



**ADDENDUM #1**

***CHILDREN IN FOSTER CARE  
OR RECEIVING ADOPTION ASSISTANCE  
AND CERTAIN YOUTHS COMMITTED INTO JUVENILE JUSTICE***

**TO THE**

**CONTRACT BETWEEN**

**THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

**AND**

**AMGP GEORGIA MANAGED CARE COMPANY, INC.  
D/B/A AMERIGROUP COMMUNITY CARE**

**FOR**

**PROVISION OF SERVICES TO GEORGIA FAMILIES**

**Contract No. 0652**

# TABLE OF CONTENTS

<u>TITLE</u>	<u>PAGE</u>
<b>I. SCOPE AND PURPOSE OF THIS ADDENDUM</b>	<b>4</b>
<b>II. BACKGROUND</b>	<b>4</b>
<b>III. SPECIFIC PROVISIONS FOR FCAAP AND DJJP</b>	<b>5</b>
<b>1.0 SCOPE OF SERVICE</b>	<b>5</b>
<b>1.2 Eligibility for Georgia Families</b>	<b>5</b>
<b>1.4 Definitions</b>	<b>7</b>
<b>1.5 Acronyms</b>	<b>19</b>
<b>2.0 DCH RESPONSIBILITIES</b>	<b>21</b>
<b>2.3 Eligibility and Enrollment</b>	<b>21</b>
<b>2.4 Disenrollment</b>	<b>21</b>
<b>2.12 Information Systems</b>	<b>22</b>
<b>2.13 Readiness or Annual Review</b>	<b>23</b>
<b>4.0 SPECIFIC CONTRACTOR RESPONSIBILITIES</b>	<b>27</b>
<b>4.1 Enrollment</b>	<b>27</b>
<b>4.2 Disenrollment</b>	<b>30</b>
<b>4.3 Member Services</b>	<b>31</b>
<b>4.5 Covered Benefits and Services</b>	<b>34</b>
<b>4.8 Provider Network and Access</b>	<b>39</b>
<b>4.9 Provider Services</b>	<b>42</b>
<b>4.11 Utilization Management and Care Coordination Responsibilities</b>	<b>44</b>
<b>4.12 Quality Improvement</b>	<b>52</b>
<b>4.17 Information Management and Systems</b>	<b>55</b>
<b>4.18 Reporting Requirements</b>	<b>58</b>
<b>7.0 PAYMENT FOR SERVICES</b>	<b>60</b>
<b>14.0 CONTRACTOR: STAFFING ASSIGNMENTS AND CREDENTIALS</b>	<b>61</b>
<b>14.3 Additional Staffing Requirements for the FCAAP and DJJP</b>	<b>61</b>
<b>22.0 TERMINATION OF CONTRACT</b>	<b>64</b>
<b>22.8 Termination Provisions for Addendum #1 Services</b>	<b>64</b>
<b>IV – X ADDITIONAL PROVISIONS</b>	<b>66</b>
<b>SIGNATURE PAGE</b>	<b>68</b>
<b>EXHIBIT 1 – KENNY A. CONSENT DECREE</b>	<b>69</b>
<b>EXHIBIT 2 – FC MEMBER, AA MEMBER AND DJJP CAPITATION PAYMENTS</b>	<b>133</b>

**THIS ADDENDUM** is between the Georgia Department of Community Health (hereinafter referred to as “DCH” or the “Department”) and AMGP Georgia Managed Care Company, Inc. d/b/a Amerigroup Community Care (hereinafter referred to as the “Contractor”) and shall be effective upon DCH receipt of approval of the Addendum from the Centers for Medicare and Medicaid Services (hereinafter referred to as “CMS”), as detailed below (hereinafter referred to as the “Effective Date”). Other than the changes, modifications and additions specifically articulated in this Addendum #1 to Contract #0652, the Contract as previously amended shall remain in effect and binding on and against DCH and Contractor. Unless expressly modified, deleted, or added in this Addendum #1, the terms and conditions of the Contract and its previous amendments are expressly incorporated into this Addendum #1 as if completely restated herein.

**WHEREAS**, on June 1, 2006, Georgia implemented its full-risk Medicaid Managed Care program known as Georgia Families (“GF”);

**WHEREAS**, the Parties entered into a Contract for the provision of services to members of the Georgia Families program (hereinafter “the Contract”);

**WHEREAS**, the Department has determined that the managed care approach utilized by Contractor under the Contract would also be appropriate for Medicaid Foster Care and Adoption Assistance populations (hereinafter “FCAAP” when referring to the collective group and “FCAAP Member” when referring to a single individual) previously excluded from the GF program;

**WHEREAS**, the Department has determined that the managed care approach utilized by Contractor under the Contract would also be appropriate for youth in Department of Juvenile Justice (DJJ) custody while residing in community residential facilities but not in joint custody with the Division of Family and Children Services (hereinafter “DJJP” when referring to the collective population and “DJJP Member” when referring to a single individual);

**WHEREAS**, the Parties desire to add the FCAAP and DJJP to the Contract to allow Contractor to provide GF program services to the FCAAP and DJJP in accordance with the terms of the Contract and the additional requirements and conditions stated herein;

**WHEREAS**, the Department has submitted a Section 1932(a) State Plan amendment to CMS to implement the terms and conditions of this Addendum;

**WHEREAS**, the parties understand and agree that CMS must approve the Section 1932(a) State Plan amendment (or an alternate request filed by DCH to implement the program described herein), the Capitation Rates and this Addendum as a condition precedent to its becoming effective for any purpose; and

**WHEREAS**, pursuant to **Section 32.0, Amendment in Writing**, DCH and Contractor desire to amend the above-referenced Contract as set forth below.

**NOW THEREFORE**, for and in consideration of the mutual promises of the Parties, the

terms, provisions and conditions of this Addendum and other good and valuable consideration, the sufficiency of which is hereby acknowledged, the Parties hereby agree as follows:

## **I. SCOPE AND PURPOSE OF THIS ADDENDUM**

This Addendum provides GF program requirements specifically for the FCAAP and DJJP. The Contractor shall remain responsible for complying with all of the terms and conditions of the Contract. Requirements stated in the Contract shall apply to all Members, including the FCAAP and DJJP. As of the effective date of this Addendum, any reference in the Contract to Members shall be construed to include the FCAAP and DJJP, as well as other populations and eligibility categories currently covered by the GF program. However, the provisions of this Addendum shall apply exclusively to the FCAAP and DJJP. In the event of a conflict between the provisions of this Addendum and the Contract, the provisions of this Addendum shall take precedence and control.

## **II. BACKGROUND**

- A. Beginning in August 2011, DCH began analyzing redesign options for managing the financing and care of populations enrolled in the Medicaid and Children's Health Insurance Programs. As a result of the analysis, DCH identified a need for enhanced care coordination and service integration for children in foster care and adoption assistance, and those youth in Department of Juvenile Justice custody while residing in community residential facilities. Based on these identified needs, DCH is mandatorily enrolling children in foster care and adoption assistance and the DJJP in a single care management organization (CMO) within the State's Medicaid managed care program, Georgia Families.
- B. Children in foster care and adoption assistance often do not receive timely and optimal health care because of frequent changes in placements and health care providers, fragmented medical records and inconsistent access to appropriate care. Likewise, youth in Department of Juvenile Justice (DJJ) custody while residing in community residential facilities have a greater need for coordination of health care services due to the number and complexity of issues impacting their physical and mental well being. DCH's goals for enrolling the FCAAP and DJJP with one Georgia Families CMO are to:
- i) Enhance the coordination of care and access to services;
  - ii) Improve health outcomes;
  - iii) Develop and utilize meaningful and complete electronic medical records; and
  - iv) Comply fully with regulatory reporting requirements.
- C. DCH has convened stakeholder task forces that provided input about program design and will be consulted on an ongoing basis after implementation of GF for the FCAAP and DJJP program. Additionally, DCH has formed a Foster Care, Adoption Assistance and Juvenile Justice Joint Task Force which is an interagency team that includes representatives from DCH and the following state agencies:

- i) Department of Behavioral Health and Developmental Disabilities (DBHDD);
- ii) Department of Juvenile Justice (DJJ);
- iii) Department of Human Services (DHS), the Division of Family and Children Services (DFCS);
- iv) Department of Public Health (DPH);
- v) Department of Early Care and Learning (DECAL); and
- vi) Department of Education (DOE).

D. The Joint Task Force is advisory in nature and its goal is to provide input into the transition of FCAAP and DJJP to GF. Input from Joint Task Force members has helped to ensure a program that is child-centric and focused on coordination of care.

### **III. SPECIFIC PROVISIONS FOR FCAAP AND DJJP**

The parties agree to modify the Contract to add the following provisions for the FCAAP and DJJP:

#### **1.0 SCOPE OF SERVICE**

#### **1.2 ELIGIBILITY FOR GEORGIA FAMILIES**

##### **1.2.1 Medicaid**

1.2.1.1A The following Medicaid eligibility categories are required to enroll in Georgia Families as part of the FCAAP. Some of these eligibility categories (specifically (a), (c), (d) or (f) may include children or youth who are in joint custody of DFCS and DJJ).

- a) Children and young adults less than twenty-six (26) years of age who are receiving foster care under Title IV-B or Title IV-E of the Social Security Act.
- b) Children less than twenty-one (21) years of age who are receiving other adoption assistance under Title IV-B or Title IV-E of the Social Security Act.
- c) Children and young adults less than twenty-six (26) years of age who are receiving foster care under Title IV-B or Title IV-E of the Social Security Act and are eligible for Supplemental Security Income.
- d) Children and young adults less than twenty-six (26) years of age who are receiving foster care under Title IV-B or Title IV-E of the Social Security Act and are enrolled in the State Children's Health Insurance Program (SCHIP), PeachCare for Kids®.

- e) Children less than twenty-one (21) years of age who are receiving adoption assistance under Title IV-B or Title IV-E of the Social Security Act and are enrolled in the State Children's Health Insurance Program (SCHIP), PeachCare for Kids.
- f) Children and young adults less than twenty-six (26) years of age who are in foster care or less than twenty-six (26) and receiving adoption assistance under Title IV-B or Title IV-E of the Social Security Act and are enrolled in one of the following home and community-based services (HCBS) 1915(c) waiver programs:
  - i. Elderly and Disabled Waiver Program: Provides services to people who are functionally impaired or disabled, helping members to remain in their own homes, the homes of caregivers or in other community-based settings as long as possible.
  - ii. New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program (COMP): Offers HCBS services for people with intellectual or developmental disabilities.
  - iii. CBAY (Community-Based Alternatives for Youth): Provides intensive behavioral health supports to children who have been diagnosed with a serious emotional disturbance.
  - iv. Young adults less than twenty-six (26) who are in foster care or receiving adoption assistance under Title IV-E of the Social Security Act and are enrolled in the Independent Care Waiver Program (ICWP). ICWP provides services for people with physical disabilities who remain in their own homes or in the community instead of in a hospital or nursing home.
- g) Children eighteen (18) years of age and under who are eligible for Georgia Families as part of the FCAAP pursuant to the Interstate Compact for the Placement of Children (ICPC).
- h) Children and youth who are eligible for Georgia Families as part of the FCAAP pursuant to the Interstate Compact for Adoption and Medical Assistance (ICAMA). The age limitations for these children are based on the DFCS eligibility requirements for AA Members. In ICAMA cases where Georgia is the receiving state and the child is receiving Adoption Assistance from another state, Georgia can provide Medicaid coverage under ICAMA for the period of time that the sending state continues to provide Adoption Assistance under the Adoption Assistance agreement. Age

limitations and eligibility criteria vary by state and will be based on the sending state's criteria instead of DFCS' eligibility requirements.

1.2.1.1.B The following youth in the Juvenile Justice System are eligible for Enrollment in GF:

- a) For the DJJP, children and youth less than nineteen (19) years of age who are eligible for Right from the Start Medicaid and who are placed in community (non-secure) residential care as a result of their involvement with the juvenile justice system.
- b) For the DJJP, children and youth less than nineteen (19) years of age who are eligible for Right from the Start Medicaid and Supplemental Security Income and who are placed in community (non-secure) residential care as a result of their involvement in the juvenile justice system.

### 1.2.3 Exclusions

1.2.3.1A The following recipients are excluded from Enrollment in GF, even if the recipient is otherwise eligible for GF per Section 1.2.1: children less than twenty-one (21) years of age who are in foster care or receiving adoption assistance under Title IV-E of the Social Security Act and are enrolled in the Georgia Pediatric Program (GAPP).

## 1.4 DEFINITIONS

**Activities of Daily Living (ADL):** Daily self-care activities including bathing, dressing, feeding, toileting, grooming, and transferring (walking, transferring from bed to wheelchair or wheelchair to toilet, etc.) and continence.

**Adoption Assistance (AA):** A program established by the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) that provides financial and medical benefits to adoptive families who adopt children with special needs up to eighteen (18) years of age. There are three (3) categories of adoption assistance: (1) monthly adoption assistance payments; (2) Medicaid benefits; and (3) non-recurring adoption assistance (such as adoption fees, court costs, attorney fees and other expenses). Georgia's Adoption Assistance Policies can be found online at [http://www.odis.dhr.state.ga.us/3000\\_fam/3120\\_ado/Manual/109.doc](http://www.odis.dhr.state.ga.us/3000_fam/3120_ado/Manual/109.doc)

**AA Member Capitation Rate:** The fixed monthly amount, including the VBP withhold, that the Contractor may receive from DCH for each AA Member assigned to the Contractor to ensure that Covered Services and Benefits under this Contract are provided. Payments are contingent upon the availability of appropriated funds.

**AA Member Capitation Payment:** A payment, fixed in advance as the AA Member Capitation Rate less the VBP withhold, that DCH makes to Contractor for each AA Member covered under the Contract for the provision of medical services and assigned to the Contractor. This payment is made regardless of whether the AA Member receives Covered Services or Benefits during the period covered by the payment. Payments are contingent upon the availability of appropriated funds.

**AA Member Consecutive Enrollment Period:** The consecutive twelve (12) month period beginning on the AA Member's first day of Enrollment in the FCAA CMO or the date DCH sends the AA Member the notice of Enrollment, whichever is later. For AA Members that use their option to return to the Medicaid Fee-For-Service delivery system without cause during the AA Member Fee-For-Service Selection Period, the twelve-month consecutive Enrollment period will commence when the AA Member is enrolled in the Medicaid Fee-For-Service delivery system. This is not to be construed as a guarantee of eligibility during the AA Member Consecutive Enrollment Period.

**AA Member Fee-For-Service Selection Period:** The ninety (90) Calendar Day period beginning on the AA Member's initial enrollment in the FCAA CMO or the date DCH sends the AA Member notice of the Enrollment, whichever is later. During this period an AA Member may elect to opt out of the FCAA CMO without cause and return to the Medicaid Fee-For-Service delivery system. AA Members who do not make a choice to return to the Medicaid Fee-For-Service delivery system during this ninety (90) Calendar Day period will be deemed to have chosen to remain enrolled in the FCAA CMO until the Member's next AA Member Consecutive Enrollment Period.

**Adoptive Parent:** An adult who provides a child a permanent home through a court process that once final names the adoptive parent as the child's legal parent.

**Babies Can't Wait:** Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. Established by Part C of the Individuals with Disabilities Education Act (IDEA).

**Behavioral Health:** Includes mental health and substance abuse.

**Behavioral Health Crisis:** An intensive behavioral, emotional or psychiatric situation that exceeds an individual's current resources and coping mechanisms which, if left untreated, could result in an emergency situation.

**Behavioral Health Services:** Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

**Care Coordination:** A set of Member-centered, goal-oriented, culturally relevant, and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care Coordination is also referred to as Care Management.

**Care Coordination Team or CCT:** The CMO will assign a Care Coordination Team to each FCAAP and DJJP Member. The Care Coordination Team will assist the FCAAP Member or DJJP Member in navigating the health care system and will coordinate with DFCS or DJJ to develop work flows and processes, including those related to the transmission of clinical and non-clinical FCAAP Member and DJJP Member information. These workflows and processes shall be subject to the approval of DCH. Professionals of the CCT will be assigned based on the FCAAP or DJJP Member's individual needs and may include, but not be limited to nurses, licensed social workers, behavioral health specialists, substance abuse specialists and developmental disability specialists. The CCT activities, meeting regularity, and intensity will correlate to the assessed needs of the Member. The CCT will not substitute any of the interdisciplinary teams or case management functions supporting HCBS.

**Care Coordinator:** The lead member of the Care Coordination Team and who serves as the key point of contact between the CMO and State agencies, the FCAAP or DJJP Member, the Foster Parent(s), Adoptive Parent(s), Caregivers and Providers. The qualifications of the Care Coordinator will be based on the FCAAP or DJJP Member's individual needs.

**Caregiver:** The DFCS-authorized caretaker for a FC Member may be the FC Member's Foster Parent(s), relative(s), or 24-hour childcare facility staff.

**Child Protective Services (CPS):** An office within DFCS that investigates reports of child abuse or neglect and provides services to protect the child and strengthen the family.

**Children 1<sup>st</sup>:** A state program administered by DPH which identifies and screens children (birth to age 5) at risk for poor health and developmental outcomes, refers children to appropriate services, and monitors health status. The program is designed to serve as a single point of entry to a statewide collaborative system of public health and other prevention based programs and services.

**Comprehensive Child and Family Assessment (CCFA):** An assessment provided to children in Foster Care through the Department of Human Services, Division of Family and Children Services (DFCS) which includes the following components: family assessment, Trauma Assessment, Medical Assessment, relative and non-relative home evaluation and reassessments. The Contractor will be responsible for ensuring that the Medical Assessment and Trauma Assessments are completed within the timeframes set forth in this Addendum.

**Core Service:** Those non-specialty community mental health or addictive disease service rendered by Core Providers to children and youth meeting DBHDD's core customer classification and eligibility determination requirements.

**Core Provider:** Those service providers that are deemed to satisfy the staffing and service scope requirements for DBHDD's core customers as defined in DBHDD's provider manual.

**CCFA Provider:** All CCFA providers are independently contracted by DFCS and those who provide clinical services to children and families will also be contracted with the Contractor. CMO-contracted CCFA Providers are responsible for: (1) the completion of the Trauma Assessment included in the CCFA; and (2) the submission of the Medical Assessment and Trauma Assessment to the DFCS-contracted CCFA Provider for the final CCFA report. DFCS-contracted CCFA Providers are responsible for: (1) conducting non-Medicaid covered services, such as family assessments and home evaluations; and (2) the development of the final CCFA report that is shared with the CMO and DFCS. CMO-contracted CCFA providers must meet the enrollment criteria for Georgia Fee-for-Service Medicaid and the Contractor's Credentialing requirements.

**Crisis:** A condition of instability/danger or dramatic emotional or circumstantial upheaval in a person's life requiring action or change.

**Dental Home:** A Dentist who has accepted the responsibility for providing or coordinating the provision of all dental care services covered under the Medicaid State Plan for the FCAAP or DJJP Member.

**Detention Hearing (also known as 72-Hour Hearing or Probable Cause Hearing):** An informal hearing within 72 hours of a child's removal from the home is required when the juvenile court or the court intake officer has not released the child to the custody of his or her parents after removal from the home. If the 72-hour period expires on a Saturday, Sunday, or legal holiday, the hearing must be held on the next day of business which is not a Saturday, Sunday, or legal holiday. O.C.G.A. § 15-11-49(c)(3). At the 72-hour hearing, the judge will determine whether it is safe to return the child to the home or if the child should be detained until a full hearing can be held to determine whether the child is deprived.

**Department of Behavioral Health and Developmental Disabilities (DBHDD):** The Georgia state agency that provides treatment and support services to people with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD serves people of all ages with the most severe and likely to be long-term conditions, including consumers with forensic issues.

**Department of Early Care and Learning (DECAL):** The Georgia state agency that is responsible for meeting the child care and early education needs of Georgia's children and their families. Also known as "Bright from the Start."

**Department of Juvenile Justice (DJJ):** The Georgia state agency that serves the state's youthful offenders up to the age of 21. While holding youthful offenders accountable for their actions through probation supervision and secure detention, DJJ provides youth with

medical and psychological treatment, as well as specialized programs designed to equip youth with the social, intellectual and emotional tools they will need as adults.

**Department of Public Health:** The Georgia state agency with the ultimate responsibility for the health of communities and the entire population.

**Division of Family and Children Services (DFCS) in the Department of Human Services:** DFCS has statutory responsibility for the care of children and young adults who have been removed from the home and placed in the conservatorship of DFCS.

**Division of Family and Children Services (DFCS) Case Manager:** A staff professional who provides assistance to children and families by helping them address psychological and social problems related to child abuse and neglect. DFCS Case Managers provide interventions and perform duties related to various social services program areas such as Child Protective Services (CPS), Foster Care, resource development, and Adoption Assistance.

**Division of Family and Children Services (DFCS) Revenue Maximization Specialist (RMS):** A regional eligibility specialist trained in Title IV-E foster care and adoption assistance programs and Medicaid eligibility with data entry in SHINES and SUCCESS for child welfare funding determinations and Medicaid eligibility.

**Division of Family and Children Services (DFCS) Clinical Program Specialist:** DFCS region-specific staff whose responsibilities include, but are not limited to, the following:

1. Oversight of DFCS children receiving Behavioral Health Services and collaborating with the DBHDD program specialist serving specific regions.
  - a) Reviews the status of any child receiving inpatient treatment at a psychiatric residential treatment family or psychiatric hospital at least monthly.
  - b) Participates in discharge goals and planning
2. Monitors all Foster Care children receiving psychotropic medication.
3. Maintains a regional listing of available Behavioral Health providers.
4. Guides or assists DFCS Case Managers as FC Members receiving Behavioral Health Services, developmental disability services, or special medical services transition from non-Foster Care Medicaid to Foster Care Medicaid and vice versa to ensure continuity of services.

**Execution Date:** The date the Addendum has been signed by both parties.

**FCAA CMO:** The CMO serving the FCAAP and DJJP pursuant to this Addendum, a/k/a Amerigroup Community Care.

**FC Member and DJJP Capitation Rate:** The fixed monthly amount, including the VBP withhold, that the Contractor may receive from DCH for each FC Member and DJJP Member assigned to the Contractor to ensure that Covered Services and Benefits

under this Contract are provided. Payments are contingent upon the availability of appropriated funds.

**FC Member and DJJP Capitation Payment:** A payment, fixed in advance as the FCAAP and DJJP Capitation Rate less the VBP withhold, that DCH makes to Contractor for each FC Member and DJJP Member covered under the Contract for the provision of medical services and assigned to the Contractor. This payment is made regardless of whether the FC Member or DJJP Member receives Covered Services or Benefits during the period covered by the payment. Payments are contingent upon the availability of appropriated funds.

**Foster Care:** Twenty-four (24) hour substitute care for children placed away from their parents or guardians and for whom the title IV-E agency (DHS) has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes. 45 C.F.R. § 1355.20(a).

**Foster Parent:** A substitute caregiver who assumes the daily caretaking responsibilities for children in DFCS custody who have been placed in their home.

**Georgia Crisis and Access Line (GCAL):** A 24-hour phone line sponsored by DBHDD to assist with coordinating access to care or provide support in an emergency or a crisis.

**Georgia Statewide Health Information Network (“GaHIN Network”):** A mobilization of healthcare information electronically across organizations to facilitate regional information exchange within the State.

**GaHIN Authorized Users:** Qualified Entities and GaHIN Member Users having authorized access to the GaHIN.

**GaHIN Member Users:** Any entity, organization or individual person who has been identified and authorized by a Qualified Entity to access the GaHIN, in a manner defined by the respective Qualified Entity, in compliance with an agreement between the Member User and the Qualified Entity and applicable law. Member Users may include, but are not limited to, hospitals or healthcare systems, and employees, contractors, or agents of a Qualified Entity.

**GaHIN Member Agreements:** Written agreements that DCH and/or its agents determine are required as a condition for a Qualified Entity’s participation in the GaHIN.

**Health Care Service Plan:** An individualized plan developed with and for a FCAAP or DJJP Member which includes, but is not limited to, the following: (1) the FCAAP Member’s or DJJP Member’s history; (2) summary of current medical and social needs and concerns; (3) short and long term needs and goals; (4) a treatment plan to address the FCAAP Member’s or DJJP Member’s physical, psychological, and emotional health care problems and needs including a list of services required, their frequency; and (5) a

description of who will provide such services. The Health Care Service Plan will be coordinated by the CCT.

**Health Risk Screening:** The Health Risk Screening is used to collect comprehensive information on the FCAAP or DJJP Member's health status.

**Home and Community-Based Services (HCBS):** Includes all services included in a Home and Community Based Waiver Program. Georgia HCBS programs include the Independent Care Waiver Program, the Community Based Alternatives for Youth (CBAY) Program, the New Options Waiver (NOW) Program, the Elderly and Disabled Waiver Program, and the Comprehensive Supports Waiver Program (COMP). Contractor is not required to provide Home and Community Based Services, but must provide all other Medicaid State Plan services required under this Addendum for any FCAAP or DJJP Member enrolled in an HCBS waiver program.

**Intensive Family Intervention (IFI):** A service intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues (i.e. psychiatric hospital, therapeutic foster care, psychiatric residential treatment facilities, or therapeutic residential intervention services) for the identified youth. Services are delivered utilizing a team approach and are provided primarily to youth in their living arrangement and within the family system. Services promote a family-based focus in order to:

- Defuse the current behavioral health crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
- Ensure linkage to needed community services and resources; and
- Improve the individual child's/adolescent's ability to self-recognize and self-manage behavioral health issues, as well as the parents'/responsible caregivers' capacity to care for their children.

IFI services should include crisis intervention, intensive supporting resources management, individual and/or family counseling/training, and other rehabilitative supports to prevent the need for out-of-home placement or other more intensive/restrictive services. Services are based upon a comprehensive, individualized assessment and are directed towards the identified youth and his or her behavioral health needs/strengths and goals as identified in the Individualized Resiliency Plan.

**Intensive Family Intervention Provider (IFI Provider):** Those service providers that are deemed to satisfy the staffing and service scope requirements for DBHDD's core customers as defined in DBHDD's provider manual.

**Interstate Compact on Adoption and Medical Assistance (ICAMA):** Established in 1986, an agreement among member states to safeguard and protect the interstate interests of children covered by an adoption assistance agreement when they move or are adopted across state lines. ICAMA, which has the force of law within and among party states, enables the provision of medical benefits and services when a child with special needs is adopted by a family from another state, or the adoptive family moves to another state.

**Interstate Compact on the Placement of Children (ICPC):** Enacted by Georgia in 1977, a uniform law that has been enacted by all 50 states, the District of Columbia, and U. S. Virgin Islands. It establishes orderly procedures for the interstate placement of Foster Care children and assigns responsibility for those involved in placing the child.

**Juvenile Probation and Parole Specialist (JPPS):** A DJJ staff professional who provides intake, informal adjustment, and probation services to youth for the Juvenile Court and aftercare and commitment services to youth under DJJ supervision. At a minimum, JPPS will be solely responsible for coordinating youth placements in residential treatment settings, supervision in their communities, development of service plans that may consist of health care, mental health, and educational needs identified during the youth's initial assessment that may not be limited to referrals to collaborative agencies or resource providers.

**Kenny A. Consent Decree:** In June 2002, Children's Rights, Incorporated out of New York, filed a class action lawsuit against the State of Georgia on behalf of children in the state's legal custody. The lawsuit alleged violations of constitutional and statutory rights arising out of the operation of the state's foster care systems in Fulton and DeKalb counties. In October 2005, the plaintiffs and defendants settled the lawsuit under the Kenny A. vs. Sonny Perdue Consent Decree.

Under the terms and conditions of the Kenny A. Consent Decree, the State is to achieve and sustain 31 outcomes, as well as maintain certain practice standards related to service planning, placement experience, health care, investigation of maltreatment allegations concerning children in foster care, court reviews and reporting. Some of these standards are new requirements for administrators and case managers, and others are existing agency policy and practice requirements receiving heightened attention. In addition, the consent decree stipulates various state and county infrastructure requirements. These stipulations pertain to automation, caseload sizes, training, supervision of private providers, foster parent licensing, and financing. A copy of the decree is attached hereto as Exhibit 1 and is incorporated by this reference as if fully written herein.

The Kenny A. vs. Perdue Consent Decree established independent accountability agents with the responsibility of monitoring the state's progress and producing public reports every six (6) months. These reports are available at: <http://www.aysps.gsu.edu/kennya.html>.

