UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

EMILY Q. et al., Plaintiffs, v. DIANA BONTÁ, Defendant.	CASE NO. CV 98-4181 AHM (AJWx) SPECIAL MASTER'S REPORT REGARDING DISPUTED ISSUES AND IMPLEMENTATION AND THIRD QUARTERLY REPORT IN RESPONSE TO COURT'S ORDER APPOINTING SPECIAL MASTER Honorable A. Howard Matz Ctroom: 14

1. On December 29, 2004, the Court appointed a special master in part "because a special master will be better able to monitor the status of the case so that progress does not become stalled, discuss the barriers to achieving compliance and make recommendations for effective strategies to achieve compliance in the future" (page 4, line 6, paragraph 6, Order Appointing special master). The specific duties for the special master included:

- Recommending to the parties and the Court whether there is a need for a minimum benchmark for Therapeutic Behavioral Services (TBS) and if a benchmark is needed, determining what this benchmark should be;
- Overseeing the conduct of the focused reviews of Mental Health Plan (MHP) performance, including determining a reasonable number of reviews to be conducted, making recommendations to

the Court and the parties concerning the content and implementation of the review protocol, the adequacy of the completed reports following a focused review, and the adequacy of the corrective action plans developed by the MHPs in response to the reviews;

- Recommending to the Court and the parties whether there is a need for, and if so the adequacy of, corrective actions by MHPs which are not subject to focused reviews, based on review of the data and performance indicators developed through the agreement of the parties and through other sources, such as complaints and grievances; and through such other means as the special master determines are necessary and appropriate;
- Making other recommendations to the Court and the parties on how to improve delivery of TBS and effectuate the purpose of the Judgment, including how to audit providers' performance without having an adverse effect on TBS utilization; and
- Recommending to the Court the appropriate resolution of any other disputes which the parties cannot resolve.

2. The purpose of this report is to provide an assessment of the implementation of the Court's Judgment of May 11, 2001, and subsequent orders of the court including the Interim Order Clarifying Judgment, Extending Jurisdiction and Directing the Parties to Collaborate Regarding Further Relief, filed January 29, 2004, and a second order issued July 29, 2004, and an additional order filed on August 17, 2004. The purpose is also to provide recommendations to the court regarding the specific matters outlined above in the duties of the special master including how to improve delivery of TBS and effectuate the purpose of the Judgment.

1
2 **Brief Factual Background (See 208 F.Supp.2d 1078, page 7)**
3 3. Early and Periodic Screening Diagnosis and Treatment ("EPSDT")
4 Federal Medicaid law requires that states implement EPSDT for
5 children under the age of 21. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B).
6 Under EPSDT, Defendant is obligated to cover a broad range of mental
7 health services for Medi-Cal eligible children under the age of 21 pursuant to 42
8 U.S.C. §§ 1396a(a)(43), 1396d(a) and (r).
9 In 1995, California began implementing a Medicaid mental health
10 managed care program under a federal waiver. Under the managed care waiver, the
11 authority and responsibility for payment authorization for EPSDT specialty mental
12 health services covered by the waiver rest with county MHPs, not with the
13 Department of Mental Health (DMH) or the Department of Health Services (DHS).
14 In 1967, Congress amended Title XIX of the Social Security Act,
15 adding the requirement of EPSDT to the Medicaid Act. By this amendment,
16 "Congress intended to require states *to take aggressive steps to screen, diagnose and*
17 *treat children with health problems*."(emphasis added). *Stanton v. Bond,* 504 F.2d
18 1246, 1249 (7th Cir. 1974) (holding that Indiana failed to comply with the EPSDT
19 provisions of the Social Security Act). "Senate and House Committee reports
20 emphasized the need for extending outreach efforts to create awareness of existing
21 health care services, to stimulate the use of these services, and to make services
22 available so that young people can receive medical care before health problems
23 become chronic and irreversible damage occurs."
24 The EPSDT program has two primary components:
25 1. The state "must assure the availability and accessibility of
26 required health care resources;" and
27 2. The state must "[help] Medicaid recipients and their parents or
28

guardians effectively use [the required health care resources]." HCFA, *State Medicaid Manual* § 5010B (April 1990).

