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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 JUNE 2014  
PROGRESS REPORT ON THE  
IMPLEMENTATION OF THE  
KATIE A. PLAN**

Crtrm: 750

Judge: Honorable John A. Kronstadt

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1  
2  
3 **SECTION ONE: INTRODUCTION**  
4

5 This Progress Report is submitted to the Court in accordance with the Katie A. Court's  
6 Orders dated March 19, 2014 and May 21, 2014 (Crt. Dkt. 887) directing the Special Master to  
7 file a status report due on or before June 16, 2014.

8 Before filing the Progress Report with the Court, the Special Master discussed his report  
9 with Parties and received comments. The views expressed in the Special Master's report on the  
10 State's progress in implementing the Katie A. Implementation Plan, hereafter referred to as the  
11 Plan, are those of the Special Master only and do not necessarily represent the views of the  
12 various parties and partners involved in implementing the Katie A. Plan. The Court also ordered  
13 any responses shall be filed no later than June 26, 2014.

14 There continues to be progress with the State's implementation of the Plan. Additionally,  
15 the implementation efforts have been augmented by the Parties having reached agreement on a  
16 Katie A. Service Delivery Action Plan and Updated Treatment Foster Care (TFC) Work Plan  
17 dated March 4, 2014 Court Dkt. 883, further specifying additional implementation detail that  
18 underscores current progress and future expectations. As ordered, the Special Master filed  
19 Monthly Updates with Court on the progress of implementing the Plan. Updates were filed for  
20 the months of March and April, 2014, and the June 1, 2014 Update on implementation will be  
21 incorporated into this report.

22  
23 **Purpose and Organization of this Report**

24 This report has two purposes: (1) update the Court on progress made in implementing the  
25 Katie A. Plan since the November 18, 2013 Status Conference; and (2) provide the Court with  
26 additional recommendations regarding the implementation of the Plan.

27 This Progress Report is a follow up to the July 26, 2013 report (Crt. Dkt. 855). For that  
28 report, I compiled three documents, the Katie A. Implementation Plan – Phase One, (Crt. Dkt.  
29 819-1), and Phase Two (Crt. Dkt. 828-1) along with the Timeline Modifications (Crt. Dkt. 839)  
30 into one description of all the deliverables from all the various documents, with duplicate  
31 deliverables removed for the sake of simplifying the Progress Report. That compilation was well

1 received by the Court and the Parties and I will use that approach for this June 2014 Progress  
2 Report. In addition to this compiled information, I will also include details from the Katie A.  
3 Service Delivery Action Plan and the Therapeutic Foster Care Work Plan (Crt. Dkt. 883) that  
4 specify additional implementation expectations. This larger compilation, which I will refer to as  
5 *The Special Master's Consolidated Plan of Katie A. Deliverables*, will serve as the key reference  
6 document for this current June 2014 Progress Report. A complete copy of the Consolidated Plan  
7 is attached at the end of this report as Exhibit 1, along with the various Court-approved  
8 documents that informed it. These include the *Katie A. Implementation Plan – Phases One and*  
9 *Two* (Exhibits 1.1 and 1.2); the *Timeline Modifications* (Exhibit, 1.3); the *Katie A. Service*  
10 *Delivery Action Plan* (Exhibit 1.4); and the *Therapeutic Foster Care Work Plan* (Exhibit 1.5).

11 For this June 2014 Progress Report I will change the order of my discussion from past  
12 reports to better summarize implementation progress made to date. In my previous Special  
13 Master' Progress Reports, the Katie A. implementation effort consisted almost entirely of plan  
14 development, consequently, those previous progress reports focused on what planning steps had  
15 been accomplished, and those reports were organized to reflect the organization of the plans—  
16 essentially those reports described the Parties' planning efforts as preliminary steps toward actual  
17 implementation. For this report, however, there has been a full year of implementation plan  
18 rollout—the plans have been put into action—and with this June 2014 progress report I can now  
19 describe actual progress that has been made in providing Katie A. services to eligible subclass  
20 members and in forming the new system structural relationships called for in the Plan. That is,  
21 rather than report only on planning I can now talk about progress that has resulted in subclass  
22 members actually receiving ICC and IHBS as medically necessary and consistent with the Core  
23 Practice Model. Additionally, I can now report on efforts to establish and sustain a State and  
24 local Shared Management Structure and transparent Accountability, Communication, and  
25 Oversight system.

26 For this reason I will approach the discussion with a different presentation format. This  
27 June 2014 report begins with a discussion of the actual delivery of services to Katie A. children,  
28 which is at the heart of the Katie A. Settlement Agreement, highlighting quantitative service  
29 delivery data provided by the counties as an empirical base for discussing the other ongoing  
30 aspects of Katie A. implementation such as formation of new system structures and the various  
31 trainings and technical assistance efforts that are now rolling forward.

1 As such, this report is organized into six sections plus exhibits:

- 2 • One: Introduction
- 3 • Two: Katie A. Services to Subclass Members
- 4 • Three: Katie A. State and County Structures
- 5 • Four: Katie A. Training and Technical Assistance
- 6 • Five: The Special Master's Summary and Findings
- 7 • Six: The Special Master's Recommendations to the Court
- 8 • EXHIBITS

9  
10  
11 **SECTION TWO: KATIE A. SERVICES TO SUBCLASS MEMBERS**

12 Service delivery implementation is occurring in several steps: identifying subclass members  
13 for whom Katie A. prescribed services are medically necessary, transitioning subclass members  
14 who are currently receiving other intensive mental health services to the Katie A. model,  
15 providing Intensive Care Coordination (ICC), and providing Intensive Home Based Services  
16 (IHBS) consistent with the Core Practice Model. In addition, the State Department of Health  
17 Care Services (DHCS) is pursuing federal approval of Therapeutic Foster Care (TFC) through a  
18 State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS),  
19 although TFC has not yet been implemented. Progress in implementing each of these five  
20 activities is summarized in this section.

21  
22 **Identifying and transitioning eligible subclass members to Katie A. services**

23 During the past year, the 58 California counties have started identifying Katie A. subclass  
24 members and some counties have reported providing them with mental health services as  
25 medically necessary. Many of the children identified by the counties in the October 2013 and  
26 May 2014 County Semi-Annual Progress Reports as receiving Katie A. services during the  
27 reporting period were already receiving intensive mental health services prior to the Katie A.  
28 rollout and are now being reported as subclass members served. The county reports, described in  
29 detail below, show that in the majority of counties relatively few of these children received either  
30 ICC or IHBS. That is, these children were not necessarily new to the system and newly  
31 receiving Katie A. services, rather they are ongoing clients being newly accounted for through

1 the Katie A. reporting process—their service records have been transitioned to the Katie A. effort  
2 but they are not necessarily receiving ICC or IHBS.

3 The counties also have been reporting services to subclass members through the Short-  
4 Doyle Medi-Cal (SDMC) claims system; these claimed services also are described in detail in  
5 the following paragraphs. The combination of County Progress Reports and State SDMC claims  
6 summary reports provide a significant amount of service delivery data that adds a new dimension  
7 to this Special Master's Progress Reports: the ability to describe actual services that are being  
8 delivered to members of the Katie A. subclass in every county statewide. As noted above, earlier  
9 Special Master Reports were limited to describing progress in plan development, while this  
10 current report will focus on describing the early implementation stages of providing actual  
11 services to eligible subclass members. These actual service numbers also provide a foundation  
12 for discussing progress being made in developing county and state service system structures, and  
13 in providing training, technical assistance, and quality improvement plans and actions as  
14 necessary to the counties.

#### 15 16 **County Semi-Annual Progress Reports and State-reported SDMC Claims**

17 Counties were required to submit semi-annual progress reports by October 1, 2013 and May  
18 1, 2014. These two reports provide numeric and narrative information about Katie A.  
19 implementation in each county. In addition, DHCS published three monthly reports (March,  
20 April and May 2014) summarizing Short-Doyle Medi-Cal claims for fiscal year 2013-14. These  
21 SDMC reports, presented as graphs and spreadsheets, supply very precise claims data covering  
22 the broad array of mental health services provided to subclass members, including ICC and  
23 IHBS. Data from these five reports, distinguishing between county-reported and State-reported  
24 data, provide a foundation for the discussion in this section.

#### 25 26 **County-reported service data**

##### 27 *County estimate of potential subclass members identified during the reporting period*

28 In addition to reporting the numbers of children served, all counties were asked in their May  
29 report to calculate and report the number of potential subclass members who could be  
30 determined eligible for intensive Katie A. mental health services based on criteria provided by  
31 the State. Stated simply, this number represents the best estimate, developed collaboratively by

1 the Child Welfare Services and Children's Mental Health departments within each county, of the  
2 total number of potentially eligible subclass members in each county. Although this number is  
3 not an exact case count, it is an informed estimate that reflects each county's best understanding  
4 of the number of subclass members who might be eligible for medically necessary mental health  
5 services under the Katie A. criteria. A few small county May reports are missing (Lassen,  
6 Mariposa, Merced, Plumas, and Sierra), although their absence does not have significant impact  
7 on the overall compiled findings.

### 8 9 *Service delivery data*

10 The following paragraphs present several basic summaries of the data covering county self-  
11 reported efforts to estimate the number of potential subclass members, to identify subclass  
12 members, to provide ICC and IHBS, and to begin claiming those services through SDMC. In  
13 order to analyze this array of data, I have used the five reports to compile key quantitative data  
14 from each county into a document I have attached to this report as Exhibit 2, *Katie A. County*  
15 *Headcount Tables*. This is a Special Master constructed report that has recently been shared with  
16 the parties for their comments and suggestions. Its purpose is to put information from multiple  
17 reports into a single format to make it easier for the Court and Parties to see and understand the  
18 data.

### 19 20 *Compiling the county self-reported data*

21 Combining the number of potential subclass members with the numbers of subclass  
22 members who were reported by counties as actually served in the May 2014 County Semi-  
23 Annual Progress Reports suggests the following statewide totals (it is important to note that the  
24 reported subclass count for one county has been removed because of an apparent and significant  
25 reporting error):

- 26 • Total number of potential subclass members statewide: 35,389
- 27 • Total statewide subclass actually served by the counties: 14,616
- 28 • Total statewide who received ICC: 3,912
- 29 • Total statewide who received IHBS: 2,808

1 *Percentage of subclass served—statewide*

2 Combining each county's May 2014 estimate of potential subclass members with the actual  
3 numbers of subclass members the county reported serving offers a method to develop an  
4 informed estimate of progress each county has made to date in implementing ICC, IHBS, and  
5 other intensive mental health services. That is, by dividing the number of children actually  
6 served (numerator) by the number of potential subclass members estimated in the county  
7 (denominator), a percentage can be generated—with the proviso that the calculation is not a firm  
8 number, but rather an informed estimate supported by the best data currently available.

9 Dividing the total reported statewide number of subclass members reported served (14,616)  
10 by the total estimated statewide number of potential subclass members (35,389) suggests that  
11 about 41.3 percent of potential subclass members received some form of intensive mental health  
12 services under Katie A. during the most recent reporting period (per the May 2014 report).  
13 Similarly, dividing the total reported statewide number of subclass members who received ICC  
14 (3,912) by the total reported statewide potential (35,389) suggests that about 11.0 percent of  
15 potential subclass members received ICC services during the reporting period. And dividing the  
16 total reported statewide number of subclass members who received IHBS (2,808) by the total  
17 reported statewide potential (35,389) suggests that about 7.9 percent of potential subclass  
18 members received IHBS services during the reporting period. Again, as noted above, these  
19 calculations are based partially on an estimated number of potential subclass members and  
20 should not be interpreted as a firm calculation. Nonetheless, these are numbers generated by  
21 each county themselves and represent the best estimate available at this time. These percentages  
22 represent the level of progress made during the first year of Katie A. service delivery  
23 implementation and are expected to increase as the rollout moves forward.

