UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

KATIE A., et al., Plaintiffs, **v.** **DIANA BONTA, et al.,** Defendants.	Case No. 2:02-cv-05662 JAK (SHx) **SPECIAL MASTER'S NOVEMBER 2014 PROGRESS REPORT ON THE IMPLEMENTATION OF THE KATIE A. PLAN** Date: November 24, 2014 Time: 3:00p.m. Crtrm: 750 Judge: Honorable John A. Kronstadt

TABLE OF CONTENTS

SECTION ONE: INTRODUCTION

This Progress Report is submitted to the Court in accordance with the Katie A. Court's Order dated October 16, 2014, Court Dkt 918. Special Master had planned on distributing a draft Report for the Parties review and comment on before filing the Progress Report with the Court but due to time constraints the Special Master was unable to provide the Parties with a draft prior to filing the Report. The timing of the receipt of the implementation updates from the State and the time necessary for the Special Master to read, analyze and reasonably respond to the updates, did not allow enough time to provide a draft Report for the Parties and also meet the November 20, 2014 filing date.

The views expressed in the Special Master's report on the State's progress in implementing the Katie A. Implementation Plan (hereafter referred to as "the Plan") are those of the Special Master only and do not necessarily represent the views of the Parties in implementing the Katie A. Plan, who may provide the Court with their own written responses to this report.

The Special Master expects this to be his final Report to the Court on the progress of the State's implementation of Katie A. The Court has indicated that the Status Conference set for November 24, 2014 will be the final Status Conference.

Purpose and Organization of this Report

This report has two purposes: (1) update the Court on progress made in implementing the Katie A. Plan since the October 16, 2014 Status Conference; and (2) provide the Court with a summary of Post Jurisdiction opportunities and challenges.

The Special Master recognizes that the Court's jurisdiction over this matter is scheduled to end December 5, 2014. The current report will not attempt to review the extensive description and discussion on the State's implementation of the Plan that were covered in previous Reports to the Court. In particular, the Special Master will not revisit, unless necessary, successes and challenges in the State's effort to implement the Plan that were thoroughly reviewed in the Special Master's, June 16, 2014, Report, Court Dkt 899.

This November 2014 Report begins with the focus on the State's current progress and results in implementing the *Katie A. Service Delivery Action Plan and Updated Therapeutic Foster Care (TFC) Work Plan, March 4, 2014,* Court Dkt 883, and with the Plaintiffs', State Defendants', and Special Master's *Statement of Agreement on Selected Recommendations* from the Special Master's Report, Court Dkt 913, August 15, 2014 and *Statement of Agreement on Recommendation 1-4,* October 28, 2014, Court Dkt 919.

The report will focus primarily on those implementation activities related to promoting, supporting and ensuring the delivery of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) (once implemented) to Katie A. children, as medically necessary, which is at the heart of the Katie A. Settlement Agreement. Additionally, this report will provide a review and update on the development of new State structures for a Shared Management System between the State Departments of Social Services (DSS) and Health Care Services (DHCS), and a State and county quality assurance and oversight structure/system. As such, this report is organized into sections *plus exhibits*:

- One: Introduction
- Two: Katie A. Services to Subclass Members
- Three: Status on State Activities for Increasing Services to Subclass Members in Selected Counties
- Four: New Katie A. State and County Structures
- Five: Parties' Plan to Maintaining Communication Post Jurisdiction
- Six: The Special Master's Summary and Findings
- Seven: The Special Master's Recommendations to the Court
- EXHIBITS

SECTION TWO: KATIE A. SERVICES TO SUBCLASS MEMBERS

There now has been over a year and half of Katie A. implementation and data collection by the State and counties. The Special Master's June and September 2014 Reports provided an extensive review of the data available at that time. I will not provide such an extensive review of the current data but will instead provide the State's *'Initial Observation'* of the counties October

2014 Semi-Annual Progress Report and provide an update on the relationship between estimated number of potential subclass members self-reported by the counties in their October 2014 Semi-Annual Progress Report and the unduplicated count by DHCS mental health claims data of subclass members actually receiving ICC and IHBS. (DHCS's October 6, 2014 Twelve Month Rolling Claims Data Report Oct 2013 – Sept 2014.)

This section will conclude with an update that will also be provided on the status of Therapeutic Foster Care (TFC) implementation.

California Counties October 2014 Semi-Annual Progress Report-State Report

The State has provided the Special Master with the following '*Initial Observation*' dated November 10, 2014 of the counties October 2014 Semi-Annual Progress Report:

Overview

The Katie A settlement agreement was designed to transform the way California's child welfare and mental health systems work together to meet the mental health needs of children and youth involved with both systems. This transformation is being accomplished across the state through the adoption of a Core Practice Model (CPM) and provision of Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) and Therapeutic Foster Care (TFC) (once clarified by the Federal Government) to children who meet certain eligibility criteria as members of the subclass. The state has guided and monitored implementation and delivery of these services through a series of county semi-annual progress reports, which have been used to understand factors behind both successes and challenges of implementation and what is needed to ensure continued success.

As the following tables demonstrate, services implementation is dramatically increasing over time. The May 2014 progress reports indicated considerable increases in the numbers of subclass members identified and provided with ICC and IHBS services (Table 1). This substantial increase is likely due to the initial launch efforts and subsequent push toward full implementation by counties. The October 2014 progress reports show more modest increases that reflect a shift from initial implementation efforts to ongoing sustainability of services (Table 2).

Key indicators of county progress between the October 2013 and May 2014 progress reports.

Measure	October 2013	May 2014	Percent Difference
Subclass Members Identified	12,538	16,577	↑ 32 percent
Counties Providing ICC and IHBS	16	42	↑ 163 percent
Children & Youth Receiving ICC	500	3,969	↑ 694 percent
Children & Youth Receiving IHBS	312	2,862	↑ 817 percent
Children & Youth Projected for Services by Next Report Period[1]	5,060	7,353	↑ 45 percent

Table 1

Key indicators of county progress between the May and October 2014 progress reports. [2]

Measure	May 2014	October 2014	Percent Difference
Subclass Members Identified	16,577	19,679	↑ 19 percent
Counties Providing ICC and IHBS	42	50	↑ 19 percent
Children & Youth Receiving ICC	3,969	5,800	↑ 46 percent
Children & Youth Receiving IHBS	2,862	4,006	↑ 40 percent
Children & Youth Projected for Services by Next Report Period	7,353	8,553	↑ 16 percent

Table 2

Status of Previously Identified Issues

[1] The numbers shown reflect children projected to receive ICC Services. Some of those children are also projected to receive IHBS.

[2] Final numbers are subject to change pending receipt of all October 2014 progress reports and completion of a full review and analysis.

The State provides assistance to counties on issues identified as a barrier to successful implementation of services. Solutions are often developed and always implemented at the local level. For example, staffing needs and concerns are common throughout the State, and relate to managing turnover, the associated initial and ongoing training needs, as well as efforts to increase the size of their local workforce. To address these needs, counties report expanding the size of their workforce for child welfare and mental health, increasing contracts with service providers, revising local staffing plans, and sharing training resources across agencies as well as among neighboring counties. The State is also exploring options to help address the unique needs of small, rural counties.

An issue many counties faced in the past related to questions about information sharing practices and privacy laws. Given that CDSS and DHCS do not have the authority to implement a statewide solution, the State actively sought alternative ways to address these concerns. Some counties have developed and implemented solutions, such as standing court orders, memoranda of understanding, or other agreements. In addition, the State invited the California Office of Information Integrity (CalOHI) to speak during one of the regular technical assistance calls (October 8, 2014). The CalOHI has the expertise and statutory authority to speak for the State on these matters, and provided information to the counties about state and federal laws, including where exceptions exist regarding disclosure restrictions. Solutions are being implemented successfully in many locations across the State, and this issue has subsided substantially.

In the May 2014 progress reports, counties voiced strong concerns regarding increased administrative workload associated with completing the progress reports. In response, additional funding was identified and made available for counties beginning with the October 2014 report. The Governor's Budget for Fiscal Year 2014/2015 includes $2 million to cover costs associated with counties completion of the progress reports.

Initial Observations from Current Reports

During its initial review of the October 2014 progress reports, the State observed issues and trends that will continue to be areas of focus going forward. Some of these issues, which are described below, are discussed during technical assistance calls with individual counties. It is important to note, however, that in many cases additional information from counties is needed to understand the issues fully.

