpatient services. A copy of that algorithm is attached as Appendix 2. If the algorithm is revised in light of modifications to the CANS, the revised algorithm will be substituted in Appendix 2.

If the preliminary assessment with the CANS indicates that the child has a pattern of need requiring more than outpatient services, then the child is provided a comprehensive assessment from the Community Services Agency or home-based provider that serves the community where the child resides. If the child has had a preliminary assessment within the past six months that can reliable determine if the child has a pattern of need for more than outpatient services, no further assessment is required at that time. Periodic assessments using the CANS-MH should be completed when indicated.

B. Automatic Referral for a Comprehensive Assessment

If the child is hospitalized in a public or private mental health facility or a psychiatric unit of a general hospital for more than two weeks, or is at imminent risk of a second hospitalization in a year, then the child will automatically receive a comprehensive assessment without the need for a preliminary assessment. Similarly, if a child is in an acute residential setting funded or operated by DMH, DSS, DYS, MBHP, other behavioral health carve out entity, or MCO, or is at imminent risk of such residential placement, the child will automatically receive a comprehensive assessment without the need for any further preliminary assessment.

[3] The term "Community Services Agency" (CSA) is used by the Commonwealth in its remedial plan to describe the lead home-based services provider for a specific geographical area. It is adopted herein to avoid confusion and promote consistency. The authority, role, qualifications, and standards for the Community Services Agency are described in detail in Section 5 of this Plan.

C. Request for a Comprehensive Assessment

Any child or family can request a comprehensive assessment based upon a determination from a mental health provider that such an assessment is medically necessary. There is no separate eligibility requirement for a comprehensive assessment. The preliminary assessment determination or prior history of hospitalization or residential placement constitutes a finding of medical necessity for a comprehensive assessment.

D. Coordination of the Comprehensive Assessment

Comprehensive assessments are coordinated by a qualified mental health professional who is employed by, or affiliated with, the Community Services Agency for the community where the child resides. Assessments include a home visit, often include a school visit, are based upon information collected from relevant providers and other involved entities such as state agencies or community organizations, and must be done in a culturally competent manner. Assessments focus on the multiple domains of the child, including emotional and behavioral health, physical health, family stability, safety, education, vocational, housing, social, and recreational. Assessments include a complete treatment history, a diagnostic assessment by a qualified mental health professional if the child does not already have a current mental health diagnosis, and available information on the child's strengths, skills, and challenges.

E. Instruments for Conducting the Comprehensive Assessment

There are a variety of instruments and processes that may assist the clinician or clinical team in conducting comprehensive assessments. The process and instruments used by MHSPY and CFFC provide useful models that should be adopted.

F. Findings of the Comprehensive Assessment

The findings of the comprehensive assessment are used to guide the treatment planning process, and include a determination of whether the child has a serious emotional disturbance (SED) and needs in-home support services. SED children have a mental health diagnosis that is contained in the Diagnostic and Statistical Manual, Version IV (DSM IV), and a functional impairment that substantially interferes or limits a child's role in the family, school, social relationships, or community, or that substantially interferes with or limits a child or adolescent from achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

If during the assessment process, it appears that the child is in crisis or in urgent need of specific in-home support services, such services will be deemed medically necessary and will be provided promptly, unless the parent or guardian objects.

VII. Unified Care Management

A. Assignment of the Care Manager

If the comprehensive assessment indicates that the child needs in-home support services beyond traditional outpatient services, s/he is promptly assigned a care manager. Each child has one care manager with the overall responsibility for the child's treatment.

B. Levels of Care Management

There are two basic levels of care management services: care management and intensive care management. Since a child's need for a particular level of care management may vary over time, the Child and Family team has the responsibility and authority to modify the ISP, and the level of care management incorporated in the ISP, to reflect those changing needs. In determining the level of care management, the team will consider the child's needs, available supports including the family, the involvement of state agencies, and other factors relevant to the individual child. The team should review the level of care management at least every six months. A change in the level of care management does not require nor necessarily result in a change in the care manager. The team's decision concerning the level of care management constitutes a medical necessity determination with respect to both those services and that level of intensity, after review by a psychologist or psychiatrist.

1. Care Management primarily is for children with SED who have a functional impairment that requires treatment that is beyond the scope of clinic-based outpatient services. They are assigned a care manager who has a caseload of approximately 16-20, and who visits the child and family at least bi-weekly. An initial Individual Services Plan (ISP) is completed within thirty days, and reviewed at least every ninety days. The child is eligible for all covered in-home support services and is provided those in-home support services identified in the ISP.

2. Intensive Care Management primarily is for children with SED who are experiencing serious mental health and/or behavioral issues and have a significant functional impairment. These children meet the criteria for in-home support services, but also have significant functional impairments at home, school, or in the community that usually result in involvement with two or more services systems and that may place them at serious risk of institutionalization in a residential treatment center, correctional facility, or psychiatric hospital. They are assigned a care manager who has a caseload of approximately 8-10, and who visits the child and family at least weekly. Services are available promptly (usually within days of referral), but at least within thirty days of the assignment of a care manager. These children are eligible for all covered in-home support services, but generally require a greater intensity of services as determined by the Child and Family team. The team meets every thirty days for the first six months after developing the ISP, and then every sixty days thereafter to review the plan, unless the team determines that more frequent meetings are appropriate for the child.

C. Responsibilities of the Care Manager

The role of the care manager is to coordinate services and allow the child to receive services in accordance with his or her changing needs. Additionally, the care manager is responsible for promoting integrated services, with links between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services. The care manager is the single point of accountability for developing and implementing in-home support services for the child. While there may be other individuals from state agencies that have specific statutory responsibilities, like DSS social workers or DYS workers, these other individuals fulfill their responsibilities under the auspices of the single Child and Family team and through the single care manager with respect to all aspects of the in-home support services program.

Regardless of the level of in-home support services, care managers perform the same basic responsibilities, including: (1) identifying the members of the interdisciplinary Child and Family team; (2) identifying the strengths of the child and family, as well as any community supports; (3) collecting background information and plans from other agencies; (4) convening, coordinating, and communicating with the team; (5) preparing, monitoring, and modifying the ISP, as directed by the team; (6) accessing the specific in-home support and other services identified in the ISP; (7) working directly with the child and family; (8) collaborating with other caregivers on the child and family's behalf; and (9) planning for aftercare or alternative supports when in-home support services are no longer needed. Care managers are not responsible for active 51A investigations of the Department of Social Services nor for the other statutory responsibilities of DSS or DYS workers.

D. Qualifications and Training of the Care Manager

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

E. Affiliation of the Care Manager

Care managers are employed by, or affiliated with, the Community Services Agency or home-based provider for the community where the child lives.

VIII. Single Child and Family Team

A. Composition of the Child and Family Team

The care manager convenes a single Child and Family team that is responsible for developing, coordinating, monitoring, and modifying the overall treatment plan (ISP) that directs the child's mental health care, as well as for identifying and providing the services set forth in the ISP. The team is comprised of the family and child, existing or prospective mental health professionals and home-based services providers, representatives of involved state or local (school) agencies, and other natural supports including neighbors, friends, or extended family members.

While involved state agencies workers may have specific statutory duties that cannot be compromised, they undertake these responsibilities through the team process. The Child and Family team endeavors to reach consensus on all central issues, and specifically on the content and implementation of the ISP. There is a conflict resolution process for resolving disagreements amongst members of the team. While the procedure does not obviate the statutory duties of team members, it does provide a mechanism for allowing state agency staff to fulfill those duties in concert with team members, in so far as possible.