24

25 *County groupings by population size*

26 Because of the extreme variation in county size (from the largest, Los Angeles with a 2014  
27 population of 10,041,797 to the smallest, Alpine with a population of 1,079) it is helpful to  
28 subdivide the full set of 58 counties into clusters based on population size. The California  
29 Mental Health Directors Association (CMHDA) County Directors' list characterizes counties  
30 with populations of less than 400,000 as Small Counties, which is a useful distinction and is well  
31 established in many years of mental health administrative initiatives. For the purposes of this

1 report I further break out Los Angeles as a unique and distinct stand-alone county, both because  
2 of its very large population and because the county has considerable experience with Katie A.  
3 implementation through its separate settlement under the Katie A., et al. v. Diana Bonta, et al.  
4 lawsuit. In this discussion I also find it useful to divide the small counties into two groups—  
5 what are sometimes referred to as “medium size” counties with a population fewer than 400,000  
6 but greater than 100,000 and the remaining small counties with populations fewer than 100,000.  
7 Dividing the 58 counties into these four groups based on similar population sizes provides  
8 additional perspective into the level of Katie A. implementation around the state. These four  
9 cluster groupings include:

- 10 • Los Angeles County (2014 population 10,041,797) as a stand-alone county.
- 11 • 20 large counties – San Diego (3,194,362), Orange (3,113,991), Riverside (2,279,967),  
12 San Bernardino (2,085,669), Santa Clara (1,868,558), Alameda (1,573,254), Sacramento  
13 (1,454,406), Contra Costa (1,087,008), Fresno (964,040), Kern (873,092), Ventura  
14 (842,967), San Francisco (836,620), San Mateo (745,193), San Joaquin (710,731),  
15 Stanislaus (526,042), Sonoma (490,486), Tulare (459,446), Santa Barbara (433,398),  
16 Monterey (425,756), and Solano (424,233).
- 17 • 14 medium sized counties – Placer (366,115), San Luis Obispo (272,357), Santa Cruz  
18 (271,595), Merced (264,922), Marin (255,846), Butte (222,316), Yolo (206,381), El  
19 Dorado (182,404), Imperial (180,672), Shasta (179,412), Madera (153,897), Kings  
20 (150,181), Napa (139,255), and Humboldt (134,648).
- 21 • 23 small counties – Nevada (97,225), Sutter (95,733), Mendocino (89,029), Yuba  
22 (73,682), Lake (64,699), Tehama (63,717), San Benito (57,517), Tuolumne (53,604),  
23 Siskiyou (45,231), Calaveras (44,650), Amador (36,151), Lassen (32,581), Glenn  
24 (28,353), Del Norte (28,131), Colusa (21,660), Plumas (19,140), Inyo (18,590), Mariposa  
25 (18,467), Mono (14,143), Trinity (13,389), Modoc (9,197), Sierra (3,089), and Alpine  
26 (1,079). (All 2014 population estimates are from the California Department of Finance  
27 web site.)

28 The combined number of potential subclass members and service totals for each clustered county  
29 grouping, as self-reported by counties in the May 2014 County Semi-Annual Progress Reports,  
30 are as follows:

- 1 • Statewide: Potential subclass=35,389; Subclass served=14,616; ICC served=3,912; IHBS  
2 served=2,808.
- 3 • Los Angeles County: Potential subclass=11,763; Subclass served=6,391; ICC  
4 served=1,749; IHBS served=1,770.
- 5 • Large counties: Potential subclass=19,101; Subclass served=6,566; ICC served=1,800;  
6 IHBS served=861.
- 7 • Medium counties: Potential subclass=3,260; Subclass served=1,032; ICC served=234;  
8 IHBS served=101.
- 9 • Small counties: Potential subclass=1,265; Subclass served=627; ICC served=129; IHBS  
10 served=76.

11  
12 ***Percentage of subclass served—statewide and by counties clustered by population size***

13 Percentages for these four county cluster groupings are somewhat different from the total  
14 statewide percentages of subclass served (p.9). The percentages of subclass members that the  
15 counties self-reported in May 2014 as receiving Katie A. services per the total number of  
16 potential subclass members suggest the following:

- 17 • Statewide: Subclass served=41.3%; ICC served=11.0%; IHBS served=7.9%.
- 18 • Los Angeles County: Subclass served=54.3%; ICC served=14.9%; IHBS served=15.0%.
- 19 • Large counties: Subclass served=34.4%; ICC served=9.4%; IHBS served=4.5%.
- 20 • Medium counties: Subclass served=31.6%; ICC served=7.2%; IHBS served=3.1%.
- 21 • Small counties: Subclass served=49.6%; ICC served=10.2%; IHBS served=6.0%.

22  
23 It is interesting to note that there was some variation between county clusters, with the  
24 medium-size counties reporting lower percentages than the other counties. I will discuss these  
25 differences below in Section Five Special Master Findings and Comments.

26  
27 **State-reported service data**

28 ***Short-Doyle Medi-Cal claims data***

29 The State DHCS has published several monthly reports of county claims for Katie A.  
30 services received through the Short-Doyle Medi-Cal (SDMC) claiming system. According to  
31 these State documents, total claims statewide and for counties in each of the four clusters are as

1 follows:

- 2 • Statewide: Subclass claimed=6,358; ICC claimed=3,438; IHBS claimed=3,848.
- 3 • Los Angeles County: Subclass claimed=2,159; ICC claimed=1,858; IHBS
- 4 claimed=1,894.
- 5 • Large counties: Subclass claimed=3,422; ICC claimed=1,214; IHBS claimed=1,796.
- 6 • Medium counties: Subclass claimed=580; ICC claimed=260; IHBS claimed=110.
- 7 • Small counties: Subclass claimed=197; ICC claimed=106; IHBS claimed=48.

8  
9 The corresponding percentages of potential subclass members for each grouping (dividing  
10 the State SDMC claims numbers by the county May report estimates of potential subclass  
11 members) are as follows:

- 12 • Statewide: (Potential subclass=35,389); Subclass claimed=17.9%, ICC claimed=9.7%,  
13 IHBS claimed=10.9%.
- 14 • Los Angeles County: (Potential subclass=11,763); Subclass claimed=18.4%, ICC  
15 claimed=15.8%, IHBS claimed=16.1%.
- 16 • Large counties: (Potential subclass=19,101); Subclass claimed=17.9%, ICC  
17 claimed=6.4%, IHBS claimed=9.4%.
- 18 • Medium counties: (Potential subclass=3,260); Subclass claimed=17.8%, ICC  
19 claimed=7.9%, IHBS claimed=3.4%.
- 20 • Small counties: (Potential subclass=1,265); Subclass claimed=15.6%, ICC  
21 claimed=8.4%, IHBS claimed=3.8%.

22

### 23 **Brief observations**

24 As reported in the May County Semi-Annual Progress reports, the clustered county  
25 breakouts suggest that the medium sized counties reported significantly fewer subclass members  
26 served (31.6%) compared to the statewide average (41.3 percent). On the other hand and as  
27 reported on the State SDMC claims reports, the percentage of claimed services was fairly evenly  
28 distributed among the four clusters with the exception that Los Angeles County is claiming a  
29 higher percentage than the other counties. It is also interesting to note that statewide total  
30 number of children for whom counties claimed ICC (3,848) significantly exceeds the number of  
31 children counties reported as receiving IHBS (2,808). These and other observations regarding

1 services to and claims for subclass members will be discussed in Section Five: Special Master's  
2 Summary and Findings.

3 It also appears that the relatively rapid increase in the number of subclass members reported  
4 served in the time period between the October and May County Semi-Annual Progress Reports  
5 and increases in the number of subclass members claimed on the State SDMC reports between  
6 March and May most likely occurred through transitioning subclass members who were  
7 receiving ongoing mental health services prior to the Katie A. rollout, rather than through  
8 bringing newly identified subclass members into services. This point is supported by the  
9 relatively lower numbers of children who counties reported as receiving and who counties  
10 claimed as receiving ICC and IHBS.

11 The DHCS *Katie A. Report on County on Vendor Status* (Exhibit 3) indicated that as of May  
12 31, 2014 several counties were not claiming or were not able to claim Katie A. services through  
13 SDMC. Forty-six counties were providing and submitting claims for ICC and/or IHBS, ten  
14 counties had the ability to process ICC and/or IHBS but were not yet providing the services, and  
15 two counties did not have the ability to process ICC and/or IHBS claims and were not providing  
16 the services at that time. Since the May report two counties that had been able to claim but were  
17 not providing the services in April 2014 are now providing and submitting claims for ICC and  
18 IHBS.

19

#### 20 **County narrative comments from the May reports**

21 The October 2013 and May 2014 Semi-Annual Progress Reports also contained many  
22 narrative comments from the counties regarding service delivery to subclass members, as well as  
23 comments regarding county efforts to implement the Katie A. initiative. I would like to highlight  
24 a few comments regarding services to subclass members that various counties expressed in their  
25 May 2014 County Semi Annual Progress Reports. Overall, these county comments speak for  
26 themselves.

#### 27 ***Moving forward***

28 Glenn: *Human Resource Agency (HRA) and the Health Services Agency (HSA)/Mental*  
29 *Health Services (MHS) continue to collaborate on developing a comprehensive service*  
30 *delivery system to meet the needs of children and youth who meet the criteria for the Katie*  
31 *A. subclass.*

1 San Diego: An increase in staff in all regional mental health clinics is planned to occur  
2 beginning in July 2014 to assist with the increase capacity projections.

3 Solano: Despite lack of state funding the county agencies are creatively using available  
4 resources to implement new and promising practices and explore evidence based practices.

5 **Early stages**

6 Placer: Just getting started and operational challenges.

7 Ventura: The current system's capacity is not sufficient to meet the projected need for  
8 increased screening and assessment and enhanced, integrated services under the Katie A  
9 mandate.

10 Napa: Our barrier to implementation of ICC and IHBS has been the infrastructure to  
11 support the programs. We have made a conscious decision to delay implementation until we  
12 have hired new staff and make a seamless coordinated service.

13 **Funding barriers**

14 Contra Costa: The state has not allocated enough funding to properly implement Katie A.  
15 and to allow the hiring of additional staff or increase provider contracts.

16 Fresno: A significant lack of funding provided by the State to meet the program needs,  
17 teaming, monitoring and data reporting... directly attributed to Katie A. Settlement  
18 Agreement with State agencies that are now being passed down to counties. Therefore the  
19 participation by mental health in working with children and families in Child Welfare Team  
20 Meetings hasn't occurred due to the lack of resources.

21 Riverside: New funding has not been provided to pay for the increased services to the  
22 children and to support the administrative structures.

23 Orange: Barrier to implementation is funding to hire staff in the clinics to provide IHBS.

24 Madera: The dollars allocated for Katie A are inadequate to serve all the children in the  
25 class.

26 Humboldt: Completion of both the data and narrative portions of this report should not be  
27 interpreted as agreement with the State's position on expanded service obligations or on  
28 other fiscal issues. Humboldt County DHHS does not waive its right to a future Prop 30  
29 claim.

30 **Interdepartmental and contractor barriers**

31 Los Angeles: Given the size and scope of the County and the size of contract procurement

1 needs, County requirements require extra time for implementation.