These components allow Medicaid agencies to systematically:

- Seek out eligible individuals and inform them of the benefits of prevention and the health services and assistance available,
- Help them and their families use health resources, including their own talents and knowledge, effectively and efficiently,
- Assess the child's health needs through initial and periodic examinations and evaluation, and
- Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

Under the EPSDT program, states participating in Medicaid must provide screening services to identify defects, conditions, and illnesses. 42 U.S.C. § 1396d(r)(1).

States' EPSDT programs must then provide children with diagnostic and treatment services "to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening service, *whether or not such services are covered under the state plan.*" (emphasis added) 42 U.S.C. § 1396d(r)(5).

California uses the term "EPSDT supplemental services" to refer to EPSDT services that are required by federal law but are not otherwise covered under the Medi-Cal plan for adults. 22 C.C.R. § 51184(c).

Reasonable Promptness

4. Under 42 U.S.C. § 1396a(a)(8) and the implementing regulation, 42 C.F.R. § 435.930(a), the state must ensure that Medi-Cal services are furnished with reasonable promptness to all eligible individuals, and without any delay caused by

the state agency's administrative procedures. TBS must be delivered in compliance with this federal requirement.

State Wideness

5. Federal law requires that a state Medicaid plan shall be in effect and in operation in all political subdivisions of the state. 42 U.S.C. § 1396a(a)(1); 42 C.F.R. § 431.50(b)(1). The courts have interpreted this to mean that the Medicaid program offering a particular service such as dental care "shall be in existence, operational and functioning" in every county (*Clark v. Kizer*, 758 F.Supp. 572, 580 (E.D.Cal. 1990)) and must "operate uniformly across the state" (*Morgan v. Cohen,* 665 F.Supp. 1164, 1178 (E.D. Pa. 1987)). This requirement is violated by a "state scheme which denies access to a Medicaid covered medical treatment or service based on the recipient's county of residence." *Sobky v. Smoley*, 855 F.Supp. 1123, 1136 (E.D. Cal. 1994). TBS must be delivered in compliance with this Federal requirement.

Therapeutic Behavioral Services

6. TBS is an EPSDT supplemental service benefit for children/youth with serious emotional problems who are experiencing a stressful transition or life crisis, which, without adequate short-term support, puts them at risk of placement in an institution or group home RCL 12-14, or of being unable to transition from that level to a lower level of residential care.

TBS provides critical, short-term support services for full scope Medi-Cal children/youth for whom other specialty mental health Medi-Cal reimbursable interventions have not been, or are not expected to be, effective without additional supportive services.

TBS involves a qualified provider/staff person being immediately available during designated time periods to provide individualized behavioral interventions as needed at home, school, or other community-based setting.

TBS is supposed to be provided as part of a comprehensive treatment plan; it is not to be provided as the only specialty mental health service. TBS is one type of a broad variety of individualized services that may be used in a "wraparound" process.

The wraparound process is not a program or a type of service.

The wraparound process can include any combination of services and supports. The guiding principle of the wraparound process is to do what is needed when it is needed to achieve the child/youth's treatment goals.

The July 23, 1999, DMH policy letter sets forth the criteria for Medi-Cal reimbursement of TBS. The child/youth must:

(a) be a full-scope Medi-Cal beneficiary under age 21;

(b) meet the MHP medical necessity criteria; and

(c) be a member of the certified class or the child/youth must have previously received TBS while a member of the certified class.