The Child and Family team is responsible for implementing the ISP, but not any separate agency or school plans.

B. Functions of the Child and Family Team

The clinical, operational, and administrative functions of the Child and Family team include, at a minimum:

1. Ongoing engagement of the person, family and others who are significant in meeting the behavioral health needs of the child, including active participation in the decision-making process:

2. Use of the comprehensive assessment performed to elicit strengths, needs and goals of the child and his/her family, and identification of the need for further or specialty evaluations that support development of a service plan which effectively meets the child's needs and results in improved health outcomes;

3. Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the child and input from the person and his/her team resulting in modification to the Individual Service Plan, if necessary;

4. Provision of all Medicaid covered services as identified in the Individual Service Plan, including referral to community resources as appropriate;

5. Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of covered services is important to achieving positive outcomes, (e.g., primary care providers, school, child welfare, juvenile or adult probations, other involved service providers);

6. Leadership of the team by the assigned care manager to provide oversight and consistency of the assessment and service planning processes;

7. Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist children who are moving to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system; and

8. Development and implementation of transition plans prior to discontinuation of in-home support services.

C. Decisions of the Child and Family Team

The Child and Family team will exercise the authority to identify and arrange for all medically-necessary services needed by the eligible child with SED. The team's decision is reviewed and approved by a psychiatrist or psychologist who is affiliated with the team, consistent with outlier standards for certain covered services. The team's decision concerning the in-home support and other services that are needed by the child constitutes a medical necessity determination with respect to such services.

EOHHS, in conjunction with DMH, will establish utilization parameters for certain in-home support services. These parameters will establish an outlier standard for the intensity and duration of certain in-home support services. The outlier standard for a particular service will be set at a level that is greater than the utilization of that service by at least 90% of children served by CFFC, MHSPY, and WCC during the past year. The team's medical necessity determination for services below the outlier standard is only subject to retrospective review by the managed care organization or behavioral health carve-out. Team recommendations that exceed the outlier standard may be subject to further review by the Community Service Agency.

D. Affiliation of the Child and Family Team

The team operates within the CSA or home-based provider for the community where the child lives, which is ultimately responsible for the structure and functioning of the teams, including the implementation of the team's decisions and the resolution of conflicts amongst team members.

IX. Single Treatment Plan: The Individual Services Plan (ISP)

A. Elements of the ISP

Each child who needs in-home support services has an Individual Service Plan (ISP) that: (1) describes the child's strengths and needs; (2) proposes treatment goals, objectives, and timetables for achieving these objectives; (3) sets forth the specific in-home support services and other supports that will be provided to the child, including the frequency and intensity of each service or activity; (4) incorporates the child and family's crisis/safety plans; and (5) identifies professional and generic providers, including natural supports, for each service or activity. Where other agencies are required to develop separate plans on specific issues (DSS reunification plans or a LEA's Individual Education Plan), these plans are integrated into, and consistent with, the ISP.

B. The ISP Process

There are nine essential steps in the ISP process that will be described in detail in an ISP manual. These steps include: (1) engagement of the child and family; (2) immediate crisis stabilization; (3) identifying the child and family strengths, needs, culture and vision; (4) forming the Child and Family team; (5) developing the ISP; (6) implementing the ISP; (7) ongoing crisis and safety planning; (8) monitoring and modifying the ISP; and (9) transition planning and implementation.

C. Coordination and Review of the ISP

Individual Service Plans are coordinated and monitored by the care manager at least monthly, and often weekly for children requiring the most intensive level of in-home support services, by the care manager. Plans should be reviewed by the Child and Family team at least every sixty for children with intensive care management and ninety days for all other children, and modified as necessary by the team.

X. Interim Services

If the CSA or home-based services provider determines, based upon the preliminary assessment or during the comprehensive assessment, that the child needs in-home support services, it refers the child for interim in-home services. This referral constitutes a medical necessity determination that interim in-home services are medically necessary. The qualified mental health professional or care manager is responsible for arranging these interim services immediately. A Child and Family team meets shortly thereafter to review these services and develop a plan for ongoing treatment.

SECTION 4: COVERED SERVICES

XI. Medicaid Covered In-Home Support Services

A. Provision of Medically Necessary EPSDT Services

Consistent with the requirements of the Medicaid Act, EOHHS shall provide children with SED with all diagnostic, preventative, and rehabilitative services, including any remedial services, for the maximum reduction of mental disability and the restoration of the child to the best possible functional level, regardless of whether the service is on the list of covered services in this Plan.

The provision of in-home support services are based upon the child's individual needs. All children who need in-home support services will have access to the same Medicaid-covered services, although the intensity, frequency, and duration of each service may vary according to the needs of the individual child. Each covered service shall be provided promptly, once be approved by the Child and Family team, but without prior authorization by the Community Service Agency, MBHP, other behavioral health carve out, MCO, or MassHealth, unless the intensity or duration of services exceeds an outlier standard. In-home support services are provided as long as necessary to meet the child's individual needs.

B. Covered Services Described in the Plan

This covered services described in this Plan include those medically necessary, in-home support services that a child needs to remain in his home and home community, as determined by his/her treating clinician.[4] Services provided outside of the home or community, such as those inpatient, outpatient, and residential services currently funded or provided by DMH, DMR, DSS, DYS, MBHP, other behavioral health carve out, or MCO are not included in this Plan,[5] but, if otherwise covered under the Medicaid Act, shall be provided when medically necessary. Thus, children who are determined to need in-home support services will have access to at least the covered services described below, plus existing Medicaid covered inpatient, outpatient, and residential support services.

The covered services in this Plan are divided into three categories: Crisis Management Services, Home-Based Services, and Coordination of Care. While

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[4] Several States and home-based programs throughout the country have developed a list of covered services that reflect a broad range of children and mental health treatment needs, their experience in providing and funding in-home support services, and approval from CMS for specific services and service descriptions. The list of covered services borrows from and incorporates the services of several nationally-acclaimed programs as well as those mental health services mandated by the recent court decision in *Katie A. v. Bonta* in California.

[5] MassHealth will continue to fund substantially the same inpatient and outpatient services described in the 2001 PCC Behavioral Health contract with the Massachusetts Behavioral Health Partnership, Appendix A, sections A, C, and D(1)-(3).

Community Service Agencies or home-based providers may also arrange and coordinate residential, outpatient, and inpatient services for children enrolled in its program, these facility-based services are not considered in-home support services, and, therefore, are not included in this Plan. Nevertheless, children in certain out of home settings may need and benefit from the in-home support services on this list, both to treat their psychiatric, behavioral, and emotional conditions, and to facilitate their return to the community.

The covered services described below include only services that are covered by Medicaid and eligible for FFP, unless the Commonwealth determines to include additional services. These covered services shall be available throughout the Commonwealth and shall be consistent within each Community Service Agency, MBHP, other behavioral health carve-out, or MCO.

Each covered service includes a service description and, where appropriate, the qualifications of the staff who provide the service. Rates shall be established for each service.