2 Alameda: At the direction of County Counsel, BHCS and DCFS are currently engaged in a  
3 "risk analysis" to update existing MOU with agreements that allow for the sharing of  
4 mental health data that DCFS needs to identify subclass more completely.

5 El Dorado: We must rely on the capacity of our contract providers who do all Children's  
6 Services. This has been a challenge and will likely continue to be a challenge without  
7 additional funds for this mandate.

8 Kern: Issues in relation to maintaining HIPAA mandates especially in data collection.  
9 However, when trying to coordinate data it does become much more difficult to verify if  
10 releases are in place for 500 plus children.

11 Humboldt: County Contracting Process – IHBS RFP has been in development for  
12 approximately seven months. County RFP process was revised during that time, and many  
13 changes had to be made to the original RFP.

14 San Mateo: The count for ICC is low because BHRS contractors have not yet established an  
15 electronic data tracking system.

16 Kings: County is continuing to provide direction to the contracted provider on expectations  
17 that all subclass members be Medi-Cal billed within the next month. There have been some  
18 delays with the provider getting the Katie A. Identification form...

19  
20 **Therapeutic Foster Care (TFC)**

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

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

1 The original January 1, 2014 planned date for statewide implementation of TFC has been  
2 extended seven months to August 1, 2014 (Crt. Dkt. 883) due to the lengthy process of approval  
3 through the federal Centers for Medicare and Medicaid Services (CMS). DHCS submitted a  
4 State Plan Amendment (SPA) for TFC to CMS on March 31, 2014, starting the ninety day  
5 waiting period for CMS to respond to the State SPA. Since submission of the SPA, CMS has  
6 requested additional information from DHCS on TFC parent training and qualifications and has  
7 posed several TFC service utilization questions. DHCS is in the process of responding to these  
8 questions after consultation with national consultants, plaintiffs, and following a DHCS internal  
9 review. Additional activities and timelines which must be completed before TFC can be  
10 implemented on August 1, 2014 are described in the TFC Work Plan.

### 11 12 13 **SECTION THREE: KATIE A. STATE AND COUNTY STRUCTURES**

14  
15 The Katie A. Settlement Agreement (Exhibit 4) and subsequent implementation plans call  
16 for the State to establish an array of State—and eventually county—service system structures  
17 and processes that will oversee, promote, monitor, provide quality oversight, and ensure the  
18 sustained implementation of Katie A. services.

#### 19 20 **Joint Management Taskforce (JMT)**

21 The purpose of the JMT is to make recommendations to DHCS and DSS for the  
22 establishment of a Shared Management Structure (SMS) that will oversee the Katie A. initiative  
23 for the long term. (The overall JMT objectives and intended results are set forth in the *Joint*  
24 *Management Taskforce (JMT) Charter*, (Exhibit 5). The Settlement Agreement anticipated that  
25 on or before September 2, 2012, JMT recommendations would be submitted to DHCS and DSS  
26 (Exhibit 4, Paragraph 20(d)), the Implementation Plan – Phase Two (Exhibit 1.2, Section One),  
27 and the JMT Charter (Exhibit 5, Page 1)). The JMT Charter also indicated that DHCS and DSS  
28 would respond with a decision regarding those recommendations by December 2012. This  
29 timeline was not met and was revised during the development of the Implementation Plan –  
30 Phase Two, with a projected timeline of six to eight months for JMT recommendations to be  
31 submitted to DHCS and DSS. Once the recommendations had been submitted, the State

1 departments would publish their response within ninety days, with an anticipated publication  
2 date of October 1, 2013 (Crt. Dkt. 839).

3 The Implementation Plan – Phase Two, called for DHCS and DSS to use the JMT  
4 recommendations to establish a Shared Management Structure by October 1, 2013 with a shared  
5 vision and mission statement that would set policy and program direction, provide clear and  
6 consistent guidance, and identify outcomes and accountability measures that are consistent with  
7 the Katie A. Core Practice Model (CPM). The SMS would provide the framework, models, and  
8 technical assistance for county child welfare and mental health agencies to consider in order to  
9 work more effectively together at the local level consistent with the CPM, and also to involve  
10 families and youth in local decision making. The JMT was also tasked with incorporating the  
11 functions of the Accountability, Communication, and Oversight System (ACO) Taskforce. ACO  
12 Taskforce recommendations would be submitted by the JMT to the State departments for action  
13 within ninety days. (The purpose and progress of the ACO Taskforce are discussed below.) The  
14 October 2013 timeline for DHCS and DSS to act on the JMT/SMS recommendations was  
15 extended a second time to November 2013 (Crt. Dkt. 839), and then extended a third time in  
16 April 2014 with a due date of August 12, 2014 (Crt. Dkt. 892), nearly two years later than the  
17 original September 1, 2012 date established in the Settlement Agreement.

18 Three JMT meetings were held between October 2012 and July 2013 without producing  
19 recommendations. The JMT was expected to meet over the summer of 2013 to finalize its  
20 recommendations to DHCS and DSS, however recommendations were not developed. The JMT  
21 created a Steering Committee in December 2013 initially comprised of DHCS, DSS, the  
22 California Mental Health Directors Association (CMHDA), the County Welfare Directors  
23 Association of California (CWDA), the Plaintiffs, providers, and the Special Master to accelerate  
24 the process of reviewing assembled materials and proposals in an effort to present draft  
25 deliverables to JMT before June 2014—however, this did not occur. In April 2014 the Court  
26 authorized the Special Master to hire two consultants to assemble the written JMT products to  
27 date, which included the JMT and ACO Charters, the ACO Mappings Recommendations,  
28 materials from earlier meetings, and written input submitted earlier by the JMT members. These  
29 consultants have been hired and are contracted to provide the JMT Steering Committee, which  
30 now includes additional members representing parent and youth perspectives, with suggested  
31 recommendations by the end of June 2014. The JMT is projected to finalize its SMS and ACO

1 recommendations in July 2014 and forward its recommendations to DHCS and DSS, which in  
2 turn will publish a response to the recommendations by August 12, 2014.

3  
4 **Accountability, Communication and Oversight System (ACO) Taskforce**

5 The purpose of the ACO Taskforce is to make recommendations to DHCS and DSS for the  
6 adoption of a statewide quantitative and qualitative data-informed system of oversight,  
7 accountability, and communication. (The overall objectives and intended results are set forth in  
8 the Implementation Plan – Phase Two, Exhibit 1.2, Sections I and VI) The ACO Taskforce  
9 recommendations are intended to promote the development and use of the Core Practice Model,  
10 to ensure effective, quality mental health services, and to efficiently monitor, measure, and  
11 evaluate access to services, service delivery, and costs at the individual, program, and system  
12 levels. The ACO Charter indicated that the objectives and intended results of the ACO  
13 recommendations were not expected to be fully achieved before the end of Court jurisdiction on  
14 December 31, 2014. The Taskforce recommendations and report were to reflect three stages of  
15 implementation:

- 16 • Stage 1 – Implementation planning  
17 • Stage 2 – Implementation during court oversight  
18 • Stage 3 – Post court jurisdiction

19 The ACO Taskforce was initially intended to be a sub-committee of the JMT, or part of the  
20 SMS if it were implemented prior to the ACO completing its work. However, it was concluded  
21 by the parties, and approved by the Court, that the membership of the JMT included many of the  
22 same representatives who would also sit on the ACO Taskforce. So—striving for efficiency and  
23 effectiveness—it made practical sense for members of the JMT to also serve as the ACO  
24 Taskforce with the addition of key program and quality assurance representative from the State,  
25 counties, and providers.

26 The Settlement Agreement anticipated that on or before September 2, 2012, the JMT  
27 recommendations would be submitted to DHCS and DSS (Katie A. Settlement Agreement at  
28 paragraph 20(d) and JMT Charter). This date was not met. The Taskforce was also to receive  
29 recommendations from the ACO Mapping Group made up of subject matter experts charged  
30 with developing an inventory and report describing the current array of ongoing State and county  
31 data efforts by DSS and DHCS and others. The ACO Mapping Group work was to be completed

1 and presented to JMT on or before its second monthly meeting scheduled for May 2012. This  
2 date was not met.

3 The Implementation Plan – Phase Two, established a new date for the ACO Taskforce to  
4 begin meeting by February 28, 2013, with a projected timeline of six to eight months for ACO  
5 recommendations to be submitted to DHCS and DSS through the JMT. Once the  
6 recommendations had been submitted, the State departments would publish their response within  
7 ninety days, with an anticipated publication date of October 1, 2013 (Crt. Dkt. 839). As occurred  
8 with the JMT timeline discussed above, the October 2013 timeline for DHCS and DSS to act on  
9 the JMT/SMS recommendations, which contained the ACO recommendations, was extended a  
10 second time to November 2013, and then extended a third time in April 2014 with a due date of  
11 August 12, 2014 (Crt. Dkt. 892), nearly two years later than the original September 1, 2012 date  
12 established in the Settlement Agreement.

13 The JMT/ACO Taskforce has been convened two times since June 2013. A JMT Steering  
14 Committee was formed in early 2014 to prepare materials for the JMT to consider for the SMS  
15 and ACO deliverables, and is currently coordinating input from the consultants on the JMT/ACO  
16 recommendations. The CPM Fiscal Taskforce recommendations (discussed below) will be  
17 forward along with the JMT/ACO recommendations to DHCS and DSS by the August 12, 2014  
18 timeline established by Crt. Dkt. 892.

19  
20 **Core Practice Model (CPM) Fiscal Taskforce**

21 The purpose of the CPM Fiscal Taskforce is to develop a strategic plan using fiscal  
22 incentives and reduced administrative barriers to accomplish statewide adoption of the *Katie A.*  
23 Core Practice Model (CPM), deliver intensive home and community based services to subclass  
24 members within the CPM framework, and reduce the use of congregate care. (The overall  
25 objectives and intended results are set forth in the Implementation Plan – Phase One, Exhibit 1.1,  
26 Section VI.)

27 The original due date for the CPM Fiscal Taskforce to complete its recommendations and  
28 forward them to JMT was June 15, 2012 (CPM Fiscal Task Force Charter, Exhibit 6) but was  
29 extended during the development of Phases One and Two of the Implementation Plan to October  
30 2013, and was extended again to November 1, 2013 (Crt. Dkt. 839). The taskforce met  
31 regularly, finalizing and submitting its recommendations to the JMT Taskforce by the November

1 2013 deadline. CPM Fiscal Taskforce recommendations are currently awaiting review and  
2 comment by the JMT and will be forwarded to DHCS and DSS for action according to the  
3 revised timeline of August 12, 2014 (Crt. Dkt. 892).

4  
5 **Katie A. Advisory Group**

6 The purpose of the Katie A. Advisory Group is to provide collaborative support, guidance,  
7 and feedback on changes in policy and practice to promote the overarching goals of the Katie A.  
8 settlement. Once formed, the membership will include key State and county partners, youth,  
9 families, and other community partners and advocates involved with child welfare and/or mental  
10 health services. As collaborative partners, the Advisory Group will be charged with providing  
11 support, advice, and feedback about State policies and programs relevant to service delivery, data  
12 collection, quality improvement, and accountability regarding child welfare youth and families  
13 who need mental health services.

14 The Advisory Group—which has not yet been formed or convened—would be a  
15 repurposing and recasting of what was formerly the Katie Negotiation Workgroup, which official  
16 ended more than a year ago on April 18, 2013. The general concept of an Advisory Group has  
17 been supported by the State departments but at this time implementation has been postponed.