**Local Interagency Planning Teams (LIPT):** A requirement of Georgia law, these teams are responsible for improving and facilitating the coordination of services for children with severe emotional disorders (SED) and/or addictive disease (AD). Team membership may include representatives from DFCS, DBHDD, DJJ, DPH, Service Providers, educators, and Foster Parents or parent advocates, when their child is discussed. Teams meet as needed, usually no less than once a month, depending on the needs of the children.

**Medical Assessment:** An initial medical evaluation completed for FC Members and DJJP as follows:

1. For each child newly entering or re-entering Foster Care, the Medical Assessment is part of the CCFA. These assessments must follow the requirements set forth in Georgia's Medicaid EPSDT program, and include dental, hearing and developmental screenings.
2. For the DJJP, a Medical Assessment must follow the requirements set forth in Georgia's Medicaid EPSDT program, including dental, hearing and developmental screenings.

**Medical Home:** A PCP or specialty care Provider who has accepted the responsibility for providing or coordinating the provision of all necessary Health Care services for the Member.

**Member Education and Outreach Plan (a/k/a the "FCAAP and DJJP Member Education and Outreach Plan"):** The plan detailing all education and outreach activities that the Contractor will use to reach FCAAP and DJJP Members. The FCAAP and DJJP Member Education and Outreach plan must be approved by DCH.

**Members with Special Health Care Needs (MSHCN):** Any Member who:

- (1) ranges in age from birth up to but not including age twenty-one years (1<21);
- (2) requires regular, ongoing therapeutic intervention and evaluation by Medicaid-enrolled Health Care Professionals; and
- (3) either (a) has a serious ongoing illness, a complex chronic condition, or a disability that has lasted or is anticipated to last at least twelve (12) continuous months or more; or (b) has an illness, condition or disability that significantly limits Activities of Daily Living or social roles in comparison with accepted pediatric age related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development.

**Multidisciplinary Team (MDT):** A team consisting of persons representing various disciplines associated with key components of the Foster Care assessment process. The purpose of the MDT meetings is to review the outcome and recommendations of the CCFA Provider related to the assessment of the FC Member and the Member's family. The disciplines which may participate as part of the MDT should include, but are not limited to the following:

- (1) Legal custodian (DFCS Case Manager, CPS investigator, CPS ongoing case manager, DFCS supervisor, and/or independent living coordinator for any youth fourteen (14) years or older);
- (2) CCFA Provider conducting the Trauma Assessment;
- (3) School system representative with direct knowledge of the educational status of the child;

- (4) Medical health provider with direct knowledge of the medical and dental status of the Foster Care child including the Babies Can't Wait service coordinator if applicable;
- (5) Representative from the appropriate court system if the child had any court or law enforcement involvement including local law enforcement officials or a Court Appointed Special Advocate (CASA);
- (6) A mental health representative with direct knowledge of the mental health or substance abuse issues affecting the child or family;
- (7) Foster Parent(s) or Out of Home Placement provider where the child resided during the assessment process with direct knowledge of the child's behavior and activity during the assessment; and
- (8) Any other individual having appropriate information directly related to the FC child's case.

The MDT meeting is coordinated and facilitated by the individual who completed the family assessment.

**National Child Traumatic Stress Network:** Established by the U.S. Congress in 2000 as part of the Children's Health Act, the National Child Traumatic Stress Network (NCTSN) is a collaborative of over 150 centers in university, hospital, and diverse community-based organizations committed to raising the standard of care and improving access to services for traumatized children, their families and communities.

**Non-Capitated Services:** Services not included in the CMO's Capitation Rate.

**Nurse Case Manager (NCM):** Contractor staff responsible for assisting FCAAP and DJJP Members identified through the health assessment as Members with Special Health Care Needs. The NCM will help Members with Special Health Care Needs obtain Medically Necessary care, health-related services and coordinate clinical care needs with holistic consideration.

**Ombudsman Liaison:** An employee of the Contractor who is responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that the FCAAP and DJJP Members have access to Covered Services and non-covered services. The Ombudsman Liaison is also responsible for interacting with DCH's equivalent ombudsman staff and submitting reports to DCH.

**Ombudsman Coordinator:** An employee of the Contractor who is responsible for supporting the Ombudsman in coordinating services with local community organizations and working with local advocacy organizations. The Ombudsman Coordinator is also responsible for interacting with DCH's equivalent ombudsman staff.

**Operations Start Date:** January 1, 2014 or an alternate date set by DCH based upon CMS approval of FCAAP and DJJP enrollment into Georgia Families. This is the date that the FCAAP and DJJP will begin receiving services from the Contractor.

**Out of Home Placement:** The separation of a child from his/her parent or legal guardian because of abuse and/or neglect or special medical circumstances. The child may be placed in a variety of placement settings including, but not limited to, the home of a relative, a DFCS or Child Placing Agency (CPA) family foster home, or a twenty-four (24) hour child care institution.

**Primary Dental Provider (Dentist):** A licensed dentist who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required general dental services to the FCAAP and DJJP. A Dentist shall include general dental practitioners provided that the Dentist is able and willing to carry out all Dentist responsibilities in accordance with these Contract provisions and licensure requirements. The Dentist is responsible for coordinating referrals, as needed, with Dental Subspecialty Providers and all subsequent dental care.

**Psychiatric Residential Treatment Facility (PRTF):** A separate, standalone entity providing a range of comprehensive psychiatric services to treat the psychiatric condition of residents under age twenty-one (21) years on an inpatient basis under the direction of a physician. The purpose of such comprehensive services is to improve the resident's condition or prevent further regression so that the services will no longer be needed. (42 CFR §483.352, subpart D of part 441)

**Qualified Entities (QEs):** Entities that have permission from DCH and/or its designee to access services available on the GaHIN Network and meet a set of DCH-established criteria, have completed an approval process, and have signed participation documentation with Contractor. QEs ensure that Participant Users and/or vendors with which they have agreements comply with the applicable terms of participation and related policy documentation.

**Query-Based Exchange:** Technology and functionality that GaHIN Authorized Users will use to search for and locate individual Member records.

**Regional Interagency Action Team (RIAT):** These teams provide feedback from each of DBHDD's five (5) regions for collaborative learning regarding the operation of the LIPT. The RIAT addresses service gaps, barriers, fragmentation and duplication across partners at the regional level, as well as other issues relating to children's Behavioral Health. Membership includes the chairpersons of the LIPTs located within the region, regional representation by mandated agencies, LIPT trainers, and a Member's family representative. These teams are not required by law.

**Residential Placement:** An out of home placement setting designed to meet the needs of children and youth with behavioral, emotional and mental health needs that prevent them from being able to reside in a less structured family home setting. A residential treatment facility offers a structured physical environment and a treatment program designed to help children improve their ability to function in multiple areas of life. For the DJJP, Residential Placement may also be referred to as Room Board and Watchful Oversight (RBWO).

**Residential Placement Provider:** A provider contracted with DFCS or DJJ providing Residential Placements.

**Service Providers:** An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the CMO for the delivery of Covered Services to the FCAAP and DJJP.

**SHINES:** A web-based, statewide automated child welfare information system (SACWIS) that offers DFCS child welfare professionals a comprehensive case management tool.

**Special Health Needs Care Managers:** Provides clinical service to facilitate development of a FCAAP or DJJP Health Care Service Plan and coordination of clinical services among PCPs and specialty providers to ensure FCAAP and DJJP Members with Special Health Care Needs have access to, and appropriately utilize, Medically Necessary Covered Services.

**Substantiated Maltreatment:** A disposition of a Child Protective Services (CPS) investigation which concludes that child maltreatment, as defined by federal and state law, and CPS policy, has occurred as supported by a preponderance of the evidence.

**System for the Uniform Calculation and Consolidation of Economic Support Services (SUCCESS):** An integrated computer system utilized by DHS and DCH to record information and generate benefits to assistance units (group or individual(s) applying for or receiving benefits).

**System of Care:** A spectrum of effective, highly-coordinated community-based services and supports for children and youth with or at risk for mental health or related challenges and their families, that is organized into a network of meaningful partnerships with multi-child-serving agencies and driven by the families and youth's needs to help them to function better at home, in school, in the community, and throughout life.

System of Care core values and philosophy include an expectation that services and supports: are culturally and linguistically competent; ensure availability and access to effective traditional and nontraditional services as well as natural and informal supports that address physical, emotional, social, and educational needs; are planned in true partnership with the child and family and a family peer professional representative; and include intensive care management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.

*This definition is culled from an Issue Brief by the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, <http://gucchdtacenter.georgetown.edu/resources/>. The Contractor will*

*reference and incorporate revised definitions, protocol, and operations as indicated according to published updates issued by the National Technical Assistance Center for Children's Mental Health.*

**Transition of Care:** The movement of patients made between health care practitioners and/or settings as their condition and health care needs change. For FCAAP or DJJ Members, Transition of Care planning may involve activities or needs related to a Member's placement in DFCS custody or under DJJ supervision, transition from FFS Medicaid or commercial health plans to the FCAAP and DJJP CMO; transition from a CMO to the FCAAP and DJJP CMO, changes in Residential Placement, aging out of Foster Care or exiting DJJ supervision.

**Trauma Assessment:** A component of the CCFA provided to FC Members placed in DFCS custody. The comprehensive Trauma Assessment involves an in-depth exploration of the nature and severity of the traumatic events experienced directly or witnessed by the child, the sequelae of those events, and the current trauma-related symptoms to determine the best type of treatment for that specific child. A CCFA Provider must use an assessment tool approved by DCH to identify the types and severity of symptoms the child is experiencing. The comprehensive Trauma Assessment must provide recommendations to coordinate services and meet the child's needs.

**Trauma Screening:** A brief, focused inquiry to determine the specific traumatic events experienced by the child. A Trauma Screening is conducted to direct the Trauma Assessment.

**Value Based Purchasing:** An enhanced approach to purchasing and program management that focuses on value over volume. It is part of a comprehensive strategy that aligns incentives for FCAAP and DJJP Members, Providers, the Contractor and the State to achieve the program's overarching goals.

**Virtual Health Record (VHR):** A virtual view of many data sources that contain patient health records. The VHR enables authorized users to query FCAAP and DJJP Member health information.

## **1.5 ACRONYMS**

**AA Member** – Adoption Assistance Member

**CAPTA** – Child Abuse Prevention and Treatment Act

**CBAY** – Community-Based Alternatives for Youth

**CCFA** – Comprehensive Child and Family Assessments

**COMP** – Comprehensive Supports Waiver Program

**DBHDD** – Department of Behavioral Health and Developmental Disabilities

**DECAL** – Department of Early Care and Learning

**DFCS** – Division of Child and Family Services

**DHS** – Department of Human Services

**DJJ** – Department of Juvenile Justice

**DJJP** – Department of Juvenile Justice Population

**DOE** – Department of Education

**DPH** – Department of Public Health

**GCAL** – Georgia Crisis and Access Line

**FC Member** – Foster Care Member

**FCAAP** – Foster Care and Adoption Assistance Population

**GAPP** – Georgia Pediatric Program

**GFMOCC** – Georgia Families Monitoring and Oversight Committee

**HCBS** – Home and Community-Based Services

**ICAMA** – Interstate Compact on Adoption and Medical Assistance

**ICPC** – Interstate Compact on the Placement of Children

**ICWP** – Independent Care Waiver Program

**IFI** – Intensive Family Intervention

**LIPT** – Local Interagency Planning Team

**MSHCN** – Members with Special Health Care Needs

**MDT** – Multidisciplinary Team

**NCM** – Nurse Care Manager

**NCTSN** – National Child Traumatic Stress Network

**NOW** – New Options Waiver Program

**RIAT** – Regional Interagency Team

**SSI** – Supplemental Security Income

**SUCCESS** – System for the Uniform Calculation and Consolidation of Economic Support

**VBP** – Value Based Purchasing

**VHR** – Virtual Health Record

## **2.0 DCH RESPONSIBILITES**

### **2.3 ELIGIBILITY AND ENROLLMENT**

2.3.16 FCAAP and DJJP Members shall be enrolled in the CMO within forty-eight (48) hours of DCH's receipt of the FCAAP Member's or DJJP Member's eligibility file from DFCS.

### **2.4 DISENROLLMENT**

2.4.5 AA Members enrolled in the FCAA CMO may elect to disenroll from the FCAA CMO without cause within the first ninety (90) Calendar Days following the date of the AA Member's initial enrollment in the FCAA CMO or the date DCH sends the AA Member notice of the Enrollment, whichever is later ("AA Member Fee-For-Service Selection Period"). AA Members disenrolling from the FCAA CMO shall return to the Medicaid Fee-For-Service delivery system. The change in CMO enrollment will be reflected in the updated GF Member eligibility roster and associated change in AA Member Capitation Rate. The disenrollment from the FCAA CMO will be processed within two (2) Business Days of the date that the AA Member completes the requirements for disenrolling from the FCAA CMO and the effective date of such change will be date the disenrollment requirements were met by the AA Member.

2.4.5.1 If an AA Member does not elect to disenroll from the FCAA CMO during the AA Member Fee-For-Service Selection Period, such AA Member shall remain in the FCAA CMO until the end of the AA Member's Consecutive Enrollment Period, subject to eligibility and Sections 4.2.2 and 4.2.3 of the Contract.

DCH or the FCAA CMO will notify AA Members at least once every twelve (12) months, and at least sixty (60) Calendar Days

prior to the date upon which the AA Member Consecutive Enrollment period ends (the annual Enrollment opportunity), that they have the opportunity to disenroll from the FCAA CMO without cause and return to the Medicaid Fee-For-Service delivery system. AA Members who do not make a choice to return to the Medicaid Fee-For-Service delivery system during this sixty (60) Calendar Day period will be deemed to have chosen to remain enrolled in the FCAA CMO until the AA Member's next AA Member Consecutive Enrollment Period.

2.4.5.2 AA Members who disenrolled from the FCAA CMO pursuant to Sections 2.3.17, 4.2.1.4 and 4.2.1.5 may request to re-enroll in the FCAA CMO at any time, subject to eligibility and Sections 4.2.2 and 4.2.3 of the Contract. The change in FCAA CMO enrollment will be reflected in the updated Member eligibility roster and associated change in AA Member Capitation Rate. The re-enrollment in the FCAA CMO will be processed within two (2) Business Days of the date that the AA Member completes the requirements for re-enrollment into the FCAA CMO and the effective date of such change will be date the re-enrollment requirements were met by the AA Member.

2.4.6 If an AA Member is hospitalized in an inpatient facility on the first day their Disenrollment from the FCAA CMO is to be effective pursuant to Sections 2.4.5, 4.2.1.4 and 4.2.1.5, the AA Member will remain enrolled in the FCAA CMO until the date discharged from the inpatient facility. If an AA Member is hospitalized in an inpatient facility on the first day their Disenrollment from the Fee-For-Service delivery system and return to the FCAA CMO is to be effective pursuant to Section 2.4.5.2, the AA Member will remain enrolled in the Fee-For-Service delivery system until the date discharged from the inpatient facility.

## **2.12 INFORMATION SYSTEMS**

2.12.2 DCH and/or its designee will develop and maintain Virtual Health Records (VHR) for FCAAP and DJJP Members to ensure that health information provided to DCH Staff, DFCS, DJJ, other state agencies as appropriate, network Providers, and other GaHIN Network Authorized Users is timely, portable and readily accessible. The VHR will provide data sharing capabilities between the Contractor, DCH, state agencies, Providers, Foster Parents, Adoptive Parents, and FCAAP and DJJP Members.

2.12.3 DCH and/or its designee will structure the Virtual Health Record in a manner to provide the data in a summarized, user friendly,

printable format and shall employ hierarchical security measures to limit access to designated persons as defined by DCH.

- 2.12.4 The VHR will be available twenty-four (24) hours per day, seven (7) days per week, except during limited scheduled system downtime. DCH and/or its designee will post routine scheduled downtime on its website. DCH shall make reasonable attempts to communicate non-routine scheduled downtime to Contractor before the scheduled downtime occurs.

## **2.13 READINESS OR ANNUAL REVIEW**

### **2.13.3 Project Plan**

- A. Within thirty (30) Calendar Days of the Execution Date, the Contractor shall submit a detailed project plan (“Project Plan”), including a project schedule, to DCH outlining the specific Contract requirements and timeframes, and identifying dedicated Contractor staff. The Project Plan should address the planning, implementation and deployment phases of the Contract. The format for the Project Plan shall be in a version of Microsoft Excel and Microsoft Project agreed upon by DCH. DCH shall have five (5) Calendar Days to review the Project Plan and project schedule, and Contractor shall have five (5) Calendar Days from completion of DCH’s review to submit the finalized Project Plan and project schedule to DCH.
- B. Within ten (10) Calendar Days of the Execution Date, the Contractor must designate a dedicated project manager “CMO Project Manager” and CMO project management team (“CMO Project Management Team”). The CMO Project Manager must be stationed at the CMO’s metropolitan Atlanta headquarters. The CMO Project Manager must also be onsite at the DCH offices in Atlanta, Georgia during times specified by DCH during the planning, implementation and deployment phases of the Contract.
- C. The Contractor must continue to submit revised Project Plans and project schedules throughout the planning, implementation and deployment phases based upon requested updates or revisions from DCH.

### **2.13.4 Staffing Plan**

Within thirty (30) Calendar Days of the Execution Date, the Contractor must submit a staffing plan (“Staffing Plan”) to DCH, specifically addressing anticipated timeframes for hiring and staff training; the proposed organizational chart, reporting responsibilities, Contractor staff

to Member ratios, and the physical location of staff for each functional area referenced in the Contract. DCH shall have five (5) Calendar Days to review the Staffing Plan and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized Staffing Plan to DCH.

2.13.5      **Subcontractors**

Within thirty (30) Calendar Days of the Execution Date, the Contractor must provide a listing, including detailed contact information, for all of its Subcontractors involved in the execution of this Addendum, including a description of the Subcontractor's organization and the responsibilities that are delegated to the Subcontractor. Contractor will not contract or permit the performance of any work or services by Subcontractors without prior written consent of DCH.

2.13.6      **Transition of Care Plan**

Within thirty (30) Calendar Days of the Execution Date, the Contractor must provide a high-level draft of Transition of Care plan for those FCAAP and DJJP Members enrolled in Medicaid prior to the Operations Start Date and who will transition to the FCAAP and DJJP CMO on the Operations Start Date ("Transition of Care Plan"). At a minimum, this plan shall address the data and claims requirements, data analysis methodology, communications and outreach, specific timeframes for executing the Transition of Care Plan, dedicated Contractor staff involvement in the Transition of Care Plan, approach and involvement with sister agencies, ensuring continuity of care and plans for conducting all applicable health and trauma assessments, if applicable. DCH shall have fifteen (15) Calendar Days to review the draft Transition of Care Plan and Contractor shall have fifteen (15) Calendar Days from completion of DCH's review to submit the finalized Transition of Care Plan to DCH.

2.13.7      **Dental Home**

The Contractor shall submit policies and procedures for providing a Dental Home for FCAAP and DJJP Members to DCH for review and approval within one hundred twenty (120) Calendar Days of the Operations Start Date. DCH shall have fifteen (15) Calendar Days to review the policies and procedures and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized policies and procedures to DCH.

2.13.8      **Health Risk Screening**

The Contractor shall submit policies and procedures for conducting the Health Risk Screening and the tools that will be used to conduct the screenings to DCH for review and approval within one hundred twenty (120) Calendar Days of the Operations Start Date. DCH shall have fifteen (15) Calendar Days to review the policies and procedures and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized policies and procedures to DCH.

## 2.13.9 **Readiness Reviews**

2.13.9.1 For the FCAAP and DJJP CMO, DCH will conduct series of Readiness Reviews prior to the Operations Start Date. The initial review will document the baseline level of CMO readiness and subsequent reviews will document the status of the Contractor's readiness to meet the requirements set forth in this Addendum.

The level and type of Readiness Review will be conducted by specific multidisciplinary teams appointed by DCH.

The scope of the reviews will include, but not be limited to, review and/or verification of:

- Network Provider composition and access with specific focus on providers with experience in trauma-informed care, pediatricians, primary care providers, specialist, Behavioral Health providers, CCFA Providers, and dental provider;
- Staffing Plan and staffing levels dedicated to the requirements set forth in this Addendum for the FCAAP and DJJP with special emphasis on Care Coordinators, Nurse Case Managers, staff with System of Care knowledge and experience, quality management and utilization management personnel, and ombudsman staff;
- Progress and status in hiring and training staff, and cross-training staff;
- Transition of Care Plan for FCAAP and DJJP Members enrolled in Medicaid prior to the Operations Start Date and who will transition to the FCAAP and DJJP CMO on the Operations Start Date;
- Contractor's plans for building relationships with DFCS staff at the regional and county level and the DFCS units designated for Kenny A., ICAMA and ICPC services, and

such plan shall address education, training and process development;

- Contractor's plans for building relationships with DJJ staff at the regional level, and such plan shall address education, training and process development;
- Activities related to the System of Care approach in the delivery of physical and behavioral health care services to FCAAP and DJJP Members;
- Ability to provide all required health screenings and assessments set forth in this Addendum within the prescribed timeframes;
- Activities detailed in the FCAAP and DJJP Member Education and Outreach Plan;
- Training of providers, CMO staff, court personnel, law enforcement and others on trauma-informed care, the System of Care approach; new policies and procedures; Care Coordination Teams, Virtual Health Records, privacy requirements and other activities or requirements specific for the FCAAP and DJJP Members;
- Implementation of a dental home include provider education and outreach, and any applicable system changes required by the CMO and DCH;
- Readiness to participate in the GaHIN;
- Privacy policies and procedures for the FCAAP and DJJP, including staff and provider training and re-training protocols;
- Detailed policies and procedures for the ombudsman staff;
- Ability to share care coordination and case management information electronically with DFCS staff;
- Development of policies and procedures required under the terms of this Addendum;
- Educational and outreach materials;
- Content of Provider agreements

- Member services capability, including 24/7 Call Center;
- Development of policies with protocols with GCAL;
- Comprehensiveness of quality and Utilization Management strategies;
- Participation in the Georgia Families Monitoring and Oversight Committee;
- Policies and procedures for the Grievance System and Complaint System;
- Financial solvency; and
- Information systems' capabilities including the ability to process eligibility, conduct enrollment activities, process prior authorizations and claims payments, etc.

2.13.9.2 The Readiness Reviews will assess the Contractor's ability to meet any requirements set forth in this Addendum and the documents referenced herein. Members will not be enrolled in the FCAAP and DJJP CMO until DCH has determined that the Contractor is capable of meeting these requirements. The Contractor's failure to pass the final Readiness Review thirty (30) days prior to the Operations Start Date may result in immediate termination of FCAAP/DJJP Addendum #1 services pursuant to Section 22.8.

DCH will provide the Contractor with a summary of the findings as well as areas requiring remedial action after each Readiness Review.

#### **4.0 SPECIFIC CONTRACTOR RESPONSIBILITIES**

##### **4.1. ENROLLMENT**

###### **4.1.1 Enrollment Procedures**

4.1.1.5 Contractor shall enroll FCAAP and DJJP Members in the CMO upon receipt of the FCAAP Member's or DJJP Member's eligibility file from DCH.

## **4.1.2 Selection of a Primary Care Provider (PCP)**

- 4.1.2.1.3 If the DFCS Case Manager, Caregiver, Foster Parent or FC Member does not voluntarily select a PCP upon enrollment in the CMO, as discussed in Section 4.1.2.1 of the Contract, the Contractor shall Auto-Assign the FC Member a PCP within two (2) Business Days of receipt of notification of the FC Member's enrollment in the CMO. An eligibility file from DCH or written notification from DCH or DFCS will serve as notification.
- 4.1.2.1.4 If AA Member or Adoptive Parent does not voluntarily select a PCP upon enrollment in the CMO, as discussed in Section 4.1.2.1 of the Contract, the Contractor shall Auto-Assign the AA Member a PCP within two (2) Business Days of receipt of notification of the AA Member's enrollment in the CMO. An eligibility file from DCH will serve as notification.
- 4.1.2.1.5 For DJJP Members, if the Residential Placement Provider's identified Core Provider does not voluntarily select a PCP upon enrollment in the CMO, as discussed in Section 4.1.2.1 of the Contract, the Contractor shall Auto-Assign the DJJP Member a PCP within two (2) Business Days of receipt of notification of the DJJP Member's enrollment in the CMO. An eligibility file from DCH or written notification from DCH or DJJ will serve as notification.
- 4.1.2.1.6 Following notification of a change in a FC Member's Out of Home Placement, the Contractor must assess the FC Member's access to the PCP within one (1) Business Day. If the PCP no longer meets the geographic access standards as defined in Section 4.8.14 of the Contract, the DFCS Case Manager, Caregiver, Foster Parent or FC Member must select a new PCP within two (2) Business Days of the Member's relocation or the Contractor shall reassign a PCP within three (3) Business Days of receipt of notification of the FC Member's relocation. An eligibility file from DCH or written notification from DCH or DFCS will serve as notification of the FC Member's relocation.
- 4.1.2.1.7 Following notification of a change in a DJJP Member's Residential Placement Provider, the Contractor must assess the DJJP Member's access to the PCP within one (1) Business Day. If the PCP no longer meets the geographic access standards as defined in Section 4.8.14 of the Contract, the Residential Placement Provider's identified Core Provider must select a new PCP within two (2) Business Days of the DJJP Member's relocation or the Contractor shall reassign a PCP within three (3) Business Days of

receipt of notification of the DJJP Member's relocation. An eligibility file from DCH or written notification from DCH or DJJ will serve as notification of the DJJP Member's relocation.

#### **4.1.5 Selection of a Primary Dental Provider (Dentist)**

- 4.1.5.1 If the DFCS Case Manager, Caregiver, Foster Parent or FC Member does not voluntarily select a Dentist upon enrollment in the CMO, the Contractor shall assign the FC Member a Dentist within five (5) Business Days of receipt of notification of the FC Member's enrollment in the CMO. An eligibility file from DCH or written notification from DCH or DFCS will serve as notification of the FC Member's enrollment.
- 4.1.5.2 If an AA Member or Adoptive Parent does not voluntarily select a Dentist upon enrollment in the CMO, the Contractor shall assign the AA Member a Dentist within five (5) Business Days of receipt of notification of the AA Member's enrollment in the CMO. An eligibility file from DCH will serve as notification of the AA Member's enrollment.
- 4.1.5.3 For a DJJP Member, if the Residential Placement Provider's identified Core Provider does not voluntarily select a Dentist upon enrollment in the CMO, the Contractor shall assign the DJJP Member a Dentist within five (5) Business Days of receipt of notification of the DJJP Member's enrollment in the CMO. An eligibility file from DCH or written notification from DCH or DJJ will serve as notification of the DJJP Member's enrollment.
- 4.1.5.4 For a change in a FC Member's Out of Home Placement, the Contractor must assess the FC Member's access to a Dentist within two (2) Business Days of receipt of notification of the Member's relocation. An eligibility file from DCH or written notification from DCH or DFCS will serve as notification of the FC Member's relocation. If the Dentist no longer meets the geographic access standards as defined in Section 4.8.13 of the Contract, the DFCS Case Manager, Caregiver, Foster Parent or FC Member must select a new Dentist within two (2) Business Days of the Member's relocation or the Contractor shall reassign a Dentist within five (5) Business Days of receipt of notification of the FC Member's relocation.
- 4.1.5.5 For a change in a DJJP Member's Residential Provider Placement, the Contractor must assess the DJJP Member's access to the Dentist within two (2) Business Days of receipt of notification of the Member's relocation. An eligibility file from DCH or written

notification from DCH or DJJ will serve as notification of the DJJP Member's relocation. If the Dentist no longer meets the geographic access standards as defined in Section 4.8.13 of the Contract, the Residential Placement Provider's identified Core Provider must select a new Dentist within two (2) Business Days of the Member's relocation or the Contractor shall reassign a Dentist within five (5) Business Days of receipt of notification of the DJJP Member's relocation.

## **4.2 DISENROLLMENT**

### **4.2.1 Disenrollment Initiated by the Member or P4HB Participant**

4.2.1.4 AA Members enrolled in the FCAA CMO may elect to disenroll from the FCAA CMO without cause during the AA Member Fee-For-Service Selection Period. AA Members disenrolling from the FCAA CMO shall return to the Medicaid Fee-For-Service delivery system.