C. Qualifications of Professional and Paraprofessional Providers

The following definitions apply to the provider qualifications that appear in the descriptions of the covered services in this Plan:

> "Qualified, licensed clinician" and "qualified paraprofessional" refer to individuals with specific licensure, education, training, and/or experience, as will be set forth in standards to be established by EOHHS and DMH, with the assistance of local experts. Such individuals will be authorized to provide specific services referred to herein.
>
> A licensed clinician is an individual licensed by the Commonwealth to provide clinical services within a particular scope as defined by the applicable licensing authority or statute, including, but not necessarily limited to, physicians, psychiatrists, licensed clinical psychologists, licensed independent clinical social workers, licensed clinical social workers and licensed mental health counselors.
>
> A paraprofessional is an individual who, by virtue of certification, education, training or experience is qualified to provide therapeutic support services under the supervision of a licensed clinician.

D. Covered Services

1. Crisis Management Services

Mobile Crisis Intervention

A mobile, on-site, face-to-face therapeutic response to a child experiencing a mental health crisis for the purpose of identifying, assessing, treating, and stabilizing the

situation in community settings (including the child's home) and reducing the immediate risk of danger to the child or others. Mobile crisis services may be provided by a single professional crisis worker or by a team of professionals trained in crisis intervention. Services are available 24-hours a day, seven days a week. Phone contact and consultation may be provided as part of the intervention. Providers are qualified, licensed clinicians or in limited circumstances qualified paraprofessionals supervised by qualified, licensed clinicians.

Crisis Stabilization

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

2. Home and Community-Based Services

These services may be provided in any setting where the child is naturally located, including, but not limited to, the home including foster homes and therapeutic foster homes, child care centers, respite settings, and other community settings. These services may be provided as a bundled service by a team or as a discrete clinical intervention depending upon the service needs of the child.

In-home Behavioral Services

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

(1) Behavior management therapy is provided by a trained professional, who assesses, treats, supervises, and coordinates interventions to address specific behavioral objectives or performance. Behavior management therapy addresses challenging behaviors which interfere with the child's successful functioning. The therapist develops and monitors specific behavioral objectives and interventions including a crisis response strategy that are incorporated into the child's treatment plan. The therapist may also provide short-term counseling and assistance, depending on the child's performance and the level of intervention required. Behavior management therapy is provided by qualified, licensed clinicians.

(2) Behavior management monitoring is provided by a trained behavioral aide, who implements and monitors specific behavioral objectives and interventions developed by the behavior management therapist. The aide may also monitor the child's behavior and compliance with therapeutic expectations of the treatment plan. The aide assists the therapist to teach the child appropriate behaviors, monitors behavior and related activities, and provides informal counseling or other assistance, either by phone or in person. Behavior management monitoring is provided by qualified paraprofessionals supervised by qualified, licensed clinicians.

In-home Therapy Services

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

(1) A structured, consistent, therapeutic relationship between a licensed clinician and the family and/or child for the purpose of meeting specific emotional or social relationship issues. The licensed clinician, in conjunction with the Child and Family team, develops and implements therapy goals and objectives which are incorporated into the child's treatment plan. Clinical services are provided by a qualified, licensed clinician who will often work in a team that includes a qualified paraprofessional who is supervised by the qualified, licensed clinician.

(2) Ongoing therapeutic training and support to the child / adolescent to enhance social and communication skills in a variety of community settings, including the home, school, recreational, and vocational environments. All services must be directly related to the client's treatment plan and address the child's emotional/ social needs, including family issues related to the promotion of healthy functioning and feedback to the family. This service is provided by a qualified paraprofessional who is supervised by the qualified, licensed clinician. This paraprofessional may also provide behavior monitoring as described above.

Mentor Services

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

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

behavioral plans. Child/Family mentors are qualified paraprofessionals and are supervised by a licensed, qualified clinician.

Child/Family Support Trainings

Parenting classes or other structured group activities designed to enhance the parent-child relationship. Training normally involves a curriculum or defined set of experiences that promote usable learning and skill development to promote the child's behavioral health and functioning. Providers are licensed or Master level clinicians.

Multi-Systemic Therapy

An evidence based practice that integrates family-focused, strength-based wraparound services primarily for children involved in juvenile justice system. Services are provided by a professional and paraprofessional supervised by a licensed clinician.

Therapeutic After School Services

Services include individual and related therapies and counseling in a therapeutic setting with an emphasis on skill building, psychosocial skills, occupational training, and relationship problem-solving. Staff are qualified and trained professionals, with assistance from supervised paraprofessionals.

Special Therapies

Occupational, physical, and speech therapies, including physical and sensory integration techniques, provided to children in home, school and community settings. Providers will possess related educational experience and certification. Documentation includes diagnostic impressions and progress toward identified outcomes.

Interpreters

Interpretive services (sign language or oral (non-English) interpretation to allow the child and family to participate in treatment planning and treatment services.

3. Coordination of Care

Comprehensive Assessment

Services include face-to-face contact for the purpose of assessing the family's and child's strengths and needs; an evaluation of the child's current living situation, relationship, and family functioning; and a review of information regarding the child's clinical, educational, social, behavioral health, and criminal justice history. Assessments should be completed in the family home whenever possible and support the cultural context of the family. Providers are Master level or above clinicians with appropriate certification. Comprehensive assessments also include a face-to-face clinical assessment of the child and

family by a Psychiatrist (MD), Psychologist, Master Level Social Worker or Clinical Nurse Specialist that includes clinical impressions, DSM IV Axis Diagnosis, and recommendations for treatment planning.

Care Management and Intensive Care Management

As described in Section VII of the Plan, Care Management and Intensive Care Management are outcome-focused, strength-based services that assist families and children by locating, accessing, coordinating and monitoring mental health, social services, educational and other services. Care Management and Intensive Care Management services include assembling and coordinating the Child and Family team, coordinating the development of the ISP, arranging and monitoring services described in the ISP, regularly reviewing the ISP, facilitating collaborative communication and decision-making across child welfare, juvenile justice, mental health, corrections, and educational systems; and assisting in emergency or crisis situations. Care Management and Intensive Care Management also include face-to-face activities or collateral contacts that directly benefit the child and family. Services may be provided by licensed or Master level clinicians.

Care Management primarily is for children with SED who have a functional impairment that requires treatment which is beyond the scope of clinic-based outpatient services. A care manager has a caseload of approximately 16-20, and visits the child and family at least bi-weekly.

Intensive Care Management is for children with SED who are experiencing serious mental health and/or behavioral issues and have a significant functional impairment. An intensive care manager has a caseload of approximately 8-10 and visits the child and family approximately weekly.

Case Consultation

In-person or telephone meeting between the care manager, treating providers, physician, and other health care professionals or paraprofessionals involved in the child's care to develop, monitor, or modify a comprehensive assessment or Individual Service Plan, or to review services and progress towards objectives in the ISP, including their attendance or participation in Child and Family team meetings or educational case conferences.

SECTION 5: THE METHOD FOR PROVIDING IN-HOME SUPPORT SERVICES

XII. Community Services Agencies

A. Designation of Service Areas

Each service area or relevant community in the Commonwealth will have a Community Services Agency. There may be a separate Community Service Agency for a portion of a city (Boston), in order to reflect cultural and linguistic characteristics, or the same Community Service Agency may serve several counties (Franklin and Hampshire). The determination of relevant service areas generally will reflect DMH areas.

Within three months of the approval of this Plan, EOHHS and DMH will determine the number and geographical boundaries of the service areas for in-home support services. Although the service areas will generally mirror DMH catchment areas, areas may be consolidated in order to promote consistency, quality, and efficiency. However, in order to ensure community connectedness and involvement, as well as cultural and ethnic diversity, in no event will there be less than fifteen or more than thirty areas.