18  
19  
20 **SECTION FOUR: KATIE A. TRAINING AND TECHNICAL ASSISTANCE**

21  
22 The Katie A. Settlement Agreement and subsequent implementation plans call for the State  
23 to provide training, develop cross-system training curricula and educational materials and  
24 manuals, endorse practice tools, and provide technical assistance and support for problem  
25 solving and guidance for child welfare and mental health leadership, the workforce, families, and  
26 youth that is consistent with the Katie A. Core Practice Model (CPM).

27  
28 **Manuals**

29 *The Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services*  
30 *(IHBS) and Therapeutic Foster Care (TFC) for Katie A. Subclass Members* (Medi-Cal  
31 Documentation Manual)

1 The purpose of the Medi-Cal Documentation Manual is to provide the county Mental Health  
2 Plans (MHPs) and Medi-Cal providers with standards and guidelines for delivering and billing  
3 Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and once it has been  
4 approved, Therapeutic Foster Care (TFC). The documentation manual is a companion document  
5 to the Core Practice Manual (CPM) Guide (discussed below) which describes a shift in how  
6 individuals service providers and systems are expected to address the needs of children/youth  
7 and families in the child welfare system.

8 The original December 31, 2012 timeline for implementation of the Medi-Cal  
9 Documentation Manual was extended to March 1, 2013 (Crt. Dkt. 828) and the manual was  
10 released statewide by that date, accompanied by an All County Letter (ACL) and an All County  
11 Information Notice (ACIN) which announced the manual and included a schedule of statewide  
12 regional trainings.

13  
14 ***The Pathways to Mental Health Services: Core Practice Model Guide*** (CPM Guide)

15 The CPM Guide is intended to be the first in a series of resources for the child welfare and  
16 mental health systems to assist with the implementation of the Core Practice Model. The  
17 purpose of the guide is to provide practical guidance and direction for county child welfare and  
18 mental health agencies, other service providers, and community and tribal partners who will be  
19 implementing the CPM when working with children and families involved with child welfare  
20 who have or may have mental health needs. The guide is intended to facilitate a common  
21 strategic and practical framework that integrates service planning, delivery, coordination and  
22 management among all those involved or working with children who are being served through  
23 multiple service systems. The guide underscores the value of a family centered approach that  
24 collaboratively works together as team to improve outcomes for children, youth, and families.

25 The initial January 1, 2013 deadline for implementation of the CPM Guide was extended to  
26 March 31, 2014 to coordinate its release with the release of the Medi-Cal Documentation  
27 Manual (Crt. Dkt 828). The Guide was issued concurrent with an All County Letter and All  
28 County Information Notice announcing implementation of the Guide and a schedule of statewide  
29 regional trainings.

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**Technical Assistance**

***Problem Solving Forum and technical assistance conference calls***

The Technical Assistance and Training timelines were extended from January 16, 2013 to March 31, 2013. The purpose of the weekly technical assistance conference calls is to provide a forum for information sharing, technical assistance, and problem solving for county child welfare, mental health agencies, providers, parents, youth, and other stakeholders. State staff from DHCS and DSS routinely schedule and provide weekly one hour conference calls. State staff also post and respond to Frequently Asked Questions (FAQs) on the DSS and DHCS webpage and have developed webinars to address reoccurring issues or questions. State staff also are available for off-line conversations to discuss and seek solutions with individuals on issues or problems that were not suited for a problem solving forum call.

The Weekly Technical Assistance calls began in March 2013 immediately following implementation of the Medi-Cal Documentation Manual and CPM Guide. Calls have occurred generally on a weekly basis, primarily focusing on implementation of ICC and IHBS, including billing and claiming issues and completion of or updating County Readiness Assessments and Semi-Annual Progress Reports. Calls will be moving to every two weeks beginning in June 2014.

***Confidentiality***

In the October and May Semi-Annual Progress Reports and during the State-county weekly technical assistance calls, counties have identified confidentiality barriers in sharing data and information between child welfare and mental health agencies for the purposes of treatment planning, utilization review and quality improvement. These confidentiality barriers are impeding efforts in some counties to develop the electronic data and verbal communication infrastructure necessary to effectively ensure and manage access, service coordination, and utilization of mental health services for Katie A. class and subclass members. Counties are asking for guidance and technical assistance from each other and from the State to address these issues. While some counties have developed county-specific solutions to address the problem or have created work-around solutions, many remain frustrated that they cannot resolve these confidentiality barriers.

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**Regional Trainings on the Medi-Cal Documentation Manual and the CPM Guide**

The State departments have conducted Statewide Regional Trainings to provide an orientation to and basic information on the purpose, goals, and use of the Medi-Cal Manual and the CPM Guide. Additionally, the regional trainings were intended to provide a forum for an in-person question and answer opportunity so that counties, providers, parents, youth, and other stakeholders could become more familiar with the background and expectations in implementing Katie A.

The Regional Trainings were initially scheduled to begin by February 28, 2013 but were extended to April 28, 2013. While the Implementation Plan only called for four regional trainings, trainings were completed in eight locations around the state, including San Jose, Davis, Fresno, Redding, Pasadena, Anaheim, Sacramento, and Riverside.

**Statewide Trainings to support implementation of Katie A.**

The Statewide Training and Education Committee (STEC) that State DSS uses to coordinate child welfare training efforts was tasked to develop and endorse practice tools, training and coaching curricula, and practice improvement protocols to support the shared CPM and service integration and the implementation of Katie A. STEC is made up of representatives from DSS, DHCS, the University of California, Davis, the Resource Center for Family Focused Practice, the California Social Worker Education Committee (CalSWEC), the Regional Training Academies, the California Institute of Mental Health, and the Child and Family Policy Institute of California. STEC was launched in April 2013 and, working closely with DHCS and DSS, laid the groundwork for the implementation of the Learning Collaboratives and a series of Webinars/In Person Trainings.

**Webinars and In-Person Trainings**

The State developed and has implemented Webinars and In Person Trainings as a series of focused trainings for counties, providers, parents, youth, and other stakeholders to support the implementation of Katie A. STEC and CalSWEC have been working together since January 2014 to provide a series of Webinar Trainings. Eight webinar trainings have already occurred and three additional webinars are scheduled in the coming months. Webinars are generally

1 ninety minutes in duration. Topics have ranged from Training the Trainer on Facilitating a Child  
2 and Family Team, Teaming and Engaging Families, Using Evidence Based Practices for System  
3 Change, and Continuous Quality Improvement. STEC has also constructed a Learning  
4 Collaborative Tool Kit webpage to publish the successes and challenges of the Southern Region  
5 Learning Collaborative. Planned future webinars will cover Engaging Youth and Families as  
6 Partners, Outcomes, Developing Measures and Processes for Accountability and Improvement,  
7 and Transitions-Moving from Formal to Informal Supports.

### 8 9 **The Partnership for Wellness**

10 The State departments also convened a Statewide Institute to provide training with a specific  
11 focus on the implementation of Katie A. The institute, held in June 2014 and titled Partnerships  
12 for Wellness, repurposed a previously-planned national Wraparound Institute conference to  
13 focus in large part on the implementation of Katie A. Nearly one thousand people attended,  
14 including county representatives, providers, parents, youth, and other stakeholders.

### 15 16 **Learning Collaborative Counties**

17 Four regional Learning Collaboratives have been formed to identify Model/Early  
18 Implementer counties as a strategy to roll out implementation of the Core Practice Model for the  
19 full Katie A. class, and to promote shared accountability and outcomes across county child  
20 welfare services and mental health. Learning Collaborative goals include creating an  
21 environment for shared learning within and among county child welfare services and mental  
22 health agencies and their key partners, facilitating peer-to-peer learning, identifying shared needs  
23 and solutions to meet those needs, and connecting counties to experts in other counties and in the  
24 field. The learning collaborative approach is a model of training where multiple teams work  
25 together to adopt or improve a system practice and focus on learning from collective experience  
26 in diverse service settings. The process includes counties being able to share and learn from one  
27 another's collective experiences, challenges, skills, and strategies. Information from the  
28 Collaboratives will inform the State on supports needed and also will be shared with all counties  
29 and stakeholders through CalSWEC's Learning Collaborative Webpage. The Learning  
30 Collaborative regions include Northern, Central, and Southern California and the San Francisco  
31 Bay Area.

1  
2 Learning Collaborative implementation, initially scheduled to begin by June 30, 2013 with  
3 the identification of counties interested in participating in the Collaboratives, was officially  
4 launched with a statewide meeting in October 2013. The Special Master's November 4, 2013  
5 Report to the Court (Crt. Dkt. 865) reviewed this launch. The four regional collaboratives  
6 include: *Bay Region*—Contra Costa, San Francisco, Santa Cruz and Solano; *Central Region*—  
7 Fresno, San Luis Obispo, and Santa Barbara; *Southern Region*—Los Angeles, Orange, San  
8 Bernardino, Riverside, Imperial, San Diego, and Ventura; and *Northern Region*—Glenn, Inyo,  
9 Humboldt, Mendocino, Shasta and Tuolumne. Other counties have also attended the Regional  
10 Collaborative meetings to get updates on implementation and technical assistance. Each of the  
11 four regions hold regularly scheduled conference calls and periodic face to face meetings. Also  
12 participating in the Learning Collaboratives are representatives from collaborating organizations  
13 that include DHCS and DSS, the California Social Work Education Center (CalSWEC), the  
14 Child Welfare Regional Training Academies, the Resource Center for Family-Focused Practice,  
15 the California Institute of Mental Health (CiMH), the Child and Family Policy Institute of  
16 California, Rady Children's Hospital/Chadwick Center for Children and Families, and Parents  
17 Anonymous, Inc.

18 The Collaboratives have developed and shared annotated bibliographies regarding Child and  
19 Family Teams, screening methods, and outcome measure/indicators. CalSWEC has developed a  
20 Web page for the Child Welfare/Mental Learning Collaboratives to coordinate communication  
21 and training. The Web page has an extensive amount of information relevant to the  
22 implementation of Katie A. including a section for sharing resources and a County Toolkit. The  
23 Toolkit is essentially a warehouse of information submitted by any participant of the Learning  
24 Collaboratives and covers various topics including assessment and screening tools,  
25 communication tools, policies and procedural tools, fiscal and funding tools, technical assistance  
26 and training, coaching, and transfer of learning tools. The Toolkit is a work in progress and will  
27 continue to evolve over time. The second statewide convening of the Learning Collaboratives is  
28 scheduled for August 2014.

29  
30 **Other trainings**

31 State Katie A. leadership frequently attends their respective county association monthly

1 meetings to ensure that Katie A. implementation is on the agenda and to sustain discussion of  
2 Katie A. implementation issues, provide informal updates, and solve problems. Meetings  
3 include the California Mental Health Directors Association (CMHDA) committee meetings  
4 (e.g., Children's Systems of Care, Medi-Cal Policy, Information Technology, Financial Services  
5 and Executive Board), and the California Welfare Directors Association (CWDA) Children's  
6 Operations and Executive Committees, as well as the CWDA Board of Directors.

7 CWDA and State DSS are launching a statewide CWS Core Practice Model implementation  
8 effort across county child welfare agencies. Although CWS CPM implementation is on a  
9 different timeline than Katie A. CPM implementation, the values, principles, and objectives for  
10 both models are similar, and in many aspects, the same. The Katie A. and CWDA/DSS CPM  
11 implementation efforts share a common goal of aligning the mental health and child welfare  
12 workforces with a shared practice approach to services, interventions, and decision-making.  
13 CWDA and DSS are working collaborative with their partners, including mental health agencies,  
14 in an effort to ensure the two CPM initiatives complement one another and to the extent possible  
15 are the same.