4.2.1.5 AA Members may disenroll from the FCAA CMO for cause at any time and return to the Medicaid Fee-for-Service delivery system. The following constitutes cause for Disenrollment by the AA Member:

- The FCAA CMO does not, because of moral or religious objections, provide the Covered Service the AA Member seeks;
- The AA Member needs related services to be performed at the same time and not all related services are available within the network. The AA Member's Provider or another Provider have determined that receiving service separately would subject the AA Member to unnecessary risk; and
- Other reasons, per 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of Providers experienced in dealing with the AA Member's Health Care needs. (DCH or its Agent shall make determination of these reasons.)

### **4.2.5 Change in Enrollment Status of a FCAAP Member or DJJP Member**

In the event a FCAAP or DJJP Member's eligibility category changes to a category ineligible for the FCAA CMO (as stated in Section 1.2.1 of this Addendum) and the Member remains eligible for Medicaid, the Member shall remain enrolled with the CMO as a non-FCAAP or non-DJJP Member until the Member's next Enrollment Period with the exception of youth enrolled in

Supplemental Security Income (SSI) who will return to the Medicaid Fee-For-Service delivery system. The change in CMO enrollment will be reflected in the updated GF Member eligibility roster and associated change in Capitation Rate. The disenrollment will be processed within three (3) Business Days of the date that the FCAAP or DJJP eligibility category actually changes and will not be made retroactive.

The Contractor shall be responsible for issuing new Member enrollment materials pursuant to Section 4.1.1 of the Contract.

### **4.3 MEMBER SERVICES**

#### **4.3.3 Member Handbook and Information Requirements**

4.3.3.6 The Contractor shall provide DCH a FCAAP and DJJP Member Education and Outreach Plan (hereinafter “Outreach Plan”) within one hundred fifty (150) Calendar Days of the Operations Start Date and shall adhere to all requirements included in Section 4.4.3 of the Contract. DCH shall have at least ten (10) Calendar Days to review the Outreach Plan and Contractor shall have five (5) Calendar Days from the completion of DCH’s review to submit the finalized Outreach Plan to DCH. In addition to the other requirements included in Section 4.3 of the Contract, the FCAAP and DJJP Member Education Outreach Plan shall address the development of the following:

- a) FCAAP and DJJP Member Information Packet;
- b) FCAAP and DJJP Member Handbook;
- c) Member Identification Card;
- d) 24 hour Call Center; and
- e) Other outreach or education activities identified by the Contractor and approved by DCH.

4.3.3.7 The Contractor shall send electronically via secure methods a FC Member and DJJP Member information packet to the DFCS Case Managers for FC Members and to the JPPS for DJJP Members who are newly enrolled in the CMO within five (5) Calendar Days of receipt of the eligibility file from DCH. Upon request, the Contractor will mail the Member information packet to the Foster Parent, Caregiver, Residential Placement Provider or State agency staff. The Contractor shall mail the Member information packet to the AA Member or Adoptive Parent for AA Members who are newly enrolled in the CMO within five (5) Calendar Days of receipt of the eligibility file from DCH. The information packet shall include but not be limited to the following:

- a) A welcome letter that includes the name and contact information for the FCAAP and DJJP Member's Care Coordinator;
- b) A FCAAP and DJJP Member Handbook;
- c) A new member ID card;
- d) A PCP change form and a Dentist change form;
- e) A form requesting information about any special health care needs and specific services for which the Contractor may need to coordinate services;
- f) Information for FCAAP and DJJP Members about the roles of the Care Coordination Team and how to seek help in scheduling appointments, and accessing Care Coordination services;
- g) Information for FCAAP and DJJP Members about the role of the FCAAP and DJJP Call Center and how to access the Call Center;
- h) Explanation of the disenrollment procedures for AA Members stated in Sections 2.3.17, 4.2.14 and 4.2.1.5;
- i) Information about seventy-two (72) hour emergency prescription drug supply;
- j) For FC Members in DFCS custody in DeKalb and Fulton counties only, information on the Kenny A. health care requirements; and
- k) Information on the Ombudsman Liaison.

4.3.3.8 The Contractor shall develop within one hundred twenty (120) Calendar Days of the Operations Start Date a FCAAP and DJJP Member Handbook (hereinafter "Handbook") specific to the needs of FCAAP and DJJP Members and shall adhere to all requirements included in Section 4.3.3 of the Contract. DCH shall have fifteen (15) Calendar Days to review the Handbook and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized Handbook to DCH.

4.3.3.9 At a minimum the FCAAP and DJJP Member Handbook shall address the following topics:

- a) Roles of DFCS and DJJ in consenting to the FC Members' and DJJP Members' health care services;
- b) How to access the Care Coordination Team;
- c) Role of Care Coordination Team related to coordination of care and services; and
- d) Continuity of care and transition issues.

#### **4.3.6 Member Identification (ID) Card**

- 4.3.6.7 The Contractor shall reissue the FC Member ID card if a FCAAP Member, DFCS Staff, Caregiver or Foster Parent reports a lost card; if there is a FC Member name change; if the FC Member, DFCS staff, Caregiver or Foster Parent requests a new PCP; if the FC Member moves to a new placement; or for any other reason that results in a change to the information disclosed on the FC Member's ID card. The ID card shall be issued initially within five (5) Calendar Days of receipt of the eligibility file from DCH and reissued within five (5) Calendar Days of a request for reissue based on the events named above.
- 4.3.6.8 The Contractor shall reissue the AA Member ID card if an AA Member or Adoptive Parent reports a lost card; if there is an AA Member name change; if the AA Member or Adoptive Parent requests a new PCP; or for any other reason that results in a change to the information disclosed on the A Member's ID card. The ID card shall be issued initially within five (5) Calendar Days of receipt of the eligibility file from DCH and reissued within five (5) Calendar Days of a request for reissue based on the events named above.
- 4.3.6.9 The Contractor shall reissue the DJJP Member ID card if the JPPS or Residential Placement Provider reports a lost card; if there is a DJJP Member name change; if the JPPS or Residential Placement Provider requests a new PCP; if the DJJP Member moves to a new placement; or for any other reason that results in a change to the information disclosed on the DJJP Member's ID card. The ID card shall be issued initially within five (5) Calendar Days of receipt of the eligibility file from DCH and reissued within five (5) Calendar Days of a request for reissue based on the events named above.

#### **4.3.7 Toll-Free Member Participant Services Line**

- 4.3.7.10 The Contractor must provide a twenty-four (24) hour Call Center staffed with experienced personnel familiar with the FCAAP, DJJP, Georgia child-serving agencies and the Georgia provider community. Call Center staff must be able to assist FCAAP and DJJP Members with general FCAAP and DJJP Member inquiries and provide referrals to GCAL or other appropriate resources for emergency and crisis needs. Crisis protocols will be developed in coordination with GCAL. Contractor shall submit such protocols to DCH for review and approval within ninety (90) Calendar Days of the Operations Start Date. DCH shall have fifteen (15) Calendar Days to review the protocols and Contractor shall have five (5)

Calendar Days from completion of DCH's review to submit the finalized protocols to DCH.

4.3.7.11 The Contractor shall develop FCAAP and DJJP Call Center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. Contractor shall meet the following standards for the FCAAP and DJJP Call Center operations: (a) ninety percent (90%) of calls shall be answered within thirty (30) seconds by a live operator measured weekly; (b) one percent (1%) Blocked Calls; and (c) the standards for Abandoned Calls shall be equivalent to or greater than the standards provided in Section 4.3.7.7 of the Contract.

4.3.7.12 The Contractor shall submit Call Center Policies and Procedures, including performance standards pursuant to Section 4.3.7.7 and reporting requirements included in Section 4.3.7.9 of the Contract, to DCH for review and approval within ninety (90) Calendar Days of the Operations Start Date. DCH shall have fifteen (15) Calendar Days to review the Call Center Policies and Procedures and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized Call Center Policies and Procedures to DCH.

## **4.5 COVERED BENEFITS AND SERVICES**

### **4.5.7 General Requirements for the FCAAP and DJJP**

4.5.7.1 The Contractor shall at a minimum provide Medically Necessary Services and Benefits pursuant to the Georgia State Medicaid Plan, and the Georgia Medicaid Policies and Procedures Manuals. Such Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition. All benefits and services should be provided in the most appropriate service location for the service rendered based on the FCAAP and DJJP Members' individual needs at a specific point in time.

4.5.7.2 CCFAs

- a) The Contractor shall be responsible for ensuring that the Medical and Trauma Assessments required for the FC Members as part of the CCFA are conducted and reported in a

timely manner as set forth herein. Each instance of failure to meet a timeframe specified in this Section 4.5.7.2 shall constitute a Category 3 event as set forth in Section 23.4.1 of the Contract.

- b) **Medical Assessments for FC Members.** The Contractor shall be responsible for assuring the CCFA Medical Assessments are completed within ten (10) Calendar Days of the Contractor's receipt of the eligibility file from DCH or written notification from DFCS whichever comes first for a Member newly entering or re-entering Foster Care as a FC Member. Contractor is responsible for sending the outcomes of the Medical Assessments to the DFCS-contracted CCFA Provider preparing the final CCFA report within twenty (20) Calendar Days of Contractor's receipt of the eligibility file from DCH or written notification from DFCS whichever comes first for a Member newly entering or re-entering Foster Care as a FC Member. The medical components of the CCFA include an initial medical evaluation that includes all components of the EPSDT periodicity schedule relevant for the age of the FC Member. These components include age appropriate developmental, vision, hearing and dental screens.
  
- c) **Trauma Assessments.** The Contractor shall contract with CCFA Providers for all Trauma Assessments required for FC Members or AA Members.
  
- d) The CCFA Trauma Assessment, at a minimum, shall include:
  - i) A trauma history with information about any trauma that the child may have experienced or been exposed to as well as how they have coped with that trauma in the past and present.
  - ii) Completion of the age appropriate assessment tool.
  - iii) A summary of assessment results and recommendations for treatment (if needed).
  
- e) **Members Newly Entering or Re-entering Foster Care**  
The Contractor shall be responsible for assuring CMO-contracted CCFA Providers conducting Trauma Assessments for FC Members meet the following requirements:
  - i) Ensure that the CMO-contracted CCFA Provider has initiated contact with or visit(s) with the Member newly entering or re-entering Foster Care as a FC Member and begins the Trauma Assessment within ten (10) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's 72-Hour Hearing. The

Contractor must coordinate all necessary visits with the CMO-contracted CCFA Provider in order to ensure that the final Trauma Assessment is completed within the timeframes referenced in this Addendum.

- ii) The CMO-contracted CCFA Provider must prepare a written Trauma Assessment report and submit such report to the DFCS-contracted CCFA provider preparing the final CCFA report within twenty (20) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's 72-Hour Hearing.
- iii) If the CMO-contracted CCFA Provider is unable to meet the timeframe for the written Trauma Assessment report, the CMO-contracted CCFA Provider may verbally report the Trauma Assessment findings and recommended treatment during the FC Member's MDT meeting. In the case of a verbal report, the Contractor shall be responsible for assuring the CMO-contracted CCFA Provider submits the final written Trauma Assessment report to the DFCS-contracted CCFA provider preparing the final CCFA report within thirty-five (35) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's 72-Hour Hearing.

**f) AA Members and Enrolled FC Members**

Trauma Assessments may be required for AA Members in the event of abuse or neglect as reported by a Provider, Adoptive Parent or others. Trauma Assessments may also be required for a Member who has been a FC Member for a period of twelve (12) or more months and whose completed CCFA is more than twelve (12) months old. Under these two circumstances, the Contractor shall:

- i) Ensure that the CMO-contracted CCFA Provider has initiated contact with or visit(s) with the AA or FC Member and begins the Trauma Assessment within ten (10) Calendar Days of the Contractor's receipt of written notification from DFCS. Contractor must coordinate all necessary visits with the CMO-contracted CCFA Provider in order to ensure that the final Trauma Assessment is completed within the timeframes referenced in this Addendum.
- ii) The CMO-contracted CCFA Provider must prepare a written Trauma Assessment report and submit such report to the DFCS-contracted CCFA provider preparing the final CCFA report within twenty (20)

Calendar Days of the Contractor's receipt of written notification from DFCS.

- iii) If the CMO-contracted CCFA Provider is unable to meet the timeframe for the written Trauma Assessment report, the CMO-contracted CCFA Provider may verbally report the Trauma Assessment findings and recommended treatment. In the case of a verbal report, the Contractor shall be responsible for assuring the CMO-contracted CCFA Provider submits the final written Trauma Assessment report to the DFCS-contracted CCFA provider preparing the final CCFA report within thirty-five (35) Calendar Days of the Contractor's receipt of written notification from DFCS.
  
- g) The Contractor shall coordinate for and ensure that FC or AA Members follow up on and receive any care specified within the Trauma and Medical Assessments in accordance with the following timeliness requirements. The Contractor shall:
  - i) Provide follow up for dental treatment within thirty (30) days of the EPSDT dental visit if the dental screening yields any concerns or the need for dental treatment.
  - ii) Obtain an audiological assessment and treatment or prescribed corrective devices initiated within thirty (30) days of the screening, based on the results of the hearing screening.
  - iii) Provide a developmental assessment if the developmental screening completed as part of the EPSDT visit yields any developmental delays or concerns. The EPSDT provider is responsible for making a referral for the assessment, and the Contractor is responsible for ensuring the child has the assessment within thirty (30) days of the screening.

4.5.7.3 The Contractor shall ensure that Providers refer FC Members ages three (3) years and under who are exposed to Substantiated Maltreatment to the Children 1st program for a developmental screening as required by the Child Abuse Prevention and Treatment Act (CAPTA).

4.5.7.4 Medical Assessments for DJJP Members. The Contractor shall be responsible for assuring the Medical Assessments for the DJJP are completed within ten (10) Calendar Days of the Contractor's receipt of the eligibility file from DCH or written notification from DJJ whichever comes first for a Member newly entering or re-entering as a DJJP Member. Contractor is responsible for sending the outcome of the Medical Assessment to the DJJP Member's

Residential Placement Provider within fifteen (15) Calendar Days of Contractor's receipt of the eligibility file from DCH or written notification from DJJ, whichever comes first, for a Member newly entering or re-entering as a DJJP Member. The medical components of the Medical Assessment for the DJJP Member shall include an initial medical evaluation that includes all components of the EPSDT periodicity schedule relevant for the age of the DJJP Member.

4.5.7.5 The Contractor shall provide a Health Risk Screening within thirty (30) days of receipt of the eligibility file from DCH. The Health Risk Screening is used to develop a comprehensive understanding of the FCAAP and DJJP Members' health status and will be used by the Contractor to develop the Health Care Service Plan and used by the Care Coordination Team to determine the FCAAP and DJJP Members' Care Coordination needs. The Health Risk Screening is independent of the assessments conducted for the CCFA; however, the Contractor may utilize the information from the CCFA assessments it coordinates to further inform the comprehensive understanding of the FCAAP Member's health.

a) The Contractor shall assess the need to complete a new Health Risk Screening each time a FCAAP or DJJP Member moves to a new placement and complete a new Health Risk Screening when necessary based on a change in the FCAAP Member's or DJJP Member's medical or behavioral health as identified by Providers. Related decision logic shall be described in the policies and procedures created in response to the requirement in Section 4.13.7.

4.5.7.6 Value Added Services. The Contractor is encouraged to include Value Added Services. Value added services are not considered during the Capitation Rate development process.

4.5.7.7 The Contractor shall provide all Medical Services and adhere to all timeliness requirements defined in the Kenny A. Consent Decree (Exhibit 1) for FC Members in custody of Fulton and DeKalb counties.

4.5.7.8 Contractor shall provide all Medicaid State Plan services required by Section 4.5.7.1 above for FCAAP Members enrolled in an HCBS waiver program except any services provided under the applicable 1915(c) waiver which shall remain available to such members via the Fee-for-Service program. DCH shall have the final determination as to which services are covered under the waiver and which services are the responsibility of Contractor.

## **4.8 PROVIDER NETWORK AND ACCESS**

### **4.8.1 General Provisions**

- 4.8.1.13 For the FCAAP and DJJP, the Contractor's provider network shall include:
- a) primary care and specialist providers who are trained or experienced in trauma-informed care and in treating individuals with complex special needs, including the FCAAP and DJJP.
  - b) providers who have knowledge and experience in identifying child abuse and neglect.
  - c) Providers who render Core Services and IFI services.
  - d) significant traditional Medicaid, DFCS, DJJ and DPH providers, as recommended by DCH, to ensure network access for the FCAAP and DJJP. Such providers must meet Contractor's Credentialing requirements.

### **4.8.2 Primary Care Providers (PCPs)**

- 4.8.2.13 The Contractor shall have processes in place to assure that every FCAAP and DJJP Member has a designated PCP who will serve as the FCAAP and DJJP Members' Medical Home within two (2) Business Days of receipt of the eligibility file from DCH and at all times during active eligibility. The Medical Home is intended to increase access to and improve continuity of care, facilitate early identification and treatment of chronic health conditions and promote better care coordination.
- 4.8.2.14 For FC Members, Contractor shall allow the FC Member, DFCS staff, Caregiver or Foster Parent to change the PCP designation based on the needs of a child and with any change in placement. For AA Members, Contractor shall allow the AA Member or Adoptive Parent to change the PCP designation based on the needs of a child. For DJJP Members, Contractor shall allow the JPPS or Residential Placement Provider's designated Core Provider to change a PCP designation based on the needs of the youth and with any change in placement.

### **4.8.3 Direct Access**

The Contractor shall have a procedure by which the PCP in consultation with the Contractor's Medical Director and specialists, if appropriate, may request that a FCAAP or DJJP Member who needs ongoing care from a specialist receive a standing referral to such

specialist. The Contractor shall not be required to permit a FCAAP or DJJP Member to elect to have a non-participating specialist if a network provider is available. Such referral shall be pursuant to a treatment plan approved by the Contractor in consultation with the PCP, the specialist, and the Care Coordinator, or, where applicable, DFCS, DJJ, the Foster or Adoptive Parent or Caregiver, FC Member or AA Member or DJJP Member. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the PCP with regular treatment updates and demonstrate medical necessity.

- 4.8.3.5 The Contractor shall provide for a review by a specialist of the same or similar specialty with experience in the FCAAP and DJJP as the type of physician or provider to whom a referral is requested before the Contractor may deny a request for referral to a specialist provider.

#### **4.8.12 Dental Practitioners**

- 4.8.12.8 The Contractor shall have processes in place to assure that every FCAAP and DJJP Member has a designated Dentist who will serve as the FCAAP and DJJP Members' Dental Home within five (5) Business Days of receipt of the eligibility file from DCH and at all times during active eligibility. The Dental Home is intended to increase access to and improve continuity of care and facilitate early identification and treatment of dental health conditions.

- 4.8.12.9 For FC Members, Contractor shall allow the FC Member, DFCS staff, Caregiver or Foster Parent to change the Dentist designation based on the needs of a child and with any change in placement. For AA Members, Contractor shall allow the AA Member or Adoptive Parent to change the Dentist designation based on the needs of a child. For DJJP Members, Contractor shall allow the JPPS or Residential Placement Provider's designated Core Provider to change a Dentist designation based on the needs of the youth and with any change in placement.

#### **4.8.15 Credentialing**

- 4.8.15.7 For the FCAAP and DJJP, the Contractor shall include providers recommended by DFCS, DBHDD, DJJ, DOE, DECAL or DPH in their provider network if the provider or agency meets the enrollment criteria for Georgia Fee-For-Service Medicaid and meets the Contractor's credentialing requirements.

#### **4.8.17 Coordination Requirements**

- 4.8.17.7 For FCAAP and DJJP Members entering and exiting the CMO, the Contractor must ensure continuity of care. The Contractor will coordinate with DCH, DFCS, DPH, DJJ, DOE, DBHDD and DECAL as needed when a FCAAP or DJJP Member transitions into or out of the CMO to maintain continuity of care and services and minimize disruptions to the FCAAP and DJJP Members.
- 4.8.17.8 If a FC Member or DJJP Member is transitioning from another CMO or from private insurance, the Contractor shall contact the FC Members' or DJJP Members' prior CMO or other insurer and request information about the FC Member's or DJJP Member's needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of receipt of the eligibility file from DCH and receipt of a signed release of information form from DFCS or DJJ. If an AA Member is transitioning from another CMO or from private insurance, the Contractor shall contact the AA Members' prior CMO or other insurer and request information about the AC Member's needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of receipt of the eligibility file from DCH and receipt of a signed release of information form from the Adoptive Parent.
- 4.8.17.9 If a FC Member or DJJP Member is transitioning from Fee-for-Service Medicaid the Contractor shall coordinate with DCH staff designated to coordinate administrative services for the FCAAP and DJJP, and contact the FC Member's or DJJP Member's prior Service Providers including but not limited to PCPs, specialists and dental providers, and request information about the FC Members' or DJJP Members' needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of the receipt of the eligibility file from DCH and receipt of a signed release of information form from DFCS or DJJ. If an AA Member is transitioning from Fee-for-Service Medicaid the Contractor shall coordinate with DCH staff designated to coordinate administrative services for the AA Member, and contact the AA Member's prior Service Providers including but not limited to PCPs, specialists and dental providers, and request information about the AA Members' needs, current medical necessity determinations, authorized care and treatment plans within two (2) Business Days of the receipt of the eligibility file from DCH and receipt of a signed release of information form from the Adoptive Parent.

- 4.8.17.10 To ensure continuity of care for a FCAAP or DJJP Member receiving services authorized in all treatment plans by their prior CMO, private insurer or through Fee-for-Service Medicaid, the Care Coordinator will authorize the FCAAP or DJJP Member to continue with his or her providers and current services, including the issuance of an Out-of-Network authorization to ensure the FCAAP Member's or DJJP Member's condition remains stable and services are consistent to meet the FCAAP and DJJP Members' needs. All such authorizations or allowances will continue for the latter of a period of at least thirty (30) days or until the Contractor's authorized Health Care Service Plan is completed.
- 4.8.17.11 The Contractor shall employ System of Care principles in the coordination and delivery of services to ensure coordinated planning across and between multiple child-serving agencies which also serve the FCAAP and DJJP Members.
- 4.8.17.12 The Contractor shall provide additional coordination to ensure continuity of care for Members with Special Health Care Needs as detailed in Section 4.11.8 Care Coordination of this Addendum.

#### **4.8.19 Out-of Network Providers**

- 4.8.19.4 If the Contractor does not have a health care provider with appropriate training and credentials in its panel or network meeting geographic access requirements defined in Section 4.8.13 of the Contract to meet a FCAAP Member's or DJJP Member's particular health care needs, Contractor shall make a referral to an appropriate out-of-network provider, pursuant to a treatment plan approved by the Contractor in consultation with the PCP, the non-contracted provider and, or where applicable, the Foster or Adoptive Parent, Caregiver, DFCS staff or DJJ staff, at no additional cost to the FCAAP or DJJP Member.

### **4.9 PROVIDER SERVICES**

#### **4.9.2 Provider Handbook**

- 4.9.2.4 The Contractor shall develop and provide to DCH within one hundred twenty (120) Calendar Days of the Operations Start Date a FCAAP and DJJP Provider Handbook specific to the needs of the FCAAP and DJJP. DCH shall have at least ten (10) Calendar Days to review the handbook and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized handbook to DCH.

4.9.2.5 The FCAAP and DJJP Provider Handbook must contain special requirements for FCAAP and DJJP Members, including how FCAAP and DJJP Members, Caregivers, Foster and Adoptive Parents, DFCS staff and DJJ staff may access care management, the requirements that Behavioral Health Providers and PCPs must share a FCAAP Member's or DJJP Member's physical and behavioral health clinical information, and requirements included in the Kenny A. Consent Decree. The FCAAP and DJJP Provider Handbook must also detail provider requirements and legal obligations for providing medical information as required by DFCS and DJJ, and/or necessary for court hearings.

### **4.9.3 Education and Training**

4.9.3.4 The Contractor shall submit to DCH a FCAAP and DJJP Provider education and training approach within one hundred fifty (150) Calendar Days of the Operations Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH. The education and outreach approach must include, at a minimum:

- a) Obtaining recommendations from experts in the field including DFCS, DBHDD, DOE, DPH, DECAL and DJJ to identify relevant training modules.
- b) Initial and ongoing training of Contractor staff and the Provider network as applicable to each that addresses, but is not limited to, the following issues:
  - i) Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from commercial coverage rules.
  - ii) Coordinating care utilizing a System of Care approach between: Foster Parents and Caregivers; DFCS Case Managers, JPPS or other involved case managers; attorneys ad litem; judges; law enforcement officials; Adoptive Parents; and other involved parties from State agencies.
- c) Requirements for providing Health Care Services to the FCAAP and DJJP, including:
  - i) Medical consent requirements;
  - ii) Required timelines for services and assessments;

- iii) Specific medical information required for court requests and judicial review of medical care;
  - iv) Appropriate utilization of psychotropic medications;
  - v) Evidence-based Behavioral Health treatment interventions; and
  - vi) Specific behavioral and physical health needs of these children and young adults.
- d) Training in trauma-informed care;
  - e) The effect of abuse and neglect on the developing brain;
  - f) The effect of intrauterine assault, fetal alcohol syndrome and shaken baby syndrome;
  - g) How to screen for and identify Behavioral Health disorders;
  - h) The Contractor's referral process for Behavioral Health services; and
  - i) The availability of a Care Coordination Team for Members and how to access the Care Coordinator.

4.9.3.5 Training for Law Enforcement Officials and Judges

The Contractor shall provide training for law enforcement officials, judges, district and county attorneys representing DFCS and DJJ and attorneys ad litem about the requirements of the Contract and needs of FCAAP and DJJP Members. DCH, DFCS, DJJ and other sister agencies may also participate in these trainings. The Contractor shall submit a training plan that includes proposed locations, dates of trainings and training materials to DCH sixty (60) Calendar Days prior to the Operations Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH. The Contractor shall update training materials annually, at a minimum, and more often if a change in law or policy alters the content of the training materials.

**4.11 UTILIZATION MANAGEMENT AND CARE COORDINATION RESPONSIBILITIES**

**4.11.2 Prior Authorization and Pre-Certification**

4.11.2.7 Requirements for FCAAP and DJJP Members

- a) The Contractor may require that the prescriber's office request Prior Authorization as a condition of coverage or payment for a prescription drug provided that a decision whether to approve or deny the prescription is made within twenty-four (24) hours of the Prior Authorization request, and if a FCAAP Member's or DJJP Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the Contractor must allow the pharmacist to dispense a seventy-two (72) hour emergency supply of the prescribed. The Contractor must reimburse the pharmacy for the temporary supply of medication and contracted dispensing fee.
- b) The Contractor's Prior Authorization processes for Behavioral Health Services shall recognize the intensive and/or ongoing need for these services often present among the FCAAP and DJJP, and should not be unnecessarily burdensome to Providers or FCAAP and DJJP Members.
- c) Prior Authorization will not be required for the first ten (10) individual or group outpatient psychotherapy sessions provided by a contracted behavioral health provider, per twelve (12) month rolling period. Such sessions may include the initial evaluation. Additional visits will be reviewed and approved based on a Medical Necessity review conducted by the Contractor.

#### **4.11.4 Transition of Members**

##### **4.11.4.4 Discharge Planning**

- 4.11.4.4.2 The Contractor shall submit to DCH for review and approval its transition policies and procedures, including the guidelines it uses to identify FCAAP and DJJP Members with Special Health Care Needs requiring priority coordination and care, within ninety (90) Calendar Days of the Operations Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.
- 4.11.4.4.3 Contractor will support DFCS and participate in DFCS transitional roundtables in transition planning for FC Members turning eighteen (18) and exiting Foster Care. DFCS will begin transition planning one (1) year prior to a

FC Member reaching their eighteenth birthday and aging out of Foster Care (and will repeat the planning process one (1) year prior to the twenty first (21<sup>st</sup>) birthday if the youth elects to continue services to age twenty one (21). For FC Members electing to continue services to age twenty six (26), Contractor shall offer transition planning services to the FC Member at age twenty five, but shall not be required to provide such services if the FC Member declines to receive them. Transition planning for members entering the CMO on or after their seventeenth birthday shall start within one (1) month of entry into the CMO. A youth exiting FC due to age should not need to transition to a nursing facility or institution because they lacked a plan for continued support. Transition planning activities may include but are not limited to:

- a) Assess the FC Member's home and community support needs to remain in the community and maintain stability through the transition out of foster care including but not limited to the following:
  - i. Determine and identify the array of services needed and providers of these services.
  - ii. Assess needs and provide recommendation for access for specialized supports including but not limited to positive behavioral supports, medication support, durable medical equipment, communication devices or vehicle or home adaptations.
- b) Review the FC Member's health status and other appropriate factors to determine if the FC Member meets the general eligibility criteria for entering a HCBS waiver program.
  - i. Initiation of the waiver application processes and if necessary, place youth on waiver waiting list(s).
- c) In collaboration with DFCS, educate FC Members about options for services and supports available after eligibility terminates. Such options may include Independence Plus, IDEA participation, and application for post-secondary options. Education shall include information on accessing disability services available from educational institutions and employers where appropriate.