As described in the Core Components portion of this Plan (Section 3), there will be a Community Services Agency provider for each service area that is responsible for conducting comprehensive assessments, providing care management, coordinating and overseeing Child and Family teams and Individual Service Plans, developing clinical partnerships and affiliation agreements with direct care service providers, and providing or arranging all in-home support services, either directly or through its partnership. Other agencies ("alternative home-based services providers") may also provide these functions in the same area.

B. Selection of Community Services Agency

The Community Services Agency provider must be an agency that is responsive to the needs and strengths of the local community, that operates in collaboration with public agencies including DMH, DSS, DYS, DMR and local educational authorities, and that is committed to the CASSP values and principles for providing home-based services. EOHHS, in conjunction with DMH, and after consultation with DSS, DYS, DMR, local experts, and the plaintiffs, will establish rigorous qualifications and operational standards for a Community Services Agency.

The Community Services Agency provider will be selected by a competitive bid process pursuant to these criteria. EOHHS and DMH, in conjunction with DSS, DYS, DMR, community leaders, and local experts, will select the Community Services Agency provider for each community.

Within nine months of the approval of this Plan, EOHHS and DMH, after consultation with other EOHHS agencies, families, and local system of care experts, will select and contract with Community Services Agencies for one-third of the service areas. EOHHS and DMH, using the same process, will select and contract with Community Services Agencies for an additional one-third of the service areas within eighteen months and for the remainder of the services areas within twenty-four months of the approval of this Plan.

C. Roles and Responsibilities of Community Services Agencies

All Medicaid-eligible children in the same community, regardless of their health plan, will have access to the same Community Services Agency. If there is another qualified alternative home-based services provider that offers all of the core components of in-home support services for that community, children may elect that alternative home-based services provider.[6] If in-home support services are offered to Medicaid recipients who are not part of a managed care plan, they may access these services through the Community Services Agency for their community or alternative home-based services provider in their community. Children and families will not be required to enroll in a specific health plan (MCO or PCC) to obtain in-home support services or disrupt existing relationships with medical care providers in order to access in-home support services.

The Community Services Agency and alternative home-based services provider are required to:

1. serve all Medicaid-eligible enrolled children in their relevant community who need a comprehensive assessment and in-home support services;

2. provide certain core services and ensure prompt access to all other covered services;

3. develop clinical partnerships and affiliations with qualified providers of in-home support services, determine the providers which will offer specific services to an individual child as set forth in the ISP, and monitor the services provided by these providers to ensure consistency, quality, efficiency, and effectiveness;

4. operate pursuant to statewide policies and procedures for conducting assessments, providing care management, making medical necessity determinations concerning needed services, and accessing and providing in-home support services;

[6] It is unclear whether there will be alternative home-based services providers, or where they will be located. This alternative would offer a choice to families, as well as comply with provisions of the Medicaid Act concerning qualified providers.

5. meet statewide performance standards and outcome measures; and

6. collect and disseminate performance and outcome data.

In order to ensure consistency and quality, Community Services Agencies and alternative home-based services providers will be rigorously monitored by EOHHS.

D. Services Provided by Community Services Agencies

1. <u>Core Services</u>

The Community Services Agency and alternative home-based services provider are responsible for conducting assessments, providing care management, coordinating and overseeing the Child and Family team, and approving the Individual Service Plan. They are also responsible for providing, or ensuring immediate access to, certain core mental health services, including crisis and respite services.

The Community Services Agency and alternative home-based services provider must have qualified and trained staff and supervisors who conduct comprehensive assessments for all referred children, and complete all relevant intake activities. They must have a sufficient number of qualified and trained care managers and clinical supervisors to satisfy the caseload ratios for the level of care management that is needed by the children they serve. A psychiatrist or psychologist employed by the Community Services Agency and alternative home-based services provider will approve all Individual Service Plans and confirm the medical necessity of all services incorporated in the ISP.

The Community Services Agency and alternative home-based services provider are responsible for the functioning of the treatment teams that serve children in its community. They must have relationships and agreements with state and local educational agencies in its communities. They must have policies and procedures for the structuring, functioning, and monitoring of these treatment teams, and have effective procedures to ensure that conflicts amongst members of the team are efficiently resolved.

The Community Services Agency and alternative home-based services provider must provide, or ensure immediate access to, specialized mobile crisis and emergency services for children, either through their own staff or through contracts with other agencies, to serve the children in its community. The Community Services Agency and alternative home-based services provider's crisis program must have the capacity to evaluate the child in the home, and provide direct clinical interventions in the home for up to three days, through crisis workers or specialists. The crisis program must operate a crisis shelter or community living arrangement where a child may remain for up to seven days and receive intensive crisis services from qualified mental health professional and crisis workers. If the child is in a crisis at any entry point along the pathway to in-home support services, or if a state agency or mental health provider determines that the child is in, or imminently at risk of, a crisis, then the child should be evaluated in the child's

home by a mobile crisis/emergency services program, whenever possible, unless clinically inappropriate.

2. Other In-home Support Services

The Community Services Agency and alternative home-based services provider must promptly provide the array of covered services, either through its own staff or through clinical partnerships and affiliation agreements with other agencies, to serve all of the children in its community who need in-home support services. They must use other affiliated providers in the relevant community to offer at least some in-home support services, in order to promote choice for families, afford timely access particularly in large geographical communities, ensure cultural competency, and promote community involvement.

If in-home support services are provided through other agencies, then the Community Services Agency and alternative home-based services provider must develop clinical partnerships and affiliation agreements with these providers; approve, coordinate, and monitor these affiliated providers; ensure timely access to clinical services; be accountable for the performance of the affiliated providers; and ensure that all services are provided in an integrated, coordinated, and consistent manner.

3. Administrative Services

The fiscal and administrative services necessary to operate and support the Community Services Agency's and alternative home-based services provider's clinical partnership, including information technology, data management, claims processing, and payment will be the responsibility of the managed care organization or behavioral health carve-out.

E. Relationship between the Community Services Agency and Alternative Home-based Services provider and the Managed Care Organization

In order to ensure access, consistency, and quality, each managed care organization and the behavioral health carve-out will contract with the same Community Services Agency for the relevant community, using a standard contract. The standard contract will describe the same roles and responsibilities; cover the same services; establish the same utilization procedures, performance measures, outcomes, and data collection obligations; and reimburse providers at the same rates for in-home support services.

In appropriate circumstances, where the criteria for the Community Services Agency are met by an existing in-home support services entity or program operating within a managed care organization, or where in-home services and other medical services are to be provided through an integrated network, the Community Services Agency may be the entity or program within the managed care organization. That Community Services Agency may also become the Community Services Agency or

alternative home-based services provider for other communities or areas. In that case, the same requirements, roles, responsibilities, policies, procedures, covered services, performance measures, and outcomes would apply to the managed care organization's Community Services Agency, although there may not be a separate contract between the MCO and Community Services Agency.

F. Qualifications and Standards for the Community Service Agency

The Community Services Agency and alternative home-based services provider will operate pursuant to statewide standards an procedures for conducting comprehensive assessments; for assigning care managers; for creating and overseeing treatment teams; for developing, reviewing, modifying, and implementing treatment plans; for providing timely in-home support services; for receiving and responding to consumer complaints and appeals; and for collecting and reporting relevant outcome data that is regularly reviewed and assessed to determine if appropriate quality services are being provided to the children.