While additional hiring and increased staffing were reported by many medium and large sized counties, many small and a few large counties continue to experience challenges in this area. Several small counties report that capacity is a barrier to providing services due to a shortage in staff. Rural counties in particular struggle with recruiting and retaining qualified staff.

Data reported by some counties may have been calculated incorrectly. It appears the State's methodology remains a source of confusion for some counties. The number of potential subclass members, was first added to the May 2014 progress report. This is just the second report to include these elements. The State's efforts to clarify the methodology were helpful in many counties. Nevertheless, some county reports have been flagged for follow up to request further information or explanation. Questions include things such as, whether confirmed subclass members are included in the number of potential subclass members, how children in group homes are reflected, and how a county defines "unknown to the County MHP." Questions like these and others occur most often for counties that did not provide any information in Column 2 of their report, which is where the State looks to find additional information about the data.

Other questions related to data center on information concerning potential subclass members. Enclosure 1, Part A is used for counties to report numbers of potential subclass members, which relate directly to the process counties use to screen, refer, and assess a child's mental health needs. The State is gaining a better understanding of these processes and their effectiveness. In particular, the progress reports indicate the need to examine how referrals are documented and tracked across both child welfare and mental health agencies. These issues will be discussed in greater detail when a full analysis of the reports is complete.

Although data shows that the provision of ICC and IHBS continued to increase following the previous reporting period, the data may not accurately reflect the number of subclass members receiving ICC and IHBS. Some counties have indicated in their progress reports, as well as in conversations with the State, that a number of subclass members are receiving ICC and IHBS, but that the county is billing it as a different service, such as Targeted Case Management or Mental Health Services. This appears to be occurring more frequently with ICC than IHBS. Consequently, several counties report to the State that the number of subclass members receiving ICC and IHBS is actually higher than what appears on monthly SDMC claiming reports.

Based on the progress reports, as well as conversations with counties, it appears that there

are instances where identified subclass members may not be currently receiving little or any mental health services. Although the reasons for this vary by county and by individual subclass member, it is an issue that remains a concern and focus of the State's continued outreach with the counties. Both the State and counties recognize that this issue must continue to be further analyzed, addressed, and monitored until every subclass member is receiving appropriate mental health services.

Progress

Any examination of progress must include a point of reference. Understanding where we are requires understanding where we began; to ensure that conclusions are drawn in the proper context and that next steps are appropriate and likely to produce meaningful results. With this is mind, it is helpful to consider a few points of history.

Using information from the May 2014 progress reports, just one year after the CPM Guide and Documentation Manual were released and the initial steps of implementation taken, 42 counties reported providing ICC to 3,969 children, with some of those children also receiving IHBS. The relative significance of these numbers can be understood better through a review of California's earlier implementation of Wraparound Services. These two implementation efforts differ in a number of important ways, but the service models of the programs themselves share several key elements, making the comparison relevant to understanding the context in which current efforts are taking place.

As the table below shows (Table 3), California Wraparound Services programs were approved in 47 counties between 1997[3] and 2010.[4] The number of children receiving Wraparound Services in 2010 was approximately 3,400.[5] When considered alongside these numbers, the substantial and rapid implementation progress achieved in Katie A seems clear. Put another way, it took just one year for ICC and IHBS to reach the capacity that Wraparound needed 13 years to achieve.

[3] Wraparound Services were established in California in 1997 through Senate Bill 163.
[4] With the passage of Realignment 2011, counties are not required to submit Wraparound Implementation Plans to CDSS for approval. The last Implementation Plan review and approval occurred in 2010.
[5] Estimate based on monthly Wraparound Count Reports submitted to CDSS by counties.

Implementation of Family-Centered Services Through Interagency Collaboration		
Measure	***ICC***	***Wraparound***
Time Period Reviewed	*May 2013 – Feb 2014*	*1997 - 2010*
Total Time to Achieve Service Level	*One Year*	*13 Years*
Counties Providing Services	*42*	*47*
Children Receiving Services	*3,969*	*3,400 (estimated)*

Table 3

The Katie A. progress is also evident by way of infrastructure established in many counties. Several counties have created a shared management structure between child welfare and mental health, which has led to better communication and increased collaboration. This shared management structure includes, but is not limited to, regular leadership meetings, Memoranda of Understanding, co-located staff and jointly developed policies and procedures. The establishment of such infrastructure has not only contributed to the success of current implementation efforts, but will also ensure continued progress and sustainability going forward.

Another positive sign of successful implementation is the increased use of parent and family partners across the state. Many counties have reported that efforts have been devoted to recruiting and training parent partners. Counties also discuss the participation of parent partners in Child and Family Team meetings and the positive impact it has had on the children/youth and families receiving services.

Katie A. sCount: Estimated Potential Number of Subclass Members, Subclass Members, and Provision of ICC and IHBS to Subclass Members

Estimated Potential Subclass Member Size: The October 2014 Counties Semi-Annual Progress Report estimated the number of potential subclass members at 43,112 and increase of 7,723, a twenty-two percent increase from the counties May 2014 Semi-Annual Progress Report.

DHCS Rolling Claims Report of ICC and IHBS Provided to Subclass Members: The October 6, 2014 DHCS Twelve Month Rolling Claims Data reported 11,738, unduplicated subclass members received one or more types of mental health services, and increase of fifteen percent from September 15, 2014 claims report.

The October 6, 2014 Claims report indicated that of the 11,734 subclass members who received one or more types of mental health services, 6,672 subclass members received Intensive Care Coordination (ICC) and 5,531 subclass members received Intensive Home Based Services (IHBS), a thirteen and fourteen percent increase respectively from September 15, 2014 claims data report.

Highest Monthly Total of ICC and IHBS Provided to Subclass Members: The DHCS Rolling Claims Data (Oct 2013- Sept 2014) also reports unduplicated monthly totals. The highest single monthly total for subclass members receiving ICC was April 2014 where 2,871 received ICC and for IHBS, May 2014, where 2,541 received IHBS services. The highest single monthly total for subclass members receiving any type of mental health services was April 2014, where a total of 6,350 subclass members received some form of mental health service.

Therapeutic Foster Care (TFC) Implementation

TFC is an intensive, individualized behavioral health service through which a Katie A. subclass child or youth is placed with specially selected, trained, and closely supervised TFC parents. TFC services are provided based on medical necessity criteria, in accordance with the child or youth's individualized care plan. TFC is an alternative to placement in congregate care for intensive treatment needs and can be a treatment placement for subclass members stepping down from intensive congregate care facilities, thus reducing the time in congregate care placements.

The TFC parents, as Medi-Cal providers under clinical supervision, serve as primary change agents in the therapeutic treatment process and share responsibility for implementing the child or youth's care plan by working closely with the mental health ICC coordinator, child welfare social worker, and other members of the child and family team (CFT).

DHCS is continuing to seek approval of TFC by the Centers for Medicare and Medicaid Service (CMS) as a Medi-Cal covered service. DHCS provided responses to the Centers for Medicare and Medicaid Services' (CMS) Request for Additional Information (RAI) by September 23, 2014 as specified in Recommendation 2 from the Plaintiffs', State Defendants', and Special Master's Statement of Agreement filed with the court on August 15, 2014.

The DHCS has informed the Special Master that:

"DHCS has had conversations on October 30, 2014, and November 6, 2014, with CMS regarding the TFC State Plan Amendment (SPA) #14-011. CMS indicated that there have been

problems with TFC SPAs in other states and that CMS is looking at TFC SPAs with a different lens. CMS informed DHCS that on October 14, 2014, CMS denied the State Of Mississippi's SPA on TFC for comparability reasons (limiting the service to children in foster care versus all eligible children). CMS understands the importance of TFC services for California and are willing to work with DHCS to determine an appropriate and approvable method for implementing TFC. This is a normal process with how CMS and DHCS work together through SPAs. CMS was going to internally research and discuss strategies and get back to DHCS. CMS must either approval or deny the SPA by December 22, 2014, which is when their 90-day clock ends. (If CMS is not ready to approve the SPA by December 22, 2014, DHCS would have the option to withdraw its' responses to the RAI which would take the SPA "off the clock" and allow additional time, if needed. This, too, is standard protocol when more time is needed to work through complexities of a SPA). CMS has not yet provided a definitive response to whether or not a SPA is necessary to implement TFC."