The July 23, 1999, DMH policy letter also sets forth the criteria for TBS eligibility as follows:

(a) The child/youth must be receiving other specialty mental health services; and

(b) The clinical judgment of the mental health provider indicates that it is highly likely that without the additional short-term support of TBS that:

(i) The child/youth will need to be placed in a higher level of residential care, including acute care because of a change in the child/youth's behaviors or symptoms which jeopardize continued placement in a current facility; OR

(ii) The child/youth needs this additional support to transition to a lower level of residential placement. Although the

child/youth may be stable in the current placement, a change in behavior or symptoms is expected and TBS is needed to stabilize the child in the new environment.

DMH has structured TBS services to involve one-on-one services that are intended to reduce or increase behaviors through functional behavioral analysis or cognitive restructuring using behavioral interventions, cognitive behavioral approaches, gradual exposure as well as other strategies or intervention techniques. They also intend that the services be done in collaboration with and support for the family caregivers efforts to provide a positive environment for the child. These examples were outlined in the DMH letter N0: 99-03 attachment 2. Exhibit 1.

The May 11, 2001, Judgment requires the defendant, the Director California DHS and her agent, California DMH, to ensure that members of the certified class have access to TBS services, a mental health service for children and youth that has been found to have great benefit for class members. The Judgment also requires that the defendant "ensure that class members have access to TBS services within their respective MHPs." The defendant shall ensure that an MHP expands its network or takes other measures if necessary for that MHP to meet its obligation to TBS class members within its jurisdiction. Among other aspects of the remedial scheme, the Judgment required DMH to identify county MHPs with "disproportionately low TBS utilization" and take corrective actions.

Class members are all current and future beneficiaries of the Medicaid program below the age of 21 in California who: (a) are placed in a Rate Classification Facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs; (b) are being considered for placement in one of these facilities; or (c) have undergone at least one emergency psychiatric hospitalization related to their current disability within the last 24 months. Members of the plaintiff class are not eligible to receive TBS services while in residency in an

Institution for Mental Disease (IMD). However, while in such facilities, they can establish their eligibility to receive TBS services immediately upon leaving the IMD.

Current Implementation Status

7. In November 2003, plaintiffs filed a motion seeking modification of the Judgment to include additional remedial measures based on evidence that defendant had failed to comply with the Judgment. The Court made findings that utilization of TBS had remained low even by defendant's own standards that TBS was underutilized leaving thousands of class members without access to this service, that defendant had failed to determine or demonstrate what constitutes an adequate TBS approval rate or to take effective corrective actions against county mental health plans where either no class members or a disproportionately low number of class members have been approved for TBS as required by the Judgment, that many class members were not receiving the services to which they are entitled, and that the purpose of the Judgment was not being filled in a material respect (Interim Order Clarifying Judgment, Extending Jurisdiction and Directing the Parties to Collaborate Regarding Further Relief, filed January 29, 2004). The Court ordered changes in DMH's procedure for authorizing TBS, extended its jurisdiction over the Judgment for an additional 18 months to November 11, 2005, and directed the parties to meet and work together to develop a plan to significantly increase TBS utilization and better monitor compliance. In July 2004 the parties stipulated and the court ordered re: Plan To Increase TBS Utilization and Joint Stipulation In Support Thereof. This order contained a set of activities that the state agreed to do to address the underutilization of TBS.

8. Since the special master's appointment by the court in January 2005, the special master has worked with the parties to gain an understanding of how TBS

services, specifically, and the overall EPSDT program operates. The special master has reviewed utilization data regarding EPSDT eligible children, eligible clients receiving services, and TBS clients. The data have also included utilization data of services including state hospital, inpatient, and RCL 12 and higher. In general, these data included some breakouts by age and frequently by county. In addition, the special master participated in focused reviews of five counties (Yolo, San Bernardino, Contra Costa, Napa, and Los Angeles). The focused reviews included presentations by MHP management and staff, interviews with clinicians, child welfare staff, providers including TBS providers, and some parent input. In addition, the special master participated in the debriefings of each of the individual cases that were reviewed.