4.11.4.4.4 Contractor will support DJJ and participate in DJJ transitional roundtables in transition planning for DJJP Members returning to their homes. The transition planning will begin upon the DJJP Member's enrollment in the CMO and the transitional roundtable will be initiated by DJJ. Transition planning activities may include but are not limited to:

- a) Assess the DJJP Member's home and community support needs to remain in the community and maintain stability through the transition out of the juvenile justice system including but not limited to the following:
  - i. Determine and identify the array of services needed and providers of these services.
  - ii. Assess needs and provide recommendations for access for specialized supports including but not limited to positive behavioral supports, medication support, durable medical equipment, communication devices or vehicle or home adaptations.
- b) Review the DJJP Member's health status and other appropriate factors to determine if the DJJP Member meets the general eligibility criteria for entering a HCBS waiver program.
  - i. Initiation of the waiver application processes and if necessary, place youth on waiver waiting list(s).
- c) In collaboration with DJJ, educate DJJP youth about options for services and supports available after eligibility in the CMO terminates. Such options may include Independence Plus, IDEA participation, application for post-secondary options, housing and vocational opportunities. The DJJ and CMO education shall include information on accessing disability services available from educational institutions and employers where appropriate.

#### **4.11.8 Care Coordination Responsibilities**

4.11.8.5 Administrative Processes Required for FC Members and the DJJP

- a) The Contractor shall implement a systematic administrative process to coordinate with DFCS, including providing DFCS with requested information and coordinating with PCPs or specialists for medical information when required by DFCS

and/or necessary for court hearings for FC Members. Such materials shall be due within one hundred fifty (150) Calendar Days of the Operations Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

- b) The Contractor shall implement a systematic administrative process to coordinate with DJJ, including providing DJJ with requested information and coordinating with PCPs or specialists for medical information when required by DJJ and/or necessary for court hearings for DJJP Members. Such materials shall be due within one hundred fifty (150) Calendar Days of the Operations Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

4.11.8.6 The Contractor shall have documented FCAAP and DJJP Care Coordination Policies and Procedures for coordinating care and creating linkages with external organizations, including but not limited to school districts, child protective service agencies, early intervention agencies, behavioral health, and developmental disabilities service organizations. Such policies and procedures must include details on the Contractor's approach for documenting care coordination activities and creating linkages with external organizations for each FCAAP and DJJP Member. Contractor shall submit the policies and procedures to DCH for review within one hundred twenty (120) Calendar Days of the Operations Start Date and within ten (10) Calendar Days of any subsequent updates. In both instances, DCH shall have at least ten (10) Calendar Days to review the materials and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

4.11.8.7 The Contractor shall use the results of all assessments and screenings included in Section 4.5.7 to develop a Health Care Service Plan for all new FCAAP and DJJP Members within thirty (30) Calendar Days of Member enrollment. The Contractor must document the involvement of the FCAAP Member's or DJJP Member's PCP, Dentist, Behavioral Health Providers, specialists or other providers in the development of the Health Care Service Plan and provide evidence of such documentation to DCH, DFCS and DJJ.

4.11.8.8 The Contractor shall develop a process by which Contractor will

regularly review and update the FCAAP and DJJP Members' Health Care Service Plans which shall include:

- a) the detailed description of the involvement of the FCAAP Member's or DJJP Member's PCP, Dentist, Behavioral Health Providers, specialists or other providers in the development of the Health Care Service Plan;
- b) the approach for updating or revising the Health Services Plan; and
- c) details on the monitoring and follow-up activities conducted by the Contractor with the FCAAP or DJJP Members' providers.

Such process shall be submitted to DCH for review and approval within ninety (90) Calendar Days of the Operations Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

4.11.8.9 The Contractor is responsible for ensuring that the Health Care Service Plan for FCAAP and DJJP Members with Severe Emotional Disturbance (SED) shall include a safety and contingency crisis plan. The development of such a plan will be coordinated between the Contractor, Core Services Providers and/or IFI Providers.

4.11.8.10 The Contractor shall develop interdisciplinary Care Coordination Teams to provide Care Coordination services for FCAAP and DJJP Members. Each FCAAP and DJJP Member will be assigned a Care Coordination Team to provide necessary Care Coordination services. Care Coordination Teams will be responsible for coordinating all services identified in the FCAAP and DJJP Members' Health Care Service Plan. The Care Coordinator shall provide information to and assist Providers, FCAAP Members, DJJP Members, Foster Parents, Caregivers, DFCS staff and DJJ staff with access to care and coordination of services.

4.11.8.11 The Care Coordination Team for FCAAP and DJJP Members must include, at a minimum, the following elements:

- a) Ensure access to primary, dental and specialty care and support services, including assisting FCAAP and DJJP Members, Caregivers, Foster and Adoptive Parents, DFCS staff and DJJ Staff with locating Providers, and scheduling and obtaining appointments as necessary.

- b) Expedite the scheduling of appointments for Medical Assessments used to determine Residential Placements as requested by DFCS and DJJ. The Contractor must give top priority to this function in its care coordination operations.
- c) Assist with coordinating non-emergent transportation for FCAAP Members as needed for provider appointments and other Health Care Services.
- d) Document efforts to obtain provider appointments, arrange transportation, establish meaningful contact with the FCAAP and DJJP Members' PCP, Dentists, specialists and other providers, and arrange for referrals to community-based resources. Such documentation shall include details on any barriers or obstacles to obtaining appointments, arranging transportation, establishing meaningful contact with Providers or arranging referrals to community-based resources.
- e) Ensure Providers, DFCS, DJJ and DBHDD staff, Caregivers, Foster and Adoptive Parents, FCAAP Members and DJJP Members access to information about the Prior Authorization processes of the Contractor and its business partners.
- f) Define program requirements and processes, including the FCAAP Member Appeals processes and how the Contractor will provide assistance to Providers and FCAAP and DJJP Members with navigating these processes.
- g) Educate the Contractor's staff about when medical information is required by DFCS and DJJ and/or necessary for court hearings. If the Provider has not timely responded to a DFCS or DJJ request and/or a court's subpoena or request for such information, the Contractor must timely contact the Provider in question to require him or her to provide the requested information. The Contractor shall remind the Provider of his or her legal obligations to produce such information, including those obligations arising out of the Network Provider agreement with the Contractor.
- h) The Contractor shall include a Nurse Care Manager (NCM) to assist FCAAP and DJJP Members identified through the health assessment as Members with Special Health Care Needs. The NCM will help Members with Special Health Care Needs obtain Medically Necessary care, health-related services and coordinate clinical care needs with holistic consideration. The

Contractor's NCM must coordinate across a FCAAP Member's or DJJP Member's providers and health systems. The Contractor must have a process to facilitate, maintain and coordinate both care and communication with State agency staff, Providers, Caregivers, Foster or Adoptive Parents, Service Providers, and FCAAP and DJJP Members.

- i) To ensure continuity of care for MSHCN receiving services authorized in a treatment plan by their prior health plan, the Contractor and Care Coordinators shall work with the FCAAP Member's or DJJP Member's current PCP and specialists to address issues that will help FCAAP Member's or DJJP Member's condition remain stable and services are consistent to meet the FCAAP Member's or DJJP Member's ongoing needs.
- j) Provide application assistance to MSHCN who may qualify for Supplemental Security Income (SSI) benefits.

#### 4.11.8.12 Health Outcomes

The Contractor shall submit written policies and procedures for tracking and reporting individual FCAAP and DJJP Member health outcomes, including the mechanism for reporting whether a Member's health outcomes improved as a result of the CMO's care coordination and case management activities. Contractor shall submit such policies and procedures to DCH for review within ninety (90) Calendar Days of the Operations Start Date and within ten (10) Calendar Days of any subsequent updates. In both instances, DCH shall have at least ten (10) Calendar Days to review the materials and Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.

#### 4.11.8.13 Children 1<sup>st</sup> and Babies Can't Wait (BCW)

- a) The Contractor shall educate network Providers about the federal laws on child find (e.g., 20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)) and require network Providers to identify and refer any FCAAP Member birth through thirty-five (35) months of age suspected of having a developmental delay or disability, or who is at risk of delay, to the designated Children 1st program for assessment and evaluation.
- b) Evidence of this education shall be documented and available to DCH or its designee.

4.11.8.14 Contractor shall send appropriate staff to attend LIPT and RIAT meetings when its enrolled FC Member or DJJP Member is on the agenda.

4.11.8.15 Medication Management

The Contractor shall develop a medication management program specific to the needs of the FCAAP and DJJP. At a minimum, the medication management program must assess prescribing patterns and treatment plans for psychotropic medications, medications at risk of abuse and other medications identified by DCH or the Contractor. An annual report describing activities and the effectiveness of the efforts over the reporting period and the future efforts and activities planned for the next reporting period.

#### **4.11.13 Health Coordination and Integration for FCAAP and DJJP Members**

4.11.13.1 The Contractor shall encourage PCPs, Behavioral Health Providers, developmental disability providers and dental providers to effectively and efficiently share behavioral and physical health clinical FCAAP and DJJP Member information.

4.11.13.2 The Contractor shall submit an annual Health Coordination and Integration report to the Department due June 30th of each calendar year of this Addendum for the prior calendar year beginning January 1, 2015. This report is subject to approval by the Department. At a minimum, this report shall include:

- a) Summary of activities and efforts to integrate and coordinate behavioral and physical health;
- b) Effectiveness measures with clear metrics;
- c) Successes (e.g., exceeding performance targets) and opportunities for improvement;
- d) Plans to implement initiatives to address identified opportunities for these improvements and to achieve expected outcomes; and
- e) Roadmap of activities planned for the next reporting.

### **4.12 QUALITY IMPROVEMENT**

#### **4.12.10 Value Based Purchasing (VBP) Program for the FCAAP and DJJP**

- 4.12.10.1 The Contractor shall collaborate with DCH to implement a VBP model for the FCAAP and DJJP. DCH and Contractor shall finalize the VBP model, priority areas, measures and target for year one of the Contract. Such final VBP model shall be completed by July 22, 2013.
- 4.12.10.2 Prior to the Operations Start Date, DCH will establish a VBP governing board (“VBP Governing Board”). The Contractor shall have a senior executive available to participate on the VBP Governing Board that is responsible for setting statewide priorities and overseeing the execution of the VBP model.
- 4.12.10.3 Prior to the Operations Start Date, DCH will establish a VBP performance management team (“VBP Performance Management Team”). The VBP Performance Management Team will work collaboratively with Contractor to identify targets for each Contract year, review Contractor progress on a monthly, quarterly and/or annual basis, determine incentive payments, and determine the need to modify priority areas, measures and targets.
- 4.12.10.4 Strategic goals for year one of the VBP program are transaction-oriented and are designed to support the seamless transition of the FCAAP and DJJP into the Georgia Families. DCH shall withhold five percent (5%) of the FC Member, AA Member and DJJP Capitation Rates (“VBP Withhold”) and such VBP Withhold amounts will be placed by DCH in an escrow account from which it will make payments to the Contractor for achieving the VBP targets.
- 4.12.10.5 Strategic goals for subsequent years of the VBP program shall be developed through a collaborative process between DCH and Contractor. The VBP Withhold will apply to all subsequent years of the VBP program.
- 4.12.10.6 In the event that the parties cannot agree on goals, measures and targets, DCH shall finalize these components of the VBP and such decision shall be binding on the parties.
- 4.12.10.7 The Contractor shall recruit and incentivize Providers to participate in VBP and may also incentivize Members. The Contractor shall develop a plan subject to DCH approval for distributing to Providers fifty percent (50%) of the VBP Withhold payments received from DCH for achieving targets. The Contractor shall submit such plan for provider incentives to DCH for review and approval within one hundred twenty (120) Calendar Days of the

Operations Start Date. DCH shall have fifteen (15) Calendar Days to review the plan and Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized policies and procedures to DCH.

4.12.10.8 The Contractor shall make available and provide information on the FCAAP and DJJP as requested by DCH for its monitoring processes. DCH will conduct monthly reviews of compliance reports and quarterly performance reviews. If a significant unfavorable variance is observed, DCH may request a Corrective Action Plan from Contractor which shall be submitted to DCH for review and approval within seven (7) Calendar Days of the request from DCH. For each identified significant variance, the Corrective Action Plan must include, but not be limited to the following items:

- a) Name, title and contact information for the staff person responsible for implementing and overseeing the action plan;
- b) Description of the root cause reason for the variance;
- c) Detailed description of the proposed corrective action(s);
- d) Description of how the corrective action(s) resolve the identified variance for the specific measure;
- e) Explanation of the process to prevent recurrence of the identified variance (e.g., staff training, provider engagement, new initiatives);
- f) Selection of measures of success to track the effectiveness of the corrective action(s); and
- g) Timeframes for projected improvement and completion of the action plans.

4.12.10.9 DCH will publish a VBP operations manual ("VBP Operations Manual) and will be responsible for updates to such manual as determined by DCH. Contractor shall comply with the requirements set forth in the VBP Operations Manual.

4.12.10.10 The Contractor shall submit an Annual Performance and Innovation plan. The Contractor shall submit its initial plan within thirty (30) Calendar Days after receiving written notice from DCH of the VBP measures and targets but no later than thirty (30) Calendar Days prior to the Operations Start Date. The Contractor shall submit annual updates to the plan to DCH for approval within thirty (30) Calendar Days after the Governing Board's meetings or upon request from the Performance Management Team. The annual plan will be both retrospective to the prior year and prospective to the following year. The plan updates must include the following information, at a minimum:

- a) Prior year's results, including a retrospective quantitative and qualitative analysis of performance and will describe the results of key initiatives, innovation solutions implemented and lessons learned. The Contractor should include innovative solutions that were implemented in the prior year
- b) Plans for upcoming year, including objectives and strategies for achieving program goals, VBP targets and improving performance. It will also include targeted results that are measurable and innovative. The Contractor should specify milestones and accomplishments by selecting outcome measures that are specific, measureable, accountable, realistic and time dependent.

#### **4.12.13 Monitoring and Oversight Committee**

Contractor shall participate in the Georgia Families Monitoring and Oversight Committee ("GFMO") and associated subcommittees. The GFMO and associated subcommittees will assist DCH in assessing the performance of the Contractor and developing improvements and new initiatives specific to the FCAAP and DJJP. The GFMO will serve as a forum for the exchange of best practices and will foster communication and provide opportunity for feedback and collaboration between State agencies, the Contractor and external stakeholders. Members of the GFMO will be appointed by the DCH Commissioner or his designee. The GFMO meetings must be attended by Contractor decision makers defined as one of the following: Chief Executive Officer, Chief Operations Officer, or equivalent named position, and Chief Medical Officer.

### **4.17 INFORMATION MANAGEMENT AND SYSTEMS**

#### **4.17.2 Health Information Technology and Exchange**

4.17.2.4 Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).

- a) If not already participating in the GaHIN, Contractor shall sign and execute all required GaHIN participation documentation within ten (10) Calendar Days of the Execution Date (or an alternative date approved in writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such application process shall include successful completion of the GaHIN accreditation process.
- b) Contractor shall make business and technology resources available to work with the GaHIN technology vendor to

- develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH.
- c) DCH and/or its designee shall provide detailed on-boarding information for use by Contractor to establish interoperability with the GaHIN.
  - d) Costs incurred by Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.

4.17.2.5 Contractor shall make FCAAP and DJJP Member health information accessible to the GaHIN.

- a) Through their system and interoperability with the GaHIN, Contractor shall provide the following types of patient health information on FCAAP and DJJP Members including, but not limited to:
  - i. FCAAP and DJJP Member-specific information including, but not limited to name, address of record, and date of birth, race/ethnicity, gender and other demographic information, as appropriate, for each FCAAP and DJJP Member.
  - ii. Name and address of each FCAAP and DJJP Member's PCP and Caregiver.
  - iii. Name and contact information of each FC Member's or DJJP Member's DFCS Case Manager, JPSS or Residential Placement Provider, as well as non-medical personnel such as the CMO Care Coordinator, as appropriate.
  - iv. Acquisition and retention of the FCAAP or DJJP Member's Medicaid ID is required, but due to a lag in the assignment of the Medicaid ID number, the Contractor shall utilize and retain the FCAAP Member's DFCS personal identification number ("Person ID") to identify and link each Member to a unique Medicaid ID after it has been assigned. Both of these values shall be available and distinguishable in the VHR. The Contractor may choose to assign an additional unique identifier for each FCAAP and DJJP Member for internal use, if appropriate.
  - v. Description and quarterly update of each FCAAP or DJJP Member's individual Health Care Service Plan, including the plan of treatment to address the FCAAP

or DJJP Member's physical, psychological, and emotional health care problems and needs.

- vi. Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials.
- vii. Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnosis, and treatment given, including drugs prescribed.
- viii. Record of future scheduled service appointments, if available, and referrals.
- ix. Record of all diagnoses applicable to the FCAAP or DJJP Member, with emphasis on Behavioral Health diagnoses utilizing either the DSM IV-R or ICD-9 or ICD-10 national code sets as based on claims submitted.
- x. Record of current and/or past medications and doses (including psychoactive medications), and where available, the prescribing physician, date of prescription(s) and target symptoms.
- xi. Monthly progress notes from Behavioral Health exams or treatments. A Provider must submit notes at more frequent intervals if necessary to document significant changes in a FCAAP or DJJP Member's treatment or progress. Notes should include the following:
  - 1. Primary and secondary (if present) diagnosis. Assessment information, including results of a mental status exam, history or assessments used for Residential Placement purposes.
  - 2. Brief narrative summary of a FCAAP or DJJP Member's progress or status.
  - 3. Scores on each outcome rating form(s).

4. Referrals to other providers or community resources.

5. Any other relevant care information.

xii. Listing of a FCAAP or DJJP Member's known clinical history, health problems and allergies.

xiii. Complete record of all immunizations.

xiv. Listing of the FCAAP or DJJP Member's Durable Medical Equipment (DME) shall be reflected in the claims or "visits" module of the VHR.

xv. Record of notification within two (2) Business Days of the provision of Emergency Services to a FCAAP Member if the Foster Parent, Adoptive Parent, Caregiver or DFCS Staff did not provide consent.

xvi. Any utilization of an informational code set, such as ICD-9 or ICD-10, should provide the used code value as well as an appropriate and understandable code description. This is applicable to codes pertaining to a service event, health care provider, and FCAAP or DJJP Member records.

4.17.2.6 Contractor shall access the GaHIN to display FCAAP or DJJP Member health information within their system for the purpose of care coordination and management of the FCAAP and DJJP.

4.17.2.7 Contractor shall provide DCH with a list of Authorized Users who may access patient health data from Contractor's systems. DCH shall review and approve the list of Contractor's Authorized Users who may access patient health data from Contractor's systems. Contractor shall be permitted to access the GaHIN for purposes associated with this Addendum only.

#### **4.18 REPORTING REQUIREMENTS**

4.18.7 Contractor must submit the following data reports relating to the FCAAP and DJJP as indicated below based on the specifications provided by DCH. Contractor shall provide sample reports for DCH approval within thirty (30) Calendar Days of the Operations Start Date. The submission of such sample reports is dependent upon DCH's submission of report templates to Contractor.

Report	Timeframe
DCH Required Reports: All reports must be submitted in compliance with HIPAA and other applicable privacy regulations and laws.	
Utilization reports: <ul style="list-style-type: none"> <li>• ER visits</li> <li>• Medical Assessments or ESDT screenings completed for newly enrolled FC Members within the first twenty-five (25) days of enrollment in the CMO. Reports should include county, child's name, Medicaid identification number, date of service, and diagnoses. Reports should also be available upon request by DCH.</li> <li>• Medical Assessment Compliance Report</li> <li>• Trauma Assessment Compliance Report</li> <li>• Ombudsman Activity Report</li> </ul>	Monthly and Quarterly
Psychotropic Medication Utilization which shall include county, child's name, Medicaid identification number, date of service, diagnoses, and medications prescribed.	Monthly
Health Risk Screening Report	Quarterly
Member Call Center Report	Monthly and Quarterly

Report	Timeframe
<p>DHS and DJJ Management Reports: Contractor shall make the data listed below available through an interface with SHINES. Until such interface is completed, Contractor shall provide the reports directly to DCH and/or its designee.</p> <ul style="list-style-type: none"> <li>• Members with Special Health Care Needs (By county, child’s name, MHN, SSN, dates of service, and diagnoses such as visual impairments or autism)</li> <li>• Infants treated for alcohol exposure (By county, child’s name, Medicaid identification number, date of service, and diagnoses associated with the exposure)</li> <li>• Psychiatric Residential Treatment Facility (PRTF) Census Report: Census data from the prior month including the facility name, the FCAAP or DJJP Member’s name, Medicaid identification number, county, admission or discharge dates, length of stay, and diagnoses. Report should also be available as needed.)</li> <li>• FCAAP Members who receive Health Care Services out of State, including county, Member’s name, Medicaid identification number, date of service, nature of care, diagnoses. Such report must also be available upon request.</li> <li>• Court Reports (as requested)</li> </ul>	<p>Monthly</p>
<b>Kenny A Consent Decree Reporting Requirements in DeKalb and Fulton Counties</b>	
<ul style="list-style-type: none"> <li>• Number of unmet medical, dental, mental health, educational, or other service needs included in the child’s Health Care Service Plan</li> <li>• Foster Care Discharge Medical Reports (Kenny A counties) including the FC Member’s name and Medicaid identification number, county, date of service, and all outcomes relevant to the health of the child at discharge from Foster Care. Such report must also be available upon request.</li> </ul>	<p>Semi-annually</p> <p>Monthly</p>

**7.0 PAYMENT FOR SERVICES**

**7.1.1 General Provisions**

7.1.1.2 DCH will compensate the Contractor on a per member per month basis for each FC Member, AA Member and DJJP Member enrolled in the Contractor’s plan as detailed in Exhibit 2 (“FC Member, AA Member and DJJP Capitation Payments”) which is

incorporated by this reference as if fully written herein. For the first partial month of a FC Member's, AA Member's or DJJP Member's enrollment in the Contractor's plan, DCH will prorate the FC Member, AA Member and DJJP Capitation Payment on a per Calendar Day basis for the remainder of the calendar month. The FC Member, AA Member and DJJP Capitation Payment will be prorated on a per Calendar Day basis for any partial month of Member enrollment in the CMO. The number of enrolled FCAAP and DJJP Members will be determined by the records maintained in the Medicaid Member Information System (MMIS) maintained by DCH's fiscal agent. The FC Member, AA Member and DJJP Capitation Payment will be multiplied by the number of enrolled FC Members, AA Members and DJJP Members. The Contractor must provide to DCH, and keep current, its tax identification number, billing address, and other contact information. Pursuant to the terms of this Contract, should DCH assess liquidated damages or other remedies or actions for noncompliance or deficiency with the terms of this Contract, such amount shall be withheld from the prepaid, monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.

#### **14.0 CONTRACTOR: STAFFING ASSIGNMENTS & CREDENTIALING**

#### **14.3 ADDITIONAL STAFFING REQUIREMENTS FOR THE FCAAP AND DJJP**

The Contractor shall provide the following staff specific to serving the FCAAP and the DJJP:

##### **14.3.1 Care Coordination Teams**

- 14.3.1.1 The Contractor shall develop Care Coordination Teams. Each FCAAP and DJJP Member will be assigned a Care Coordination Team to provide necessary Care Coordination services.
- 14.3.1.2 The Care Coordination Team will coordinate with DFCS and DJJ to develop work flows and processes, including those related to the transmission of clinical and non-clinical FCAAP and DJJP Member information. These workflows and processes shall be subject to the approval of DCH.
- 14.3.1.3 The Care Coordinator shall provide information to and assist Providers, FCAAP Members, Foster Parents, Adoptive Parents, Caregivers, DFCS Staff, DJJP Members,

JPPS and Residential Placement Providers with access to care and coordination of services in accordance with Section 4.11.8. The Care Coordinator will ensure the Care Coordination Team has the information it needs to make timely and appropriate authorizations and referrals to meet FCAAP and DJJP Member needs. This includes, but is not limited to, contacting prior health plans and providers for information the Care Coordination Team may need to work with current providers to develop treatment plans. The Care Coordinator will ensure that approved care plans and authorizations are communicated timely to treating providers, DFCS, DJJ and other agencies as required, whether via the Virtual Health Record or by direct communications. The Care Coordinator will ensure that FCAAP and DJJP Members, Providers, Caregivers, Foster and Adoptive Parents, DFCS, DJJ, Residential Placement Providers and other agencies also have the most current information regarding community resources available to assist FCAAP and DJJP Members with meeting their needs and assist FCAAP and DJJP Members with connecting with these resources.

14.3.1.4 The Contractor shall maintain adequate Contractor staff to Member ratios and number of Care Coordination personnel and management staff having expertise in physical health, Behavioral Health, and the FCAAP and DJJP to build Care Coordination Teams. The Contractor will continue to assess the staff's ability to complete these functions in a timely nature, and will take corrective action as necessary.

14.3.1.5 Unless otherwise allowed in writing by the Department, the Contractor shall require Care Coordination Teams and any other staff positions that may have direct contact with FCAAP and DJJP Members or FCAAP and DJJP Member information to pass a background check as a condition of hire, and every two (2) years thereafter. The Contractor's staff will not be placed in contact with FCAAP or DJJP Members, nor be permitted to co-locate in DFCS or DJJ offices or access FCAAP and DJJP Member information, until the Contractor has completed the initial background check and staff has passed the background check. The Contractor shall ensure that all Contractor staff who have not passed a background check or who are alleged to have committed a criminal offence that would prohibit him or her from having contact with FCAAP and DJJP Members or accessing their information are not permitted to work

with FCAAP and DJJP Members or have access to their information.

14.3.1.6 The Contractor will build individual Care Coordination Teams for FCAAP and DJJP Members based on their specific needs and will assign the Care Coordination Team within one (1) Business Day of enrollment. The Care Coordination Team will be updated as necessary as determined by the FCAAP Member's and DJJP Member's Health Care Service Plan. Contractor staff available to participate in Care Coordination Teams shall include at a minimum:

- a) Masters level licensed social worker or counselor
- b) Nurse Care Manager
- c) Care Coordinator

14.3.1.7 The Care Coordination Team shall involve and include the preferences of the FCAAP or DJJP Member and the family (Adoptive Parent(s), Foster Care Parent(s), Caregiver and/or biological family members as indicated by DFCS or DJJ) in Care Coordination processes, care planning, and care plan implementation) in adherence to System of Care youth- and family-driven principles.

#### 14.3.2 Ombudsman Staff

14.3.2.1 The Contractor must offer FCAAP and DJJP Members an Ombudsmen Liaison and Ombudsman Coordinator during the entire Contract term.

14.3.2.2 Contractor must have at a minimum one (1) Ombudsmen Liaison and one (1) Ombudsman Coordinator. The Contractor must consider and monitor current enrollment levels when evaluating the number of Ombudsman Liaisons necessary to meet FCAAP and DJJP Member needs. The Contractor must also at least annually evaluate the Ombudsman Liaison and Coordinator positions, work plan(s) and job duties, and allocate an additional FTE Ombudsmen position or positions to meet Ombudsmen duties based on increases in the number of FCAAP and DJJP Members.

14.3.2.3 The CMO Ombudsmen staff is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration

includes working with DCH staff on issues of access to health care services, and communication and education for the FCAAP, the DJJP, Providers, Caregivers, Foster and Adoptive Parents, State agencies and Residential Placement Providers. The Contractor shall provide monthly detailed reports on activities associated with the CMO's responsibilities detailed in Section 14.3.2.5 of this Addendum.