Within six months of the approval of this Plan, EOHHS and DMH will develop qualifications and standards for a Community Services Agency and alternative home-based services provider. The qualifications and standards will include, among others:

1. standards to ensure clinical staffing, competency, and supervision of the Child and Family teams;

2. standards to determine that care managers are properly trained and competent to coordinate assessments, develop ISPs, and lead Child and Family teams;

3. standards for the clinical supervision of care managers;

4. standards for the format and timely completion of comprehensive assessments and Individual Service Plans;

5. standard checklists to ensure that all components of the comprehensive assessment and Individual Service Plan are completed;

6. standard instruments to assess whether ISPs are adequate and consistent with the quality criteria used in the Child Service Review, as described in the Compliance Evaluation section of this Plan;

7. outlier standards for certain in-home support services;

8. protocols for the review and approval by the provider's psychiatrist, psychologist, or other appropriate health care professional of the medical necessity determinations of the Child and Family teams, including the intensity, duration, and frequency of services;

9. protocols for review by MassHealth or its managed care organizations of the medical necessity of the determinations of the Child and Family teams that exceed outlier standards for certain services;

10. standards for the timely implementation of interim and other in-home support services;

11. standards for the development and oversight of the clinical partnership and affiliated providers that are offering in-home support services;

12. standards for the type and array of in-home support services that must be provided or arranged, in partnership with the affiliated providers, by the Community Services Agency and alternative home-based services provider;

13. standards for the type and array of all other Medicaid covered behavioral health services that must be provided or arranged by the Community Services Agency and alternative home-based services provider;

14. standards to prevent conflicts of interest or undue concentration of direct services by the Community Services Agency and alternative home-based services provider;

15. standards for the efficient management and operation of the Community Services Agency or alternative home-based services provider, including utilization management and review;

16. standards for the collection and maintenance of data and other information for quality improvement and for EOHHS and DMH to measure outcomes on the child and family, program, and system levels.

G. Contract with the Community Services Agency

Within eight months of the approval of this Plan, EOHHS and DMH will develop a standard contract and rates for Community Services Agency and alternative home-based services providers. The standard contract will be used by all MassHealth managed care organizations that offer in-home support services through either a Community Services Agency or alternative home-based services provider.

H. Performance Measures

Within nine months of the approval of this Plan, EOHHS and DMH, in conjunction with other EOHHS agencies, families, and local experts in system of care performance measurement, will develop specific performance measures for the Community Services Agency and alternative home-based services provider that reflect

the relevant standards set forth above. These performances measures will be used to evaluate compliance at the provider/program level, as described in the Evaluation section of the Plan.

I. Training

Community Services Agencies and alternative home-based services providers will ensure that their clinicians and care managers are adequately trained in the wraparound process and System of Care values and principles, in strength-based assessments, in the role and model of Child and Family teams, in the treatment planning process, and in the performance expectations of in-home support services. Training materials and modules used by MHSPY and CFFC will serve as models for this educational program and will be provided by the Department of Mental Health.

XIII. Service Delivery Policies, Procedures, and Performance Measures for Affiliated Service Providers

A. Affiliated Providers

Within three months of selection, each Community Services Agency and alternative home-based services provider shall establish clinical partnerships and affiliation agreements with providers that will ensure the full array of in-home support and related services in the designated service areas. The Community Services Agency and alternative home-based services provider will utilize a standard contract for each affiliated provider that incorporates the relevant EOHHS standards for the Community Services Agency and the relevant standards for affiliated providers.

B. Service Delivery Policies and Procedures

Within three months of selection, the Community Services Agency and alternative home-based services provider shall develop service policies and procedures for their programs and for affiliated providers that are consistent with the standards established by EOHHS and DMH. The procedures shall include the basic values, competencies, and access and service requirements for providing in-home support services consistent with each child's ISP, as well as the data collection needed to measure outcomes on the child and family, program, and system levels.

C. Performance Measures

Within twelve months of the approval of this Plan, EOHHS and DMH, in conjunction with other EOHHS agencies, the Community Services Agencies, families, and local experts, will develop performance measures for affiliated providers. These performances measures will be used to measure outcomes at the provider/program level, as described in the Evaluation section of the Plan.

XIV. Service Codes, Rates and Billing Procedures

A. Service Codes and Rates

Within six months of the approval of this Plan, EOHHS will increase its reimbursement rate to reasonably and fairly compensate medical providers and other health care professionals for conducting formal screens and reporting their findings from these screens. At the same time, EOHHS will establish a reasonable reimbursement rate to reasonably and fairly compensate mental health care providers for conducting preliminary assessments with the CANS and reporting their findings from these assessments.

Within six months of the approval of this Plan, EOHHS and DMH, in conjunction with other EOHHS agencies, will establish billing codes and rates for in-home support services that are reasonably calculated to ensure effective treatment, to attract a range of qualified providers, and to promote timely access to in-home support services throughout the Commonwealth. The rates will be consistent with community standards for each service. If capitation rates for managed care organizations are used to reimburse providers who serve children with SED who receive in-home support services, then a specialty plan or carve-out should be established that reflects the actual costs of these services for SED children.

B. Billing Procedures

Within nine months of the approval of this Plan, EOHHS, as the single state agency, will establish billing procedures that are reasonably calculated to promote timely payment for in-home support services and efficiency of administration. Within the same timeframe, it will develop guidelines, reporting methods, and billing procedures for conducting behavioral health screens and preliminary assessments.

XV. Roles and Responsibilities of State Agencies

EOHHS recognizes that in-home support services are more effective and efficient if the planning and delivery of these services reflects a collaborative effort of all involved child serving state agencies. Therefore, EOHHS will ensure that its agencies cooperate and collaborate in the design and delivery of in-home support services. It will appoint DMH as the lead state agency under this Plan, with the responsibility for overseeing the design, development, and delivery of in-home support services.

In addition, the Governor and EOHHS will direct each child-serving agency, and invite local educational agencies, to participate on Child and Family teams that serve children in its care or custody. EOHHS will ensure that the Community Services Agency and alternative home-based services provider has conflict resolution policies to address service planning barriers and disagreements amongst members of the team, including representatives of child serving state agencies.

EOHHS will direct each of its child serving agencies to assist in fulfilling the provisions of this Plan, in addressing interagency service planning barriers, and in undertaking the specific tasks for which the agency is responsible under this Plan and under the laws of the Commonwealth.

SECTION 6: INFORMING, OUTREACH, AND EDUCATION

XVI. Informing

EOHHS shall undertake multiple methods for effectively informing Medicaid-eligible children, their families, clinicians, providers, and state and local agencies about the purpose, benefit, scope, and coverage of in-home services and shall develop and implement strategies for measurably improving access to these services.

A. Notices and Brochures for Families

Within sixty days of approval of this Plan, EOHHS shall revise its EPSDT notices to effectively inform children and families about the Commonwealth's obligation under EPSDT to provide screening, assessment, and all behavioral health services to children, including in-home support services, that are deemed medically necessary by the child's clinician. All notices shall be translated into the relevant languages of the Massachusetts Medicaid population, as well as into accessible formats for children and families with disabilities. The revised notices will be shared with the plaintiffs for comment prior to distribution to Medicaid recipients.