9. The special master also visited and interviewed a variety of stakeholders involved in children mental health services and management teams in nine counties (Yolo, Sacramento, San Diego, Orange, Los Angles, Ventura, San Francisco, Contra Costa, Santa Clara) and reviewed data and met with staff from San Joaquin.

10. The special master has also reviewed policy documents and letters regarding EPSDT and TBS, training materials, and external quality review organization (EQRO) reports on some counties and the state wide report made available in September 2005. In addition, court documents have been reviewed including the court's orders, motions of the parties, and exhibits as well as the briefing papers prepared by the parties regarding the various disputed issues. The special master also reviewed current literature on the prevalence of mental health disorders in children and literature on "evidence-based practices" in children's mental health.

11. The essence of the continued disputed issues between the parties revolves around the issue of whether the utilization of TBS is going to be

significantly increased and, if so, by what means. The defendant continues to take the position, in spite of the court's January 2004 findings regarding TBS utilization, that "DMH maintains the position the TBS is not and never has been underutilized. DMH also notes that there are a number of factors that must be considered in the determination of adding any additional and unnecessary burden to the fragile mental health system" (page 2 of the defendant's submission to the special master dated September 30, 2005, regarding potential data measures, Exhibit 2). This position is further articulated in a letter to the special master dated September 30, 2005, from defendant counsel regarding a meeting and discussion between the special master and the Department of Mental Health Director, Dr. Mayberg (Exhibit 3). The defendant has also taken the position that they are only able to take actions that can be supported within available resources. The defendant's position has resulted in very modest efforts to improve utilization at best and yet there is substantial investment in time and resources to audit TBS for compliance purposes. A substantial amount of effort has been spent on ensuring that no child gets TBS services who should not get TBS services through the audit and pre-authorization process and the imposition of a matching fund requirement for outpatient services on counties which have only limited realignment funds to contribute. MHP staff and providers reported that there were mixed messages as to whether they were to provide TBS services or were to be extremely restrictive with the service. They described TBS services as the most regulated and scrutinized service in the EPSDT service array. The defendant reported and agreed that they were going to use CIMH to provide additional training and technical assistance to MHPs with low utilization. The defendant's response to the special master's question about CIMH activities was that little has been done in the past year on TBS. This is consistent with the input received from stakeholders in the counties.

1 12. It is recognized that the TBS services and the number of clients who
2 received them increased from roughly 238 in FY 99-00 to 2,896 in FY 03-04.
3 However, the court found as of January 2004 that TBS utilization remained low and
4 that, "The court concludes that many class members are not receiving the services to
5 which they are entitled, that the purpose of the Judgment has not been fulfilled in a
6 material respect, and that modification of the Judgment and extension of jurisdiction
7 is appropriate" (page 2, Interim Order Clarifying Judgment dated January 29, 2004).
8 Based on the data currently available, the number of persons documented to have
9 received TBS services in FY 04-05 is 2,924 which is 1.61% of EPSDT clients .09%
10 of EPSDT eligible children served, or 28 more children served in 04-05 compared
11 with 2,896 in FY 03-04. In FY 03-04 the comparable comparisons were 1.58% of
12 clients served or .09% of EPSDT eligible children. (See Exhibit 4 for data charts of
13 these numbers). This does not represent a significant increase in utilization
14 compared to January 2004. Further review of these data by county continues to
15 show a wide variability in TBS utilization by county ranging from 0 in some
16 counties to 6.02% of EPSDT eligible mental health clients served. Forty-eight
17 counties currently show no increase of the percentage of clients receiving TBS
18 served between FY 03-04 and FY 04-05. Exhibit 5 provides data provided by L.A.
19 MHP that shows that the number of children receiving TBS services and the dollars
20 expended are not increasing and, in fact, may be decreasing. The plaintiffs produced
21 a chart from the quarterly notices of TBS approvals that they receive from the
22 defendant that shows a decreasing number of approvals. Also, see Chart J showing
23 declining projected use of TBS in the four measures of TBS utilization analysis
24 prepared by the plaintiffs. (Exhibit 6)
25 13. Based on the number of persons receiving TBS since January 2004, the
26 wide variability in TBS utilization across MHPs, the findings of the focused reviews
27 and input of stakeholders regarding barriers to services, the special master finds that
28

the status of TBS utilization has not changed significantly since the court's January 2004 order.