14.3.2.4. To meet the requirements for the Ombudsman Liaison and Coordinator positions statewide, the Department encourages the Contractor to contract or have a formal memorandum of understanding for advocacy and/or translation services with associations or organizations that have culturally diverse populations within the Contractor service area. However, the Contractor has primary responsibility for the Ombudsman Liaison and Coordinator positions. The Contractor must monitor the effectiveness of the associations and agencies under contract and may alter the contract(s) with written notification to the Department.

14.3.2.5 The Ombudsman Liaison and Ombudsman Coordinator must be knowledgeable and have experience working with FCAAP and DJJP, and shall have adequate time to advocate for FCAAP and DJJP Members. Responsibilities of the CMO Ombudsman staff shall include:

- a) Investigate and resolve access and cultural sensitivity issues identified by Contractor staff, State agency staff, providers, advocating organizations, FCAAP and DJJP Members, Foster Parents, Adoptive Parents, Caregivers and Residential Placement Providers.
- b) Monitor complaints to identify trends or specific problem areas of access and care delivery.
- c) Recommend policy and procedural changes to Contractor needed to improve FCAAP and DJJP Member access to care.
- d) Provide ongoing input to the Contractor on how changes in the Contractor Provider network will affect FCAAP and DJJP Members access to medical care and continuity of care.

## 22. **TERMINATION OF CONTRACT**

### 22.8 **TERMINATION PROVISIONS FOR ADDENDUM #1 SERVICES**

## **22.8.1 Termination for Convenience**

### **22.8.1.1 Termination for Convenience by Contractor**

Contractor may terminate FCAAP/DJJP Addendum #1 services for convenience and without cause upon providing one hundred and eighty (180) Calendar Days written notice. Such termination for convenience in accordance with this paragraph shall not be deemed a breach of the Contract. In such event, the Contract shall not be affected by this termination and shall renew in accordance with DCH's exercise of its renewal option. Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by DCH.

### **22.8.1.2 Termination for Convenience by DCH**

DCH may terminate FCAAP/DJJP Addendum #1 services for convenience and without cause upon thirty (30) Calendar Days written notice. Such termination for convenience in accordance with this paragraph shall not be a breach of the Contract. The Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by DCH.

## **22.8.2 Termination by Default**

In the event DCH determines that the Contractor has defaulted by failing to carry out the substantive terms of the Contract with respect to the populations served by Addendum #1, DCH may terminate FCAAP/DJJP Addendum #1 services in addition to or in lieu of any other remedies set out in this Contract or available by law. Prior to the termination, DCH will:

- Provide written notice of the intent to terminate FCAAP/DJJP Addendum #1 services at least thirty (30) Calendar Days prior to the termination date, the reason for the termination, and a time and place of a hearing to give the Contractor an opportunity to appeal the determination and/or cure the default; and
- Provide written notice of the decision affirming or reversing the proposed termination of FCAAP/DJJP Addendum #1 services, and for an affirming decision, the effective date of the termination.

Notwithstanding the above, a default under this Section 22.2.3 shall not be deemed a default of the Contract as a whole. Any remedies taken with

respect to such default shall apply specifically to the services provided pursuant to Addendum #1.

### **22.8.3 Termination Procedures**

Upon receipt of notice of termination of FCAAP/DJJP Addendum #1 services, as directed by DCH, the Contractor shall:

- Submit a termination plan to DCH for review and approval;
- Ensure the efficient and orderly transition of FCAA and DJJP members from coverage under this Addendum #1 to coverage under any new arrangement developed by DCH;
- Take such action as may be necessary, for the protection and preservation of any and all property or information related to this Addendum #1 that is in the possession of Contractor and in which DCH has or may acquire an interest;
  1. Promptly make available to DCH any and all records, whether medical or financial, related to the Contractor's activities undertaken pursuant to this Addendum #1. Such records shall be provided at no expense to DCH; and
  2. Provide any other information as outlined in Section 22.6 of the Contract.

**IV.** The Parties agree that they have assumed an obligation to perform the covenants, agreements, duties and obligations of the Contract, as modified and amended herein, and agree to abide by all the provisions, terms, price and conditions contained in the Contract as modified and amended.

**V.** This Addendum shall be binding and inure to the benefit of the parties hereto, their heirs, representatives, successors and assigns. In the event of a conflict between the provisions of this Addendum and the Contract, the provisions of this Addendum shall take precedence and control.

**VI.** It is understood by the Parties hereto that, if any part, term, or provision of this Addendum or the Addendum in its entirety is held to be illegal or in conflict with any law of this State, then DCH, at its sole option, may enforce the remaining unaffected portions or provisions of this Addendum or of the Contract and the rights and obligations of the Parties shall be construed and enforced as if the Contract or Addendum did not contain the particular part, term or provision held to be invalid.

**VII.** This Addendum shall become effective as stated herein and shall remain effective for so long as the Contract is in effect.

**VIII.** This Addendum shall be construed in accordance with the laws of the State of Georgia.

**IX.** Each Party has had the opportunity to be represented by counsel of its choice in negotiating this Addendum. This Addendum shall therefore be deemed to have been

negotiated and prepared at the joint request, direction, and consideration of the Parties, at arms' length, with the advice and participation of counsel, and will be interpreted in accordance with its terms without favor to any Party.

- X. This Addendum may be signed in any number of counterparts, each of which shall be an original, with the same effect as if the signatures thereto were upon the same instrument. Any signature below that is transmitted by facsimile or other electronic means shall be binding and effective as the original.

*(Signatures on following page)*

**SIGNATURE PAGE**

**IN WITNESS WHEREOF**, the Parties state and affirm that they are duly authorized to bind their respective entities designated below as of the day and year indicated.

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**

Clyde L. Reese III  
Clyde L. Reese III, Esq., Commissioner

7/22/2013  
Date

Jerry Dubberly  
Jerry Dubberly, Medicaid Division Chief

7/22/13  
Date

**AMGP GEORGIA MANAGED CARE COMPANY, INC.  
D/B/A AMERIGROUP COMMUNITY CARE**

BY: Estimote  
Signature

07/18/2013  
Date

Tunde SoTunde  
Print/Type Name

Chief Executive Officer  
\*TITLE

\* Must be President, Vice President, CEO or Other Officer Authorized to Execute on Behalf of and Bind the Entity to a Contract

FILED IN CLERK'S OFFICE  
U.S.D.C. Atlanta

OCT 28 2005

LUTHER D. THOMAS, Clerk  
By:  Deputy Clerk

-----X  
 KENNY A., by his next friend, )  
 Linda Winn; et al., )  
 )  
 Plaintiffs, )  
 )  
 vs. )  
 )  
 SONNY PERDUE, in his official )  
 capacity as Governor of the )  
 State of Georgia; et al. )  
 )  
 Defendants. )  
 -----X

Civil Action No. 1: 02-CV- 1686-MHS

**CONSENT DECREE**

**Table of Contents**

1. INTRODUCTION ..... 1

2. DEFINITIONS ..... 1

3. PRINCIPLES ..... 3

4. PLANNING ..... 5

    A. For Children Entering Placement after the Entry of the Consent Decree ..... 5

    B. For Children who have Reached their Sixth Month in Care after the Entry of the Consent Decree, and for the Remaining Period of Time While in DFCS Custody ..... 7

    C. For Children who Reach their Thirteenth Month in Care after the Entry of the Consent Decree, and for the Remaining Period of Time While in DFCS custody ..... 9

    D. For Children who have Already Reached their Thirteenth Month in Care at the Time of the Entry of the Consent Decree..... 10

    E. For all Children for whom Adoption has been Identified as the Goal ..... 10

    F. For Children who Reach their Eighteenth Month in Care after the Entry of the Consent Decree, and Those who have been in Care for Eighteen Months or More upon Entry of the Consent Decree, and for the Remaining Period in Time while they are in DFCS Custody ..... 11

5. PLACEMENT ..... 12

    A. Identification of Needs and Placement Options ..... 12

    B. Reimbursement Rates for Placements ..... 13

    C. Ensuring that the Placement Process Secures the Most Appropriate Placement for All Children ..... 15

    D. Visitation ..... 19

6. HEALTH SERVICES TO CHILDREN ..... 20

7.	SINGLE STATEWIDE AUTOMATED CHILD WELFARE INFORMATION SYSTEM .....	22
8.	CASELOADS .....	22
9.	SUPERVISION OF CONTRACT AGENCIES .....	23
10.	TRAINING .....	25
11.	FOSTER PARENT SCREENING, LICENSING, AND TRAINING .....	26
12.	ABUSE IN CARE INVESTIGATIONS .....	28
13.	CORRECTIVE ACTIONS .....	30
14.	MAXIMIZATION OF FEDERAL FUNDING .....	31
15.	OUTCOME MEASURES .....	31
16.	ACCOUNTABILITY .....	38
17.	ENFORCEMENT .....	39
18.	QUALITY ASSURANCE .....	42
19.	DURATION OF DECREE .....	42
20.	MISCELLANEOUS PROVISIONS .....	43
21.	RELIEF FOR NAMED PLAINTIFFS .....	46
22.	ATTORNEYS' FEES AND EXPENSES OF LITIGATION .....	47

**1. INTRODUCTION**

Plaintiffs brought this class action lawsuit by the filing of a complaint on June 6, 2002, in the Superior Court of Fulton County, seeking declaratory and prospective injunctive relief against Defendants based upon alleged violations of constitutional and statutory rights arising out of the operation of foster care systems in Fulton and DeKalb Counties. Plaintiffs alleged both federal and state law claims. All Defendants joined in removing the case to this Court, invoking the Court's federal question jurisdiction and denying that their operation of the Fulton and DeKalb County foster care systems violated any constitutional or statutory guidelines.

In order to resolve all issues pending between these parties without the expense, risks, delays and uncertainties of a trial and any appeals that might follow such a trial, Plaintiffs and State Defendants agree to the terms of this Consent Decree as stated below. By entering into this Consent Decree, State Defendants do not admit to the truth or validity of any claim made against them by Plaintiffs. State Defendants also do not speak for the Georgia General Assembly, which has the power under Georgia law to determine the appropriations for the State's programs for child welfare. However, State Defendants acting under their existing authority agree that it will be a condition of their conduct of the child welfare program covered by this Consent Decree to comply with the Consent Decree. If Plaintiffs seek a judicial remedy for State Defendants' noncompliance in accordance with Section 17 of this Consent Decree, and at any stage of subsequent enforcement proceedings State Defendants assert insufficient funds as a legal excuse, Plaintiffs may move to rescind their consent to the Consent Decree. State Defendants submit to the enforcement of this Consent Decree to the full extent permitted by law.

All parties acknowledge that the Court has jurisdiction over this case and authority to enter this Consent Decree and to enforce its terms. The Court shall retain jurisdiction of this matter to enforce this Decree in accordance with its terms.

**2. DEFINITIONS APPLICABLE TO CONSENT DECREE**

For purposes of this Consent Decree, the following terms have the meaning indicated below.

- A. "Adoptive placement" means the interval during which a child is placed with a prospective adoptive family following the signing of the appropriate adoptive placement agreement form, but before the entry of the adoption decree by the court.
- B. "Business days" mean every day except Saturdays, Sundays and legal holidays, pursuant to O.C.G.A. § 1-4-1.
- C. "Calendar days" mean every day including Saturdays, Sundays, and legal holidays.

- D. "Child" or "children" or "class member children" or "class members" shall mean a child or children who have been, are, or will be alleged or adjudicated deprived who (1) are or will be in the custody of any of the State Defendants; and (2) have or will have an open case in Fulton County DFCS or DeKalb County DFCS.
- E. "Commissioner" means the Commissioner of the Georgia Department of Human Resources.
- F. "Corporal punishment" means any physical punishment of a child that inflicts pain.
- G. "Day" or "days" mean calendar days unless otherwise indicated.
- H. "DeKalb DFCS" means the DeKalb County Department of Family and Children Services.
- I. "DFCS" when used alone means State DFCS.
- J. "DHHS" means the United States Department of Health and Human Services.
- K. "DHR" means the Georgia Department of Human Resources.
- L. "Discipline or Other Serious Foster Care Violation" means and includes those acts or situations by the caregiver that pose an immediate or potential risk to the safety or well-being of the child in care. These may include, but are not limited to, inappropriate disciplinary measures (both physical/corporal and emotional), violations of supervision or other safety requirements that pose serious risk factors to the child.
- M. "EPSDT" means the Early and Periodic Screening, Diagnosis and Treatment Program for individuals under 21 years of age contained in Title XIX of the Social Security Act, as amended.
- N. "Fulton DFCS" means the Fulton County Department of Family and Children Services.
- O. "Georgia Health Check Program" means Georgia Medicaid's well-child or preventive health care program adopted pursuant to EPSDT, and shall contain such components as they exist in the Georgia Health Check Program as of February 1, 2005.
- P. "Governor" means the Governor of the State of Georgia.

- Q. “Legal guardianship” means the appointment of an individual as a legal guardian for a child as authorized by either the probate court under O.C.G.A. Title 29 or the juvenile court under O.C.G.A. Chapter 15-11.
- R. “One episode of foster care” means the period of time that a child is in foster care from the date of removal from the home until the child is discharged from DFCS custody, except that a runaway does not trigger a new episode of foster care.
- S. “Permanent legal custody” means custody granted in accordance with an order of the superior court or the juvenile court which places a child in the custody of an individual or individuals until the child reaches 18 years of age.
- T. “Permanent placement with relatives” means placement of a child with a relative who is willing to assume long-term responsibility for the child but has reasons for not adopting the child or obtaining guardianship or permanent legal custody, and it is in the child’s best interests to remain in the home of the relative rather than be considered for adoption, permanent legal custody, or guardianship by another person. In such circumstances, there shall be in place an agreement for long-term care signed by DFCS and the relative committing to the permanency and stability of this placement unless it is necessary to disrupt the long-term placement.
- U. “State DFCS” means the Division of Family and Children Services of the Georgia Department of Human Resources.
- V. “State Defendants” means Defendants Sonny Perdue (in his official capacity as Governor of Georgia), the Georgia Department of Human Resources, B.J. Walker (in her official capacity as Commissioner of the Georgia Department of Human Resources), Fulton County Department of Family and Children Services, Debra Keyes (in her official capacity as Administrator of Fulton DFCS), DeKalb County Division of Family and Children Services, and Walker Solomon (in his official capacity as Director of DeKalb DFCS).
- W. “Suspected abuse or neglect” means being based on reasonable cause to believe that a child may have been abused or neglected.
- X. “Suspected corporal punishment” means being based on reasonable cause to believe that corporal punishment may have been used on a child.

**3. PRINCIPLES**

The parties to this Consent Decree agree that the following are desired principles that serve as the goals of Georgia’s child welfare system and are not separately enforceable standards

or provisions under which State Defendants' conduct under the terms of this Consent Decree shall be measured.

1. Georgia's child welfare system must actively promote and support the opportunity for children to grow up within a safe, nurturing family, either their biological family or, if that is not possible, within an adoptive family.
2. When children are in foster care, all non-destructive family ties should be maintained and nurtured. If appropriate, children should be placed with relatives who are able to provide a safe, nurturing home for them. Reasonable efforts should be made to place siblings together, and relationships with relatives and siblings should be facilitated and maintained by the child welfare agency, if it is in the child's best interest to do so.
3. Foster care should be as temporary an arrangement as possible, with its goal being to provide a permanent home for the child as quickly as possible. In making the determination about what plans and services will best meet this goal, the child's interests must be paramount.
4. The state has primary responsibility for the care and protection of children who enter the foster care system. Insofar as it relies on private contractors to assist in meeting this responsibility, it should only do so according to standards set by and rigorously monitored by the state.
5. All children in need of child welfare services should receive full and equal access to the best available services, regardless of race, religion, ethnicity, or disabilities.
6. Children in foster care placement should be in the least restrictive, most family-like setting possible, and the state should make reasonable efforts to avoid the use of non-family settings for children, particularly young children.
7. Children in foster care placement should have stable placements that meet their needs and the services necessary to address both the trauma of foster care placement and the problems surrounding their removal from their family. Children in foster care placement should have placements that meet their needs and the services necessary to promote the stability of their placements.
8. The Department of Human Resources, acting through its Commissioner, has the authority and responsibility to deliver foster care services by the means it deems appropriate consistent with the requirements of law.

4. **PLANNING**

A. **For children entering placement after the entry of the Consent Decree**

1. Within 24 hours after a child's 72-hour hearing, DFCS will make a referral to a Comprehensive Child and Family Assessment ("CCFA") provider to initiate an assessment for the child.
2. An initial Family Team Meeting will be held within 3-9 days after a child comes into foster care.
  - a. Barring exigent circumstances, the Family Team Meeting participants shall include the DFCS case manager and supervisor and, if applicable, the case manager from the private contract agency which has the child in placement. DFCS will make reasonable efforts to ensure the attendance of the parents and the child (if 12 or older), and other persons significant to the family if appropriate, at the Family Team Meeting. The Family Team Meeting may also include the CCFA provider, relatives, and other persons significant to the family. A Family Team Meeting shall not be cancelled solely because of the absence of any participant as long as the required determinations can be made with the participants who are in attendance. Efforts to ensure the attendance of participants shall be documented in the child's case file.
  - b. Participants at the Family Team Meeting will identify:
    - i. The needs of the children and parents.
    - ii. Goals for meeting those needs.
    - iii. Steps for meeting the goals.
    - iv. Strengths of the family members with regard to meeting the needs of the child, the child's parents, and possible placements for the child.
  - c. At the Family Team Meeting, DFCS will make the following determinations and shall identify and ensure the provision of necessary services to achieve such determinations:
    - i. Whether the child can be safely returned home.

- ii. Whether any evaluations are necessary of the child and/or parents to ensure the development of an appropriate case plan.
  - iii. If the child cannot safely be returned home, whether there is an appropriate relative with whom the child can be placed.
  - iv. If the child has siblings in placement and the siblings are not placed together, the identity of necessary steps to place the siblings together in accordance with Section 5.C.4.d, and necessary steps to ensure sibling visitation.
  - v. If the child is of school age, the identity of steps that can be taken to ensure that the child remains enrolled in school, does not miss school days extensively, and does not have to change schools if at all possible.
  - vi. The frequency with which visiting will take place between the child and the child's parents and significant family members.
- d. If DFCS is unable to secure the parents' attendance at a meeting after the child is placed, the meeting shall nevertheless be held with the other participants, and DFCS shall make reasonable efforts to notify and review with the parents the goals outlined at the meeting, as soon thereafter as possible.
  - e. The outcomes of the Family Team Meeting will be reported to the Multidisciplinary Team ("MDT") for use at its meeting.
3. Within 25 days of a child's placement in foster care, an MDT Meeting will be held. Barring exigent circumstances, the MDT Meeting participants shall include the DFCS case manager and supervisor and, if applicable, the case manager from the private contract agency which has the child in placement. DFCS will make reasonable efforts to ensure the attendance of the parents and the child, if appropriate, at the MDT Meeting. The MDT Meeting may also include relatives, foster parents/placement providers, DFCS representatives, school representatives, therapists, mental health professionals, the CCFA provider, medical professionals, representatives from Public Health, and judicial representatives. An MDT Meeting shall not be cancelled solely because of the absence of any participant as long as the required determinations can be made with the participants who are in attendance. Efforts to ensure attendance of participants in the MDT shall be documented in the child's case file.

- a. The MDT will review the CCFA and make recommendations concerning the case plan and the services to be provided to the child and the family, including but not limited to the issues addressed at Family Team Meetings as described in section A.2. above, as well as (i) appropriateness of education (including special education); (ii) the creation and appropriateness of independent living plans and services for children 14 and older; and (iii) an appropriate permanency goal for the child and the services necessary to implement that goal. The case plan will be an outgrowth of the CCFA assessment and shall be developed at the MDT meeting.
    - b. DFCS shall identify and ensure the provision of necessary services to achieve the determinations made at the MDT meeting, and contained in the child's case plan, unless and until altered by the Juvenile Court.
  4. Within 30 days from the date of placement, a case plan with all required elements will be submitted to the Juvenile Court for approval. Case plans with all required elements and service needs shall be reviewed, updated and revised (with submission to the Juvenile Court for approval) whenever necessary, including after the MDT meeting, and at every six-month review and 12-month permanency review.
  5. DFCS will include training on facilitating family team meetings as part of its pre-service training. DFCS shall have family team specialists who will attend and facilitate all family team meetings. The Fulton County Administrator and the DeKalb County Director will designate staff to follow up on the results of all family team meetings.
- B. For children who have reached their sixth month in care after the entry of the Consent Decree, and for the remaining period of time while in DFCS custody**
1. Plaintiffs and State Defendants intend that within six months of the child's placement in foster care, and every six months thereafter, the child's case plan shall be reviewed by the Judicial Citizen Review Panel (JCRP) and/or the Juvenile Court, as long as the child remains in the custody of Fulton or DeKalb DFCS.
  2. Plaintiffs and State Defendants desire that the persons who participate at each JCRP or Juvenile Court review shall include the parents, the child, pre-adoptive parents or relatives providing care for the child, foster parents/placement providers, the DFCS case manager, the private provider case manager (if applicable), the case supervisor, other DFCS representatives, the CCFA providers, medical and mental health professionals, representatives from Public Health and the child's school,

and other professionals having specific knowledge or information relative to the child's case. The parties further desire that a JCRP or Juvenile Court review shall not be cancelled solely because of the absence of any participant as long as the required determinations can be made with the participants who are in attendance.

3. Plaintiffs and State Defendants intend that, at each six month case plan review, the JCRP and/or the Juvenile Court shall evaluate the following:
  - a. The necessity and appropriateness of the child's placement;
  - b. Whether reasonable efforts have been made to obtain permanency for the child;
  - c. The degree of compliance with the specific goals and action steps set out in the case plan;
  - d. Whether any progress has been made in improving the conditions that caused the child's removal from the home; and
  - e. Whether changes need to be made to the case plan, including a change in the permanency goal and the projected date when permanency for the child is likely to be achieved, or changes or the addition of any services needed by the child.
4. Plaintiffs and State Defendants intend that, if the JCRP conducts the case plan review, the panel will submit a report to the Juvenile Court, which shall include the panel's findings and recommendations, as well as the findings and recommendations of Fulton or DeKalb DFCS, along with Fulton or DeKalb DFCS' proposed revised plan for reunification or other permanency plan.
5. If the Juvenile Court conducts a review of the case plan, Fulton or DeKalb DFCS shall submit its recommendations to the court regarding a proposed revised plan for reunification or other permanency plan.
6. Following a JCRP or a Juvenile Court review, the Juvenile Court may adopt a revised case plan, taking into consideration recommendations made by Fulton or DeKalb DFCS, the JCRP, and/or the parents and enter a supplemental order in accordance with Chapter 11 of Title 15 of the Official Code of Georgia Annotated.

7. DFCS shall identify and ensure the provision of necessary services to achieve the determinations made following the actions of the Juvenile Court.
8. If deemed necessary by the case manager or case supervisor, additional meetings involving family members and professionals to discuss the implementation of the case plan may be conducted at any time.
9. If the Juvenile Court does not convene a six-month JCRP or Juvenile Court review within 45 days from the date that is six months after the last review, DHR/DFCS shall cause to be filed with the Juvenile Court a request for an immediate JCRP or Juvenile Court six-month review.
10. If the Juvenile Court does not convene a 12-month JCRP or Juvenile Court permanency review within 45 days from the date that is 12 months after the last permanency review, DHR/DFCS shall cause to be filed with the Juvenile Court a request for an immediate JCRP or Juvenile Court 12-month permanency review.

C. For children who reach their thirteenth month in care after the entry of the Consent Decree and for the remaining period in time while in DFCS custody

1. By the end of the 13<sup>th</sup> month after a child has been in placement, Fulton and DeKalb DFCS will forward a Permanency Report to the State Social Services Director. Prior to the forwarding of the Permanency Report, another Family Team Meeting will be convened in accordance with Paragraph A.2. of this Planning Section. This Family Team Meeting will consider the issues listed in Paragraph A.3.a. of this Section. The results of such Family Team Meeting shall be forwarded to the Social Services Director with the Permanency Report. The Permanency Report will include a profile description of the child, the case plan, a list of impediments for achieving permanency, the CCFA, and a list of steps to be taken by the county to achieve permanency. The State Social Services Director or his designee shall review the Permanency Report within five business days of its receipt, and shall either concur with the report or refer the case for a county/state staffing.
2. A county/state staffing shall be held no later than ten days after the State Social Service Director's decision.
3. Barring exigent circumstances, the county/state staffing shall include the Fulton or DeKalb County case manager and supervisor, regional adoption coordinator, regional field specialist, county program administrator, and State Social Services Director or his designee. A county/state staffing

shall not be cancelled solely because of the absence of any participant as long as the required determinations can be made with the participants who are in attendance.

4. The county/state staffing shall establish a plan to move the child toward permanency, and the State Social Services Director shall monitor the plan. DHR/DFCS shall identify and ensure the provision of necessary services to achieve the determinations made following the county/state staffing.
5. Additional meetings shall be held at any time when deemed necessary by the State Social Services Director or by the county case manager and supervisor, and may include those participants from the initial county/state staffing, provided that at least one additional county/state staffing meeting shall be conducted by the end of the 25<sup>th</sup> month after a child remains in placement. DHR/DFCS shall identify and ensure the provision of necessary services to achieve the determinations made following any subsequent county/state staffing.
6. If the Juvenile Court orders aftercare supervision, the child's case manager shall make monthly visits with the child following discharge from foster care for the period of time specified by the Juvenile Court. DFCS will determine whether additional services are necessary to ensure the continued success of the discharge.

D. For children who have already reached their 13<sup>th</sup> month in care at the time of the entry of the Consent Decree

Within 120 days from the entry of the Consent Decree, Fulton and DeKalb DFCS will submit a Permanency Report for all children who have reached their 13<sup>th</sup> month in care at the time of the entry of the Consent Decree to the State Social Service Director for a permanency review as provided in Paragraphs 1-4 of Section C, above.

E. For all children for whom adoption has been identified as the goal

1. DHR shall determine whether the foster parent(s) are appropriate potential adoptive parents and if so, determine whether they are interested in adoption, and shall make known to the foster parents the availability of adoption assistance. Foster children who meet the eligibility criteria for the program, and who are special needs children, as defined in 42 U.S.C. § 673 and DFCS policy, shall be eligible to receive an adoption assistance subsidy. If the child is eligible, DHR/DFCS will determine the child's adoption assistance subsidy based on the needs of the child. Under no circumstance shall the subsidy amount exceed the family foster care

maintenance payment that the child would be eligible to receive at the time of the adoptive placement. The amount and term of the adoption assistance subsidy shall be determined prior to the signing of the adoptive placement agreement.

2. For children for whom the foster parent(s) are either inappropriate or uninterested in becoming adoptive parents, and for whom adoptive parents are not otherwise available, DFCS shall undertake child-specific adoption recruitment. DFCS will not use as a documented compelling reason for not filing a petition for termination of parental rights the fact that there is an absence of an adoptive resource for the child.
3. Where appropriate, DFCS shall make available post-adoption services to support and stabilize adoptions for a period of at least 18 months following adoption finalization.

F. For children who reach their 18th month in care after the entry of the Consent Decree, and those who have already been in care for 18 months or more upon the entry of the Consent Decree, and for the remaining period in time while they are in DFCS custody

1. DHR/DFCS will establish a Specialized Case Manager position to focus on and to remove barriers to permanence for children in DFCS custody for 18 months or longer. The maximum caseload for any person serving in the Specialized Case Manager position will be 12.
2. Within 60 days of the entry of this Consent Decree, all children who have already reached their 18<sup>th</sup> month in care upon the date of entry of this Consent Decree shall be assigned a Specialized Case Manager as described in this Section F. Beginning 60 days after the entry of this Consent Decree and continuing thereafter, all children that reach their 18<sup>th</sup> month in care shall be assigned a Specialized Case Manager as described in this Section F. The Specialized Case Manager, once assigned to a child, shall be the sole responsible DFCS case manager for the child. To the extent possible, the child's DFCS assignment to a particular Specialized Case Manager, once made, shall continue for the remaining period of time while the child is in DFCS custody.
3. The Specialized Case Manager provided for in this paragraph shall do the following as appropriate for the children in this Section F:
  - a. Convene meetings, access funding, and make independent decisions in order:

- i. To determine the continuing appropriateness and effectiveness of the child's permanency goal and to seek court approved change of the goal if appropriate;
  - ii. To determine the continuing appropriateness and effectiveness of the services being provided to the child; whether new or different services are necessary for the child; and, if so, by whom and when they will be provided;
- b. Partner with the county Independent Living Coordinator to determine whether adequate independent living services and plans are being provided for all children age 14 and older;
- c. Evaluate the continuing appropriateness and effectiveness of services to biological parents and relatives, and determine whether new or different services are necessary to assist the biological parents and relatives in achieving the child's permanency goal;
- d. Consult with public and private professionals and take all steps necessary to ensure the provision of services leading to the child achieving permanency;
- e. No sooner than 30 days prior to discharge, regardless of the discharge destination, convene a special discharge planning meeting that shall be held to ensure that appropriate services and plans are in place to ensure a successful discharge.