Within sixty days of approval of this Plan, EOHHS also shall prepare a special notice, in understandable language, explaining in detail how children and families can obtain medically necessary services that are not covered by contracts with managed care organizations, including the documentation necessary to support requests for services, the timetable and actions for each step of the process, and the method for obtaining the services.

Within ninety days of approval of this Plan, EOHHS and DMH shall develop a special information booklet about in-home support services that describes, in understandable language: (1) what in-home support services are, and how they differ from existing behavioral health services for children; (2) the purpose and benefits of in-home services; (3) where and how to access these services; (4) the screening and assessment process for these services; (5) referrals by primary care clinicians and other health care professionals for these services; (6) the eligibility criteria for these services; (7) the pathway for obtaining these services; (8) the role and responsibilities of the Community Services Agency and any alternative home-based services provider; (9) the range of covered services available; and (10) the methods for appealing denials, modifications, and termination of services. The booklet shall contact a chart comparing current services with in-home support services, and include a list of locations and contact information for all Community Services Agencies and alternative home-based services providers. The booklet shall be submitted to the plaintiffs for comment and approval, and revised as additional Community Services Agencies are developed.

EOHHS shall require each managed care organization to revise its member handbooks within 180 days of approval of this Plan to effectively inform parents, children, and providers about the scope, screening and assessment process, eligibility

criteria, pathway, covered services, the Community Services Agency, and procedures for obtaining in-home support services. EOHHS shall revise the member handbook for the primary care clinician program. The revised handbooks shall include the special notice concerning non-covered services and the information booklet on in-home support services.

B. Communications with Families

EOHHS shall ensure that the Office of Medicaid, through its state agency staff, consumer service representatives and consumer representatives of its managed care organizations, effectively inform families using a combination of oral communications and face to face meetings. EOHHS, either directly or through its managed care organizations, shall develop public service announcements, a public awareness campaign, central telephone information resources, and other means to inform families about the Commonwealth's obligation under EPSDT to provide all behavioral health services to children that are deemed medically necessary by the child's clinician, and specifically about the benefits and availability of in-home support services.

C. Provider Manuals and Alerts

EOHHS shall require each managed care organization to revise its provider manuals within 180 days of approval of this Plan to effectively inform providers about the scope, screening and assessment process, eligibility criteria, pathway, covered services, Community Services Agency, and procedures for obtaining in-home support services. The managed care organizations shall use a variety of provider and program alerts, brochures, educational forums, electronic and other methods to inform providers about the availability of in-home services, the billing codes and rates for these services, the procedures for referring and obtaining these services for children, and the process for seeking approval of an outlier level of services. EOHHS shall use similar methods to inform primary care clinicians and other fee for service providers about these services and processes, and ensure that similar modifications are made to the PCC program manuals and alerts.

In addition, EOHHS shall:

1. Update its EPSDT regulations to reflect the program improvements described in this Plan;

2. Update Appendix W of the MassHealth Provider Manual, which describes medical protocols and periodicity schedules for EPSDT services, to reflect the program improvements described in this Plan;

3. Draft and distribute special provider communications related to the program improvements described in this Plan;

4. Update and distribute existing provider education materials to reflect the program improvements described in this Plan;

5. Expand the distribution points of existing materials regarding EPSDT generally, including the program improvements described in this Plan;

6. Implement any other operational changes required to implement the program improvements described in this Plan;

7. Hold special forums for providers to encourage clinical performance activities consistent with the principals and goals of the Plan; and

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

XVII. Outreach and Education

A. Outreach

EOHHS will promptly develop a statewide outreach initiative for families to introduce them to the purpose, benefits, and scope of in-home support services and to engage them in the development and implementation of the new program. The plaintiffs and relevant family organizations will be invited to assist in developing this initiative. Within three months of the approval of this Plan, EOHHS will implement the initiative to inform families about the pathway to in-home support services as well as the scope and availability of covered services. The initiative will include separate outreach efforts to families, adolescents and teenage children, and all entry points concerning in-home support services.

In developing and implementing this outreach initiative, EOHHS will collaborate with existing family advocacy organizations, including the Parent/Professional Advocacy League (PAL), the Federation for Children with Special Needs, Massachusetts Family Voices, the Massachusetts Chapter of the National Alliance for the Mentally Ill (NAMI), the Association for Retarded Citizens (Arc-MA), the Massachusetts Association for Mental Health (MAMH), the Massachusetts Association of Foster Families (MAFF), and the Children's League. EOHHS shall contract with a qualified family organization, jointly selected by the parties, to assist it developing and implementing its outreach initiative.

B. Education

EOHHS shall sponsor special orientation and educational meetings throughout the Commonwealth to introduce families, clinicians, providers, primary care clinicians, school officials, and community organizations to the purpose, benefits, and scope of in-home support services and the processes for accessing these services.

Within six months of approval of this Plan, EOHHS will develop and implement ongoing educational programs for families, health care professionals, state agency workers, child care center staff, school employees, mental health professionals and other relevant parties concerning the requirements of this Plan and federal law with respect to periodic and interperiodic screening, preliminary assessments, the purpose, benefit, and scope of in-home support services, the pathway to in-home support services, covered services, and methods for accessing medically necessary mental health services for children with SED.

EOHHS will provide targeted training, education and outreach to medical and other health care professional concerning formal behavioral health screening. It will provide targeted training, education and outreach to mental health and other health care providers concerning preliminary assessments.

EOHHS shall ensure that its MassHealth managed care organizations and primary care providers, Community Services Agency and alternative home-based services providers, and network providers are trained in the requirements of this Plan and federal law with respect to periodic and interperiodic screening, preliminaryassessments, the pathway to in-home support services, covered services, and the process for accessing medically necessary services for children with SED.

In addition, EOHHS will:

1. Develop and implement training programs for line staff of Departments of Mental Health, Social Services, Youth Services, Mental Retardation, Transitional Assistance, and the Office for Refugees and Immigrants on how to access preliminaryassessments, comprehensive assessments, and in-home support services for children with SED;

2. Together with the Department of Early Education and Care, educate pre-schools, childcare centers and Head Start Programs on how to access preliminaryassessments, comprehensive assessments, and in-home support services for children with SED;

3. Together with the Department of Education, provide the most up-to-date information for Public School Districts for use as part of their special education evaluations and other health efforts on how to access preliminaryassessments, comprehensive assessmens, and Medicaid in-home support services for children with SED; and

4. Together with the state Department of Public Health's School Health Program, educate school nurses on how to access preliminaryassessments, comprehensive assessments, and in-home support services for children with SED.

SECTION 7: DATA COLLECTION, EVALUATION, AND MONITORING

XVIII. Data Collection and Evaluation Program

A. Purpose and Function of Data Collection

There are four primary goals of this Plan: (1) to improve screening, diagnosis, and mental health treatment for SED children; (2) to establish an accessible and efficient system for providing in-home support and related behavioral health services to SED children; (3) to increase the type and availability of in-home support services for children with SED; and (4) to increase the effectiveness of care for children who receive in-home and other behavioral health services in the Commonwealth. With respect to the last goal, the primary emphasis is on measures of child functioning rather than just symptom reduction. This is consistent with the Court's ruling and Medicaid's emphasis on improving overall functioning. It is also consistent with the recommendations of the President's New Freedom Commission on Mental Health. There must be specific data collected on the key elements of each goal, and a method for evaluating the data that informs the parties, the Court, and the beneficiaries of this Plan.