Findings of the Focused Reviews

14. Focused reviews were conducted in five counties (Yolo, San Bernardino, Contra Costa, Napa, and Los Angeles). The focused reviews were undertaken to develop a more in-depth understanding of how access and delivery of TBS services is actually occurring for children who are eligible and in need of the services. The appropriate implementation of TBS includes the interface and linkages to other child-serving agencies and how counties operationally implement EPSDT and TBS services to ensure that class members have reasonable and timely access to appropriately delivered TBS services to assist them to live with minimal disruption in their home community or in a less restrictive placement. Implementation of appropriate TBS services includes the processes used to identify, evaluate for eligibility, determine need, and decide appropriate services, the planning and delivery of services; and measurement individually and in aggregate of the delivery of the agreed-on services, and the results of the services.

15. The review process included conducting focus group discussions with the staff of DMH and other agencies that are involved in serving children who are eligible for EPSDT and, therefore, potentially a member of the class. These "stakeholders" include:

- Providers of services, including TBS coaches and supervisors
- MHP clinicians
- Care coordinators
- Providers who do not provide TBS services
- Members of any interagency services coordination group
- Supervisors and foster care caseworkers for the child welfare agency

- Juvenile probation/juvenile justice representatives
- MHP management

16. MHP staff provided information regarding the processes they used to plan and evaluate the delivery of TBS services.

17. In addition, a small stratified sample of eligible children was reviewed, both who had and had not received TBS services. The review included both a record review and interviews with children, parents, and some of the DMH and child welfare case managers, clinicians, and providers of both TBS and other services. The reviewers worked to determine whether the persons were eligible for and needed TBS services, whether they received TBS services on a timely and appropriate basis, and whether the persons involved perceived that positive results had been achieved and whether there was, in fact, a positive outcome.

18. The special master made the following observations in the process of the reviews.

- The overall perception is that TBS services are highly beneficial and that most children who receive the service do benefit. The review team saw several excellent examples of children who got TBS services and received benefit.
- Residential and group home providers expressed some concerns about how TBS services are planned and interface with the facility when TBS services are delivered by an outside provider.
- Children who are eligible for and in need of TBS are not having timely and consistent access to TBS services in all counties. For example, the MHP and providers in L.A. MHP reported that the providers' capacity is full and that there may be waits of up to 30 days. San Bernardino had severe limitations in capacity and the clinicians interviewed indicated had at times been told not to

bother referring clients to services.

- Children placed out-of-county, particularly those who are dependents and in the custody of the state's child welfare system, have significant difficulties accessing mental health services in general and TBS services in particular. In Yolo County, for example, the child welfare agency places nearly 60% of the children in foster care out-of-county. They reported that it was very difficult to get mental health services for the children and particularly TBS. The caseworkers said that they did not refer because it was too much work compared to the likelihood that the service would be obtained.
- The certification and notification process of children referred for and receiving or denied TBS services is not being well implemented, does not provide accurate data, at least in some counties, and should probably be eliminated or significantly modified. Children were being informally referred and screened or persons were told not to bother referring (in San Bernardino, clinicians reported that they had been told not to refer as there was not adequate capacity), resulting in significant numbers of children being denied access without an appropriate assessment or documentation of denial. One of the children reviewed in San Bernardino was receiving TBS and reportedly benefiting living at home but the written focused review summary of the child failed to mention that the only reason the child got TBS services was that he was kicked out of a level 12 RCL for unmanageable behavior. There was no evidence that the child had been considered for TBS before he had to leave his biological home or