## 5. PLACEMENT

### A. Identification of Needs and Placement Options

1. DFCS agrees to obtain, by means of a Request for Proposal, a qualified external expert to conduct a needs assessment in Fulton County and DeKalb County. The needs assessment shall be based on the standards for the placement of children identified in Section 5.C. below, as applied to factual data about individual children's needs obtained in Comprehensive Child and Family Assessments and case plans pursuant to Section 4 of this Consent Decree, and as applied to other factual data relevant to determining the needs of children in the Plaintiff Class. The needs assessment shall identify what new and/or different placements and related services, if any, are needed to provide substantially for the care of the Plaintiff Class.

2. Counsel for Plaintiffs and DFCS will jointly review the responses to the Request for Proposal, which shall be drafted to accomplish the purposes of this section of the Consent Decree, and shall jointly agree to the expert. The expert shall be selected within 90 days from the entry of this Consent Decree, and shall be selected in accordance with the procurement laws of the State of Georgia.
3. The needs assessment shall be completed no later than 120 days after the expert has been retained.
4. DFCS shall provide all of the placements and related services identified in the needs assessment, except that the expert will recommend the priority for implementing the findings of the needs assessment, based on the severity of the needs of the children whose needs are currently unmet or inadequately met. DFCS will phase in the implementation of the findings of the needs assessment, with the findings substantially implemented no later than 12 months after the completion of the needs assessment.

B. Reimbursement Rates for Placements

1. Basic foster care maintenance payments:
  - a. With regard to the provision of basic foster family services, including kinship care (limited to kin who are approved foster parents), effective July 1, 2005, DHR/DFCS shall set and pay the following basic foster care maintenance payments: for each child ages 0-6, \$13.78; for each child ages 7-12, \$15.50; and for each child age 13 and older, \$17.75. DHR/DFCS shall ensure that this rate is paid to all foster parents providing basic foster family services, regardless of whether they are directly supervised by DFCS or directly supervised by private providers. These rates shall be uniform.
  - b. The Commissioner shall propose a periodic increase in the basic foster care maintenance payments referenced in subparagraph a., above, effective in succeeding fiscal years, based upon discussions with affected foster parent groups and consideration of whether an increase in any amount for any age group is needed to adequately compensate for basic foster care for the relevant age groups. Class counsel shall be notified of the amount of any such increase in the basic foster care maintenance payments within 30 days of the effective date of such change in payment.
  - c. Beginning July 1, 2007, and continuing until the termination of this Consent Decree as provided in Section 19, if Class Counsel forms a

good faith opinion that the amounts paid by DHR for basic foster care maintenance payments are insufficient to adequately compensate for foster family care, then Class Counsel may seek judicial remedies under the provisions set forth in Section 17 of this Consent Decree, and shall have the burden to show that the payment structure set by the Commissioner fails to adequately compensate for basic foster care for a particular age group or groups.

2. Within 60 days after the parties sign the Consent Decree, DHR/DFCS shall establish a Reimbursement Rate Task Force. The Reimbursement Rate Task Force shall accept and shall not revise the base-level rate for the provision of family foster care services (including kinship care) as defined in subsection 1 above. The Reimbursement Rate Task Force shall create a rate structure based on measurable outcomes for all children in foster care (excluding basic, non-therapeutic foster family care) based on the reasonable cost for achieving these outcomes. The Reimbursement Rate Task Force shall examine the Level of Care system and make recommendations for either revising or replacing it, and shall also consider the results of various pilot programs being carried out across the state. The rate structure established by the Reimbursement Rate Task Force must comply with Title IV-E and Medicaid funding guidelines so that DHR/DFCS can draw down such funds.
3. The rate structure established by the Reimbursement Rate Task Force shall serve as the basis for performance-based contracting, and shall be phased in beginning 90 days after the Reimbursement Rate Task Force issues its findings, provided that the rates fixed by the Commissioner must be fully implemented in the contracting cycle beginning July 1, 2007.
4. Beginning in the July 1, 2006 contracting cycle and continuing thereafter, DHR/DFCS shall ensure that all approved foster parents (regardless of whether they are supervised directly by DFCS or by private providers) receive the same reimbursement rate for a given level of service.
5. If DHR/DFCS directly supervises any approved foster homes that provide therapeutic services or operates any specialized group facilities, those approved foster parents or group facilities shall be paid at the same rate. All specialized group facilities shall be paid at the same rate for the same level of services.
6. The Reimbursement Rate Task Force shall be composed of the following members: James L. Kunz, Howard A. Peters III, and Becky Butler. The Task Force may meet when necessary in order to accomplish its duties, and shall work to finalize its recommendations in the most efficient and

economical manner possible. The Reimbursement Rate Task Force shall have access to data, documents and information needed, and shall otherwise have the support needed to carry out its duties. DHR shall reimburse the members of the Task Force for approved expenses and fees incurred in performing its duties, in accordance with state regulations.

7. The Task Force shall make every effort to present its findings no later than 120 days after the entry of the Consent Decree, unless the Task Force requests and the parties consent to an extension for the presentation of findings. The Task Force shall include recommendations on the priority for implementing its findings.

C. Ensuring that the placement process secures the most appropriate placement for all children.

1. Children for whom placement has determined to be necessary shall receive an assessment of their placement needs by a qualified professional no later than 30 business days after the child enters placement. The assessment shall include the initial physical health, dental health, and mental health screenings referred to in Section 6, Paragraph A. of this Consent Decree and all other required elements.
2. As soon as the placement assessment is completed, the child's current placement shall be reevaluated to ensure that it meets the child's needs and if not a new placement shall be obtained as quickly as practicable.
3. DHR shall ensure that each county has a placement process in place, including placement specialists with knowledge of both the resources available to enable the child to remain at home safely to avoid the need for placement if possible and of the placement resources, including the specific placement (foster home or group setting) available in a contract agency and its suitability for the particular child needing placement to reasonably ensure that each child receives the most appropriate placement for his/her individual needs.
4. Children shall be placed according to the following standards:
  - a. Children shall be placed in accordance with their individual needs, as determined by the needs assessment in paragraph C.1 of this section, taking into account the child's needs to be placed as close to home and community as possible, the need to place siblings together, the DHR/DFCS preference for placement with relative resources, and the need to place children in the least restrictive, most home-like setting.

- b. Children shall be placed within their own county or within 50 miles of the home from which they were removed. This provision shall not apply if (i) the child's needs are so exceptional that they cannot be met by a family or facility within their own county or within 50 miles of the home from which they were removed, (ii) the child is placed through the ICPC consistent with its terms, (iii) the child is appropriately placed with relatives, or (iv) the child is in an adoptive placement.
- c. No child shall be placed in an emergency or temporary facility or any other foster home or group facility beds used on a temporary basis, for more than 30 days. Children shall not be placed in more than one emergency or temporary facility within one episode of foster care. No child shall spend more than 23 hours in a county DFCS office, or any facility providing intake functions, including but not limited to the current Children's Center in DeKalb County and the Fulton Family Resource Center in Fulton County.
- d. Siblings who enter placement at or near the same time shall be placed together, unless doing so is harmful to one or more of the siblings, one of the siblings has such exceptional needs that can only be met in a specialized program or facility, or the size of the sibling group makes such placement impractical notwithstanding diligent efforts to place the group together. If a sibling group is separated at the initial placement, the case manager shall make immediate efforts to locate or recruit a family in whose home the siblings can be reunited.
- e. No child shall be placed in a foster home if that placement will result in more than three (3) foster children in that foster home, or a total of six (6) children in the home, including the foster family's biological and/or adopted children, without the written approval of the Social Services Director based on a reasonable determination that the home is appropriate for and can meet the needs of the additional number of children. No placement will result in more than 3 children under the age of 3 residing in a foster home. The only exception to these limits shall be circumstances in which the placement of a sibling group in a foster home with no other children in the home would exceed one or more of these limits.
- f. **Group Care Restrictions**

The capacity of a group care setting shall include all beds on the entire grounds of the setting, and includes the total number of beds in multiple cottages.

- i. No child under six years of age shall be placed in a group care setting without the express written approval of the Social Services Director based upon his or her certification that the individual child has exceptional needs which cannot be met in any foster home placement or other facility. The certification shall describe the services which are available in the group care setting to address the child's exceptional needs. No child under six years of age who shall be certified for a group care setting under the terms in this subparagraph shall be placed in any group care setting which has a total capacity in excess of 12 children. This paragraph shall not apply to a child who is under six years of age and who is also the son or daughter of another child placed in a group care setting either prior to or after the entry of this Consent Decree. This paragraph shall not apply to a child who is under six years of age who is also the sibling of another child who has been placed in a group care setting prior to the entry of this Consent Decree, except that any such sibling under the age of six shall be moved to a foster home placement within 12 months of the entry of this Consent Decree unless doing so would not be in the best interest of the children in question.
  
- ii. No child between the ages of six and 12 years of age shall be placed in a group care setting without the express written approval of the Social Services Director based upon his or her certification and specific findings that the individual child has needs which can be met in the particular group care setting and that the particular group setting is the least restrictive placement that can meet such needs. The certification shall describe the services which are available in the group care setting to address the child's needs. No child between the ages of six and 12 years of age who shall be certified for a group care setting under the terms in this subparagraph shall be placed in any group care setting which has a total capacity in excess of 12 children. This paragraph shall not apply to a child between the ages of six and 12 years who is also the sibling of another child who has been placed in a group care setting prior to the entry of this Consent Decree, except that any such sibling between the ages of six and 12 years shall be moved to a foster home placement within 12 months of the entry of this Consent Decree unless doing so would not be in the best interest of the children in question. For any other children between the ages of six and 12 who were placed in a group care setting prior to the entry of this Consent Decree, DHR/DFCS shall have 12 months from the entry of this Consent Decree to move such children to a

non-group care setting unless doing so would not be in the best interest of the child or children in question.

- iii. Children who are at least 12 years of age and older may be placed in a group care setting without any of the restrictions contained in paragraphs i. or ii., above.
  - g. Children for whom the permanency goal is adoption should, whenever possible, be placed with a family in which adoption is a possibility.
  - h. Race and/or ethnicity and/or religion shall not be the basis for a delay or denial in the placement of a child, either with regard to matching the child with a foster or adoptive family or with regard to placing a child in a group facility. Race and/or ethnicity shall otherwise be appropriate considerations in evaluating the best interest of an individual child to be matched with a particular family. DHR shall not contract with any program or private agency that gives preference in its placement practices by race, ethnicity, or religion, but may utilize its authority to contract with private providers to ensure that the pool of available foster and adoptive families reflects and meets the needs of children for whom foster and adoptive placements are needed, including placements for children for whom placement resources are scarce or unavailable.
  - i. DHR shall only contract for placements or services with licensed contractors or subcontractors. No child shall be placed in an unlicensed facility.
  - j. DFCS will ensure the basic physical needs of food, clothing and shelter for children in foster care. At the time of placement or at any placement move, DFCS will review the child's clothing needs to assess appropriateness and take necessary steps to ensure that the child has appropriate clothing.
5. DFCS shall take steps to minimize any trauma which may be experienced by a child which is associated with either a change in placement or in case managers.
6. DHR/DFCS shall take appropriate steps to ensure that foster children placed in foster family homes, whether directly supervised by DHR/DFCS or private providers, receive adequate supports, including the following:

- a. DHR/DFCS shall ensure that before a child is placed in any approved foster family home, the foster parents have received uniform and appropriate pre-service training;
- b. DHR/DFCS shall ensure that all approved foster parents with whom foster children are placed shall receive uniform and appropriate ongoing training, and that they are reasonably informed of any changes in laws or DHR/DFCS policies that affect foster parents;
- c. DHR/DFCS shall ensure that all foster parents (including kinship providers) with whom foster children are placed can contact DHR/DFCS and receive information 24 hours a day, 7 days a week, so that questions or concerns can be timely and appropriately addressed;
- d. DHR/DFCS shall ensure that available information concerning a specific foster child, including family history, medical, dental, mental health and educational information, and any other information that is relevant to the child's safety and well-being, is provided to approved foster parents, before the child is placed in the home, and that complete and accurate updated information is provided to the approved foster parents after the child is placed as such information becomes available.

D. Visitation

The frequency and intensity of in-placement visits and other visits with a child shall be determined by the individual needs of the child. An in-placement visit refers to a private face-to-face visit with the child *in the child's home/placement*, in order to monitor and document the child's adjustment to the placement, the appropriateness of the placement to meet the child's needs, the receipt of appropriate treatment and services by the child, the child's safety, and service goals. A visit refers to a face-to-face visit with the child, in order to monitor and document the child's adjustment to the placement, the appropriateness of the placement to meet the child's needs, the receipt of appropriate treatment and services by the child, the child's safety, and service goals. The following minimum in-placement visits and other visits shall apply:

1. For all children in placements other than adoptive placements:
  - a. For the first eight weeks after an initial placement or upon any change in placement, there shall be at least: (a) one in-placement visit during the first week of the placement; (b) one in-placement visit between the third and the eighth week of the placement; and (c) six additional visits during the eight week period.

- b. Thereafter, there shall be at least one in-placement visit per month and one additional private visit per month.
2. For all children in adoptive placements, there shall be (a) one in-placement visit the day after the child is placed; and (b) at least one in-placement visit per month after the placement but before the adoption petition is filed; and (c) at least one in-placement visit per quarter after the adoption petition is filed.

## **6. HEALTH SERVICES TO CHILDREN**

### **A. Initial Screenings and Follow-Up Treatment**

1. **Physical Health Screening:** All children shall receive a medical screening within ten days of placement in compliance with EPSDT standards, including at a minimum, the components identified in the Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing physician.
2. **Dental Health Screening:** All children shall receive a dental screening within ten days of placement in compliance with EPSDT standards, including at a minimum, the components identified in the Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing dentist.
3. **Mental Health:** All children four years of age and older shall receive a mental health screening conducted by a licensed mental health professional and completed within 30 days of placement in compliance with EPSDT standards, including at a minimum, the components identified in the Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing professional. The mental health screening shall be commenced prior to the MDT meeting provided in Section 4.A.3. of this Consent Decree. All children under four years of age shall receive a developmental assessment conducted by a licensed professional and completed within 30 days of placement in compliance with EPSDT standards, including at a minimum, the components identified in the Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing professional. The developmental assessment shall be commenced prior to the MDT meeting provided in Section 4.A.3. of this Consent Decree.

B. Periodic Health Screenings and Treatment

1. Ages zero through six months: All children between the ages of zero to six months shall receive no less than three periodic EPSDT/Georgia Health Check Program health screenings.
2. Ages six months through 18 months: All children between the ages of six months through 18 months shall receive no less than four periodic EPSDT/Georgia Health Check Program health screenings performed at approximate three month intervals.
3. Ages 18 months through five years: All children between the ages of 18 months through five years shall receive no less than one periodic EPSDT/Georgia Health Check Program health screening performed every six months.
4. Ages six years and over: All children of six years of age and older shall receive no less than one periodic EPSDT/Georgia Health Check Program health screening performed every year.
5. All children shall receive any follow-up treatment or care as directed by the physician who administered the periodic EPSDT/Georgia Health Check Program health screening.
6. Every child shall receive an EPSDT/Georgia Health Check Program health screening within ten days of receiving a final discharge from placement.
7. Children's health needs, including dental and mental health needs, between periodic screenings shall be met as provided by EPSDT.
8. All children age 3 and over shall receive at least one annual dental screening in compliance with EPSDT standards, including at a minimum, the components identified in the EPSDT/Georgia Health Check Program, and shall receive any and all treatment as directed by the child's assessing dentist.

- C. All medication prescribed for a child will be administered as ordered in such prescription(s). Only designated, authorized, and appropriately trained personnel shall administer the taking of any prescribed medication for children in any non-foster family care placement.

**7. SINGLE STATEWIDE AUTOMATED CHILD WELFARE INFORMATION SYSTEM**

- A. State Defendants shall have a fully implemented, single statewide automated child welfare information system ("SACWIS") containing at a minimum:
1. The system shall have the functionalities as identified and described in Appendix "A" hereto;
  2. The system shall have the data integrity and quality assurance processes as identified and described in Appendix "B" hereto; and
  3. The system shall have the security and data recording and recovery elements as identified and described in 45 CFR Part 95, Subpart F, § 95.621.
- B. The date certain for full implementation shall be set forth in a contract with a selected vendor, with the vendor selected and the contract effective on or before December 31, 2005. The date for full implementation shall be added to this Consent Decree after the contract is executed.
- C. Both leading up to and subsequent to the full implementation of a single statewide automated child welfare information system, State Defendants shall at all times satisfy all federal reporting requirements and shall maintain data integrity and accuracy on a continuous basis.

**8. CASELOADS**

- A. DFCS will phase in a reduction in its caseload in Fulton and DeKalb Counties for its CPS investigators, ongoing case managers, placement case managers, and adoption case managers over a two year period as provided below. In the event that a worker has a mixed caseload, the caseload shall be weighted to reflect the standards in this section.
1. By the end of the second reporting period, the following caseloads will exist in Fulton and DeKalb County DFCS:
    - a. No CPS case manager shall have more than 20 cases.
    - b. No ongoing case manager shall have more than 20 cases.
    - c. No placement case manager shall have more than 25 cases.
    - d. No adoption case manager shall have more than 22 cases.

2. By the end of the fourth reporting period and continuing thereafter, the following caseloads will exist in Fulton and DeKalb County DFCS:
  - a. No CPS case manager shall have more than 12 cases.
  - b. No ongoing case manager shall have more than 17 cases.
  - c. No placement case manager shall have more than 15 cases.
  - d. No adoption case manager shall have more than 16 cases.
  
- B. DFCS will phase in a reduction in the ratio of supervisors to case managers in Fulton and DeKalb County over a two-year period as provided below.
  1. By the end of the second reporting period, no supervisor shall supervise more than six case managers at any one time in Fulton and DeKalb County DFCS.
  2. By the end of the fourth reporting period and continuing thereafter, no supervisor shall supervise more than five case managers at any one time in Fulton and DeKalb County DFCS.
  
- C. DFCS will phase in elimination in the employment or utilization of temporary personnel ("PRNs") as case managers in Fulton and DeKalb County over a one-year period as provided below.
  1. From the period beginning six months from the entry of the Consent Decree up through the period ending one year from the entry of the Consent Decree, PRNs shall comprise no more than 11% of the total allocation of social services case managers for Fulton and DeKalb County DFCS, respectively.
  2. From the period beginning one year from the entry of the Consent Decree and continuing thereafter, no PRNs shall be employed or utilized as case managers in Fulton and DeKalb County DFCS.
  
- D. The caseloads for Specialized Case Managers shall be governed by Section 4.F. of this Consent Decree.

**9. SUPERVISION OF CONTRACT AGENCIES**

- A. DHR shall require, and shall take appropriate steps to ensure, that all child-caring institutions or child-placing agencies that provide placements and services to class members meet all applicable terms of this Consent Decree.

- B. This Section 9 applies to any contract for the provision of placements and services to class members into which DHR enters during the contract cycle beginning July 1, 2005, or as soon as practicable following the entry of the Consent Decree. Into any such contract, which shall be annual performance-based contracts, DHR will incorporate all applicable requirements of this Consent Decree, but will do so without reference to the Consent Decree itself. DHR will also specify in any such contract that the suspected abuse or neglect of any class member while receiving such placements or services shall be reported to DHR for investigation, that all placement providers for foster children in DFCS custody are prohibited from using or authorizing the use of corporal punishment, and that any suspected corporal punishment while in that provider's care shall be reported to DHR for screening, assessment or investigation as necessary. The findings of investigations of suspected abuse or neglect, or of the assessment or investigation of suspected corporal punishment, shall be included in the criteria that DHR uses in determining whether to renew the license of a contract agency. With respect to contract agencies' contractual violations, DHR may use such contractual remedies as provided by the contract and by applicable Georgia statutes and Rules and Regulations. The failure of a contract agency to report suspected abuse or neglect of a child to DHR/DFCS shall result in appropriate process being issued in accordance with applicable statutes, rules and regulations for immediate termination of the contract or placement of the provider on probation, and a repeated failure within one year shall result in termination of the contract.
- C. DHR shall ensure that all child-caring institutions or child-placing agencies that provide placements and services to class members report to DHR accurate data on at least a bi-annual (6 months) basis so that their compliance with the terms of this Consent Decree can be measured.
- D. DHR, through its Office of Regulatory Services ("ORS"), shall conduct licensing evaluations of all child-caring institutions and child-placing agencies providing placements and services to class members, to ensure, among other things, the safety and well being of class members and to ensure that the contract agency is complying with the applicable terms of this Consent Decree. As part of such evaluations, ORS shall ensure that each child-caring institution and child-placing agency shall receive at least one unannounced inspection a year to review all relevant aspects of the agency/institution's operations, and that, in addition, 5% of family foster homes or a total of 10 homes (whichever is greater, or all homes for agencies providing less than 10 homes in total) provided by each child-placing agency shall receive such an unannounced annual inspection to review all relevant aspects of the agency/institution's operations. ORS shall prepare a written report after each visit detailing its findings, and shall provide follow-up visits or monitoring if deemed necessary. With respect to license-holders' deficiencies, ORS may use such remedies as are provided by applicable Georgia statutes and Rules and Regulations.

## 10. TRAINING

- A. No case manager shall assume responsibility for a CPS, ongoing, foster care or adoption case, until after completing pre-service training as specified below and after passing an appropriate skills-based competency test, as determined by DHR/DFCS. No case manager supervisor shall assume supervisory responsibility until after completing pre-service training as specified below and after passing an appropriate skills-based competency test, as determined by DHR/DFCS.
- B. DFCS shall have a full time Education and Training Services Section headed by a manager of Education and Training with appropriate qualifications, as determined by DHR/DFCS.
  - 1. The training unit shall provide comprehensive and appropriate child welfare pre-service training to ensure that all case managers and supervisors responsible for children will have training to permit them to comply with the terms of this Consent Decree, law, DFCS policy and reasonable professional standards, as determined by DHR/DFCS.
  - 2. DHR/DFCS management shall determine, on an annual basis, those DFCS workers in need of re-training, as indicated by workers' failure to ensure that the cases for which they are responsible comply with the terms of this Consent Decree, law, DFCS policy and reasonable professional standards, as determined by DHR/DFCS, and shall ensure that additional training is provided to them.
  - 3. All new case managers shall have a minimum of 160 hours of pre-service training, including instructional training and supervised field training, unless waived by the Director of Education and Training Services in accordance with the Office of Child Protective Services New Case Manager Training Waiver Guidelines issued April 1, 2005, or comparable guidelines. All case manager supervisors shall receive a minimum of 40 hours of in-service training that is directed specifically at the supervision of child welfare workers, prior to receiving any supervisory duties. All case managers shall receive a minimum of 20 hours of ongoing training each year. All case managers with supervisory responsibility shall receive a minimum of 20 hours of in-service training each year.
  - 4. Private provider agencies with whom DFCS contracts for the provision of placements for children in DFCS custody shall be required, through contract provisions, to certify that employees providing case management or supervisory services for DFCS have met the following criteria:

- a. Have an undergraduate degree from an accredited college or university;
  - b. Have completed a training curriculum consisting of at least 160 hours of classroom, internet and/or supervised field instruction, unless waived by the Director of Education and Training Section in accordance with the Office of Child Protective Services New Case Manager Training Waiver Guidelines issued April 1, 2005, or comparable guidelines. The curriculum shall be approved by DHR/DFCS to ensure that the general content areas are appropriate to the work being performed. Where case work activities mirror those of DFCS case managers or supervisors, the curriculum shall be comparable to DHR/DFCS' pre-service and in-service training;
  - c. Have a passing score on the case manager and/or supervisor online assessment required for new worker certification as of July 1, 2005; and
  - d. Have 20 hours of job related ongoing professional development annually.
- C. All case manager supervisors employed after the entry of this Consent Decree shall have a minimum of a bachelor's degree in social work, and at least two years of experience as a case manager in social services.

**11. FOSTER PARENT SCREENING, LICENSING AND TRAINING**

- A. All paragraphs in this section shall apply to all class members, whether they are in placements supervised directly by DHR/DFCS, or in placements supervised directly or provided by private contract agencies.
- B. DHR/DFCS shall develop and maintain uniform standards for the approval, and re-approval, of all foster and pre-adoptive families with whom class members may be placed. These standards shall comply with federal law.
- C. The actual processes for approval and re-approval of all foster and pre-adoptive families/parents with whom class members may be placed, shall be developed and carried out by DFCS in conjunction with ORS.
- D. DHR/DFCS shall require uniform training of all foster and pre-adoptive families/parents with whom class members may be placed. Uniform training for all foster parents shall be required prior to the placement of any children with a

foster or pre-adoptive family. All foster parents shall also be required to complete annual training, as part of an annual re-approval process.

- E. Within 90 days of the entry of this Consent Decree, DHR/DFCS shall have an automated information system that can provide the following:
1. For every foster and pre-adoptive family/parents with whom class members may be placed, the name, address, phone number, and, if supervised directly by a private provider, the name and address of the private provider.
  2. For every foster and pre-adoptive family/parents with whom class members may be placed, a list of all foster children in the home, the number and age of any other children in the home, any other adults who are providing direct care or supervision for class members in the home, and the county DFCS office with custody of each foster child.
  3. For every foster or pre-adoptive family/parents with whom class members may be placed, the approval or re-approval status of the home.
  4. For every foster or pre-adoptive family/parents with whom class members may be placed, a complete history beginning in January 1, 2002 and going forward, of any reports of abuse or neglect and any substantiated reports of abuse or neglect.
  5. DHR/DFCS shall consider the information above before a child is placed with any foster or pre-adoptive family/parents, and before any approval, or re-approval is granted.
- F. DHR/DFCS shall not allow any foster or pre-adoptive family/parents to be given approval or re-approval, and shall not allow any class members to be placed or to continue to be placed with such foster or pre-adoptive family/parents, if that same foster or pre-adoptive family/parents has been found to be the perpetrator of substantiated abuse or neglect, or has had their home closed as the result of a policy violation that threatened the safety of a child, has had their home closed as a result of two violations of the corporal punishment policy, or has had their home closed as a result of a single violation of the corporal punishment policy where the family was not amenable to change, correction, or DFCS intervention. DHR/DFCS shall be able to identify if (a) foster or pre-adoptive family/parents were the perpetrators of substantiated abuse or neglect, or had their homes closed, while being supervised by a private contract agency, and they subsequently seek to become approved or re-approved with a different private contract agency or directly as a DFCS supervised foster or pre-adoptive family/parents; or (b) foster or pre-adoptive family/parents were the perpetrators of substantiated abuse or

neglect, or had their homes closed, while being supervised directly by DFCS, and they subsequently seek to become approved or re-approved with a private contract agency.

- G. DHR/DFCS shall also maintain the following information in accessible paper file form:
1. For every foster or pre-adoptive family/parents with whom class members may be placed, the approval or re-approval status of the home, and for any foster or pre-adoptive family/parents not in full approval or re-approval status, the reasons for lack of full approval or re-approval status.
  2. For every foster or pre-adoptive family/parents with whom class members may be placed, a complete history for the prior 5 years of any reports of possible abuse or neglect and any substantiated reports of abuse or neglect (and the nature of the report and the nature of the substantiation), home closings (and the reasons therefore) or refusals to place further children in the home (and reasons therefore), or other corrective actions or disciplinary actions ever taken against the foster or pre-adoptive family/parents (and reasons therefore).
  3. DHR/DFCS shall consider the information above before a child is placed with any foster or pre-adoptive family/parents, and before any approval, or re-approval is granted.

