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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SECTION ONE: INTRODUCTION

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

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

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

Purpose and Organization of this Report

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

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

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

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

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

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

- One: Introduction
- Two: Katie A. Services to Subclass Members
- Three: Katie A. State and County Structures
- Four: Katie A. Training and Technical Assistance
- Five: The Special Master's Summary and Findings
- Six: The Special Master's Recommendations to the Court
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SECTION TWO: KATIE A. SERVICES TO SUBCLASS MEMBERS

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

Identifying and transitioning eligible subclass members to Katie A. services

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

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

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

County Semi-Annual Progress Reports and State-reported SDMC Claims

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

County-reported service data

County estimate of potential subclass members identified during the reporting period

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

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

Service delivery data

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

Compiling the county self–reported data

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

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

Percentage of subclass served—statewide

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

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

County groupings by population size

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

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

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

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

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

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

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

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

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

State-reported service data

Short-Doyle Medi-Cal claims data

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

follows:

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

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

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

Brief observations

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

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

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

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

County narrative comments from the May reports

The October 2013 and May2014 Semi-Annual Progress Reports also contained many narrative comments from the counties regarding service delivery to subclass members, as well as comments regarding county efforts to implement the Katie A. initiative. I would like to highlight a few comments regarding services to subclass members that various counties expressed in their May 2014 County Semi Annual Progress Reports. Overall, these county comments speak for themselves.

Moving forward

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

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

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

Early stages

Placer: *Just getting started and operational challenges.*

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

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

Funding barriers

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

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

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

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

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

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

Interdepartmental and contractor barriers

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

needs, County requirements require extra time for implementation.

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

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

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

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

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

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

Therapeutic Foster Care (TFC)

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

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

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

SECTION THREE: KATIE A. STATE AND COUNTY STRUCTURES

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

Joint Management Taskforce (JMT)

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

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

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

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

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

Accountability, Communication and Oversight System (ACO) Taskforce

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

- Stage 1 – Implementation planning
- Stage 2 – Implementation during court oversight
- Stage 3 – Post court jurisdiction

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

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

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

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

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

Core Practice Model (CPM) Fiscal Taskforce

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

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

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

Katie A. Advisory Group

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

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

SECTION FOUR: KATIE A. TRAINING AND TECHNICAL ASSISTANCE

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

Manuals

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

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

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

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

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

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

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.

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

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

The Partnership for Wellness

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

Learning Collaborative Counties

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

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

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

Other trainings

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

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

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

Web page Development

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

SECTION FIVE: SPECIAL MASTER'S SUMMARY AND FINDINGS

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

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

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

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

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

The changed California environment

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

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

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

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

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

Plan timeline extensions

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

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

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

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

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

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

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

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

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

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

Services to subclass members

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

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

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

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

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

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

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

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

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

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

State and county structures

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

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

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

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

A. services into the future.

Training and technical assistance

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

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

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

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

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

Confidentiality

Counties continue to identify confidentiality as a barrier to sharing data and information between child welfare and mental health agencies for the purposes of treatment planning, quality improvement, and utilization review. Confidentiality issues surfaced for both child welfare and mental health agencies, but most frequently occur when mental health tries to share its client information with child welfare. County Counsels in all 58 counties wrestle with this issue within and between departments, and are frequently unable to find solutions that will provide an effective and systematic way to exchange information between child welfare and mental health agencies. There seems to be no single solution to this statewide system problem. The State has been unable to offer any statewide solution to address county confidentiality concerns, but has made an effort to help counties inform one another about strategies they have developed to solve their local confidentiality problems. It is difficult to know how many of these county-specific solutions have been adopted by other counties. From my conversations and review of reports it appears a few 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.

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

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

The Medi-Cal Documentation Manual and CPM Guide

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

Service claiming

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

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

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

Fiscal Concerns

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

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

- How do the DHCS ACIN 14-016 FY 2012-13 Behavioral Health Subaccount Allocations (Exhibit 7.1) and ACIN 14-017 2012-13 Behavioral Health Services Growth Special Account Allocations (Exhibit 7.2) help counties address their ongoing claims and assertions that they are underfunded or inadequately funded to expand existing capacity to deliver EPSDT services, even though it is an entitled service?
- 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)

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

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

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

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

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

Emerging issue

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

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

The threshold of sustainability

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

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

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

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

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

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

Key findings regarding Katie A. sustainability

As Special Master, I present the following three findings:

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

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

Finding 3 – Fiscal and ACA questions are unresolved.

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

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

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

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

SECTION SIX: SPECIAL MASTER'S RECOMMENDATIONS TO THE COURT

The Special Master makes the following recommendations to the Court:

Recommendation 1 – Increase services to subclass members in selected under-performing counties.

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

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

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

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

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

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

Recommendation 2 – Therapeutic Foster Care (TFC) Implementation.

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

Recommendation 3 – A Shared Management Structure and Accountability, Communication, and Oversight System.

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

Recommendation 4 – Statewide Coordinated System Improvement Improvement/ Performance Improvement Plan (SIP/PIP).

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

Recommendation 5 – County and State Confidentiality Barriers.

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

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

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

Recommendation 6 – Proposition 30 and EPSDT Updates.

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

Recommendation 7 – Affordable Care Act—California's Implementation Updates.

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

Recommendation 8 – Updating the Special Master and Plaintiffs.

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

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

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:

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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

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