1 while in the group home.
2 • A number of clinicians reported that the TBS service would be
3 more effective if there were more flexibility in providing the
4 services when a Medi-Cal eligible child is recognized as needing
5 the service by the clinician and likely to have to leave the home
6 in the future rather than having to wait until the child's home or
7 current living arrangement is highly likely of disruption. MHPs
8 vary as to how flexible they are in defining "being considered"
9 for placement in out-of-home placement in an RCL 12 or higher.
10 They also believe that for TBS to be most effective for some
11 families, the service needs to be delivered in the context of
12 broader therapeutic interventions that address the needs of the
13 parents and other children in the family.
14 • There is weak implementation of the policy requiring that TBS
15 services be used as an adjunct to the overall therapeutic plan and
16 other supports and therapeutic interventions that are being
17 overseen by the clinician and case manager. Multiple examples
18 were seen in the case reviews where, in reality, TBS was the
19 primary service the client was receiving and was not an adjunct
20 to a broader array of planned services being overseen by a
21 clinician.
22 • TBS services are not consistently or, in some counties, at all
23 considered for transitions to less restrictive environments (Yolo
24 MHP, for example) or for children living in group placements.
25 • Some counties did not have an adequate process in place to
26 accurately track and assess referrals, utilization, and outcomes
27 achieved (Yolo, Napa, and San Bernardino for example).
28

- Many county-level stakeholders expressed concern that the TBS audits and other input from the state level sent mixed messages as to whether they are to use TBS services as needed.

19. The overall findings were that three of the counties had both low utilization and significant systemic weaknesses in the management, delivery, and accountability for TBS services. Contra Costa had the highest utilization of TBS services and demonstrated stronger management and oversight and effective use of the resource than the other counties. Los Angeles demonstrated strengths in the oversight of the program and reported that TBS services had been audited/reviewed five times in the last three years. Examples were seen in Los Angeles of good TBS services, however, there is only a .09% penetration rate of EPSDT eligible children or 1.82% of EPSDT eligible clients who receive mental health services get TBS services. The MHP and the providers reported the TBS capacity was running full and that clients frequently had to wait up to 30 days and sometime longer to receive services and that there would be a delay receiving services from up to 40% of the providers. As noted earlier, the L.A. MHP projected that they would provide TBS to fewer children in 04-05 than they had in 03-04. When the special master asked management why utilization was decreasing, the answer was that it was a result of mandates to contain the cost of EPSDT from the state level and county. It was further stated that guidance seems to swing between extremes, either no checks or totally checked, and the program needs good oversight and administration but in balance.

20. The special master participated in the focused reviews of the five counties and appreciates the hard work of the staff who participated in the reviews. The special master was not involved or consulted in the drafting of the reports presenting the results of the focused reviews. When the special master compares the reports of the findings to his direct observations and findings in each of the counties,

the reports do not fully reflect the range of issues that were identified and minimize the problems of access to TBS, the weak implementation that was found in some counties, and the significant limits in capacity. The special master finds this particularly to be true for the Los Angeles MHP focused review report. Given the weaknesses in the reports and the current lack of information of whether the corrective action plans for the MHPs will actually increase access to TBS services for all eligible class members and increased utilization, the special master cannot, at this time, find that the focused review process is adequate or effective in improving the performance of MHPs that are under-utilizing TBS services.

Disputed Issues

21. The parties have provided briefs to the special master and the special master has discussed with the parties the following disputed issues.

A. Extension of jurisdiction

B. Clarification/modification of class membership

C. Out-of-county placements

D TBS Utilization benchmark

E. Transition age youth

F. TBS assessments for class members in high-level institutions

This report addresses the most critical issues of dispute, which are A, B, C. and D. Exhibit 7, 8, 9, and 10 contain the plaintiffs' and defendant's briefs regarding their respective issues.