## **12. ABUSE IN CARE INVESTIGATIONS**

- A. All referrals of reports of suspected abuse or neglect of children in foster care shall be investigated by DFCS child protective services staff in the manner and within the time frame provided by law and DFCS policy.
- B. All referrals of suspected abuse or neglect of foster children in institutional, group, residential or foster family homes provided or directly supervised by private providers shall also be referred to and reviewed by the Office of Regulatory Services and the Social Services Treatment Services Unit. The purpose of this review is to determine whether a pattern of abuse or neglect exists within the institutional, group, residential, foster family homes or private provider agency that contributed to the abuse or neglect; whether the contract should be terminated; whether particular homes or facilities should be closed; and what other steps are necessary to safeguard the safety and well-being of children.

C. Corporal Punishment.

1. DHR/DFCS shall continue to require that foster parents and other placement resources for children in the custody of DHR shall not use corporal punishment of children in their care, nor shall they authorize or permit any other individual or agency to administer corporal punishment.
2. When a report of suspected corporal punishment of a foster child in DHR/DFCS custody is received, the allegations must be immediately screened by the Child Protective Services intake unit or the Regional Field Program Specialist. Such personnel shall have appropriate training in child protective services including the screening of reports of potential corporal punishment and abuse/neglect and in discerning the difference between them. No such personnel shall also have any responsibility for the selection, recruitment, approval or re-approval, retention or matching of foster, adoptive or other placement options for foster children. If there is reasonable cause to believe that abuse or neglect occurred, the report of corporal punishment must be treated as an abuse referral and forwarded immediately to the Child Protective Services Supervisor who will follow policy requirements for abuse or neglect reports. All reports of suspected corporal punishment in child caring institutions shall be treated as an abuse referral and forwarded immediately to the Child Protective Services Supervisor who will follow policy requirements for abuse or neglect reports.
3. If suspected corporal punishment in DHR/DFCS custody does not result in an abuse referral, the following provisions shall apply to assessments of foster homes:
  - a. Assessment:
    - i. The assessment of suspected corporal punishment shall be conducted in the manner and within the time frames required by law and DFCS policy.
    - ii. No additional placements may be made in the foster home until the investigation is complete.
  - b. Assessment and Conclusions:
    - i. If the allegation of suspected corporal punishment is supported by the assessment findings, the home must be closed if:

- a. the violation had direct impact on the safety and well being of the child or posed a serious risk factor for the child in the home;
  - b. the violation is the second Discipline or Other Serious Foster Care Violation; or
  - c. the family is not amenable to change, correction or DFCS intervention.
- ii. If the allegation that the discipline policy has been violated is supported and none of the conditions listed in i. above is present, then the home may remain open and a corrective action plan must be developed, agreed upon, and signed by all participants. DHR/DFCS shall ensure that the corrective action plan is appropriately monitored and enforced. The county director may close the foster home in his or her discretion. In deciding whether to close the foster home, the county director should consider: the severity of the incident, the pattern of behavior and history of the foster parents, the identified needs of the child, the willingness of the foster parents to look at alternative approaches to discipline, and the quality of the relationship between the child and foster parent.
- 4. Office of Regulatory Service Regulation 290-2-5.18 prohibits the use of corporal punishment in child caring institutions. Violation of this regulation shall be enforced by the Office of Regulatory Services and shall be punishable by fine, probation, suspension or revocation of license and other sanctions under the Rules and Regulation of the Department of Human Resources.

**13. CORRECTIVE ACTIONS**

- A. Within 60 days of the final entry of this Consent Decree, DHR/DFCS shall identify all class member children in custody for 12 months or more who have not had a medical examination within the prior 12 months, and all foster children in custody for more than 30 days and less than 12 months who have not have a medical examination since their most recent entry into custody. The identified children shall be provided with a medical examination and treatment as set forth in Section 6 of this Consent Decree concerning Health Services to Children by the end of the first reporting period.

- B. Within 60 days of the final entry of this Consent Decree, DHR/DFCS shall identify all foster care placements (foster family homes or non-foster family homes, DFCS-supervised, or private provider-supervised) in which one or more class member children have been placed in the past 6 months, for which placements there have been 2 or more substantiated reports of abuse or neglect in the past 18 months. For each placement identified, by the end of the first reporting period, DHR/DFCS shall conduct an unannounced inspection of the home to determine if there are any risks to the health, safety and well-being of children living in such placements, and shall take all appropriate actions.

#### **14. MAXIMIZATION OF FEDERAL FUNDING**

DHR/DFCS shall maximize funds available to it through Title IV-B and IV-E of the Social Security Act. DHR/DFCS shall establish baselines for present levels of state and federal funding in order to identify increases in federal funding. The parties intend that any increases achieved in federal funding shall not supplant state funds for foster care services. DHR/DFCS shall demonstrate to the reasonable satisfaction of the Accountability Agents that DHR/DFCS has an appropriate mechanism in place for reporting the budgeting of both federal and state dollars. Plaintiffs' agreement herein is premised upon the good faith representation by DHR and the Governor that their policy will be to urge the General Assembly that state dollars committed to DHR/DFCS for the provision of services and resources to benefit children in the class shall not be decreased from current levels if efforts to maximize federal dollars result in additional federal funding.

#### **15. OUTCOME MEASURES**

State Defendants shall meet the following Outcome Measures in the Reporting Periods specified. Performance percentages required "by the end of" a Reporting Period will be measured during the immediately subsequent Reporting Period. Each Reporting Period shall be six months. State Defendants will comply with each Outcome Measure according to its terms for the duration provided for Outcome Measures in Section 19 of this Consent Decree.

1. Commencement of CPS investigations concerning foster children: By the end of the first reporting period, at least 95% of all investigations of reports of abuse or neglect of foster children shall be commenced, in accordance with Section 2106 of the Social Services Manual, within 24 hours of receipt of the report.
2. Completion of CPS investigations concerning foster children: By the end of the first reporting period, at least 95% of all investigations of reported abuse or neglect of foster children shall be completed, in accordance with

Section 2106 of the Social Services Manual, within 30 days of receipt of the report.

3. Contact with the alleged victim: By the end of the first reporting period, at least 99% of all investigations of reported abuse or neglect of foster children during the reporting period shall include timely face-to-face, private contact with the alleged victim, including face-to-face, private contact with a child who is non-verbal due to age or for any other reason.
4. Re-entry into care: By the end of the second reporting period, no more than 8.6% of all foster children entering custody shall have re-entered care within 12 months of the prior placement episode.
5. Maltreatment in care: By the end of the first reporting period, no more than 1.27% of all children in foster care shall be the victim of substantiated maltreatment while in foster care. By the end of the second reporting period, no more than .94% of all children in foster care shall be the victim of substantiated maltreatment while in foster care. By the end of the fourth reporting period, no more than .57% of all children in foster care shall be the victim of substantiated maltreatment while in foster care.
6. By the end of the second reporting period, 90% of all foster homes will not have an incident of corporal punishment within the previous six months. By the end of the third reporting period, 98% of all foster homes will not have an incident of corporal punishment within the previous 12 months.
7. Search for relatives: By the end of the second reporting period, at least 70% of all foster children entering care shall have had a diligent search for parents and relatives undertaken and documented within 90 days of entering foster care. By the end of the fourth reporting period, at least 95% of all foster children entering care shall have had a diligent search for parents and relatives undertaken and documented within 60 days of entering foster care.
8. (a) Of all children entering custody following the entry of the Consent Decree, at least 40% shall have had one of the following permanency outcomes within 12 months or less after entering custody: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. Performance on this measure shall be taken on the first day after the end of the second reporting period, and shall be taken at the end of subsequent reporting periods, as necessary. For example, to sustain compliance at the end of the third reporting period, of all children who entered custody after the entry of the Consent Decree, at least 40% shall

have had one of the following permanency outcomes within 12 months or less after entering custody: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. Performance on this measure shall be taken on the first day after the end of the third reporting period.

(b) Of all children entering custody following the entry of the Consent Decree, at least 74%: (1) shall have had one of the following permanency outcomes within 12 months or less after entering custody: reunification or permanent placement with relatives; or (2) shall have had one of the following permanency outcomes within 24 months or less after entering custody: adoption, permanent legal custody or guardianship. Performance on this measure shall be taken on the first day after the end of the fourth reporting period, and shall be taken at the end of subsequent reporting periods, as necessary. For example, to sustain compliance at the end of the fifth reporting period, of all children who entered custody after the entry of the Consent Decree, at least 74% shall have had one of the permanency outcomes within the types of permanent placement and time frames as listed in (1) or (2) above. Performance on this measure shall be taken on the first day after the end of the fifth reporting period.

9. Children in custody for up to 24 months and still in custody upon entry of the Consent Decree (children in the “24 month backlog pool”): For all children in the 24 month backlog pool, by the end of the second reporting period at least 35% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. For children in the 24-month backlog pool who remain in custody at the end of the second reporting period, by the end of the third reporting period at least 40% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. For children in the 24-month backlog pool who remain in custody at the end of the third reporting period, by the end of the fourth reporting period at least 40% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship.
10. Children in custody for more than 24 months and still in custody upon entry of Consent Decree (children in the “over 24 month backlog pool”): For all children in the over 24 month backlog pool, by the end of the second reporting period at least 35% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. For all children in the over 24 month backlog pool who remain in custody by the end of the

second reporting period, by the end of the third reporting period at least 35% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship. For all children in the over 24 month backlog pool who remain in custody by the end of the third reporting period, by the end of the fourth reporting period at least 35% shall have one of the following permanency outcomes: reunification, permanent placement with relatives, permanent legal custody, adoption, or guardianship.

11. By the end of the second reporting period, for all children whose parental rights have been terminated or released during the reporting period, 80% will have their adoptions or legal guardianships finalized within 12 months of final termination or release of parental rights.
12. For children whose parental rights have been terminated or released and the child has an identified adoptive or legal guardian resource at the time of the entry of the Consent Decree, 90% shall have had their adoptions or legal guardianships finalized within six months after the entry of the Consent Decree.
13. For all children for whom parental rights have been terminated or released at the time of entry of the Consent Decree, and the child does not have an identified adoptive resource, 95% shall have been registered on national, regional, and local adoption exchanges, and have an individualized adoption recruitment plan or plan for legal guardianship within 60 days of the entry of the Consent Decree.
14. Adoption disruptions: No more than 5% of adoptions finalized during the reporting period shall disrupt within the 12 months subsequent to the reporting period.
15. Permanency efforts (15/22): By the end of the second reporting period, at least 80% of all foster children who reached the point of being in state custody for 15 of the prior 22 months, shall have had either (1) a petition for the termination of parental rights filed as to both parents or legal caregivers as applicable OR (2) documented compelling reasons in the child's case record why termination of parental rights should not be filed.

By the end of the fourth reporting period, at least 95% of all foster children who reached the point of being in state custody for 15 of the prior 22 months, shall have had either (1) a petition for the termination of parental rights filed as to both parents or legal caregivers as applicable OR (2) documented compelling reasons in the child's case record why termination of parental rights should not be filed.

16. **Sibling Placement:** By the end of the second reporting period, at least 70% of all foster children who entered foster care during the reporting period along with one or more siblings shall be placed with all of their siblings. By the end of the fourth reporting period, at least 80% of all foster children who entered foster care during the reporting period along with one or more siblings shall be placed with all of their siblings.
17. **Multiple Placement Moves:** By the end of the second reporting period, at least 86.7% of all children in care shall have had 2 or fewer moves during the prior 12 months in custody. By the end of the fourth reporting period, at least 95% of all children in care shall have had 2 or fewer moves during the prior 12 months in custody.
18. **Caseworker continuity:** By the end of the second reporting period, at least 90% of all children in care at a point in time during the reporting period shall have had 2 or fewer DFCS placement case managers during the prior 12 months in custody. This measure shall not apply to cases that are transferred to an adoption worker or to a Specialized Case Manager as referenced in Section 4.F.; case managers who have died, been terminated, or transferred to another county; or case managers who have covered a case during another case manager's sick or maternity leave.
19. **Placement within county:** By the end of the second reporting period, at least 70% of all children in care shall be placed in their own county (the county from which they were removed) or within a 50 mile radius of the home from which they were removed, subject to the exceptions in Paragraph 5.C.4.b(ii) and (iii) above. By the end of the third reporting period, at least 80% of all children at a point in time during the reporting period shall be placed in their own county (the county from which they were removed) or within a 50 mile radius of the home from which they were removed, subject to the exceptions in Paragraph 5.C.4.b(ii) and (iii) above. By the end of the fourth reporting period, at least 90% of all children at a point in time during the reporting period shall be placed in their own county (the county from which they were removed) or within a 50 mile radius of the home from which they were removed, subject to the exceptions in Paragraph 5.C.4.b(ii) and (iii) above.
20. **Visitation (worker-child):** By the end of the second reporting period, at least 95% of children in care at a point in time during the reporting period shall have had at least one in-placement visit and one other visit, as defined in Section 5.D, each month by their case manager during the prior 12 months in custody.

21. Visitation (parent-child when goal is reunification): By the end of the third reporting period, 75% of the children with a goal of reunification shall have had appropriate visitation with their parents to progress toward reunification. By the end of the fourth reporting period, 85% of the children with a goal of reunification shall have had appropriate visitation with their parents to progress toward reunification.
22. Visitation (worker–caregiver): By the end of the second reporting period, at least 90% of all children in care at a point in time during the reporting period shall have had visits between their DFCS placement case manager and their foster parent, group care, institutional or other caretaker at least one time each month during the prior 12 months in custody.
23. Visitation (between siblings): By the end of the second reporting period, at least 80% of children in the Class at a point in time during the reporting period who have one or more siblings in custody with whom they are not placed shall have had visits with their siblings at least one time each month during the prior 12 months in custody, unless the visit is harmful to one or more of the siblings, the sibling is placed out of state in compliance with ICPC, or the distance between the children’s placements is more than 50 miles and the child is placed with a relative.
24. Achievement Measures on Discharge: A baseline measure shall be developed that shows the percentage of children discharged from foster care at age 18 or older during the 12 months prior to the entry of the consent decree who have graduated from high school or earned a GED. By the end of the second reporting period, that percentage shall increase by 10 percentage points. By the end of the fourth reporting period, that percentage shall increase by an additional 10 percentage points.
25. Placements not in full approval status: By the end of the first reporting period, at least 85% of all foster children in custody at a point in time during the reporting period shall be in placements that are in full approval and/or licensure status. By the end of the second reporting period, at least 95% of all foster children in custody at a point in time during the reporting period shall be in placements that are in full approval and/or licensure status. By the end of the fourth reporting period, at least 98% of all foster children in custody at a point in time during the reporting period shall be in placements that are in full approval and/or licensure status.
26. Case files not containing required court ordered language: By the end of the second reporting period, at least 85% of foster children in custody at a point in time during the reporting period shall have all applicable language in court orders necessary to assess qualification for federal funding under

Title IV-E of the Social Security Act. By the end of the fourth reporting period, at least 95% of foster children in custody at a point in time during the reporting period shall have all applicable language in court orders necessary to assess qualification for federal funding under Title IV-E of the Social Security Act. This outcome shall be measured for court orders entered after the entry of the Consent Decree.

27. By the end of the second reporting period, at least 80% of foster children in custody for six months or more shall have either had their six-month case plan review completed by the Juvenile Court within six months of their prior case plan review, or DFCS shall have submitted the child's six-month case plan to the Juvenile Court and filed a motion requesting a six-month case plan review within 45 days of the expiration of the six-month period following the last review. By the end of the third reporting period, at least 85% of foster children in custody for six months or more shall have either had their six-month case plan review completed by the Juvenile Court within six months of their prior case plan review, or DFCS shall have submitted the child's six-month case plan to the Juvenile Court and filed a motion requesting a six-month case plan review within 45 days of the expiration of the six-month period following the last review. By the end of the fourth reporting period, at least 95% of foster children in custody for six months or more shall have either had their six-month case plan review completed by the Juvenile Court within six months of their prior case plan review, or DFCS shall have submitted the child's six-month case plan to the Juvenile Court and filed a motion requesting a six-month case plan review within 45 days of the expiration of the six-month period following the last review.
28. By the end of the second reporting period, at least 95% of foster children in custody for twelve or more months shall have either had a permanency hearing held by the Juvenile Court within 12 months of the time the child entered foster care or had his or her last permanency hearing, or DFCS shall have submitted the documents required by the Juvenile Court for and requested a permanency hearing within 45 days of the expiration of the 12-month period following the time the child entered foster care or had his or her last permanency hearing.
29. By the end of the third reporting period, no more than 5% of all children in the physical custody of DHR/DFCS for 12 months or more shall have had a lapse in their legal custody within the prior 13 months. For the purposes of this outcome measure, a lapse in legal custody is defined as any period of expired legal custody. This Outcome Measure shall not apply to children who have been placed in the custody of another person and returned to the custody of DFCS during the 13-month period.

30. Meeting children's service needs: By the end of the second reporting period, at least 80% of children in care at a point in time at the end of the reporting period shall not have any unmet medical, dental, mental health, education or other service needs, according to the service needs documented in the child's most recent case plan. By the end of the fourth reporting period, at least 85% of children in care at a point in time at the end of the reporting period shall not have any unmet medical, dental, mental health, education or other service needs, according to the service needs documented in the child's most recent case plan.
31. By the end of the second reporting period and continuing thereafter, no more than 10% of all children in foster homes shall be placed in foster care homes that exceed the capacity limits referenced in Section 5.C.4.e. of this Consent Decree, concerning the requirement that no child shall be placed in a foster home if that placement will result in more than three (3) foster children in that foster home, or a total of six (6) children in the home, including the foster family's biological and/or adopted children.

## 16. ACCOUNTABILITY

- A. The Court shall appoint James T. Dimas and Sarah Morrison as the Court's independent Accountability Agents. In the event that either Mr. Dimas or Ms. Morrison is unable to fulfill his or her duties under this agreement, the parties will select a replacement with the advice and consent of the remaining Accountability Agent. The parties agree that data support will be provided to the Accountability Agents by Chapin Hall Center for Children at the University of Chicago and Georgia State University. The Accountability Agents shall conduct the factual investigation and verification of data and state documentation necessary to compile and to issue public record reports on State Defendants' performance relative to the terms of the Consent Decree directly to the Court and to the parties. These reports shall be issued for each six month reporting period, commencing approximately 90 days after the close of the first reporting period.
- B. DHR, through its employees or agents, will collect data with regard to each element of performance under this Consent Decree, and make it available on a timely basis to the Accountability Agents. DHR shall cooperate with the Accountability Agents in providing access to personnel, documents and other information necessary to perform their duties, as determined by the Accountability Agents, including without limitation interviews with agency staff, contract agency personnel, and interviews with DHR clients. The Accountability Agents shall conduct case record and other reviews as they deem necessary,

including recommending or requiring DHR to conduct regular case reviews according to a systematic process.

- C. DHR shall provide the Accountability Agents and/or the organizations through which they are employed with the necessary resources to perform their duties, including payment of their approved fees and expenses in accordance with state regulations. The Accountability Agents will prepare an initial budget proposal to the parties and the Court within 30 days of the signing of the consent decree. This budget will be updated and revised annually on or about the anniversary date of entry of the consent decree.
- D. All actions required for Plaintiff class members shall be documented within the individual case file of each member of the class on a timely and accurate basis. DFCS shall ensure that all required information concerning all foster parents, whether supervised by DFCS or by private providers, is timely and accurately entered into a foster parent file for each foster parent. DFCS shall ensure that a copy of all required information concerning contract agency providers is timely and accurately entered into a file for each contract agency provider and housed centrally at DFCS.

**17. ENFORCEMENT**

- A. Except for the Principles set forth in Section 3 (“the Principles”), all provisions of this Consent Decree are separately and independently enforceable.
- B. All provisions of this Consent Decree shall apply to all class members, regardless of whether they are in custody under the direct supervision of DCFS or of a contract provider.
- C. If Class Counsel notify State Defendants that, to the best of Class Counsel’s knowledge, information, and belief (formed after an inquiry reasonable under the circumstances), State Defendants are in violation of this Consent Decree, Plaintiffs may give notice to State Defendants in writing, and if so shall state with specificity the alleged noncompliance.
- D. Except when Class Counsel allege, in conformity with subsection E below, the existence of imminent danger of substantial harm to class members, the provisions of this paragraph shall apply.
  - 1. When notice of an alleged violation is given pursuant to subsection C, above, State Defendants shall respond to Class Counsel in writing within 25 days by asserting that Class Counsel has alleged only a violation of the Principles, by denying that any substantial noncompliance has occurred, or

by accepting (without necessarily admitting) the allegation of noncompliance and proposing steps that State Defendants shall take, and by when, to cure the alleged noncompliance.

2. If State Defendants (a) fail to respond within 25 days; (b) assert that Class Counsel has alleged only a violation of the Principles; or (c) deny that any substantial noncompliance has occurred, Class Counsel may thereafter seek an appropriate judicial remedy.
3. If State Defendants timely respond by accepting noncompliance and proposing curative action by a specified deadline, Class Counsel may accept State Defendants' proposal or may offer a counterproposal for a different curative action or deadline and negotiate over the appropriate action and deadline, but in no event shall Class Counsel seek an appropriate judicial remedy for the accepted noncompliance until at least 45 days after State Defendants have responded under subsection D.1 above and until both sides have conferred in good faith to resolve any differences. The parties may, by mutual agreement, extend the time period specified in this subsection.
4. If no agreement on the issue of appropriate curative action or deadline is reached within the timeframe set in subsection D.3 above, Class Counsel may seek an appropriate judicial remedy.
5. If the parties reach agreement on a plan and timetable for curative action, but State Defendants thereafter fail to implement the curative action within the time specified in the agreement, Class Counsel may seek an appropriate judicial remedy upon ten (10) days written notice to State Defendants.
6. If the parties reach agreement on a plan of curative action and State Defendants implement the plan, but the plan fails to correct substantially the alleged violation within the time specified in the agreement, Class Counsel may seek an appropriate judicial remedy upon ten (10) days written notice to State Defendants, unless State Defendants issue a written revised proposal for curative action accepting that the violation alleged in Class Counsel's initial noncompliance notice is continuing, and specifying: (i) why, in their view, the initial plan of curative action failed to produce compliance by the deadline and (ii) a revised proposal for curative action specifying a deadline for compliance.
7. If State Defendants issue a timely revised proposal for curative action and deadline in conformance with subsection D.6. above, the parties shall engage in good faith negotiations to attempt to reach agreement on a

revised plan for curative action and deadline. If the parties fail to reach agreement on a revised plan within 25 days of State Defendants' issuance of a revised proposal, Class Counsel may seek an appropriate judicial remedy.

8. If the parties reach agreement on a revised plan for curative action but that revised plan fails to correct substantially the noncompliance within the time specified in the agreement, Class Counsel may seek an appropriate judicial remedy within ten (10) days written notice to State Defendants; provided, however, that the parties may, at their option, continue to attempt to reach agreement on further curative action, further extension of the compliance deadline specified in the Consent Decree, or modification of the Consent Decree.

E. The provisions of this paragraph shall apply when Class Counsel allege the existence of imminent danger of substantial harm to class members.

1. If Class Counsel acting in conformity with subsection C above notify State Defendants that, to the best of Class Counsel's knowledge, information, and belief (formed after an inquiry reasonable under the circumstances), a violation of this Consent Decree has caused or threatens to cause an imminent danger of substantial harm to class members, Class Counsel may give emergency notice of their allegations to State Defendants by electronic mail or facsimile transmission, and if so, shall state with specificity the alleged violation and the alleged imminent danger of substantial harm.
2. Within four business hours of the receipt by the State Defendants of Class Counsel's emergency notice, State Defendants shall respond with their position by electronic mail or facsimile transmission.
3. If State Defendants fail to respond within 4 business hours, or if State Defendants respond by denying the danger is imminent, the threatened harm is substantial, or there is substantial noncompliance with the Consent Decree, Class Counsel may thereafter seek an appropriate judicial remedy.
4. If State Defendants timely respond to an emergency notice with a proposal for specific investigative or curative steps, the parties shall immediately thereupon engage in good faith efforts to reach agreement on appropriate investigative or curative action, including a time period for implementation.

5. If the parties are unable after conferring in good faith to agree on appropriate investigative and curative action and a timetable for implementation, Class Counsel may seek an appropriate judicial remedy.
- F. Class Counsel and their clients shall not issue a noncompliance notice or seek a judicial remedy for the first six months after entry of this Consent Decree except with respect to an alleged case of imminent danger of substantial harm to class members, as described in subsection E above. Nothing in this Consent Decree shall authorize or enable the Class or its Counsel to initiate discovery without order of the Court following the filing of a motion by Class Counsel as authorized by the Federal Rules of Civil Procedure and the local rules of Court.

**18. QUALITY ASSURANCE**

DFCS shall maintain an appropriate quality assurance system that will meet the requirements of federal law, and will monitor, through case reviews, Fulton and Dekalb County DFCS' compliance with DFCS policy and the terms of this Consent Decree.

**19. DURATION OF DECREE**

- A. With respect to the State Defendants, this Consent Decree shall remain in effect until (1) State Defendants are in substantial compliance with the final measures on all Outcome Measures in Section 15 of this Consent Decree simultaneously for three consecutive reporting periods; and (2) a motion to terminate jurisdiction over this Consent Decree is approved by the Court. Plaintiffs shall not contest a timely and appropriate motion to terminate unless: (i) Plaintiffs dispute State Defendants' assertion that they have achieved and sustained substantial compliance on all Outcome Measures for the requisite time period; (ii) an unresolved motion relating to non-compliance with any other provision of this Consent Decree pursuant to Section 17 remains pending; or (iii) any Court Order or Stipulation providing a remedy for a prior allegation of such non-compliance with any other provision of this Decree is in effect or has not been complied with at the time of the motion to terminate.
- B. The parties intend and agree that this Consent Decree shall remain in effect and shall be enforceable by a court of competent jurisdiction for the entire duration of this Consent Decree as provided in Section 19.A. above. The parties intend and agree that State Defendants may only request termination of jurisdiction under the terms of Section 19.A.(1) above.
- C. The parties acknowledge that this Consent Decree is a final resolution of all claims of any type on behalf of Plaintiff class members, whether known or

unknown, that have been brought or could have been brought by or on behalf of the Plaintiffs against the State Defendants up through the date on which the Consent Decree is entered. This paragraph explicitly does not bar claims on behalf of any children in Fulton or DeKalb Counties concerning any programs or services for children prior to a child's placement into State custody, including, but not limited to, any diversion, differential response, or other programs or services providing an alternative to the investigation and/or substantiation of a report of abuse or neglect and/or the removal of a child from their home and placement into State custody, and any programs or services for investigations of reported abuse or neglect for children not in State custody.

- D. In the interest of permitting the parties to focus upon and achieve the objectives of this Consent Decree, Plaintiffs agree that they shall not commence any new action for systemic declaratory, injunctive or other form of equitable relief based on facts, events, actions or omissions by the State Defendants that relate in any way to any claim that was raised or could have been raised in the present case and that occur after the entry of this Consent Decree and prior to the entry of a termination order pursuant to this Section. This paragraph explicitly does not bar claims on behalf of any children in Fulton or DeKalb Counties concerning any programs or services for children prior to a child's placement into State custody, including, but not limited to, any diversion, differential response, or other programs or services providing an alternative to the investigation and/or substantiation of a report of abuse or neglect and/or the removal of a child from their home and placement into State custody, and any programs or services for investigations of reported abuse or neglect for children not in State custody.
- E. This paragraph shall not prevent an action, at any time, by an individual plaintiff for damages or equitable relief tailored solely to the specific circumstances of that individual plaintiff. Further, nothing in this paragraph shall prevent Plaintiffs in any action for systemic declaratory, injunctive or other form of equitable relief brought after the entry of a termination order pursuant to this Section and based on claims arising after the entry of such order, from offering into evidence facts arising prior to such order.