Evaluation of data is an essential element of achieving the goals of this Plan and the implementation of the Court's ruling. Current data collection and monitoring capacities will be expanded to include activities that reflect the requirements of the Plan at three distinct levels: (1) the child and family level; (2) the agency or provider level; and (3) the system level.

Collecting relevant data, evaluating this information, and taking corrective actions are necessary to ensure that the Plan achieves its specified goals. Data should be used to highlight meaningful progress and areas for improvement at the agency and system levels, as well as a means of monitoring the progress of individual children and families. This is particularly important given the Court's expectation that the results of the Plan's evaluation and monitoring mechanisms will be public and scrutinized by federal and state officials, as well as families and advocates.

The following guidelines will be used for collecting data to evaluate service and system requirements:

1. Data should be collected and Plan requirements should be evaluated at all three levels of the child mental health service system;

2. There should be transparency and public presentations of findings, regular and frequent review by key decisionmakers, feedback to those who have provided the data, and culturally and linguistically competent measures and data collection procedures;

3. The major focus of the evaluation process should be the degree of progress and success in achieving the goals of the Plan: improved screening and diagnosis; an efficient delivery system; increased access to care in a timely manner; and increased effectiveness of care that produces better functioning in the community;

4. It is also essential to collect data on a regular basis on the team planning process, plan implementation, and service utilization, with a focus on those elements that are required by the Plan.

EOHHS shall establish a data collection and evaluation program to measure the screening, assessment, and service requirements of this Plan. EOHHS shall coordinate this program, shall ensure that its agencies, including at least DMH, DMR, DSS, DYS, and the Office of Medicaid, participate in this program and share information with families and local stakeholders, and shall take the necessary actions so that these agencies engage in consistent practices to implement this program and this Plan.

B. Data Collection and Evaluation of Screening Requirements

The pathway to in-home support services includes screening, diagnosis, and assessment processes. These stages must be accurate and reliable if the children who need in-home support services actually receive them.

EOHHS will develop a data collection program that tracks whether and when a well-child visit occurred, when an interperiodic screening visit occurred, whether a formal behavioral health screen was completed during the visit using one of the approved instruments, whether the parent or guardian refused to participate in the screen, whether the screen indicated that the child had a mental health condition, whether the child was already engaged in mental health treatment, and whether a referral for a preliminary assessment was made.

EOHHS, in conjunction with DMH and families, shall establish a method for evaluating psychiatric medication management by pediatricians and primary care providers provided to children with SED, in order to ensure that such treatment is appropriate.

C. Data Collection and Evaluation of Preliminary Assessment Requirements

EOHHS will develop a data collection program that tracks which children who have been referred for a preliminary assessment; whether that referral was made by a medical provider or other health care professional pursuant to a formal EPSDT screen, by a publicly-funded entity as part of its intake and evaluation process, or by other means; whether the assessment was completed; whether the preliminary assessment concluded that the child needed a comprehensive assessment; and whether the parent or guardian refused to participate in the assessment.

EOHHS will collect data on the timeliness of the assessment processes, its adherence to professional and other standards, and its role in providing access to care for children with SED.

D. Data Collection and Evaluation of Child Service Requirements

Data must be collected with respect to the accuracy and reliability of comprehensive assessments, the appropriateness and fidelity of the treatment planning process, the consistency or "fit" between the child's identified needs and the services described in the Individual Service Plan, and the actual provision of the planned services, including the type, intensity, frequency, duration, and sequencing of each service, as well as the level of engagement of the child and family.

1. Child Service Reviews

The central approach to evaluating in-home support services, the functioning of the Child and Family teams, and the overall effectiveness of the treatment planning process is through an individualized review of a sample of children with SED who are receiving these services. EOHHS shall conduct an annual Child Service Review, using the Child and Family Team Practice Improvement Review adopted by the Arizona for its evaluation of EPSDT in-home support services or another established and validated review protocol agreed to by the parties. The Arizona review protocol is attached as Appendix 3. If the protocol is modified for use in Massachusetts, the revised form shall be substituted in Appendix 3.

The review will be conducted by qualified and trained reviewers, based upon a random sample of children who are receiving in-home support services through Community Services Agency providers. The review will be undertaken pursuant to established protocols described in a reviewer's guide or training materials. The reviewers will conduct interviews with the child, family, and treating clinician, will have access to records and other client specific information necessary to conduct the review, and will complete a review instrument, such as the Arizona Child and Family Team Practice Improvement Review Tool, which is attached as Appendix 4. If the tool is modified for use in Massachusetts, the revised form shall be substituted in Appendix 4. The review sample should be sufficiently large to generate reliable conclusions about all similarly-situated children, with a +/- 5% margin of error. Alternatively, the review can be based upon a smaller sample if the parties agree that its results are valid and reliable for all children receiving in-home support services.

EOHHS, in conjunction with its agencies, families, and local experts, shall establish a process for conducting Child Service Reviews, consistent with accepted standards of practice and the procedures utilized by other States such as Arizona and Hawaii. It shall enter into a separate contract with another qualified evaluation or research entity, agreed to by the parties, to undertake these activities and generate annual reports on Child Service Reviews.

2. Child functioning

Based upon the experience of home-based and wraparound programs in Massachusetts and elsewhere, as well as the professional literature, in-home support services that are provided consistent with the CASSP principles and within the context of coordinated care should reliably result in a significant improvement in the emotional condition, behavior, and functioning of most children who receive these services. This improvement is expressed as specific scores on various functional scales or measurements. The most important domains for evaluating a child's functioning in the community are behavioral and emotional problems, clinical functioning, school attendance and performance, law enforcement contacts, residential stability, and use of restrictive services and out of home placements. The CAFAS and the CANS-MH are among the most reliable instruments to evaluate improvements in child functioning.

EOHHS, in conjunction with its agencies, families, and local experts, shall establish a consistent procedure for collecting, reviewing, and analyzing information on child functioning, using the CANS-MH or the CAFAS, with the overall data also being disaggregated to determine the degree of change for children with different constellations of problems and different backgrounds. Unless the defendants have the internal capacity to collect, analyze, evaluate, and disseminate data on child functioning, it shall enter into a contract with a qualified evaluation or research entity or entities, agreed to by the parties, to undertake these activities and generate annual reports on outcomes.

3. Service planning and implementation

The Wraparound Fidelity Index or the Wraparound Observation Form (Second Version) are the most reliable instruments to evaluate the treatment team process and will be one key measure of the adequacy of the Child and Family teams. EOHHS, in conjunction with its agencies, families, and local experts, shall establish methods to evaluate the functioning and operation of Child and Family teams, which may be through the Child Service Review process.

E. Data Collection and Evaluation of Provider Requirements

Data must be collected on the accessibility, quality, and integration of the core components of in-home support services that are the responsibility of the Community Services Agency and alternative home-based services provider. Similarly, information about the accessibility, quality, and operations of the network providers must be collected. For all providers, data about the timeliness, cost, and availability (wait lists) of services is essential. EOHHS and its agencies will collect this information as well as data relevant to evaluate the performance of Community Services Agency, alternative home-based services providers, and affiliated providers with the measures established for each of these entities.

F. Data Collection and Evaluation of System Requirements

Data necessary to evaluate service system requirements include child and family characteristics, child functioning and family satisfaction, treatment and support planning, provider performance, and service utilization, including the frequency, duration, and intensity of services. EOHHS and its agencies will collect this information and use it to inform their judgments about the adequacy of actions to establish an effective and efficient service delivery system.