Clarification/Modification of Class Definition

22. The basic issue is whether the class definition should be modified to address two aspects of the class definition. The proposed changes would increase the number of EPSDT eligible children who would meet the class definition. The first change would modify part (c) of the class definition on page 1 of the Judgment

to include at risk of psychiatric hospitalization rather than wait until there has been at least one psychiatric hospitalization in the last 24 months before the client would be eligible for TBS. The second modification would be to defer to clinician judgment to determine when and if TBS is needed and not tie eligibility to currently being highly considered for placement in a facility. Please see the briefing papers of the parties addressing this issue (Exhibit 8).

23. The special master defers the resolution of the legal arguments regarding the appropriateness of such a modification to the court. If the court were to determine that modification is appropriate, the special master would recommend the court consider the following. Clinicians have regularly commented that TBS services would be more effective in some situations if they were provided sooner. There is concern in the L.A. MHP that there is not an RCL for young children and, even though young children may be seriously emotionally disturbed and in need of intensive intervention, they would not be eligible for TBS services because they could not be considered for an RCL 12 or higher. There is also some concern that even though a child has multiple disruptions in foster care, they cannot get access to TBS unless they are currently being considered for an RCL 12 or higher. It was reported by some stakeholders that by policy, children under ten could not be considered for RCL 12 placement by the child welfare system. Examples were cited either of children who had been referred but not approved or not referred because the understanding was that they would not be approved. It was also noted that if parents don't get intensive support until just before a child has to leave the home, they have already been through such difficulty that they are less likely to agree to or participate in a home-based intervention.

Special Master Recommendation

24. If any modification is made to the class definition, the focus should remain on children who are seriously emotionally disturbed. A modification that

allowed for more flexibility for the timely provision of services based on a clinician's judgment would increase utilization and also the probability of the TBS service being effective.

Out-of County Placement of a Medi-Cal Eligible Child

25. For Medi-Cal purposes, an out-of-county placement occurs when a child is placed in a home or facility outside of the county that is responsible for his or her Medi-Cal benefits. The placements may be supervised by the county Child Welfare Services agency or the county probation department. They may also occur if the child has been adopted through the Adoption Assistance Program (AAP), which confers ongoing Medicaid eligibility, or placed in a residential school through special education.

26. Data provided in the plaintiffs' brief on out-of-county placement indicates that approximately 22,000 children are placed outside of the county responsible for their Medi-Cal benefits (Exhibit 9 pages 1 and 2). To this number must be added children with AAP and those placed into group homes through special education, but no figures were reported for these two groups.

27. There is no question that children in foster care and those involved in juvenile justice have a high incidence of emotional and behavioral disorders. The plaintiffs' out-of-county brief provides a number of references documenting the incidence of mental health needs in these populations. The general guideline would be conservatively 40% to 60% of these children have emotional and behavioral disorders that require mental health treatment. Exhibit 11 contains a summary of data obtained from the National Survey of Child and Adolescents (n= 3,803), which is a nationally representative sample of children who have been investigated by the child welfare system and studied to determine the incidence of mental disorders and access to treatment.

28. Research studies conducted both nationally and in California have

shown that the need for mental health services is significantly greater among children in foster care than children in the general population. The incidence of emotional, behavioral, and developmental problems among children in foster care is three to six times greater than children in the community, even when children in foster care are compared to children in the community who have known similar kinds of deprivation. (California Institute for Mental Health, *Evidence Based Practices in Mental Health Services for Foster Youth*, pages 10-12 Executive Summary (2002) ("CIMH Report"), see Exhibit 12). The Little Hoover Commission reported in 2001 that nearly 70% of the 100,000 children in California's foster care system will experience a mental illness associated with their placement or the circumstances that caused their entry into the foster care system. (*Young Hearts and Minds: Making a Commitment to Children's Mental Health*, page 22 (2001)).[1]

29. Children in foster care and juvenile justice placed out-of-county have significant difficulty accessing mental health services. Stakeholders in the focused reviews consistently reported difficulties in accessing mental health services in general and TBS services specifically for children in out-of-county placement. The problem has been well acknowledged and studied by the California Mental Health Directors Association (see Exhibit 9, plaintiffs' brief on out-of-county placement, Attachments E, F, and G). The California Legislature passed legislation (SB 745) that acknowledges the high obligation the state has to ensure these children get appropriate services.