### 17 **Web page Development**

18 The State departments maintain Web pages to be as transparent as possible in providing  
19 stakeholders and the general public specific information on the implementation of Katie A. The  
20 Web pages include Katie A. background, agreement, and implementation plans, related Court  
21 documents, manuals, answers to frequently asked questions, State all county letters and all  
22 county information notices, State data, and county data and reports. The Web pages maintain a  
23 section for Frequently Asked Questions (FAQs) that are raised in the implementation of Katie A.  
24 by counties, providers, parents, youth, and other stakeholders in order to provide consistent  
25 written guidance and direction to support the successful implementation of Katie A. Twelve  
26 FAQ's were first posted in August 2013 and the State is continuing to review questions for future  
27 FAQ's. Additionally, the Web pages have links to other Katie A. implementation resources.  
28 The initial Web page implementation timeline was extended from February 1, 2013 to April 1,  
29 2013. Each department Web page has been operational since April 2013, and is regularly  
30 updated with Katie A. materials.

31

1  
2                   **SECTION FIVE: SPECIAL MASTER’S SUMMARY AND FINDINGS**  
3

4           As the Katie A. Special Master, in this section I will attempt to summarize progress and  
5 describe my findings regarding implementation of the Settlement Agreement and the  
6 Implementation Plan during the past 12 months. It is not my intention to address the full array of  
7 issues covered in previous Special Master Reports and Updates to the Court. Instead, I will  
8 focus on key matters I believe are central and pivotal to successful implementation over the past  
9 year and into the future.

10          I commend the effort and intention of all the parties in advancing the Katie A. effort. The  
11 past 30 months of implementation rollout have required massive work, especially on the part of  
12 the State departments and county agencies, along with much support, forbearance, and  
13 encouragement on the part of the Plaintiffs and the parents and providers who were members of  
14 the Negotiation Workgroup. It also is essential to acknowledge that the plan developed through  
15 the Settlement Agreement has encountered enormous challenges arising from fundamental  
16 changes in the State and county service delivery environments that occurred after the original  
17 settlement negotiations were completed—in particular, the consolidation of the former State  
18 Department of Mental Health (DMH) into the Department of Health Care Services (DHCS), and  
19 the realignment of mental health and child welfare services to the counties, along with an array  
20 of administrative and legal changes that have accompanied this fundamental restructuring of the  
21 California service delivery environment. In many ways, the Katie A. implementation effort has  
22 been “overtaken by events” that had been looming during the planning process but have only  
23 manifested fully during the past two years.

24          In this regard, the Special Master’s summary and findings discussed here are presented  
25 within the context of a rapidly and continuously changing statewide service delivery  
26 environment and with the understanding that all the Parties are working very hard to manage and  
27 respond to many significant and unanticipated changing conditions at both the county and state  
28 levels. To this end, the Parties and Special Master have continued to hold at least monthly calls,  
29 paying particular attention to the requirements, tasks, opportunities, and challenges that continue  
30 to emerge in the implementation of this section of the Plan.

31          In the following discussion, I will begin by setting a context for understanding the changed

1 California environment and the impact this has had on implementation, particularly involving a  
2 continuous series of Plan timeline extensions, and how these have impacted the various services  
3 to subclass members, State and county structures, and training and technical assistance results  
4 that have been achieved so far. I also will speak to service claiming, fiscal concerns, and issues  
5 that have emerged related to the Affordable Care Act (ACA). And I will complete my  
6 discussion with a few comments and a finding regarding a threshold of sustainability that must  
7 be reached in order to ensure the continuing success of the Katie A. initiative into the future.

8  
9 **The changed California environment**

10 Several key changes took place in California during the past few years of Katie A.  
11 implementation. In fiscal year 2011/12, Governor Brown signed legislation approving the  
12 realignment of several State programs to local county government—including Mental Health and  
13 Child Welfare Services—along with fiscal responsibility for those programs. At the same time,  
14 the Governor also approved consolidation of the State Department of Mental Health into the  
15 State Department of Health Care Services. Soon afterward, California voters passed *Proposition*  
16 *30-Realignment – Temporary Taxes to Fund Education. Guaranteed Local Public Safety*  
17 *Funding*, which in part restricts State authority to expand program requirements in the future  
18 without providing additional money to pay for increased costs, and also requires the State to  
19 share responsibility for certain unanticipated program costs resulting from court action or  
20 changes in federal statutes and regulations.

21 Although these changes have had huge impact on the Katie A. implementation effort, they  
22 were not unexpected. Throughout the period of my role as Special Master for Katie A. I have  
23 continuously expressed concern with the intended and unintended effects on the pace and  
24 success of Katie A. implementation that would come with both realignment and consolidation,  
25 and in particular how these would impact the counties, the State departments, and the  
26 relationship between the State and counties. For example, I spelled out these concerns in the  
27 Special Master's Reports dated July 22, 2011 (Crt. Dkt. 751, p 3-8, 12); February 10, 2012 (Crt  
28 Dkt. 787, p. 13, 14); April 23, 2012 (Crt. Dkt. 798, p 8, 16, 17); November 29, 2012 (Crt. Dkt.  
29 828, p 8); March 1, 2013 (Crt. Dkt. 839, p 10, 14-18); July 26, 2013 (Crt. Dkt. 855 p 45-50);  
30 November 4, 2013 (Crt. Dkt. 85, p. 9); and April 2, 2014 (Crt. Dkt. 892, p. 2-4). My concerns  
31 have also been reflected in the Court's Orders dated July 17, 2012; December 13, 2012 (Crt. Dkt.

1 834 and Cr. Transcript); August 26, 2013 (Cr. Dkt. 857); and April 11, 2014 (Cr. Dkt. 893).

2 My longstanding concerns as presented in these documents make it clear that the current  
3 difficulties posed by realignment and consolidation should be no surprise to any of the parties or  
4 to the Court. Additionally, Court transcripts from most if not all hearings also reflect the Special  
5 Master's continuous concern about the uncertainty surrounding State and county relationships,  
6 and in particular between DHCS and the county mental health agencies and their association, the  
7 California Mental Health Directors Association (CMHDA).

8 My specific concerns have always been focused on the limited transfer of institutional  
9 knowledge from DMH to DHCS that would occur with consolidation, the uncertain conditions  
10 imposed on the counties by realignment, and the effect these changes would have on DHCS'  
11 capacity to move mental health issues forward and to execute decisions with authority and  
12 responsibility in matters of services, funding, direction, guidance, and accountability. Perhaps  
13 the biggest impact consolidation and realignment have had on plan implementation has been the  
14 continuous extension of timelines and deadlines for the multitude of steps and benchmarks that  
15 have been established in all the Katie A. planning documents.

16

17 **Plan timeline extensions**

18 Serious questions about the timely implementation of the Katie A. Settlement Agreement  
19 arose during the very initial planning stage when the parties and stakeholders were trying to  
20 complete the Implementation Plan. Optimistically, in order to move things forward as quickly as  
21 possible, work began on developing the Implementation Plan in October 2012, several months  
22 prior to final Court approval of the plan which was received in December 2012. The Parties  
23 were anxious to launch the agreement and to move as quickly as possible to provide ICC and  
24 IHBS to the subclass and to begin the implementation of the system reform elements embedded  
25 in the Agreement. It is worth noting that the substantive elements of the Proposed Agreement  
26 were finalized nearly one year before the Governor and the Court had approved the agreement—  
27 such was the urgency of the parties to move forward.

28 However, with consolidation several key partners from DMH were reassigned out of the  
29 Katie A. effort, in particular veteran senior staff who understood the complex issues facing both  
30 the State and the counties. At the same time, several new partners joined the Katie A. Settlement  
31 Team—the County Welfare Directors Association of California (CWDA) sent a new

1 representative, and a new parent representative joined the team. And the California Mental  
2 Health Directors Association (CMHDA), after choosing not to participate in the development of  
3 the Agreement, decided to join the Negotiation Workgroup for the Implementation Plan  
4 development phase. All new members of the Workgroup were oriented to the process and  
5 updated on the Settlement Agreement, its timelines, and its expectations.

6 Consolidation of DMH into DHCS moved the DHCS representative into the forefront of  
7 planning leadership without the level of subject matter expertise, technical support, and  
8 institutional memory that had been provided in the past by DMH. DHCS did bring in additional  
9 staff to assist, but they were unfamiliar with the thinking and planning that had occurred during  
10 the previous two years of negotiating the Settlement Agreement, and they had limited experience  
11 negotiating policy and implementation with the county Mental Health Plans (MHPs).

12 Consequently, DHCS as the lone representative for state mental health was left in a  
13 weakened position, especially in terms of anticipating and planning the myriad details of mental  
14 health services and system structural changes at the county level. Unfortunately, the weakened  
15 institutional capacity of DHCS allowed the CMHDA representative, who had purposefully not  
16 participated in the original settlement negotiation process, to challenge parts of the agreements  
17 that had already been settled. As a result, attention that could have been devoted to the many  
18 demands of developing and providing complex services to Katie A. subclass members was  
19 diverted toward rehashing and renegotiating the fiscal interests of the counties.

20 Over the next year, valuable time that should have been devoted to fleshing out the details of  
21 the Settlement Agreement for the benefit of Katie A. children and families was consumed by  
22 many hours of CMHDA questioning and repeatedly compelling discussions of county agency  
23 issues that had been set aside during the first phase of the settlement negotiations. Again and  
24 again, actions that could have been taken under the original agreement were postponed due to the  
25 inability of the Workgroup to reach consensus, largely because of the single issue focus of  
26 CMHDA. County fiscal issues and CMHDA inflexibility were not the sole reasons for delays  
27 and timeline extensions, but the inability of the State DHCS to assert authority over the  
28 counties—mainly as a result of realignment and consolidation and the impact overload these had  
29 on DHCS—greatly contributed to the many timeline setbacks that occurred.

30 These were difficult months and proved over time very frustrating to most of the Workgroup  
31 members. As Special Master, I commend the Negotiation Workgroup's professionalism and

1 patience in enduring the confusion, frustrations, and generally chaotic conversations that took  
2 place for so long. In spite of the conflicts, the Workgroup was able to reach agreement after this  
3 twelve month process to develop Phases One and Two of the Implementation Plan.

4 In the fall of 2012 CMHDA withdrew from the planning effort and filed a formal complaint  
5 with the State regarding the Workgroup process. The Court directed the DHCS Director to  
6 engage CMHDA and confirm the State's claim that they will continue to participate with DHCS  
7 in the implementation of Katie A. The DHCS Director secured a letter of continued support and  
8 willingness to remain engaged from CMHDA. Unfortunately, county difficulties with service  
9 delivery, claiming, training, staffing, and interagency information sharing continue to complicate  
10 the implementation rollout effort. Perhaps if CMHDA had elected to participate in the initial  
11 Negotiation Workgroup *Interest Based Decision Making* consensus development phase that  
12 resulted in the Court-approved Settlement Agreement, their finance and governance interests  
13 could have been addressed and many current county difficulties could have been avoided.