EOHHS will collect data on the utilization and the cost of covered services by children with SED. This data also will include information about the request for, and approval of, services that exceed outlier standards.

EOHHS, in conjunction with its agencies, families, and local experts, shall establish a process and collect data to evaluate system requirements across all child service agencies, such as number and percentage of children being served in out-of-home care, and percentage of children in need who are receiving in-home support services.

XIX. Reporting and Corrective Actions

A. Reports

EOHHS will generate quarterly reports on EPSDT periodic and interperiodic screens, preliminary assessments, comprehensive assessments, service recommendations, and the utilization of covered services that include all of the data and information described in this Plan.

EOHHS' contractors shall generate annual reports on the findings of their Child and Family team evaluations, child functioning evaluations, and Child Service Reviews, including systemic and individual findings, conclusions, and recommendations for improvement.

B. Corrective Actions

EOHHS, in conjunction with its agencies, families, and local experts, will develop and implement corrective actions to address problems identified with the rate, referrals, or results of periodic and interperiodic screening and preliminary assessments. EOHHS will review the data on EPSDT periodic and interperiodic screens to determine if all children are receiving appropriate and timely behavioral health screens and whether the findings of the screening process properly result in referrals for preliminary assessments. If the data indicate problems in the rate, referrals, or outcomes of the EPSDT screens, EOHHS will take adequate and effective actions to correct these problems in a timely manner.

EOHHS, in conjunction with DMH and families, will develop and implement corrective actions to address problems identified with the treatment of children with SED by pediatricians or family practitioners.

EOHHS will review the data on preliminary assessments to determine if all children who are referred for these assessments receive them and whether the findings of the assessment process properly result in referrals for comprehensive assessments. If the data indicate problems in the rate or outcomes of the preliminary assessments, and specifically any discrepancy between referrals for, and completion of, preliminary assessments, EOHHS will take adequate and effective actions to correct these problems in a timely manner.

EOHHS, in conjunction with its agencies, families and local experts, will develop and implement corrective actions to address problems identified in the functioning and operation of Child and Family teams.

EOHHS, in conjunction with its agencies, families, and local experts, will develop and implement corrective actions to address problems identified with the utilization of covered services, the review of outlier requests, and the consistent implementation of Individual Service Plans.

If the desired outcomes are not achieved or if problems are identified in the Child Service Reviews, then EOHHS, in conjunction with its agencies, families, and local experts, shall take all necessary actions to review the performance of the Community Services Agency and alternative home-based services provider and the affiliated providers of in-home support services; the functioning of the Child and Family teams; the actions of state and other agencies involved in the planning, funding, or delivery of in-home support services; and the policies, procedures, and processes that have been established to guide the provision of in-home support services across all child-serving agencies. As a result of this review, EOHHS shall take appropriate corrective action designed to improve the outcomes for children with SED.

EOHHS will consider the recommendations for improvement set forth in the annual reports on Child and Family teams, child functioning evaluations, and the Child Service Reviews, and, in conjunction with its agencies, families, and local experts, will develop and implement strategies or corrective actions to address these recommendations.

XX. Monitoring, Dispute Resolution, and Modification

A. Compliance Coordinator

The defendants shall designate an individual to serve as its Compliance Coordinator. The Coordinator shall have the necessary authority to review, evaluate, and design and implement strategies to facilitate compliance with this Plan and the Court's orders by the defendants, their agencies, agents, and employees. The Coordinator shall

identify any obstacles to timely compliance and have the authority to implement actions that effectively address such obstacles.

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

The defendants shall establish a Compliance Committee comprised of representatives of EOHHS, DMH, DMR, DSS, DYS, the Office of Medicaid, EOAF, and the Governor's Office to oversee compliance with this Plan. The Committee will be staffed by the Compliance Coordinator.

B. Compliance Meetings

The plaintiffs, Compliance Coordinator, and the Compliance Committee will meet quarterly to discuss the implementation of this Plan and any obstacles to its full and timely implementation. The meetings will be facilitated by the Court Monitor.

C. Court Monitor

1. Appointment

The Court shall appoint a Monitor to oversee the implementation of its remedial order and this Plan. The Monitor shall serve at the discretion of the Court, and shall undertake those tasks described in the Court's orders.

The plaintiffs and defendants shall propose two qualified candidates to serve as the Monitor. If the parties cannot agree on a person to serve as the Monitor, the Court shall select the Monitor. In the event that the Monitor resigns or otherwise is unable to continue to serve, the same process shall be used to select a replacement.

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

2. Authority

The Monitor shall have the authority to: (1) collect information relevant to the defendants' obligations under the Court's orders and this Plan; (2) coordinate and facilitate meetings between the parties; (3) independently review the defendants' compliance with the Court's orders and this Plan; (4) respond to complaints concerning compliance or other actions of the defendants; (5) recommend corrective or further actions necessary to redress any problems identified in implementing the Court's orders

or this Plan; (6) mediate disputes between the parties; and (7) take whatever actions are useful to facilitate the timely implementation of the Court's orders and this Plan.

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

3. Termination

The reporting and monitoring requirements of this section will terminate two years after the system of in-home supports is fully developed and all other provisions of the Plan have been implemented.

D. Dispute Resolution Procedure

Any party may present a dispute concerning any aspect of the Plan to the Monitor for resolution. Any party may appeal of a decision of the Monitor to the Court for final resolution. The Monitor shall establish a dispute resolution process to address disagreements or issues concerning the Plan.

Except in cases of an emergency, thirty days prior to filing a motion with the Court, a party shall give the other parties and the Monitor written notice of the substance of the motion and be available to meet to discuss the matter. With the assistance of the Monitor, the parties shall make good faith efforts to resolve the matter, but may file the motion without further delay if these efforts are unsuccessful.

E. Modifications of the Plan

It is understood that provisions of the Plan may need to be modified based upon new information, experience, and legal requirements. Any modification must be consistent with the goals and purposes of the Plan, the orders of the Court, and federal Medicaid law.

1. Standards for Modification

A party may seek to modify a provision of the Plan if one of the following criteria are satisfied:

1. Evolving professional standards, emerging best practices, or new information indicates that the requirement is no longer consistent with those standards and practices;

2. A change in law has made compliance with a provision illegal or impractical;

3. Evidence demonstrates that the requirement is inefficient or ineffective at promoting the purpose of that provision;

4. CMS has communicated in writing that FFP is not available for a specific service or activity; or

5. Unforeseen circumstances render compliance with that requirement impossible or excessively burdensome.

2. Procedures for Modification

Any provision of the Plan that vests the defendants with the discretion to implement a requirement based upon the agencies' judgment and experience can be modified in the discretion of that agency, provided that the modification is consistent with one of the five standards set forth above. The defendants shall inform the plaintiffs of the modification. If the plaintiffs believe the matter is not entrusted to the discretion of the defendants pursuant to the Plan, the plaintiffs may invoke dispute resolution process.

All other provisions of the Plan may be modified only after prior notice and the opportunity to object. If a party objects to the modification, the Monitor shall determine if the proposed modification is consistent with the goals and purposes of the Plan and the Court's orders, is consistent with one of the five standards set forth above, and appropriate in light of new information and evolving professional standards. Any party dissatisfied with the Monitor's decision may present the proposed modification to the Court pursuant to Fed. R. Civ. P. 60.