SECTION: THREE: STATUS ON STATE ACTIVITIES FOR INCREASING SERVICES TO SUBCLASS MEMBERS IN SELECTED COUNTIES

According to the Statements of Agreement on Selected Recommendations, Recommendation 1, Increase Services to Subclass Members In Selected Under-Performing Counties, Court Dkt 913, August 15, 2014, the Statement of Agreement on Recommendations 1, Identify Measurable Growth Trends, Court Dkt 919, October 28, 2014, and utilizing the overarching framework established in the Service Delivery Action Plan, Crt Dkt 883, March 4, 2014 the State was to address utilization of ICC and IHBS in the twelve counties with the largest child welfare caseload, as well as in the counties not yet providing services (regardless of their size).

Furthermore, the State was to begin to identify for each county: a) performance goals for increasing the number of children and youth receiving ICC, IHBS, and TFC (once implemented), and (b) a projected timeline for achieving these goals. These goals would be based on county-specific or local conditions.

DSS and DHCS completed its initial round of work with eight counties on September 15, 2014. The results of their initial actions with the eight counties was reported in the Special Master's October 2014 Report.

Activities on Increasing ICC and IHBS and Identifying County Performance Goals

The State has provided the Special Master the following summary of the status of State's activities on increasing ICC and IHBS and on identifying performance goals for increasing the number of subclass members receiving ICC and IHBS and TFC (once implemented):

Sixteen Counties *- Consistent with Recommendation 1 of the August 15, 2014 filing of Plaintiffs', State Defendants', and Special Master's Statement of Agreement on Selected Recommendations, the State has continued its work to increase the provision of ICC and IHBS to subclass members (SCM) in selected lower-performing counties or counties with the largest child welfare caseloads. As noted in the Special Master's September 26, 2014 report to the court, the State completed this work with the first eight counties by the September 15, 2014 deadline set forth in Recommendation 1. The State committed to working with the remaining sixteen counties with its initial outreach to each one to be completed by October 31, 2014. The State has now concluded this work with all sixteen counties which included: Contra Costa, Fresno, Kern, Lake, Lassen, Mariposa, Modoc, Mono, San Bernardino, San Diego, San Joaquin, San Mateo, Santa Clara, Sierra, Sutter, and Yuba.*

The State also initiated a series of calls, to reach out to the counties to ascertain if any specific barriers existed that prevented them from accurately identifying subclass members and/or prevented them from delivering ICC and IHBS to subclass members. Counties were also asked what actions they were taking to address those barriers. With that information, the State assessed how effective each county's actions were likely to be in addressing the identified barriers. In some instances, the State reached out to counties on multiple occasions to better understand their issues or planned actions. The State then identified the specific actions it would take with regard to these specific counties to address the identified issue or barrier, including developing general timelines for resolution.

Issues or Barriers Identified by the State or County

Most counties reported a heightened effort to ensure that children entering the child welfare system, and those already in the system, are promptly screened and referred for assessments. Most of the larger counties reported that they had completed the development of policies and procedures to address screening, referral and assessment, but a few smaller counties had not yet completed these tasks but were in the process of doing so.

While several counties reported having sufficient capacity to serve all subclass members (SCM's) either currently or within the next few months, others reported numbers showing that there were identified SCM's not yet receiving ICC and IHBS services. Explanations for this included the following: SCM's were placed in group homes for whom ICC could not be billed until 30 days before discharge, SCM's were placed out of county; Medi-Cal billing of ICC or IHBS has been delayed or incorrectly billed as another type of service such as Targeted Case Management. A county that reported a large proportion of children placed out of county stated that they will be working with the placement counties to ensure that out of county youth receive appropriate services. Several counties pointed out that children were receiving other types of services that could properly be viewed as ICC, such as wraparound, although not billed as such. A few counties reported methodological difficulties in reporting accurately the number of children identified as SCM's or those projected to receive services; for example, one county did not understand that the number of projected cases should be cumulative and another county corrected its report by eliminating duplicate entries which decreased its reported numbers of identified SCM's.

Some counties reported difficulties in recruiting and retaining qualified staff and other capacity issues, particularly in small, rural counties. Several counties reported a need to improve coordination between local mental health and child welfare agencies and requested training to assist with the development of administrative structures to facilitate this; however, it should be noted that, at this time, none of the 16 counties contacted reported difficulties in sharing information across agencies as creating a barrier to appropriate identification or provision of services to SCM's.

Implementing CFT's was also an issue for some counties. Among these counties, several reported a need to develop policies and procedures on CFT's and requested training. Several counties are using the Safety Organized Practice approach to providing services, which provides further use of CFTs and evidenced based practices consistent with the Core Practice Model.

Pro-active County Actions

Counties are taking various steps to improve screening of potential subclass members, and identification of SCM's, which will increase the number of children receiving ICC and IHBS. Several counties reported screening all new cases; other counties have adopted a Quality Assurance practice of reviewing all open cases on a periodic basis to ensure that they are

screened and referred for assessment if the screening indicates it is needed. For example, one county runs a monthly report of children with open child welfare services who are not receiving mental health services to ensure that they are screened and referred if necessary. Another county has a special unit that works with children in group homes to ensure the availability of services that align with the CPM by providing coordination of services, and is training providers to track the provision of these services.

While a few counties reported some lack of clarity around application of the Core Practice Model, most of the 16 counties contacted are developing, or have developed, practices and procedures to facilitate adoption of the model. Some counties are hiring additional staff that will focus on teaming, namely the facilitation of the team meetings and coordination of services. In addition, several counties report that they provide ongoing training to contract and county staff on the Core Practice Model and Katie A related intervention strategies; others have requested state assistance in addressing training needs. Some counties are providing training on proper billing of services. Where needed, counties have been taking positive steps to ensure adequate capacity to screen and provide services by hiring staff and expanding provider contracts. For example, a larger county reporting low provision of ICC and IHBS services stated that it has recently expanded its provider contracts to include ICC and IHBS, and has plans to expand them once again in FY 2015-2016 to double its capacity to provide these services. Another county that has reported difficulty providing CFT due to staffing shortages has co-located staff at the child welfare agency, which has helped with coordination between the child welfare and mental health agencies.

State Assessment of County Actions

In general, several counties have the capacity to provide ICC and IHBS to all identified SCM's and are providing those services. For those not yet fully serving all SCM's, the State believes that the actions the counties are taking to increase the provision of ICC and IHBS are appropriate and effective. In some instances, the State believes that the actions counties are taking could be further bolstered by training or closer monitoring.

With respect to the 16 counties discussed in this report, the State notes that adoption of the Core Practice Model is increasing, through training as well as through the use of the Safety Organized Practice model. Additionally, counties have been successful in developing strategies to increase screening and assessment of potential subclass members for both children entering

the child welfare system and those already in the system, and to increase the provision of ICC and IHBS services. Some of the difficulties that appeared to be more prevalent during the initial implementation efforts, such as difficulties in sharing information across agencies, are no longer reported as presenting barriers to effective implementation. However, the difficulties that smaller counties encounter, such as recruitment and retention of staff and the development of administrative processes, remain present amidst their efforts to implement the Katie A. settlement agreement. Nevertheless, these counties are addressing these issues or are requesting State or county peer-to-peer assistance. For example, one county is considering enlisting the help of staff from neighboring counties to cover certain roles.

State Action

The State will take or has taken various actions in response to its conversations with counties. In some instances, continued State monitoring is all that is required. In others, the State believes that more direct State involvement would be most helpful in increasing service delivery. For example, some counties have requested training on teaming or use of the Core Practice Model, which the State has provided and will continue to provide. The training for the smaller counties will include examples from other small counties of successful administrative practices and processes that facilitate interagency collaboration and teaming. Training will also address how to adapt/leverage existing teaming processes to meet CFT requirements. In other instances, the State is planning to conduct site visits to more closely monitor and assist county efforts to increase the number of SCM being served. These visits will also be used to assist the counties with increasing recruitment, expanding provider contracts, and to offer other training if needed. For counties with billing issues, the state will follow up to ensure they are resolved and that claims for ICC and IHBS continue to increase as expected.

Recommendation One

Since filing the October 28, 2014 Plaintiffs', State Defendants', and Special Master's Statement of Agreement, the State has begun the work of implementing Recommendation 1, in which the State agreed to set performance goals for counties in implementing the Katie A services. The State intends to fold this work into its efforts with the 24 counties. The State team tasked with contacting the 24 counties (the 8 previously reported to the court in addition to the 16 discussed here) has begun incorporating performance goals in the tools used to conduct the State team's work with counties. The State team has also started instructing staff as to how to integrate

setting of performance goals into conversations with counties. Leadership from each Department has engaged the county associations on this topic. The State expects to begin contacting counties in January 2015 to set and ensure achievement of the counties' respective performance.