14 Overall, the Katie A. implementation effort has been marked by a continuous series of  
15 timeline extensions, caused by a variety of factors including the massive impact of consolidation  
16 and realignment. Some important schedules originally built into the Settlement Agreement still  
17 have not been met 30 months into the 36 month period of Court jurisdiction. As Special Master I  
18 am concerned that these delays, which I will discuss below, are having a deleterious effect on  
19 implementation, and that many underlying barriers continue to hinder the timely and effective  
20 delivery of Katie A. services as well as the development of State and county structures to ensure  
21 the success and sustainability of the Settlement Agreement.

### 22 23 **Services to subclass members**

24 The County Semi-Annual Progress Reports provide important data regarding county efforts  
25 to identify and provide services to Katie A. subclass members. As noted in Section Two, nearly  
26 every county has begun the arduous process of identifying, transitioning, and serving subclass  
27 members under the Katie A. protocol. The county self-reports suggest that fewer than half of  
28 potential subclass members statewide (41.3%) are currently being counted and served by the  
29 counties. However, county-reported data also indicate that relatively few potential subclass  
30 members in the counties are receiving the two central Katie A. subclass services, Intensive Care  
31 Coordination and Intensive Home Based Services. Based on their own counts and reporting

1 efforts, the counties are currently providing ICC to slightly more than ten percent (11.0%) of  
2 potential subclass members and IHBS to slightly fewer than eight percent (7.9%).

3 I am particularly concerned with the number of large and medium size counties that are  
4 reporting disproportionately low percentages for ICC and IHBS services. According to the May  
5 2014 County Semi-Annual Progress Reports, the average percentages of potential subclass  
6 members receiving ICC and IHBS from the large counties are 9.4 percent for ICC and 4.5  
7 percent for IHBS, and the average percent of subclass members receiving ICC and IHBS from  
8 the medium counties are 7.1 percent for ICC and 3.1 percent for IHBS. My concern with low  
9 average scores for these two county groups is that half of the counties in each group are  
10 providing ICC and IHBS to fewer than the average—with some counties in both groups  
11 reporting ICC and IHBS services to two or one or zero percent of their potential subclass  
12 members. These numbers are not from the SDMC claims reports, which in some counties are  
13 caused by problems filing claims—these numbers are the actual numeric counts the counties  
14 reported in their semi-annual reports and are the best data currently available to describe the  
15 level of services to subclass members. I will discuss this concern further in my  
16 recommendations to the Court.

17 For the most part, it appears that the majority of subclass members being counted and  
18 reported by the counties are children and youth who were formerly receiving intensive mental  
19 health services through typical mental health service programs and have now been reclassified as  
20 Katie A. subclass members. That is, most subclass members now being reported have not yet  
21 begun receiving ICC or IHBS but, rather, have been administratively shifted into the Katie A.  
22 pool as a first step in transitioning existing subclass members into Katie A. services.

23 Short-Doyle Medi-Cal (SDMC) Claims Reports published by the State DHCS show a  
24 similar trend as the county progress reports. That is, the majority of counties have begun  
25 claiming Katie A. services through the new Demonstration Project Indicator (DPI) billing code  
26 and, statewide, just under 18 percent (17.9%) of potential subclass members' services are being  
27 claimed via SDMC. The State claims data also indicate that ICC services to slightly fewer than  
28 ten percent (9.7%) of potential subclass members and IHBS services to slightly more than ten  
29 percent (10.9%) of potential subclass members are currently being claimed.

30 It also is important to note that DHCS has not yet secured approval from the federal Centers  
31 for Medicare and Medicaid Services (CMS) to provide and claim Therapeutic Foster Care (TFC)

1 services under Medi-Cal, and progress on TFC implementation appears to have slowed. The  
2 TFC Workplan (Exhibit 1.5) extended the date for TFC implementation from December 31,  
3 2013 to August 1, 2014 due to conflicting workload demands and the time required to submit the  
4 State Plan Amendment (SPA) and respond to CMS. The extension also identified critical  
5 decision points and timelines that must be met to achieve implementation by August 1.

6 The Workplan set March 31, 2014 as the date by which the State, Plaintiffs, and their  
7 assisting national experts would answer a set of TFC/SPA questions posed by CMS regarding  
8 provider qualifications and service utilization. In March, the State received responses and  
9 recommendations from the Plaintiffs and the national consultants on the CMS questions, and the  
10 State appears to agree with these recommendations—however as of June 2014 the State has not  
11 yet responded to CMS. Several other milestones also appear not to have been met regarding  
12 documentation requirements, medical necessity/service criteria, lockouts and limitations, state  
13 law change questions, rates approval, plus others. At this time, CMS is waiting for the State's  
14 responses.

15 Achieving implementation by August will require strict adherence to the TFC Workplan  
16 timelines; unfortunately, the plan schedule again is falling behind. As Special Master I have  
17 submitted questions to DHCS regarding these and other related issues critical to meeting the  
18 August 2014 TFC Workplan timeline. As of this time, I have not received complete responses  
19 from the State and have requested that DHCS be prepared to address TFC Workplan timelines  
20 and the Special Master's Questions at the July 2, 2014 Status Conference.

21 And, as quoted in Section Two above, many of the counties reported difficulties in  
22 implementing Katie A. services to subclass members, including early stage capacity challenges,  
23 funding barriers, and communication and collaboration obstacles between county departments  
24 and with contractors. These all are common difficulties associated with any startup effort, and  
25 are to be expected with a statewide initiative on the scale of the Katie A. implementation.  
26 Nonetheless, these are real and significant barriers that are impeding progress in many counties  
27 and are keeping subclass members from receiving entitled services.

28  
29 **State and county structures**

30 Three Taskforces—Joint Management (JMT); Accountability, Communication, and  
31 Oversight (ACO); and Core Practice Model (CPM) Fiscal—were chartered to make

1 recommendations regarding a Shared Management Structure (SMS) to DHCS and DSS  
2 leadership for consideration followed by action within ninety days of receiving the  
3 recommendations. As discussed earlier in Section Three, the work of the Taskforces, including  
4 their recommendations to DHCS and DSS, was to be completed by January 1, 2013 in order to  
5 inform and guide the implementation process. This has not happened. While it is certain and  
6 understandable that the changing and challenging state environment discussed above has  
7 significantly affected the State departments' workloads, decision-making, and resource  
8 management—thereby delaying progress with the restructuring effort—the SMS is essential to  
9 implementation plan success, and the lengthy delay in developing the SMS has seriously  
10 impaired the overall implementation effort. The recommendations of the JMT and ACO are  
11 considered the “bookends” of the implementation plan that would provide the support, context,  
12 and framework to sustain Katie A. implementation and promote the system changes embedded in  
13 the Settlement Agreement. Similarly, the CPM Fiscal Taskforce recommendations are essential  
14 to promoting the Core Practice Model to all children in the Katie A. class. In that regard, these  
15 recommendations are of paramount importance in the overall implementation effort.

16 As Special Master, I have repeatedly identified in my reports the importance of early  
17 implementation of the SMS and ACO at the State level as spelled out in the Agreement and  
18 JMT/ACO Charters, as well as promoting similar actions at the local level. A new timeline  
19 extending the deadline was set in the Service Delivery Action Plan (Exhibit 1.4) to, August 12,  
20 2014, has been approved by the Court for JMT, ACO, and CPM Fiscal to complete their work  
21 and for DHCS and DSS to take action on the recommendations. And in addition, as Special  
22 Master I requested and received Court approval to hire to outside consultants to ensure that these  
23 tasks are completed on time. Having these two core requirements of the Settlement Agreement  
24 delayed this long, coupled with delays in counties providing ICC and IHBS, raises questions in  
25 my mind about the level of implementation that has taken place to date. I cannot overstate the  
26 importance of completing this part of the plan as soon as possible.

27 Considering the many uncertainties that continue to unfold as a result of realignment—and  
28 specifically the fiscal matters (discussed below) of the Proposition 30 mandates and EPSDT  
29 funding, along with the counties' ability to meet the entitlement requirements of Katie A.  
30 services—I am uncertain whether or not the implementation effort is approaching a sufficient  
31 level of structural change and service delivery capacity to ensure successful and sustained Katie

1 A. services into the future.

2

3 **Training and technical assistance**

4 *Katie A.* Training and Technical Assistance has been one of the bright spots in the  
5 implementation effort. The weekly technical assistance calls, the regional orientations on ICC  
6 and IHBS, the Webinars, the in-person trainings, the County Learning Collaborative Process, and  
7 the State Katie A. Web pages all are either completed or up and running. All of these activities  
8 experienced some lag in implementation due to delays in completing the Medi-Cal  
9 Documentation Manual and the CPM Guide, along with time consumed in selecting counties for  
10 the Learning Collaboratives. Initially, I was initially critical of DHCS and DSS implementation  
11 of the Training and Technical Assistance effort through the Statewide Training and Education  
12 Committee (STEC), however over time many of my concerns have been addressed. I am  
13 particularly encouraged by the launch of the Learning Collaboratives, development of the  
14 CalSWEC Webpage as a communication tool, engagement and coordination with child welfare  
15 and mental health training institutes, and overall development and implementation of the various  
16 Katie A. trainings. STEC and its key partners should be commended for their effort. The State  
17 staff and leaders have been essential to this success.

18 Another bright spot in CPM implementation and training, although not directly tied to the  
19 implementation of Katie A., is the CWDA and State DSS initiative to develop, plan, and launch a  
20 statewide CPM with child welfare staff. As discussed earlier, although the CWS CPM is not  
21 identical to the Katie A. CPM, there is enough similarity between them to promote the changed  
22 practice embedded in the Katie A. CPM, and the CWDA/DSS effort underscores the value of the  
23 Katie A. Core Practice Model implementation system wide.

24 As Special Master I have on many previous occasions commented on the interagency  
25 teaming that takes place between DHCS and DSS. Their ongoing partnership can be seen during  
26 their weekly shared meetings, technical assistance calls, and when problem solving the various  
27 issues that continually arise as the implementation effort rolls out. Their collaborative work  
28 reviewing and analyzing the County Semi-Annual Progress Reports and Service Delivery  
29 Readiness Assessments has enabled the Team to gain a broader understanding of how child  
30 welfare and mental health agencies work together at the local level. As the ACO and SMS are  
31 implemented, the State departments will continue to grow in capacity and skill in assisting

1 counties to meet the needs of their shared children, youth, and families. With regard to training  
2 and technical assistance, the State leadership deserves great credit for working hard to model  
3 interagency collaboration at the highest level.

4 Unfortunately, CPM implementation and support has been limited by continuous delays in  
5 DHCS DSS considering and acting on the CPM Fiscal Task Force Recommendations described  
6 above regarding funding strategies for statewide implementation of the CPM, including training,  
7 coaching, and mentoring. These delays have significantly limited the counties' capacity to  
8 develop, implement, and support CPM at this early stage of implementation.

9  
10 **Confidentiality**

11 Counties continue to identify confidentiality as a barrier to sharing data and information  
12 between child welfare and mental health agencies for the purposes of treatment planning, quality  
13 improvement, and utilization review. Confidentiality issues surfaced for both child welfare and  
14 mental health agencies, but most frequently occur when mental health tries to share its client  
15 information with child welfare. County Counsels in all 58 counties wrestle with this issue within  
16 and between departments, and are frequently unable to find solutions that will provide an  
17 effective and systematic way to exchange information between child welfare and mental health  
18 agencies. There seems to be no single solution to this statewide system problem. The State has  
19 been unable to offer any statewide solution to address county confidentiality concerns, but has  
20 made an effort to help counties inform one another about strategies they have developed to solve  
21 their local confidentiality problems. It is difficult to know how many of these county-specific  
22 solutions have been adopted by other counties. From my conversations and review of reports it  
23 appears a few counties have developed county-specific solutions to address the problem or have  
24 created work-around solutions, many remain frustrated that they cannot resolve these  
25 confidentiality barriers.