## 20. MISCELLANEOUS PROVISIONS

- A. Each party agrees that it will perform its obligations under this Consent Decree in accordance with all applicable laws.
- B. Unless otherwise provided in this Consent Decree, all notices under this Consent Decree shall be deemed duly given upon delivery by hand, or three days after posting, if sent by registered mail, return receipt requested. All notices under this Decree shall be provided to the party at the address set forth as follows:

As to Plaintiffs:

Marcia Robinson Lowry, Esq.  
Ira Lustbader, Esq.  
Children's Rights, Inc.  
404 Park Avenue South, 11<sup>th</sup> Floor  
New York, NY 10016  
Phone: (212) 683-2210  
Facsimile: (212) 683-4015  
E-mail: [mlowry@childrensrights.org](mailto:mlowry@childrensrights.org); [ilustbader@childrensrights.org](mailto:ilustbader@childrensrights.org)

Jeffrey O. Bramlett, Esq.  
Bondurant, Mixson & Elmore, L.L.P.  
3900 One Atlantic Center  
1201 West Peachtree Street  
Atlanta, Georgia 30309  
Phone: (404) 881-4100  
Facsimile: (404) 881-4111  
E-mail: [Bramlett@bmelaw.com](mailto:Bramlett@bmelaw.com)

As to State Defendants:

Brenda K. Woodard, Esq.  
Chief Legal Officer  
Georgia Department of Human Resources  
2 Peachtree Street, N.W.  
Atlanta, GA 30303  
Phone: (404) 656-4421  
Facsimile: (404) 657-1123  
E-mail: [bkwoodard@dhr.state.ga.us](mailto:bkwoodard@dhr.state.ga.us)

Steven E. Love (or his successor)  
Acting Director, Division of Family and Childrens Services  
Georgia Department of Human Resources  
2 Peachtree Street, N.W.  
Atlanta, GA 30303  
Phone: (404) 657-5202  
Facsimile: (404) 657-5105  
E-mail: [selove@dhr.state.ga.us](mailto:selove@dhr.state.ga.us)

Shalen S. Nelson, Esq. (or her designee)  
Senior Assistant Attorney General

State Law Department  
132 State Judicial Building  
40 Capitol Square, S.W.  
Atlanta, GA 30334  
Phone: (404) 656-3377  
Facsimile: (404) 463-1062  
E-mail: [shalen.nelson@law.state.ga.us](mailto:shalen.nelson@law.state.ga.us)

- C. This Consent Decree constitutes the entire agreement between the parties with regard to the subject matters contained therein, and hereby supersedes all prior agreements, representations, statements, negotiations, and undertakings.
- D. All parties to the Consent Decree have participated in its drafting and, consequently, any ambiguity shall not be construed either for or against any party.
- E. If, for any reason, the Court fails or refuses to enter this proposed Consent Decree as signed by the authorized signatories, or as altered in accordance with their consent freely given prior to entry, then the proposed Consent Decree itself, and any agreement or statement contained in the proposed Consent Decree, is null and void and may not be enforced.
- F. The Department of Human Resources shall bear all costs of notice prescribed by the Court pursuant to Fed. R. Civ. P. 23 in connection with the process for final Court approval of this Consent Decree.
- G. DHR agrees to provide data and information concerning children in Fulton and DeKalb Counties to the Accountability Agents sufficient to enable the Accountability Agents to issue reports at the intervals specified in Section 16.A., verifying the items below. For purposes of the following items, "children" is meant to include only those children who were not in foster care custody at the time that the substantiated maltreatment took place, and "cases" is meant to include only those cases involving families with children who were not in foster care custody at the time there was a referral into DHR's diversion program.
  - 1. (a) The number of children in each county who, during the reporting period, experienced substantiated maltreatment, and (b) the number and percentage of children in (a) of this item who also experienced substantiated maltreatment during the preceding 12 month period. For purposes of this item, for the term "percentage," the numerator would be the number of children in (a) who had substantiated maltreatment during the preceding 12 months, and the denominator would be all children who had substantiated maltreatment during the reporting period.

2. (a) The number of cases in each county during the reporting period in which there was a referral into DHR's diversion program, and (b) the number and percentage of the cases in (a) of this item in which there was substantiated maltreatment within 11 – 365 days after the referral. For purposes of this item, for the term "percentage," the numerator would be the number of cases in (a) in which there was substantiated maltreatment within 11-365 days after referral to DHR's diversion program, and the denominator would be all cases referred to DHR's diversion program during the reporting period. In addition, for purposes of this item, "DHR's diversion program" refers to action taken by the Department which provides for an alternative to the opening of a CPS case and/or the removal of children from their home and placement into state custody by providing additional instruction, services, or support to the child's legal custodian either by DFCS or other family and child services agencies and programs.

**21. RELIEF FOR NAMED PLAINTIFFS**

- A. The State Social Services Director shall monitor the individual cases of the named plaintiffs in this action for as long as they are in DHR/DFCS custody, or if they are discharged from and return to DHR/DFCS custody, to ensure that all necessary and appropriate plans are developed and implemented and that all necessary placements and services are provided. As of the date of the signing of this Consent Decree, two named plaintiffs are in DHR/DFCS custody.
- B. The parties shall meet and attempt to agree on necessary services and plans for the named plaintiffs that remain in DHR/DFCS custody within 60 days after the parties sign this Consent Decree.
- C. The DHR Commissioner, through the State Social Services Director, shall ensure that Plaintiffs' Counsel receive documents and reports every 90 days concerning the status of the named plaintiffs in this action, services that have been provided, and implementation of plans, for as long as they are in DHR/DFCS custody. Plaintiffs' Counsel shall receive notification within one calendar day of any significant events or developments concerning the named plaintiffs in this action for as long as they are in DHR/DFCS custody, including but not limited to: any change in placement, services, permanency goal or permanency plans; any reports of any incident of alleged abuse or neglect or violations of disciplinary policy involving any of the named plaintiffs or occurring at the placements where any of the named plaintiffs are placed; any other serious incidents involving any of the named plaintiffs or occurring at the placements where any of the named plaintiffs are placed.

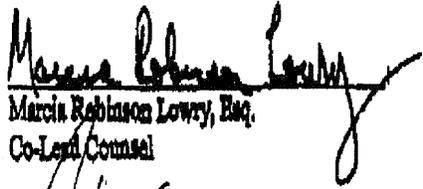
- D. A staffing shall be held in-person or by conference call every 90 days upon Plaintiffs' request, within 10 days after Plaintiffs receive updated documents and reports referenced in Paragraph C above, for the purpose of discussing, with Plaintiffs' Counsel, the status of the named plaintiffs in this action for as long as they are in DHR/DFCS custody, services that have been provided, and implementation of plans. The staffing shall include plaintiffs' counsel, the State Social Services Director or his designee, the child's DFCS case manager, the private agency case manager, if any, the child, and such others that may be needed for the discussion. The parties may on consent modify the schedule of any particular staffing under this paragraph.

**22. ATTORNEYS' FEES AND EXPENSES OF LITIGATION**

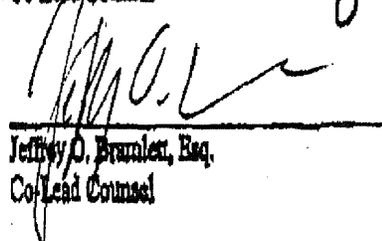
- A. For purposes of the Consent Decree, the parties acknowledge that Plaintiff Class is entitled to recover its expenses of litigation, including reasonable attorneys' fees and nontaxable costs, pursuant to 42 U.S.C. § 1988 and Fed. R. Civ. P. 23(h).
- B. The parties shall attempt without court intervention to resolve the proper amount of Class Counsel's fees and expenses of litigation. If any agreement is reached by the parties regarding recovery of fees and expenses of litigation, the Court shall determine whether the agreed amount and mode of payment are appropriate in accordance with applicable law and procedure.
- C. If the parties cannot reach agreement on the proper amount of attorneys' fees and expenses of litigation, Class Counsel shall file an application for fees and expenses in accordance with the requirements of applicable law and procedure within twenty-five (25) days following entry of this Consent Decree. Any objection to Class Counsel's motion seeking a fee award shall be filed within twenty-five (25) days following the docketing of Class Counsel's motion. The amount of any award shall be determined by the Court in accordance with the requirements of applicable law and procedure.
- D. All parties reserve whatever rights each may have to appeal the amount of attorneys' fees and expenses awarded by the Court.

CONSENTED TO:

For the Plaintiff:

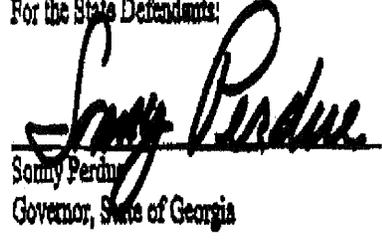
  
\_\_\_\_\_  
Marcia Robinson Lowry, Esq.  
Co-Lead Counsel

6/15/05  
Date

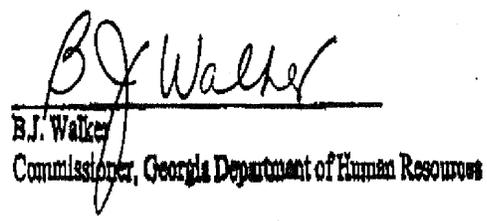
  
\_\_\_\_\_  
Jeffrey D. Brunetti, Esq.  
Co-Lead Counsel

6.15.05  
Date

For the State Defendants:

  
\_\_\_\_\_  
Sonny Perdue  
Governor, State of Georgia

6/27/05  
Date

  
\_\_\_\_\_  
B.J. Walker  
Commissioner, Georgia Department of Human Resources

6/29/05  
Date

## APPENDIX A

### I. REQUIRED PROGRAM / SYSTEM FUNCTIONS:

A. **INTAKE MANAGEMENT:** This function consists of processing referrals for service, conducting an investigation, and assessing the need for service.

#### 1. INTAKE

- a. **Record contact/referral** – The automated system must record initial contacts regarding allegations of abuse or neglect, or provide for the input of a formal referral for protective services, voluntary placement services, juvenile corrections and other services.
- b. **Collect intake/referral information** – The automated system must allow for input of available situation and demographic information, including the cross-referencing of relationships among participants and the reason for referral.
- c. **Search for prior history (persons/incidents)** – The automated system must provide for a search to the database(s) to check for prior incidents and other available information. For a single incident, the system must allow for more than one report of that incident by including information on each individual or agency making a report (such additional reports may or may not be counted in the total number or reports, depending on State policy).
- d. **Record “information only” requests** – The automated system must provide for the recording of calls or contacts that do not involve a specific allegation or referral.

#### 2. SCREENING

- a. **Evaluate intake information** – The automated system must support the evaluation of the received information to determine the necessity of establishing a case.
- b. **Record the results of the screening evaluation** – The automated system must provide for the recording of the determination resulting from the screening process.

- c. **Establish case record** – The automated system must provide for the establishment of a new case, the association of a new allegation with an existing open case, or the re-opening of a closed case.
- d. **Assign case to worker** – The automated system must support and record the assignment of the case to a worker and for the tracking of that case through the process.
- e. **Refer for investigation and/or service, as appropriate** – The automated system must support the referral/transfer of the case for investigation, if necessary, or for assessment, if the allegation is not related to maltreatment.

### 3. INVESTIGATION

- a. **Collect and record investigation information** – The automated system must provide for the input of information collected during the investigation process, including the recording of contacts made during the investigation.
- b. **Record investigation decision** – The automated system must provide for the recording of the decision resulting from the investigation.
- c. **Generate documents as needed in response to investigation** – The system must support the preparation of alerts, notifications and reports required during, and as a result of, the investigative process.

### 4. ASSESSMENT

- a. **Determine and record risk assessment** – The automated system must support the evaluation and determination of risk factors affecting the case (this may be initiated during intake or investigation)
- b. **Perform risk assessment** – The automated system must perform an automated risk assessment, which may use rules-based technology to determine the relative level of risk.
- c. **Collect and record special needs/problems** – The automated system must assist in the determination and documentation of special needs/problems (e.g., special

education, developmental disabilities, medical assessment, etc.).

- d. **Determine and record needed services** – The automated system must support the determination of needed services and record those services, including the assignment and recording of the level of care (placement locations, in-home care, etc.)
- e. **Record client contacts** – The automated system must provide for the recording of client contacts in the electronic case folder.
- f. **Prepare and record referrals to other agencies** – The automated system must provide for the preparation and recording in the electronic case folder of referrals to other agencies.
- g. **Collect and record further case information** – The automated system must provide for the recording in the electronic case record of additional case information gathered during the assessment process.
- h. **Generate documents, notices and reports based on review as needed** – The automated system must support the generation of documents, notices, and reports during, or resulting from, the assessment process.

B. **ELIGIBILITY:** This function consists of determining programs for which funding support is available for clients receiving services. Program eligibility must include funding for foster care/adoption payments and determining the type of programs that will allow a client to receive Medicaid coverage. This function is usually initiated sometime during the Intake Function.

1. **INITIAL ELIGIBILITY DETERMINATION**

- a. **Determine title IV-E eligibility** – The automated system must provide for the exchange and referral of information necessary to determine eligibility under title IV-E through an interface with the title IV-A system.
- b. **Verify eligibility for other programs** – The automated system must provide for the exchange and referral of information necessary to determine eligibility/status under

other related programs such as title XIX (Medicaid) and title IV-D.

- c. **Record authorization decisions** – The automated system must provide for the recording of the eligibility authorization decisions.
- d. **Generate documents related to eligibility determinations** – The automated system must produce the alerts, notices and reports (e.g., exception reports) needed to provide information on and track the initial eligibility determinations.

## 2. **CHANGES IN ELIGIBILITY**

- a. **Redeterminations** – The automated system must provide for the processing of regularly scheduled and as needed program redeterminations and recording of redetermination decisions.
- b. **Generate documents related to eligibility determinations** – The automated system must produce the alerts, notices and reports (e.g., exception reports) needed to provide information on and track the changes in eligibility status.

C. **CASE MANAGEMENT:** This function entails the preparation of service plans, determining whether the agency can provide the services, authorizing the provision of services, and managing the delivery of those services. The service/case plan must include the required elements specified in section 475.

### 1. **SERVICE/CASE PLAN**

- a. **Prepare and document service/case plan** – The automated system must support case plan development by documenting the services, available in the State, that are required to meet the specific needs identified in the assessment function in such areas as:
  - i. **Adoption:** record and track information about adoptive placements and post-adoptive services, including subsidy benefits
  - ii. **Family preservation:** institute in-home services to prevent the need for placement

- iii. **Foster care:** determine and track level of care, placement information, reunification services, legal requisites
- iv. **Independent living:** determine and track services to provide transitional living assistance for State foster care youths
- v. **Interstate compact:** process/submit supervision requests from/with other states for children and youth
- vi. **Identify and match services to meet client's case plan needs** – The system must provide automated support in the identification and matching of service needs and available resources.
- vii. **Record contact with and acquisition of needed resources/services** – The automated system must support and record the preparation of necessary service requests or referrals.
- viii. **Track and update service/case plan** – The automated system must support the monitoring of the progress of plan and update of the service/case plan in the electronic folder.
- ix. **Match client to placement alternatives, if needed** – The system must provide automated support in the identification and matching of clients with available placement alternatives.
- x. **Generate documents as needed** – The automated system must support the generation of alerts, notices, and reports as necessary to track the progress of the service/case plan.
- xi. **Request and record supervisory approval of plan, if needed** – The automated system must provide support for obtaining supervisory approval of the service/case plan.
- xii. **Compute estimated and track actual costs of resources/services** – The automated system must include a component which estimates and tracks the

costs of required/provided resources and services to assist in service/case plan management and tracking.

- xiii. **Identify program outcome measures** – The automated system must include a component which identifies and tracks program outcome measures.

## 2. **CASE REVIEW/EVALUATION**

- a. **Generate alerts to conduct case review/evaluation as needed** – The automated system must support the timely identification and continued tracking of cases requiring review/evaluation.
- b. **Conduct and record results of case review** – The automated system must support the case review process and provide for documentation of the reassessment decisions in the electronic case folder, including documentation of action items resulting from the reassessment.
- c. **Generate documents, notices and reports based on review as needed** – The automated system must support the generation of documents, notices, and reports during, or resulting from, the evaluation process.
- d. **Record collateral contacts** – The automated system must provide for the recording of client collateral contacts and information resulting from those contacts.

## 3. **MONITORING SERVICE/CASE PLAN SERVICES**

- a. **Track and record services identified in the service/case plan** – The automated system must provide for the recording in the electronic case folder of the types, duration, and frequency of services.
- b. **Generate documents, notices and reports** – The automated system must support the generation of documents, notices, and reports to track the services and provided to the client.

- D. **RESOURCE MANAGEMENT:** This function supports the maintenance and monitoring of information on an array of service providers, including prevention programs, placement services, and foster care providers.

1. **FACILITIES SUPPORT**

- a. **Record and update provider information** - The automated system must support the collection and maintenance of provider information such as license/certification status, types of services, level of care provided, level of care compliance and cost of care.
- b. **Generate alerts/action items on licensing status changes** - The automated system must support the timely identification and continued tracking of cases and/or facilities requiring a review or other action as a result of a change in provider information.
- c. **Generate reconciliation and evaluation reports as needed** – The automated system must support the generation of documents, notices, and reports, as needed.

2. **FOSTER /ADOPTIVE HOMES SUPPORT**

- a. **Maintain and update foster care and adoptive home information as needed** – As appropriate to the type of home, the automated system must support the collection and maintenance of foster care and adoptive home information such as licensing decision, violations and revocations, required AFCARS information and received training.
- b. **Record foster care home abused/neglect allegations and investigation results** – The automated system must support the identification of foster care families where allegations of abuse/neglect been reported and substantiated, as required by State law. The automated system must support the investigation of such allegations and document the results.
- c. **Process foster care/adoptive home applications** – The automated system must provide for the recruitment and processing of foster family applications.
- d. **Generate alerts/action items as needed if foster care license is revoked** - The automated system must support

the identification and tracking of cases requiring a review or other action as a result of changing information.

3. **RESOURCE DIRECTORY**

- a. **Maintain directory** – The automated system must provide a directory/inventory of available resources and services.
- b. **Generate reports** – The automated system must support the generation of management reports, as well as other alerts, bulletins notices related to resource availability.

E. **COURT PROCESSING:** This function encompasses an array of legal activities and documentation procedures involving judicial events requiring action on the part of the State agency.

1. **COURT DOCUMENTS** - The automated system must provide for the preparation of State agency documents for the courts, such as petitions, letters, attorney approvals, and supervisory approvals.
2. **NOTIFICATIONS** - The automated system must provide notifications to inform relevant parties of impending court actions.
3. **TRACKING** – The automated system must be used to monitor and track court-related events requiring State agency action, such as recording and outcomes for all petitions, trials, hearings, detention proceedings, periodic reviews, adoptions, and change of placements. Court decisions may be recorded in the electronic case folder.
4. **INDIAN CHILD WELFARE ACT** - The automated response systems must be used to support the Indian Child Welfare Act requirements.

F. **FINANCIAL MANAGEMENT:** This function tracks and manages financial transactions. It may be part of the SACWIS itself or may be an automated interface to a department or statewide financial system.

1. **ACCOUNTS PAYABLE** – The automated system must provide support for accounts payable to providers (billing, vouchers, etc.).
2. **ACCOUNTS RECEIVABLE** – The automated system must provide support for accounts receivable (e.g., overpayments, trust funds, SSI, etc.).

3. **CLAIMS** – The automated system must provide support for the generation of provider payment and remittance advice. The automated system must support the update procedures necessary to adjust the claims process as a result of notification of status changes (including information received from title IV-A and other Federal/State programs), including termination of the case.

G. **ADMINISTRATION:** This function incorporates procedures for ensuring support for efficient management of as well as reliable and accurate operation of the system.

1. **STAFF MANAGEMENT** - This function covers various aspects of agency human resources, maintaining information of employees, work assignments, and staff performance.
  - a. **Record and update employee information** – The system must contain records of employees, showing name, employee number and office. These records must also contain demographic information and results of Background Criminal Investigation (BCI) checks.
  - b. **Record and track case assignment** – The system must provide for the assignment of cases to workers, track workload assignments and identify on-call staff.
  - c. **Assist in workload management** – The system must support the decision-making process and the assignment of case to workers and help workers to manage their own caseloads by providing “to do” lists and prioritization of alerts.
2. **REPORTING** – This function produces information on a periodic and as-needed basis.
  - a. **Produce Federal and State reports** – The system must generate required State and Federal reports (e.g., AFCARS) in either paper or electronic formats as required.
  - b. **Produce reports** – The system must generate regular ad hoc management reports (e.g., workload status, client/case status, performance factors, outcome measures, etc.)
  - c. **Produce statistical reports** – The system must generate statistical reports needed to assist in the analysis of the program.

3. **ADMINISTRATIVE SUPPORT** - This function incorporates procedures for assuring adequate documentation and accurate data.
  - a. **Provide hardware and software security** – The hardware, telecommunications network, software applications and data must be secured to protect from damage, destruction and loss, as well as fraud and abuse. Contingency plans and disaster recovery plans should be tested and readied in case of emergency.
  - b. **Archive and purge** – The system must provide for purging and archiving, as needed, of inactive records and closed cases
  - c. **Provided office automation** – The system must provide automation tools (e.g., word processing, ticklers, alerts, calendaring, electronic mail, system broadcast, etc.) apart and in addition to those tools available within the program functions.
  - d. **Provide on-line system documentation** – The system must provide an on-line policy/procedure manual, user guides, and other system documentation as needed, such as field help screens.
  - e. **Provide on-line training** - The system must provide on-line, computer-based training for system users.

**II. INTERFACES:** This function creates an electronic link between the child welfare and other systems to receive, transmit, and verify case and client information.

- A. **REQUIRED INTERFACES:** The automated system must provide for a periodic electronic data interface with the following systems:
  1. **Title IV-A (AFDC/TANF):** The interface between the state's SACWIS and the Title IV-A system must (1) allow for the automatic exchange of common and/or relevant data between the two systems (to prevent duplicate entry), (2) accept and process updated or new case data and (3) identify potential duplicate payments under Title IV-E and Title IV-A programs.
  2. **Title IV-D (Child Support Enforcement):** the interface between the state's SACWIS and the Title IV-D system must (1) provide for the exchange of data necessary to

establish a child support case, (2) accurately record child support collections on appropriate Title IV-E federal reports, (3) identify potential support resources for the Title IV-E child, (4) allow for the automatic exchange of common and/or relevant data between the two systems (to prevent duplicate entry), (5) accept and process updated or new case data, (6) capture the data necessary to report AFCARS foster care data element number 62, and (7) provide the Title IV-D system with the current foster care maintenance payment either from the SACWIS or, if the state chooses, from a statewide financial system.

3. **Title XIX (Medicaid):** the interface between the state's SACWIS and the Title XIX system must (1) provide for the exchange of information needed by the State Medicaid eligibility system to calculate and track Medicaid eligibility for children in foster care, (2) allow for the automatic exchange of common and/or relevant data between the two systems (to prevent duplicate entry), and (3) capture the data necessary to report AFCARS foster care element number 63.
4. **Child abuse and neglect ("NCAND") data system:** the interface between the state's SACWIS and CAN system and must (1) allow for the automatic exchange of common and/or relevant data between the two systems (to prevent duplicate entry). Relevant data should include data collected during the screening, investigation and assessment of an incident, as well as SACWIS case management information that had been collected during a previous foster care episode.

**B. OTHER INTERFACES** - The automated system must provide for interfaces with other automated systems within the State, such as:

1. State Central Registry
2. Social Security Administration for title II and SSI information
3. State financial system
4. State licensing system
5. Vital Statistics
6. Court system
7. Juvenile Justice
8. Mental health/retardation
9. State Department of Education

## APPENDIX B

- I. QUALITY ASSURANCE:** It is essential that information systems developed under the SACWIS regulations incorporate automated quality assurance measures, processes, and functions. One aspect of quality assurance is to ensure the completeness, accuracy and consistency of critical data. In order to better assure validity and accuracy, SACWIS must be designed to support/enforce good case management practices as well as to provide the capability for profiling pertinent case file characteristics and outcome measurements. The following is necessary to meet quality assurance requirements:
- A. The SACWIS must provide appropriate edits, range checks and prompts for critical or incomplete data. Critical data includes anything required for state or federal reporting or audit (e.g., AFCARS data, child welfare program and eligibility reviews).
  - B. The SACWIS must provide for a review of case files for accuracy, completeness and compliance with federal requirements and state standards, including procedures for appropriate supervisory oversight and authorization.
  - C. The system must allow for random sampling, based on variable characteristics, for audit purposes. The system must be capable of recording and tracking the results of an audit, as well as any necessary corrective actions identified.
  - D. The system must facilitate the establishment and tracking of outcome measures by program managers, and support trend analysis of results.
  - E. The system must generate summary management reports on client demographics and needs. The system must produce reports on the length of time in foster care categorized by identified service needs and services provided.
  - F. The system must track referrals and all required time sensitive actions for Title IV-B and IV-E related cases, such as initial and ongoing Administrative Case Reviews, investigations, and time sensitive treatment and service plans. At the point a required action is delayed beyond a federal, state or court mandated time frame, the system must alert line, supervisory and management staff, when appropriate.
  - G. In cases where a reviewer enters information on an apparent problem of abuse or neglect in a foster home, the system must automatically request an investigation and track the case to ensure its completion.

- H. The system must maintain and link variable and static data used to determine eligibility for Title IV-E payments. The system must also establish data entity relationships between providers, clients and payments.
- I. The SACWIS (or separate financial system) must account for appropriate financial reconciliation of payments including overpayments and recovery by occurrence.
- J. The system must capture and transmit all known cases in the AFCARS report, including cases with incomplete information or untimely actions.
- K. The system must contain all data necessary to effectively manage a case, and must be able to track a child across multiple occurrences and/or cases.

**EXHIBIT 2**

**FC MEMBER, AA MEMBER AND DJJP CAPITATION PAYMENTS**

**A. FC Member and DJJP Capitation Payments**

For Calendar Year 2014 (CY14), the FC Member and DJJP Capitation Rate shall be [REDACTED] for each FC and DJJP Member enrolled in the Contractor’s plan. Pursuant to Section 4.12.10.4 of this Addendum, DCH shall apply the five percent (5%) VBP Withhold to such FC Member and DJJP Capitation Rate, and the FC Member and DJJP Capitation Payment to the Contractor shall be [REDACTED]. The VBP Withhold may be paid to Contractor pursuant to the terms set forth in the VBP Operations Manual.

**B. AA Member Capitation Payments**

For Calendar Year 2014 (CY14), the AA Member Capitation Rates for each AA Member enrolled in the Contractor’s plan shall be the rates in the table below (column entitled “AA Member Capitation Rate”). Pursuant to Section 4.12.10.4 of this Addendum, DCH shall apply the five percent (5%) VBP Withhold to such AA Member Capitation Rates and the AA Member Capitation Payments to the Contractor shall be the rates in the table below (column entitled “AA Member Capitation Rate with VBP Withhold”). The VBP Withhold may be paid to Contractor pursuant to the terms set forth in the VBP Operations Manual.

<b>Region</b>	<b>AA Member Capitation Rate</b>	<b>AA Member Capitation Rate with VBP Withhold</b>
<b>Adoptive Assistance Members Age 0 - 5 years</b>		
Atlanta Region	[REDACTED]	[REDACTED]
Central Region	[REDACTED]	[REDACTED]
East Region	[REDACTED]	[REDACTED]
North Region	[REDACTED]	[REDACTED]
Southeast Region	[REDACTED]	[REDACTED]
Southwest Region	[REDACTED]	[REDACTED]
<b>Adoptive Assistance Members Age 6 - 10 years</b>		
Atlanta Region	[REDACTED]	[REDACTED]
Central Region	[REDACTED]	[REDACTED]
East Region	[REDACTED]	[REDACTED]
North Region	[REDACTED]	[REDACTED]
Southeast Region	[REDACTED]	[REDACTED]
Southwest Region	[REDACTED]	[REDACTED]
<b>Adoptive Assistance Members Age 11 - 17 years</b>		
Atlanta Region	[REDACTED]	[REDACTED]
Central Region	[REDACTED]	[REDACTED]
East Region	[REDACTED]	[REDACTED]

North Region			
Southeast Region			
Southwest Region			
<b>Adoptive Assistance Members Age 18+ years</b>			
Atlanta Region			
Central Region			
East Region			
North Region			
Southeast Region			
Southwest Region			

**C. Adjustments to Capitation Payments**

The CY14 FC Member, AA Member and DJJP Capitation Rates referenced in Sections A and B of this Exhibit 2 will be adjusted by DCH to reflect the following initiatives effective January 1, 2014:

- The Patient Protection and Affordable Care Act required Federal Health Insurer Fee (Section 9010 of PPACA, as amended by Section 10905 of PPACA and Section 1406 of the Reconciliation Act);
- the Patient Protection and Affordable Care Act required Enhanced Primary Care Payment (reference is Section 1202 of PPACA); and
- the addition of new services under Georgia Medicaid Community Behavioral Health Rehabilitative Services.