The State has provided the Special Master the following Eight County Update:

Eight County Update

In addition to the work the State has completed with the sixteen counties, the State has continued its efforts to increase the provision of ICC and IHBS with the eight counties first contacted in August and September of 2014. These counties were Alameda, Napa, Orange, Riverside, Sacramento, San Francisco, Sonoma and Stanislaus.

County Barriers and County Actions

In general, the eight counties have continued their efforts to identify subclass members (SCM) or increase service delivery to SCM's in the past several weeks. For example, two counties have corrected inaccuracies in their data which will now result in more accurate reporting of SCM's. Two of the counties indicated that they will either begin claiming next month or, because claiming issues have been resolved, expect to see billing for ICC and IHBS increase in the coming months. Yet another county has made some internal organizational changes that have improved its ability to assess potential SCM's. Other work the counties committed to do is still underway or near completion such as the development of information sharing memoranda or Policies and Procedures for Child and Family Team (CFT) meetings. One county is actively developing a strategy to rectify issues it has with CFTs.

State Assessment and State Action

The State believes that the counties have been taking effective action to increase the provision of ICC and IHBS services. The State is actively monitoring these counties either on a monthly or quarterly basis. In some instances, the State is monitoring counties' efforts through claims data on a monthly basis. Further, the State has contacted or will shortly be contacting counties regarding specific issues such as the status of a data sharing agreement or the effectiveness of a contract to do CFT training. The State is also preparing to meet with one county to review what systemic issues may be a barrier to increasing services.

SECTION FOUR: KATIE A. STATE AND COUNTY STRUCTURES

The Katie A. Settlement Agreement and subsequent implementation plan calls for the State to establish an array of State—and eventually county—service system structures and processes that will oversee, promote, monitor, provide quality oversight, and ensure the sustained implementation of Katie A. services.

A number of task forces were established to make recommendations to DHCS and DSS for consideration before establishing new system structures. A brief summary of the task force charges and the status of their implementation by the State are provided below.

Joint Management Taskforce (JMT)

The purpose of the JMT is to make recommendations to DHCS and DSS for the establishment of a Shared Management Structure (SMS) that will oversee the Katie A. initiative for the long term

Shared Management Structure with its shared vision and mission Statement would set policy and program direction, provide clear and consistent guidance, and identify outcomes and accountability measures that are consistent with the Katie A. Core Practice Model (CPM). The SMS would provide the framework, models, and technical assistance for county child welfare and mental health agencies to consider in order to work more effectively together at the local level consistent with the CPM, and also to involve families and youth in local decision making.

Accountability, Communication and Oversight System (ACO) Taskforce

The purpose of the ACO Taskforce is to make recommendations to DHCS and DSS for the adoption of a statewide quantitative and qualitative data-informed system of oversight, accountability, and communication. The ACO Taskforce recommendations are intended to promote the development and use of the Core Practice Model, to ensure effective, quality mental health services, and to efficiently monitor, measure, and evaluate access to services, service delivery, and costs at the individual, program, and system levels.

Core Practice Model (CPM) Fiscal Taskforce

The purpose of the CPM Fiscal Taskforce is to develop a strategic plan using fiscal incentives and reduced administrative barriers to accomplish Statewide adoption of the *Katie A.* Core Practice Model (CPM), deliver intensive home and community based services to subclass members within the CPM framework, and reduce the use of congregate care.

Recommendations forwarded to DSS and DHCS

The Joint Management Taskforce (JMT) issued its recommendations to DSS and DHCS regarding (1) Shared Management Structure; (2) Accountability, Communications and Oversight; and (3) Core Practice Model fiscal strategies, Exhibit 1, on July 29, 2014. The recommendations included in the report address the formal requirements for establishing a Shared Management Structure. Additionally, the recommendations provide a comprehensive Accountability, Communications and Oversight framework that, among other things, calls for an evaluation of the viability of implementing a formally coordinated System Improvement Plan (SIP)/Performance Improvement Project (PIP) effort, and encourages institutionalizing quality assurance processes relating to practice improvement, Core Practice Model implementation, and timely access to Intensive Care Coordination and Intensive Home Based Services.

DHCS and DSS Actions on JMT Recommendations

The State has provided the Special Master the following State response to the Joint Management and Fiscal Task Force Recommendations:

CDSS and DHCS

Response to the Joint Management and Fiscal Task Force Recommendations

---

Background

As a result of the Katie A. v. Bonta Settlement Agreement and subsequent Implementation Plan, the California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) (the State) agreed to perform a number of actions including the establishment of a Shared Management Structure (SMS) to develop a shared vision and mission statement; provide policy and program direction with clear and consistent guidance, and develop outcome and accountability measures consistent with the Core Practice Model (CPM).

To this end, the Agreement called for the establishment of a Joint Management Task Force (JMT), Accountability, Communications and Oversight (ACO) Task Force and a CPM Fiscal Task Force. Although the ACO Task Force was initially intended to be a sub-committee of the JMT, it

was concluded by the Parties and the Court that the membership of the JMT included many of the same representatives who would also sit on the ACO Task Force. Therefore, members of the JMT also serve as the ACO Task Force with the addition of key program and quality assurance representative from the State, counties, and providers.

The JMT recommendations were submitted to the State on July 29, 2014 while the CPM Fiscal Task Force submitted its recommendations to the State in November 2013. Therefore responses to both the JMT and Fiscal Task Force's recommendations are included in this document. The recommendations and responses are organized into four separate sections:

I. Shared Governance

II. Policies and Procedures

III. Accountability, Communication and Oversight

IV. Fiscal Strategies

The State summarized the key components of each recommendation and prepared the response.

I. Shared Management Structure for CDSS and DHCS

The JMT recommends that DHCS and CDSS adopt a shared governance model consisting of a Transformation Manager/Facilitator and two leadership teams—the Executive Team (ET) and the Community Team (CT). Together, these functions will constitute the Shared Management Structure (SMS).

Transformation Manager/Facilitator

The Transformation Manager/Facilitator will provide staff support and facilitation for both of the shared management teams and report directly to the ET. This person must have the time and skills to work across both departments and lived experience or substantial experience with families and youth with lived experience.

Executive Team

The ET will provide leadership and decision-making in the implementation of Child Welfare/Mental Health state interagency and intra-agency collaborative policy and practice consistent with the CPM. The ET will operate with direction and input from the CT. Matters that cannot be resolved by this team will be elevated to the Secretary of the Health and Human Services agency for resolution.

Community Team

The CT will be comprised of family and youth members, advocates, providers, county representatives and state representatives from the executive team. The role of the CT is to ensure that stakeholders are engaged and are equal partners in leading the collaborative effort to change policy and practice. The team will provide leadership, direction, advice and feedback about state policies and programs relevant to service delivery, data collection, quality improvement and accountability regarding child welfare youth and families who need mental health services. Both the ET and CT will meet at least monthly.

The JMT recommends that the SMS be assessed using a Continuous Quality Improvement (CQI) approach. Both teams, together with the Transformation Manager, will need to continually evaluate how the teams and teaming structure is functioning and make changes as needed to ensure that goals and objectives are being accomplished, necessary work is getting done and the process reflects the vision, mission and values as they are articulated.

FixIT Teams will be created and function when there is a need to deal with a specific issue identified anywhere within the governance structure. These will be time-limited focused work groups with subject matter experts.

State Response

The State agrees to adopt the JMT recommendation to establish a Shared Management Structure as proposed subject to specified modifications regarding implementing the function of the Transformation Manager/Facilitator. The ET will provide leadership and make decisions related to the implementation of policies and practices of the CPM and use data to drive decisions and monitor service delivery fidelity. The ET will consist of designees of the CDSS and DHCS Directors who will have decision making authority and when appropriate, will elevate issues to the State Directors. The designees will be expected to engage with the CT soliciting advice and communicating feedback regarding various implementation areas. The ET will convene its' first meeting no later than January 31, 2015 and will meet quarterly or more frequently as needed.