26 It also has recently been determined that State DHCS cannot disclose county-level mental  
27 health service data due to its interpretation of HIPAA restrictions on the publication of mental  
28 health data. DHCS reports that it can only publish state-level data. Consequently, the Court, the  
29 Parties, children, youth, parents, counties, service providers, and other interested stakeholders  
30 have no access to county-level mental health data and statistical reports regarding Katie A.  
31 implementation or ongoing service delivery. This creates enormous barriers to local and

1 statewide planning, accountability, performance improvement, service planning and delivery  
2 efforts, and overall transparency for Katie A. which is essential and central to statewide  
3 implementation and overall success of the Settlement Agreement. The significance of this  
4 barrier to mental health information cannot be overstated. The DHCS has indicated to the  
5 Special Master that they are working on a plan that would allow publishing county and service  
6 level data, but at the time of writing this report it's not clear on what the outcome of that effort  
7 will be.

### 8 9 **The Medi-Cal Documentation Manual and CPM Guide**

10 DHCS decided to have an internal DHCS workgroup draft the initial Medi-Cal  
11 Documentation Manual. Public comment on the draft was very critical, with complaints that the  
12 tone was harsh and the compliance requirements were over-reaching. DHCS attempted to  
13 resolve the problems with the manual by bringing in a former DMH staff member with  
14 considerable subject matter expertise who had participated in the settlement effort but had been  
15 reassigned when DMH was consolidated into DHCS. Unfortunately, that person was not  
16 immediately available to rewrite the manual and the timeline for completing the manual had to  
17 be extended from December 2012 to March 2013. At the same time, the completion date for the  
18 CPM Guide, a companion to the Documentation Manual, was also extended to March 2013.  
19 After much internal DHCS effort, the former DHM staff expert was assigned to work with a  
20 stakeholder team made up of State, county, parent, and provider representatives to redraft the  
21 manual addressing the public comments. Both documents—which have been very favorably  
22 received by the field—were completed by the March 2013 timeline.

### 23 24 **Service claiming**

25 In December 2012, DHCS notified the California Mental Health Directors Association  
26 (CMHDA) that the new Katie A. Short-Doyle Medi-Cal (SDMC) billing codes had been  
27 developed. DHCS also published an All County Information Notice on Claiming ICC and IHBS  
28 on May 3, 2013. At that time the State also officially proposed a Demonstration Project  
29 Indicator (DPI) code for claiming Katie A. services through SDMC. The counties responded that  
30 the DPI code increased confusion about the claiming process and raised new questions about  
31 who was going to pay for the computer software updates required to implement the codes in

1 every county. This technical problem delayed claiming along with delivery of services in many  
2 counties, and has still not been fully resolved.

3 My November 4, 2013 Special Master's Progress Report and March and April 2014 Updates  
4 to the Court described efforts and progress being made to resolve the DPI and claiming services  
5 problems. Although the claiming codes for ICC and IHBS had been established and the counties  
6 notified in December 2012, many counties were not ready or prepared to provide and claim these  
7 services until nearly one year later. As noted throughout this Progress Report, implementation of  
8 the Katie A. Settlement Agreement has experienced a continuous series of delays and timeline  
9 extensions that, two-and-a-half years into the three-year Court plan, have not yet been fully  
10 resolved. Again, my greatest concern with the implementation effort to date is that the process  
11 has fallen behind, especially in terms of the relatively low numbers of children receiving ICC  
12 and IHBS and the absence of State and county structures that are absolutely essential to the  
13 success of the Plan.

14

#### 15 **Fiscal Concerns**

16 With regard to EPSDT funding, the Special Master finds the State's response to the Court's  
17 Order of April 11, 2014 (Crt. Dkt. 893) insufficient in answering the questions and assertions  
18 raised by the Court and the Executive Directors of the CMHDA and the California State  
19 Association of Counties (CSAC) in their December 6, 2013 letter (Dkt. 892, Ex. D) and in the  
20 March 18, 2014 Memorandum from CMHDA (Crt. Dkt. 892, Ex. E). As the April 11, 2014  
21 Order indicated, there will be a comprehensive and coherent discussion of all these issues at the  
22 June 19, 2014 Status Conference.

23 It will be important for the State to factor the following recent developments into its  
24 discussions:

- 25
- 26 • How do the DHCS ACIN 14-016 FY 2012-13 Behavioral Health Subaccount Allocations  
27 (Exhibit 7.1) and ACIN 14-017 2012-13 Behavioral Health Services Growth Special  
28 Account Allocations (Exhibit 7.2) help counties address their ongoing claims and  
29 assertions that they are underfunded or inadequately funded to expand existing capacity  
30 to deliver EPSDT services, even though it is an entitled service?
  - 31 • Please explain the ways in which ACIN 14-017 addresses the assertions made regarding  
EPSDT funding in the CMHDA and California State Association of Counties (CSAC)

1 letter (Exhibit 8.1) and the FY 14/15 Budget Priorities Memorandum to the Legislature's  
2 Budget Committees on March 18, 2014 (Exhibit 8.2), which were also provided to the  
3 Court in April.

- 4 • Does the policy established in ACIN 14-017 cover this year only or can the counties be  
5 assured it will continue forward? If the policy is for future years as well, do the counties  
6 know this? Where can they find the answer to these questions?
- 7 • CMHDA has raised questions about the methodology/formula that disadvantages  
8 counties and perpetuates a level of uncertainty that limits counties ability to put county  
9 dollars up front if the State isn't clear about funding. Issues appear to be around the 94  
10 EPSDT base and the rebasing going forward for growth dollars. The considerable  
11 confusion in this and needs to be addressed.
- 12 • Is there or have there been ongoing conversations with CMHDA on resolving or  
13 narrowing the differences?
- 14 • Can the State enlighten the Court on these issues and how they impact class and subclass  
15 members accessing and receiving Intensive Specialty Mental Health Services, especially  
16 ICC and IHBS for subclass members?
- 17 • What is the State's best prediction of how things will move forward in clarifying the  
18 confusion and perhaps decreasing the level of uncertainty around state funding for  
19 EPSDT?

20 With regard to *Proposition 30-Realignment – Temporary Taxes to Fund Education*.  
21 *Guaranteed Local Public Safety Funding*, the Special Master finds the State's response to the  
22 Court's Order of April 11, 2014 (Crt. Dkt. 893) insufficient in answering the questions and  
23 assertions raised by the Court and the Executive Directors of the CMHDA and California State  
24 Association of Counties (CSAC) in their December 6, 2013 letter (Dkt. 892, Ex. D) and in the  
25 March 18, 2014 Memorandum from CMHDA (Crt. Dkt. 892, Ex. E). As the April 11, 2014  
26 Order indicated, there will be a comprehensive and coherent discussion of all these issues at the  
27 June 19, 2014 Status Conference.

28 In discussing the Proposition 30 questions posed by the Court's April 11, 2014 order, the  
29 State should also take into consideration the Governors May Revise, which identified specific  
30 dollars for Katie A. as a Proposition 30 requirement and how this will impact Katie A.

31 Implementation:

- 1 • What specifically is this money for, how and when will it be allocated, and is it ongoing  
2 or one time only?
- 3 • Is there currently ongoing or planned conversation or negotiation with CMHDA or the  
4 legislature or the administration regarding expanding Proposition 30 to cover Katie A. in  
5 ways that are broader than the Gov.'s May Revise language suggested?
- 6 • With regard to the May Revise, does the State have a position on Proposition 30  
7 assertions made by the counties and submitted to the Court in April?
- 8 • Does the May Revise address the assertions made to the Legislature's Budget  
9 Committees in the March 18, 2014 CMHDA FY 14/15 Budget Priorities Letter (p 1 and  
10 2) (which was also provided to the Court in April) regarding Proposition 30?
- 11 • Do the answers to your questions reflect State policy at this time? If so where can this  
12 policy be found, and if not will it be available to the counties in writing in the near  
13 future?

14  
15 **Emerging issue**

16 The *Affordable Care Act (ACA) Implementation for California –Three-Tier Approach* is  
17 emerging as a significant concern with regard to Katie A. class and subclass services. DHCS, as  
18 the single state agency in the lead with ACA implementation, may be in the best position to  
19 clarify its implications for Katie A. subclass and class members. As Special Master, I have  
20 several questions that, if answered, might help the Court and the Parties better understand the  
21 impact of the ACA on implementation of Katie A.

- 22 • How does the State distinguish between the responsibilities of the Managed Care Plans  
23 (MCPs) and the Mental Health Plans (MHPs) in terms of screening for and providing  
24 medically necessary mental health services to Katie A. class and subclass members, and  
25 how will the MCPs and MHPs ensure that all care is coordinated and consistent with the  
26 Katie A. Core Practice Model?
  - 27 • How will the State collect, analyze, and publish service delivery data from the MCPs and  
28 the MHPs to determine what services are being provided to subclass members?
- 29  
30  
31

1 **The threshold of sustainability**

2 Throughout the Settlement Agreement negotiations, the Parties debated what type of and  
3 how much development would be necessary to ensure that the Katie A. initiative would become  
4 successful and sustainable and permanent throughout the years ahead. Specifically, what level of  
5 change would have to occur within the county agencies and the State departments to reach a  
6 point of “critical mass” where services to children in the class and subclass would become  
7 sufficiently advanced that they would not roll back to unacceptable levels or noncompliance with  
8 federal entitlement expectations? The parties identified several key accomplishments necessary  
9 to achieve this level of sustainability.

10 First and foremost, the existing barriers between child welfare services and mental health at  
11 the county and State levels would have to be replaced by permanent collaborative institutional  
12 structures and collaborative behavioral practices. These would include:

- 13 • adoption and widespread implementation of a Core Practice Model, based on the  
14 essential principles of comprehensive child- and family-based services to all children  
15 served by both child welfare and mental health;
- 16 • permanent structural linkages through a Shared Management Structure for Katie A.  
17 administration, planning, and problem-solving between county and state child welfare  
18 and mental health agencies;
- 19 • subclass members receiving Intensive Care Coordination, Intensive Home Based  
20 Services, and—if approved by CMS—Therapeutic Foster Care as medically necessary  
21 statewide; and
- 22 • a local and statewide system of accountability—an Accountability, Communication, and  
23 Outcomes structure— with standards and methods to achieve quality oversight and with  
24 broad representation from administrators, providers, parents, youth, and other interested  
25 stakeholders capable of holding county and state agencies accountable for successful and  
26 sustained Katie A. services.

27 As Special Master I believe it is my foremost responsibility to ensure that all four of these  
28 elements of sustainability are moving forward by the time Court jurisdiction ends.

29 The Settlement Agreement did not precisely identify what level of development for each of  
30 these four elements would constitute a critical mass or threshold of sustainability, but the core of  
31 the agreement holds that all four must eventually be established for the Katie A. effort to

1 succeed. It is understood by the parties that some of these expectations will require many years  
2 to fully mature, especially changing the organizational cultures of county child welfare and  
3 mental health to fully engage the Core Practice Model for all children and families they serve. It  
4 is also understood that services to subclass members, which are beginning in nearly all counties  
5 but are very far from reaching all subclass members for whom these services are medically  
6 necessary, will take some time to reach every eligible and entitled child throughout the state. At  
7 the same time, the expectation that the State departments will develop the structural linkages  
8 envisioned in the Settlement Agreement is not a many-years-long endeavor—the necessary  
9 agreements could be established within the three-year timeframe if the State departments and  
10 their control agencies assert the administrative will and leadership necessary to overcome the  
11 institutional and organizational cultural barriers that hold them apart. And, due largely to  
12 continuous delays, there has been no development of an Accountability, Community, and  
13 Outcomes system at either the State or county levels.