The State agrees with the JMT recommendation to establish a CT that will provide input, advice and feedback to the ET and State Team regarding policies and practice related to the CPM and service delivery, data collection, quality improvements and accountability. The CT will be comprised of youth, parents, providers, advocates, a local Child Welfare Services

representative, a local Mental Health Plan representative, a County Welfare Directors Association representative, a County Behavioral Health Directors Association representative, a CDSS state team member and a DHCS state team member. This team will meet quarterly. Pending installation of the shared management structure, the existing State Team, comprised of representatives from CDSS and DHCS, will continue in its role to operationalize the Service Delivery Action Plan (SDAP) and other work that may emerge from the leadership teams. The State Team will address policy and practice areas and provide technical assistance and strategies to counties and providers. The State Team will continue to meet on a bi-weekly basis. A communication and feedback strategy will be developed by the State Team during the transition to the SMS.

Regarding the JMT recommendation for a FixIT Team, the State chooses to embed the FixIT Team functions within the current State Team infrastructure. The FixIT Team function will operate as proposed by the JMT recommendations, convening as a time limited ad hoc workgroup that will include members (internal and/or external) to address issues that require special review and specific expertise. These ad hoc groups will include members of the State Team, as well as other stakeholders. Frequency of meetings will depend on the issue.

DHCS and CDSS are in support of the Transformation Manager/Facilitator function. In order to ensure that the roles and responsibilities of this function are incorporated most effectively, the Departments will need to determine whether the function requires a new position or if it can be repurposed within the Departments' existing infrastructure as well as further determine the duties and expectations of this position.

Current State and local infrastructures will be accessed in order to sustain the collaborative environment/momentum between Mental Health and Child Welfare agencies. (See Attachment A)

II. Policies and Procedures

Recommendation Summary

The JMT recommends that DHCS and CDSS enter into a Memoranda of Agreement (MOA) articulating the Interagency Policies and Procedures by December 1, 2014, in order to better coordinate child welfare and mental health systems, program, and practice efforts that will serve child welfare youth with mental health needs. The MOA terms will include but not be limited to agreement to 1) Aligning departmental policies and procedures; 2) Coordinating

routine communication prior to departmental action to assure alignment of direction and expectations; 3) Establishing joint departmental protocols for the production and distribution of information relating to and/or impacting both departments; and 4) Jointly issuing and signing All County Letters and All County Information Notices when both child welfare and county Mental Health Plans are or may be affected by the policy or practice.

State Response

The State adopts and agrees with the purpose of this recommendation and acknowledges that the State will enter into a Memoranda of Agreement (MOA) by July 1, 2015 instead of the proposed December 1, 2014. The MOA will include, but not be limited to items outlined in the JMT recommendations (Items 1-4).

III. Accountability, Communication and Oversight

Recommendation Summary

The JMT recommends that the CT develop recommendations for a comprehensive CQI and Accountability System that further integrates the efforts of DHCS and CDSS such as the Performance Outcomes System (POS), Continuum of Care Reform (CCR), Case Management System (CMS) and other activities.

The goal will be to include all efforts into a comprehensive CQI System for the purpose of guiding the state and counties in improving performance. The CT is to provide its report to the ET by June 30, 2015 for review and adoption as State policy.

The SMS is also recommended to convene a stakeholder meeting to obtain specific input for the CQI System per the Settlement Agreement.

Prior to finalizing the overall CQI System, DHCS and CDSS will meet the commitments of the SDAP and the ACO report (short term, mid-term and long term goals).

The CT will work with the State to re-establish appropriate dates and timelines for these activities. Within the overall CQI System, DHCS and CDSS will develop incremental steps to integrate compliance and quality review activities. Wherever possible, compliance and quality improvement activities will be integrated and/or coordinated to increase efficiency and reduce duplication.

State Response

The State agrees with the JMT recommendations to establish a CQ CQI and Accountability System consistent with the ACO short term, medium and long term goals. The State will review

and consider the recommendations of the Community Team's report due to the ET by June 30, 2015.

The State agrees with the goal to coordinate existing State and County quality improvement processes and systems. These quality improvement processes are associated with the DHCS Performance Outcomes System and External Quality Review Organization, the CDSS Congregate Care Reform, and the California Child and Family Services Review. The State will identify areas of natural intersection and coordination among these systems and work towards incremental integration through the use of the SMS.

The State will develop communication and input loops between counties, the families, youth, providers and associations regarding the CQI using the governance structure. Putting in place an effective communication strategy is important while the State installs the governance structure. With regard to the short-term, mid-term and long term goals outlined by the ACO, many of these activities are currently being accomplished by the State Team as outlined in the Service Delivery Action Plan developed on February 27, 2014. Per the JMT recommendation, as implementation progresses, the Service Delivery Action Plan timeframes will be modified to address any emerging issues and current commitments.

IV. Fiscal Strategies

Recommendation Summary

The JMT recommends that DHCS and CDSS develop and adopt the recommendations of the CPM Fiscal Task Force and collaboratively address budgeting and fiscal strategies that maximize the use of resources.

State Response

The State agrees with the recommendations of the CPM Fiscal Task Force and believes many are either achievable within the future shared management structure or are currently underway through other initiatives. The Departments also reserve the right to revise any method, process, and/or timelines associated with the recommendations.

Fiscal Task Force Recommendations

Recommendation 1.1.1 – The California Department of Social Services and Department of Health Care Services Should Work with the County Welfare Directors Association, California Mental Health Directors Association (Now the California Behavioral Health Directors Association), and Other Stakeholders to Develop a Plan that Invests Existing Resources into the Provision of Coordinated and Aligned Training and Coaching that Assists Line Staff, Supervisors, Subcontractors, Family Members, and Other Support Persons with Acquiring the Skills Needed to Implement and Sustain the Core Practice Model Statewide

The DHCS and CDSS have already begun work to align training and coaching through the child welfare statewide training system in collaboration with the California Institute for Behavioral Health Solutions (CIBHS). Additional discussions have occurred with other training entities including the Chadwick Center. Further alignment with other stakeholders will be explored with the Community Team once developed as part of the shared management structure.

Recommendation 1.2.1 – The Department of Health Care Services Should Publish a Comprehensive EPSDT Documentation Manual Similar to the Documentation Manual prepared by the California Institute for Mental Health (Now the California Institute for Behavioral Health Solutions)

The DHCS and CDSS will work together to convene a multi-disciplinary workgroup in summer of 2015 to revise the current Medi-Cal Manual and Core Practice Model guide, which will be more comprehensive based on lessons learned from the Statewide Learning Collaborative.

Recommendation 1.2.2 – The Department of Health Care Services and California Department of Social Services Should Prepare Clear Written Guidance for Counties and Providers Regarding Proper Cost Allocation

The DHCS and CDSS will explore what guidance will best support counties and providers regarding costs for services with the Community Team once developed as part of the shared management structure.

Recommendation 2.1.1 – The California Department of Social Services Should Consider Updating Current Regulations and Payment Structures for Group Home Providers in a Manner that Results in Short-Term Treatment and/or Crisis Residential Beds Being Available When Needed

The current regulations and payment structures are currently being addressed in the CDSS Continuum of Care Reform (CCR) framework.

Recommendation 2.1.2 – The California Department of Social Services and California Department of Health Care Services, with Input from Stakeholders, Should Explore Opportunities to Build Upon the Knowledge Gained from Prior Efforts to Shorten the Length of Stay in Group Homes and Other Institutional Placements

This information is currently reflected in the CDSS CCR framework.

Recommendation 2.3.1 – The Department of Health Care Services Should Work with County Child Welfare and Mental Health Departments to Produce an Information Notice that Encourages Counties to Invest Mental Health Services Act or 1991 Realignment Funds into Transition Programs Designed to Increase Placement Stability

The DHCS will provide technical assistance to encourage counties to invest mental health funding into transition programs to support placement stability for children and youth.

Recommendation 2.3.2 – The California Department of Social Services and Department of Health Care Services, with Input from Stakeholders, Should Explore Opportunities Under the Affordable Care Act to Increase Access to Mental Health Services to Increase Placement Stability

The CDSS and DHCS will explore these opportunities with the Community Team once developed as part of the shared management structure.

Recommendation 2.4.1 – The California Department of Social Services and the Department of Health Care Services, with Input from Stakeholders, Should Explore the Role and Continued Viability of Interagency Placement Committees and Propose Any Necessary Statutory Amendments to Clarify Their Role

Child and Family Teams are built within the CCR framework. Further, CDSS and DHCS

will examine the roles of the CFT and these committees with the Community Team once developed as part of the shared management structure.

Recommendation 3.1.1 – The California Department of Social Services and the Department of Health Care Services Should Explore with Stakeholders Opportunities for County Child Welfare and Mental Health Departments to Share Resources in Providing Care to Children and Youth in the Child Welfare System Who Need Mental Health Treatment

The sharing of resources and opportunities will be leveraged and examined within the current context of available resources and is currently being addressed in the CDSS CCR framework.

Recommendation 3.1.2 – The California Department of Social Services and California Department of Health Care Services Should Explore with Stakeholders Jointly Publishing a Document that Describes how County Child Welfare and Mental Health Departments May Negotiate Agreements to Share the Fiscal Risks and Benefits Associated with Group Home Placements

The fiscal structure of group home placements is being revised in the CDSS CCR framework.

Recommendation 3.1.3 – The California Department of Social Services and Department of Health Care Services Should Work with County Child Welfare and Mental Health Departments to Determine how the Core Practice Model will Impact Workload for Child Welfare Workers and Mental Health Clinicians

This is currently being addressed in the child welfare statewide practice model, which is being developed based on the foundational work of the Katie A. Core Practice Model. This model will support best practice for child welfare workers statewide and provide a model for a family focused approach.

Recommendation 3.2.1 – The Department of Health Care Services Should Seek Additional Resources to Provide Training and Technical Assistance to County Mental Health Departments to Assist with Proper Documentation and Claiming for Medi-Cal Specialty Mental Health Services

The CDSS and DHCS continue to work with both statewide training systems within child welfare and mental health to improve cross training and the development of trainings that further address coordination of mental health services within child welfare. Additional training needs for proper documentation and claiming for Medi-Cal Specialty Mental Health Services will also be addressed within this framework.

Recommendation 3.2.2 – The California Department of Health Care Services Should Work with the California Mental Health Directors Association to Improve the Provider Enrollment Process

The DHCS will work with the California Behavioral Health Directors Association on improvements to the provider enrollment process, while considering the new Affordable Care Act requirements to ensure program integrity.

Recommendation 3.3.1 – The California Department of Social Services and the Department of Health Care Services Should Work with Stakeholders to Prepare for Local Government Agencies and Organizations a Catalogue of Funding Sources Which May be Used to Finance the Non-Federal Share of Title XIX Services, as Well as Non-Traditional Mental Health Services

The CDSS and DHCS will explore the development of a Catalogue of Funding Sources with the Community Team once developed as part of the shared management structure.

Recommendation 3.3.2 – The California Department of Social Services and the Department of Health Care Services Should Continually Collaborate with County Child Welfare and Mental Health Departments to Seek Federal Grants or Waivers and Foundation Grants that Would Support Implementation of the Core Practice Model

The CDSS has begun this effort through the recently executed Title IV-E Waiver Demonstration Project. As part of this project, nine county child welfare departments will use Title IV-E dollars to support the implementation of the Core Practice Model using Safety Organized Practice elements.

Exhibit 1. The Shared Management Structure and Communication Plan

SECTION FIVE: PARTIES PLAN TO MAINTAINING COMMUNICATION POST JURISDICTION

The Parties have agreed to continue to maintain communication Post jurisdiction as described in some detail in the *Plaintiffs', State Defendants' and Special Master's Statement of Agreement on Recommendations 1-4*, specifically Recommendation 3, October 28, 2014, Court Dkt 919. Accordingly, "The Parties agreed that continued dialog on improving service delivery roll-out, consistent with the practice model, and avoiding future litigation would be valuable to the State, counties, Medi-Cal beneficiaries, and stakeholders."

The State and Plaintiff's have agreed that an initial meeting should occur as soon as possible, but at this time no date has been set.

SECTION SIX: SPECIAL MASTER'S SUMMARY AND FINDINGS

In this section I will summarize progress regarding implementation of the Settlement Agreement and the Plan since the October 16, 2014 Status Conference. I will also provide the Court with a Summary Finding of selected Post Jurisdiction obligations that are essential for the State to continue to implement and or to begin implementing. It is not my intention to address the full array of issues or findings from previous Special Master Reports and Updates to the Court, specifically the changed California Environment or Timeline Extensions. Instead, I will focus on key matters I believe are central and pivotal to successful implementation into the future.

The Parties have consistently acknowledged that all elements of the Settlement Agreement, the Plan, Service Delivery Action Plan and Statements of Agreement would not be fully implemented during the Court's jurisdiction. Although I have disagreed with the State at times regarding specific activities, deliverables and the number of subclass members who should have received ICC and IHBS and the level of county implementation of the Core Practice Model by the end of the Court's jurisdiction, I have not disagreed with the assertion that there would be a continuing obligation on the State to implement Katie A.

I will close this section of my Report with a list of essential deliverables, actions, activities that remain to be fulfilled post jurisdiction. This list is not intended to be all inclusive regarding what must occur for the successful implementation of Katie A. Over time, the State will need to continue to develop additional goals and new strategies in adapting to federal, state and county

conditions.

I once again want to commend the effort and intention of all the Parties in advancing the Katie A. effort. The past three years of implementation rollout have required massive work, especially on the part of the State departments and county agencies, along with much support, forbearance, and encouragement on the part of the Plaintiffs and the parents and providers who were members of the Negotiation Workgroup.

Katie A. Services to Subclass Members – State's '*Initial Observation*' of the October 2014 Semi-Annual Progress Report and DHCS Claim Data

The State's *Initial Observations* of the October 2014 County Semi-Annual Progress Reports highlight the overall increase in subclass members identified and provided with ICC and IHBS. It compared the last two Semi-Annual Progress Reports, October 2013 and May 2014, with the October 2014 Semi-Annual Progress Report, which showed modest increases. The State's characterization of the modest increase as a 'shift from the initial implementation effort to ongoing sustainability of services' is somewhat confusing. Perhaps it's the choice of words, initial implementation vs. ongoing sustainability. From my perspective the State's current efforts are more directed at assisting counties in providing or increasing ICC and IHBS to subclass members and not focused on sustaining the current level of service. Regardless, the State and counties deserve credit for these increases, as modest as they are.

The State has made progress in addressing numerous barriers identified by counties that were limiting their ability or capacity to provide ICC and IHBS. Counties have advised the State they have been able to expand their workforce, increase contract with service providers, revise local staffing plans and shared training resources across agencies and neighboring counties. Although not every county has been successful to date in addressing these issues, the smaller counties in particular have unique circumstances and challenges in these areas. The State is intending to make a special effort to engage and support these counties in finding solutions.

Information sharing practices and privacy laws have continued to be a concern but more and more counties are finding successful solutions to this problem. In part, this is a result of the State offering a wide range of technical assistance that included a consult with California Office of Information Integrity. This issue remains and will require continued support and solution focus by the State.

Even though the State provided many opportunities and hours of consultation on how to complete the data section of the Semi-Annual Progress Report, many counties continue to have difficultly completing the Semi-Annual Progress Report due to confusion about the State's methodology. Some of the data in the Report may have been calculated incorrectly. Although there may be errors, I expect the number of errors to decrease over time as the counties receive technical support from the State.

At this point in analyzing the Semi-Annual Progress Reports and DHCS Claims Data, the State is gaining a better understanding of countys' screening, referral, assessment and tracking process. This increased understanding will assist the State in its monitoring, and providing technical assistance to the counties, likely resulting in an increase in access and provision of ICC and IHBS to subclass members. Excellent Job.

Some counties may be billing other mental health services instead of ICC and IHBS. This has been a continuing problem since implementation. Counties appear either reluctant or unable to transition subclass members from other mental services to ICC and IHBS. The issue may require special attention and action by the State in order to change this situation.

I found it troubling that in the 'Progress' section the State would use the time it took (thirteen years) to successfully implement Wraparound, a discretionary program, in comparison to the implementation of Katie A, especially ICC and IHBS, which are federal Medicaid/Medi-Cal entitlements for children. I recognize it takes time to implement, but these are two very different programs, with different requirement/expectation under federal law.

Claims Data and October 2014 Semi-Annual Progress Report - Counties and the State should be commended on the continued progress in providing ICC and IHBS to an ever increasing number of subclass members as reported in the October 2014 Semi-Annual Progress Report and DHCS claims data. There is an additional context that should be taken into consideration and factored in when examining the increase in subclass members receiving ICC and IHBS. This larger context includes the 'potential/estimate number' of subclass members known to child welfare that have yet to be screened and assessed by mental health to determine subclass eligible and receive ICC and IHBS

The best data available on Katie A. subclass members receiving intensive Katie A. services comes from the Counties' Semi-Annual Progress Report and DHCS Medi-Cal claims data.

Claims data from DHCS indicate the number of subclass members receiving ICC and IHBS as medically necessary is up since my last report. That is good news.