14  
15 **Key findings regarding Katie A. sustainability**

16 As Special Master, I present the following three findings:

17 ***Finding 1*** – All four elements of the Settlement Agreement (statewide Core Practice Model,  
18 system structures, subclass services, and accountability) are insufficiently developed.

19 ***Finding 2*** – Confidentiality barriers continue to block implementation at the county level.

20 ***Finding 3*** – Fiscal and ACA questions are unresolved.

21 Given my concerns as described above, which are based on objective data provided by the  
22 State and the counties and observed by the Parties, the Special Master finds that all four elements  
23 are insufficiently developed and have not yet reached the point of sustainability without Court  
24 oversight. There are six months of Court jurisdiction remaining under the Settlement Agreement  
25 and I believe it is paramount that the State departments take every opportunity available to them  
26 to achieve as much development of the Settlement Agreement as is possible given the existing  
27 political and fiscal realities that prevail in California's complex and ever-changing environment.

28 I am fully committed to the success of the Katie A. Settlement Agreement, as are all the  
29 other parties, and I will do whatever I can to help reach the essential threshold of sustainability  
30 by December 31, 2014. But I believe that our collective success will require something more  
31 than we have achieved so far, essentially that the State DHCS and DSS must assert enough

1 leadership to convince the counties and everyone else who cares about the Katie A. children and  
2 families that these services and structures are here to stay and that everyone who needs them and  
3 meets the criteria for eligibility will receive those services in every county throughout California.

4 I am gravely concerned that the goals and achievements we all anticipated at the beginning  
5 of the implementation process have not yet been reached and it is my duty as Special Master to  
6 strongly and forthrightly report my concerns to the Court.

7  
8 **SECTION SIX: SPECIAL MASTER'S RECOMMENDATIONS TO THE COURT**

9 The Special Master makes the following recommendations to the Court:

10  
11 **Recommendation 1 – Increase services to subclass members in selected under-performing**  
12 **counties.**

13 County- and State-reported data indicate that about one-third of the counties are providing  
14 very low levels of services to subclass members, in particular ICC and IHBS as medically  
15 necessary. As Special Master, after examining numerous factors drawn largely from the May  
16 2014 County Semi-Annual Progress Reports, I have identified 16 counties—nine large and seven  
17 medium size—that appear not to be making sufficient progress in providing ICC and IHBS to  
18 subclass members. This recommendation is intended to result in measurable, significant, and  
19 rapid increases in ICC and IHBS to subclass members in these under-performing counties.

20 As Special Master, I recommend that the Court order the State to select by July 9, 2014, in  
21 consultation with the Plaintiffs and perhaps other stakeholders, a minimum of ten of these 16  
22 counties for immediate direct assistance, intervention, and/or corrective action to increase their  
23 levels of ICC and IHBS to subclass members. If the State does not make its selection by July 9,  
24 the Special Master will choose the ten counties.

25 Under this recommendation, if so ordered by the Court, the State will engage directly and  
26 intensively with each of the selected counties, guided by the Katie A. Service Delivery Action  
27 Plan parts 1.1-1.6 (with emphasis on 1.6) and Phase 2, Sec. IV, Service Delivery Rollout Action  
28 Plan parts 9. a. and 9.d. This direct State action, which will likely require State in-person visits  
29 to the selected counties, will include use of the State's compliance, corrective action, and  
30 sanction authority, as necessary, to ensure significant performance improvement in each of the  
31 ten selected counties.

1 The actions taken in each county must be tailored to the specific needs and circumstances of  
2 the county and must put into place a substantial and action-focused State-County plan that results  
3 in near-term and long-term measurable and sustainable increases in ICC and IHBS to current and  
4 potential subclass members as medically necessary. Each State-County plan must achieve  
5 sufficient measurable increases in ICC and IHBS by November 1, 2014 to demonstrate that the  
6 county is on a self-sustained trajectory toward providing ICC and IHBS to all subclass members  
7 as medically necessary in the future. Each State-County plan will prioritize action to increase  
8 ICC and IHBS to:

- 9 • Potential subclass members identified by the county but who are not currently receiving  
10 medically necessary ICC and IHBS.
- 11 • Subclass members identified as receiving specialty mental health services but who are not  
12 currently receiving medically necessary ICC and IHBS.

13 The State shall provide the Special Master with copies of each individual State-County plan  
14 as described above within a reasonable amount of time that allows for State review and  
15 consultation with the Parties and the county. All State-County Plans shall be received—either  
16 complete or in progress—by the Special Master no later than September 24, 2014 for discussion  
17 at the subsequent Status Conference regarding County progress (current and future) in providing  
18 ICC and IHBS to subclass members. The State will bear primary responsibility for  
19 demonstrating to the Court and other Parties that its efforts to increase ICC and IHBS services in  
20 the selected counties have been strenuous, practical, effective, and sufficiently strong to create  
21 immediate and lasting increases and improvements in ICC and IHBS to subclass members as  
22 medically necessary.

23  
24 **Recommendation 2 – Therapeutic Foster Care (TFC) Implementation.**

25 As Special Master, I recommend that the Court order State DHCS and DSS to implement  
26 Therapeutic Foster Care (TFC) by August 1, 2014 as indicated in the TFC Work Plan (Exhibit  
27 1.5) and that DHCS and DSS update the Court, Plaintiffs, and Special Master weekly on the  
28 steps the State is taking to meet that date.

1  
2  
3 **Recommendation 3 – A Shared Management Structure and Accountability,**  
4 **Communication, and Oversight System.**

5 As Special Master, I recommend that the Court order the State to develop, by November 1,  
6 2014, a written agreement or memorandum of understanding or proposed legislation between the  
7 State DSS and DHCS establishing a Shared Management Structure and an Accountability,  
8 Communication, and Oversight System.

9  
10 **Recommendation 4 – Statewide Coordinated System Improvement Improvement/**  
11 **Performance Improvement Plan (SIP/PIP).**

12 As Special Master, I recommend that the Court order the State DHCS and DSS to develop a  
13 plan by November 1, 2014, and implement a coordinated SIP/PIP effort that incorporates  
14 practice improvement, Core Practice Model implementation, timely access to Intensive Care  
15 Coordination and Intensive Home Based Services, and Katie A. class and subclass member  
16 referrals, access, and service delivery.

17  
18 **Recommendation 5 – County and State Confidentiality Barriers.**

19 Confidentiality continues to be a significant problem for a large number of counties,  
20 particularly with regard to sharing data and information between child welfare and mental health  
21 agencies for case planning, service delivery, cross system utilization management, and quality  
22 assurance. As Special Master, I recommend that the Court order State DHCS and DSS to pursue  
23 a solution to county-reported confidentiality barriers, perhaps using the experience of Los  
24 Angeles County as a model. The Federal Court was involved in assisting and approving a Los  
25 Angeles County legal agreement and framework for sharing information between the  
26 Departments of Mental Health and Children and Family Services, which removed significant  
27 institutional data sharing and information exchange barriers between the two departments.

28 It also has recently been determined that State DHCS cannot disclose county-level mental  
29 health service data due to its interpretation of HIPAA restrictions on the publication of mental  
30 health data. Consequently, the Court, the Parties, children, youth, parents, counties, service  
31 providers, and other interested stakeholders have no access to county-level mental health data

1 and statistical reports regarding Katie A. implementation or ongoing service delivery. This  
2 creates enormous barriers to local and statewide planning, accountability, performance  
3 improvement, service planning and delivery efforts, and overall transparency for Katie A. which  
4 is essential and central to statewide implementation and overall success of the Settlement  
5 Agreement. The significance of this barrier to mental health information cannot be overstated.  
6 As Special Master, I recommend that the Court order State DHCS to develop, by or before  
7 November 1, 2014, a solution to information sharing that allows publication of county-level  
8 Katie A. mental health data.

9  
10 **Recommendation 6 – Proposition 30 and EPSDT Updates.**

11 As Special Master, I recommend that the Court order State DHCS and DSS to update the  
12 Court, Plaintiffs, and Special Master monthly, beginning August 1, 2014, on steps the State is  
13 taking to address county concerns regarding Proposition 30 and EPSDT, including any  
14 Proposition 30/EPSDT issues and resolutions that have any bearing on the implementation of  
15 Katie A.

16  
17 **Recommendation 7 – Affordable Care Act—California’s Implementation Updates.**

18 As Special Master, I recommend that the Court order State DHCS to update the Court,  
19 Plaintiffs, and Special Master monthly, beginning August 1, 2014, on steps the State is taking to  
20 address concerns regarding how the State is going to distinguish the responsibilities of the  
21 Managed Care Plan (MCP) from the responsibilities of the MHPs in terms of screening for and  
22 providing medically necessary specialty mental health services to class members and subclass  
23 members, coordinating Care (CPM), and how the State will collect and analyze the data between  
24 the MCP and MHPs to determine what services are being provided to class/subclass members.

25  
26 **Recommendation 8 – Updating the Special Master and Plaintiffs.**

27 As Special Master, I recommend that the Court order State DHCS and DSS to update the  
28 Special Master and Plaintiffs, beginning August 1, 2014, on all actions ordered by the Court  
29 during or following the July 2, 2014 Katie A. Status Conference.

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**Recommendation 9 – The Special Master’s Fiscal Year 2014-2015 Budget.**

As Special Master, I recommend that the Court approve the Special Master’s Fiscal Year 2014-2015 budget (Exhibit 9). The budget is for six months, pending the Court’s jurisdiction ending in December 2014.

**Recommendation 10 – November, 2014 Katie A. Status Conference.**

As Special Master, I recommend that the Court schedule a Katie A. Status Conference in mid November 2014.

In closing, as Special Master I would like to thank the Court for affording me the privilege of serving as Special Master for the Katie A. case. I am very proud of the accomplishments made by the parties as reflected in the progress made implementing the Plan, and I look forward to the opportunity to continue to work with the Parties and the Court in advancing the successful implementation of the Katie A. Agreement.

Dated: June 16, 2014

Respectfully Submitted



Richard Saletta, LCSW  
Special Master

## CERTIFICATE OF SERVICE

Case Name: KATIE A., et al. v. BONTA, et al. No. 2:02-cv-05662 JAK (SHx)

I hereby certify that on June 16, 2014, I electronically filed the following document with the Clerk of the Court by using the CM/ECF system:

### **SPECIAL MASTER'S JUNE 2014 PROGRESS REPORT ON THE IMPLEMENTATION OF THE KATIE A. PLAN**

Participants in the case who are registered CM/ECF users will be served by the CM/ECF system.

I further certify that some of the participants in the case are not registered CM/ECF users. On June 16, 2014, I have mailed the foregoing document by First-Class U.S. mail, postage prepaid, for delivery within three (3) calendar days to the following non-CM/ECF participants:

John F. Toole, Esq.  
National Center for Youth Law  
405 14th Street, 15th Floor  
Oakland, CA 94612-2701

Kathleen R. Wolfe  
Travis W. England  
U.S. Department of Justice  
950 Pennsylvania Ave NWNYA  
Washington, DC 20530

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct.

This declaration was executed on June 16, 2014, at Los Angeles, California.

M. Chacon  
Declarant

/s/M. Chacon  
Signature