There is more good news on data and its analysis. The State's capacity to exchange and match DHCS and DSS data bases has recently been approved through a State Interagency Agreement (IA), Exhibit 2, that authorizes the exchange and matching of confidential data between DSS and DHCS. The use of the exchanged data is limited and qualified, but it will go a long way to improve the State's capacity and authority to provide oversight and coordination of health care services for any child in the foster care system. It makes particular reference to analyzing data regarding Katie A. and will likely become a cornerstone in the Accountability, Oversight and Communication System that will be implemented under the new Shared Management Structure between DSS and DHCS. This is a landmark accomplishment and should be applauded.

I've included Table 4(below) Statewide Headcount to indicate the level of subclass members receiving ICC and IHBS and Table 4.1 Statewide Headcount without Los Angeles.

Table 4, Katie A. Statewide Headcount, is based on two sources of information. First, it incorporates county self-reported data from the October 2014 and May 2014 County Semi Annual Progress Report. The self-reported information identifies potential subclass members (the high-risk pool for meeting subclass criteria), along with county-identified subclass members and subclass members receiving ICC and IHBS. The second source of information is from the DHCS Mental Health Services Claims Data Rolling Report for the 12-month period October 2013 through September 2014. The information from the Claims Data Report identified the number of subclass members claimed for any specialty mental health services received, along with the number of subclass members who received ICC and IHBS during the reporting period.

1

STATEWIDE			
From Katie A. Semi-Annual Progress County Self Reports			
Subclass Members Receiving Mental Health services:	Numerical Count		
	Subclass	ICC	IHBS
OCT 2014 Self report	12,538	5,800	4,006
Potential Subclass Members (from October 2014 Semi-Annual Report): 43,112			
Potential Subclass Members (from May 2014 Semi-Annual Report): 35,389			
From Katie A. Mental Health Services Reports			
Most recent report displayed first:	DHCS SD/MC Numerical Count Claimed		
	Subclass	ICC	IHBS
October 2014 (Oct 6, 2014 Rolling Total)	11,734	6.672	5,531
September 2014 (Sept 15 Rolling Total)	10,221	5,911	4,699

From Oct. 2014 Semi- Annual Report and DHCS Oct. Claimed Mental Health Services Report

Potential Subclass Self Reported	Subclass Count Self Reported	ICC Count Self Reported	IHBS Count Self Reported	Subclass Claimed Oct 14	ICC Claimed Oct 14	IHBS Claimed Oct 14
43,112	19,679 (46%)	5,800 (13%)	4,006 (9)	11,734 (27%)	6,672 (15%)	5,531 (13%)

2 Table 4

3

4

5

6

7

8

9

10

Table 4.1 (below) is the statewide Headcount, drawn from the same data sources used to produce Table 4 except that Los Angeles County data has been removed. Los Angeles County is operating under its own County Katie A. Settlement, and was uniquely positioned to implement ICC and IHBS and began implementation much earlier than the other counties. Consequently, LA County data is not representative of how the rest of the state is currently performing in providing ICC and IHBS.

STATEWIDE w/o Los Angeles			
From Katie A. Semi-Annual Progress County Self Reports			
Subclass Members Receiving Mental Health services:	Numerical Count		
	Subclass	ICC	IHBS
OCT 2014 report	26,572	3,493	1,812
Potential Subclass Members (from Oct 2014 County Semi-Annual Report): 26,849			
Potential Subclass Members (from May 2014 Semi-Annual Report): 23,626			
From Katie A. Mental Health Services Reports			
Most recent report displayed first:	SD/MC Numerical Count Claimed		
	Subclass	ICC	IHBS
October 2014 (Oct 6, 2014 Rolling Total)	8,081	3,420	2,261
September 2014 (Sept 15 Rolling Total)	6,848	2,887	1,653

From Oct. 2014 Semi- Annual Report and DHCS Oct. Claimed Mental Health Services Report						
Potential Subclass Self Reported	Subclass Count Self Reported	ICC Count Self Reported	IHBS Count	Subclass Claimed Oct. 14	ICC Claimed Oct 14	IHBS Claimed Oct 14
26,849	11,032 (41%)	3,493 (13%)	1,812 (7)	8,081 (30%)	3,420 (13%)	2,061 (8%)

Table 4.1

Based on the data presented above, it appears that statewide – both with and without Los Angeles County data, counties are claiming some form of mental services for a less than one-third (30 percent) of potential estimated subclass members. The October 2014 Self Report identified 41% of the potential subclass members receiving some form of mental health service. The State is continuing to review the difference between self reported data and actual claimed services and

self reported. These differences can be often the result of timing issues, State data more often than not lags behind county data or it can be a methodological issue in the data collection. The State will continue to work with counties to iron out these differences or irregularities in data reporting.

With regard to specific Katie A. ICC and IHBS intensive services, counties are claiming ICC for less than one-fifth (15 percent including Los Angeles and 13 percent without Los Angeles) of potential estimated subclass members, and are claiming IHBS for around one-tenth (13 percent including Los Angeles and 8 percent without) of potential estimated subclass members. This is an incremental increase since the Special Master October 2014 Report that addressed June 2014 Claims Data Report.

The statewide claims for IHBS, are slightly higher by 2 percent for ICC and 2 percent IHBS, of potential estimated subclass members compared to the October 2014 report I made to the Court, which is encouraging. The statewide numbers without including Los Angeles are up by 4 percent for ICC and 3 percent for IHBS of potential subclass members from my October Report. This is a significant and positive change and shouldn't go unnoticed. It's the first time since implementation that the State's percentage of ICC and IHBS provided to the potential subclass members has exceeded Los Angeles County. There does appear to be an increase in subclass members being identified by mental health but the rate at which these children are accessing ICC and IHBS continues to be problematic.

The gap between the number of children known to county child welfare agencies who appear to be subclass members (potential estimated subclass members) and the number of these children that are actually becoming subclass members is unacceptable. As reported in the October 2014 Special Master's Report, even by adjusting the potential estimate number of subclass members by one third, this continues to remain an unacceptable number of children not being able to receive/access ICC and IHBS, as medically necessary, a federally entitled service.

Status on State Activities for Increasing Services to Subclass Members in Selected Counties

There is good news. Looking over the October Semi-Annual Progress Report and the September 2014 DHCS Claims Data Report, there continues to be an increasing number of subclass members receiving ICC and IHBS. It's likely that State's efforts of outreaching to counties, providing a new level of monitoring, direct engagement and the provision of technical assistance for problem solving has contributed to this increase. Other factors have also

contributed to this increase as well. This includes counties preparing for the Semi-Annual Report, additional staffing at the county level and a better understanding of the implementation requirements.

The State has adopted and is successfully putting to use a 'Problem Solving' approach as they monitor and engage selected counties. This approach identifies county barriers/issues; identifies actions taken by the county to resolve the issue/barriers; assesses effectiveness of county actions; identifies State actions with timeframes, if necessary, with the specific intent on increasing the number of subclass members receiving ICC and IHBS. This problem solving approach is evident in the States Sixteen County Summary Report and in the Eight County Update.

The State's summary on their activities for increasing services to subclass members demonstrated the impact they are having by engaging counties through direct monitoring, personal involvement and technical assistance. This type of ongoing vigilance and problem solving intentionality during this critical phase of implementation will pay big dividends for increasing the number of subclass members who receive ICC and IHBS.

The State's problem solving approach should becoming increasingly more efficient and effective as the State gains an understanding of county operation issues, methods of identification of potential subclass members, screening, referral for assessment, subclass determination and the provision of ICC and IHBS.

The Sixteen County Summary and Eight County Update speaks for itself and it's very encouraging to see the State reporting out their actions and expected increases in ICC and IHBS. There are two areas of concern that have emerged in the Summary and Update. One, many counties are not transitioning subclass members who are receiving 'other mental health services' to ICC and IHBS. There are many possible reasons for this, but there are no 'substitutes or equivalents' for ICC and IHBS. It's clearly stated in the Medi-Cal ICC and IHBS Documentation Manual, subclass members are entitled to these services, as medically necessary, and should receive them consistent with the Manual. Two, there appears in the Summary and Update no acknowledgement that insufficient dollars exist to hire the staff necessary that would increase the number of subclass members receiving ICC or IHBS. If conversations were occurring about counties' limited capacity to hire staff due to lack of dollars I would hope that issue would surface sooner than later. Perhaps as the new Shared Management Structure emerges, if money to hire

staff arises as an issue, it will surface then.

The State has committed to continue to implement this approach beyond the Court's jurisdiction as one of a number of strategies to begin to significantly close the gap between the number of estimated potential subclass and subclass members receiving ICC and IHBS. This strategy alone will not be sufficient. The additional strategy described in the Recommendation One, from the Katie A. Statement of Agreement, October 28, 2014, Court Dkt 919, whereby the State will identify performance goals for counties, will strengthen the overall effectiveness of the State increasing the number of children and youth receiving ICC, IHBS, and TFC (once implemented), consistent with the CPM.

The State identifying county performance goals is in the early stages of implementing this action identified in the October, Statement of Agreement. The Sixteen County Summary and Eight County Update established a placeholder for this effort in the future, but at this time no county performance goals have been set. It's evident that the State is preparing its staff and counties for this goal setting process. It's also important that the State has been providing updates to their respective county associations regarding this activity, so there are no surprises. I'm optimistic that this work with counties will show meaningful and timely results in increasing the numbers of subclass members receiving ICC and IHBS.

The Special Master remains cautiously optimistic regarding the State's ability to keep this commitment on continuing this level of review and State actions with counties where documented access and under utilizations to ICC and IHBS for subclass members exist. Although there will be many new and potential State priorities that could redirect staff resources away from continuing the implementation of Katie A., in my conversations with State staff they continue to reflect a commitment consistent with the level of State and county engagement called for in the Statement of Agreements, Service Delivery Action Plan and the objectives of the Settlement Agreement.

In closing, ICC and IHBS are Medi-Cal/Medicaid services that the subclass members are entitled to under federal law, as medically necessary. Until a process is in place in all fifty-eight counties to ensure future potential subclass members are screened, and assessed by mental health to determine subclass eligibility and subclass members receive ICC and IHBS, the State should not reduce is efforts in implementation of Katie A.

TFC Implementation

As described earlier in this report, the State is working with CMS to secure approval of TFC. The Special Master remains optimistic that the State will secure CMS's approval to add TFC as a Medi-Cal covered service. There will be significant work that remains once CMS's approval is received in order to bring TFC online statewide. To avoid unnecessary delays in implementation it will be important that the State develop an updated work plan with timelines, to the extent possible, running concurrently with CMS review, that addresses specific implementation deliverables required for a successful statewide launch of TFC. Key deliverables will be identified in the Post Jurisdiction – Unfinished Implementation section below

State and County Structures: Implementation of a Shared Management Structure, Accountability, Communication and Oversight System and Core Practice Model Fiscal Strategies

As discussed earlier, the State has acted on the JMT/ACO recommendations. The Special Master wants to acknowledge the State for adopting the majority, if not all, of JMT/ACO recommendations. The operationalization, over the next six-eight months, of what has been adopted by DHCS and DSS will determine how effective the Shared Management Structure and Accountability, Oversight and Communication implementation will actually be. There remains a lot of decisions that need to be made, work processes to be developed and recommendations made and acted on. I have identified a number of key action items in the Unfinished Implementation Finding. I remain encouraged.

Post Jurisdiction – Unfinished Implementation Finding

The Special Master finds there remains significant unfinished and or yet to be implemented activities/deliverables from the Settlement Agreement, Court Dkt 779, Implementation Plan, Court Dkt 819-1, Service Delivery Action Plan, Court Dkt 883, Therapeutic Foster Care Work Plan Update, Court Dkt 883, *Statement of Agreement on Selected Recommendations*, Court Dkt 913, August 15, 2014 and Plaintiffs' and State Defendants', and Special Master's *Statement of Agreement on Recommendation 1-4,* October 28, 2014, Court Dkt 919. As intended, the implementation of Katie A. will continue past the Court's jurisdiction. As discussed earlier I will not list out all the activities the State will continue to undertake, instead my finding shall identify key activities or deliverables the State should begin implementing or continue implementing.

- **Executive Team**: Implement and operationalize the Shared Management Structure as

approved by DSS and DHCS. This includes convening the Executive Team meeting no later than January 15, 2015 and meet more frequently if issues arise, but to meet at least quarterly.

- **Community Team**: Implement and operationalize the Community Team component of the Shared Management Structure as approved by DSS and DHCS and meet on a quarterly basis.
- **Transformational Manager:** Finalize decision/timeline on hiring or contracting for the Transformation Manager/Facilitator function as part of the Shared Management Structure.
- **Departmental Policies and Procedures**: Develop and finalize, as part of the Shared Management Structure, a Memoranda of Agreement () between DSS and DHCS in order to better coordinate child welfare and mental health efforts to serve child welfare youth with mental health needs consistent with the activities and goals identified in the JMT recommendations i.e., operationalizing the coordination of routine communication, joint protocols for issuing and signing All County Letters and All County Information Notices.
- **Accountability, Communication and Oversight System**: As a component of the Shared Management Structure, DSS and DHCS Executive Team convene and charter the Community Team to develop recommendations for a comprehensive Continuous Quality Improvement (CQI) and Accountability as identified in the approved Shared Management Structure. Guided by the work of the JMT recommendations the Community Team make a recommendation by June 30, 2015 to the Executive Team for consideration and adopting as State policy.
- **Fiscal Strategies:** Executive Team develop and implement the DSS and DHCS approved Fiscal Strategies Recommendations 1.1.1-3.3.2, with particular emphasis on 1.1.1 as it pertains to aligning resources for training, coaching of individual to acquire the skills needed to implement and sustain the Core Practice Model Statewide and 1.2.1, DHCS publishing a comprehensive EPSDT Documentation Manual.
- **Service Delivery Action Plan and Statement Of Agreements**:

    a. Continue and/or implement the Action Plan steps the State departments will take to monitor the counties' progress in providing ICC and IHBS; improve performance of those counties that are not making sufficient progress in providing ICC and IHBS; transition subclass members who are currently receiving intensive mental

health services into ICC and IHBS and complete development of outcomes and accountability measures and quality controls systems consistent with the Core Practice Model.

b. DSS and DHCS continue its intentional focus and activities as specified in Recommendation 1, Statement of Agreement on Selected Recommendations, Court Dkt 913, for increasing ICC and IHBS, and TFC (once implemented) to subclass members in the twelve counties with the largest child welfare caseload, as well as in counties not yet providing services.

c. Implement actions/activities identified in Recommendation 1, Statement of Agreement on Selected Recommendations, Court Dkt 919 to identify for each county: a)performance goals for increasing the number of children and youth receiving ICC, IHBS and TFC (once implemented), and (b) a projected timeline for achieving these goals. These goals will be based on county-specific or local conditions.

d. Continue and implement actions/activities identified in Recommendation 2, Statement of Agreement on Selected Recommendations, Court Dkt 919, continue Counties' Semi-Annual Progress Reports.

- **TFC Implementation**: Implement TFC as a Medi-Cal service. Continue to pursue CMS's approval, and in order to promote a timely implementation of TFC. Pending CMS's approval, DHCS, and DSS and other stakeholders concurrently begin to address additional key TFC implementation areas that were identified in the TFC Work Plan Update. Potential areas include documentation requirements/progress notes, medical necessity/service criteria, service lockouts, and the development of separate but complementary provisional/draft foster care and mental health per diem rates or additional areas that have arisen since the February 2014 Work Plan Update was submitted to the Court.

SECTION SEVEN: SPECIAL MASTER'S RECOMMENDATIONS TO THE COURT

The Special Master makes no recommendations as the Court is expected to terminate its jurisdiction over this matter on December 5, 2014.

In closing, if as expected the November 24, 2014 Status Conference turns out to be the last time I will address the Court, I would like to thank the Court for affording me the privilege of serving as Special Master for the Katie A. case. It has been one of the most rewarding assignments of my career. To Judge Matz and Judge Kronstandt, the Katie A. children and families thank you for your dedication and perseverance. I can't say enough about the appreciation and gratitude I have for all those involved in the negotiation of the settlement agreement, the development of the implementation plan and monitoring its implementation. I would also like to extend a very special thank you to both Parties, counsel and program staff, for their patience, professionalism and passion for ensuring foster children and their families receive the services they need and are entitled to. I am proud of the accomplishments made by the Parties as reflected in the implementation of the Plan. I wish the State and Plaintiffs only the best as they continue to advance the implementation of Katie A. after termination of the Court's Jurisdiction.

Dated: November 20, 2014

Respectfully Submitted

Richard Saletta, LCSW

Richard Saletta, LCSW
Special Master