> Under the Federal Medicaid Act, including the Balanced Budget Act of 1997, the state has special responsibilities to children in foster care including those who are placed outside their county of residence. The state must ensure that foster children placed outside their county of

---

[1] The Little Hoover Commission Report is available from http://www.lhc.ca.gov/lhcdir/report161.html.

residence receive timely and appropriate access to necessary mental health services, including mental health services pursuant to the federal Early Periodic Screening, Diagnoses and Treatment program. (42 U.S.C. Sec 1396d(a)(4)(B))

SB 745, Section 1, paragraph E.

30. DMH has acknowledged that there are significant challenges ensuring that out-of-county placements receive the necessary and appropriate mental health services. Exhibit 9 (defendant's brief on out-of-county placement, Exhibit 4) is the letter the DMH sent to all counties in July 2005 to address the out-of-county placement issues. The dispute between the parties involves what additional steps should be taken to ensure that eligible class members in out-of-county placements receive appropriate services. The plaintiffs have proposed major changes in the reimbursement systems that the defendant argues is not necessary and that could have unforeseen consequences.

Special Master Recommendation

31. While the out-of-county dispute is a complicated issue, it is necessary that data be made available to determine whether improvement in access to mental health services, and particularly TBS, has occurred for children who have been placed out-of-county. Further, the data needs to be used to determine whether MHPs are performing to ensure that children in out-of-county placements are receiving appropriate services. The special master recommends that the court order that the defendant must begin producing data on a quarterly basis that is responsive to the data collection requirements in SB 745 Section 4 (3) (C). Specifically, that the defendant produce a routine report that shows the access to outpatient specialty mental health services including TBS by foster children placed in their county of adjudication compared with access to outpatient specialty mental health services and specifically TBS by foster children placed outside of their county of adjudication.

The first report should be provided to the special master no later than April 30, 2006.

TBS Utilization and Measures

32. The District Court has issued a series of orders and made findings regarding accountability, monitoring and compliance with the judgment:

- "DMH shall take appropriate corrective measures with regard to MHPs where either no class members or a disproportionately low number of class members have been approved for TBS." Judgment, ¶ 25.
- "Defendant has failed to determine or demonstrate what constitutes an adequate TBS approval rate." Interim Order Clarifying Judgment, January 29, 2004, page 2.
- "Unless the parties can identify and agree upon an alternative concrete standard for ascertaining the parties' compliance with, and the effectiveness of, the Permanent Injunction and Judgment, a minimum TBS utilization rate probably is necessary . . . [T]he enforcement of the Judgment does entail and require accountability." Further Order Re: Additional Modifications to Judgment or Post Judgment Relief, June 30, 2004, page 2.
- "You can't measure whether this is making a difference – whether the judgment's purposes and terms are being achieved unless you have some data. And I think that the proposal that [plaintiffs] made and that [.45%][2] level is very modest indeed. I mean, I am prepared to accept that in principle. . . . If there is

---

[2] This figure is based on the formula in the July 29, 2005 Order which compared the annual number of TBS clients to the average monthly number of EPSDT eligible children.

no agreement, and you don't have a substitute mechanism [for] achieving a better ability to monitor what is going on, to evaluate it in a concrete manner, and to achieve the purpose of the Judgment, then I'll just go ahead and order that. That one I am going to do." Reporter's Transcript of Proceedings, Motions Calendar, August 5, 2004, 30:10-24.

33. After more than year of negotiation, the parties have been unable to agree on "an alternative concrete standard for ascertaining the parties' compliance with, and the effectiveness of, the Permanent Injunction and Judgment." Further Order, June 30, 2004, page 2.

Now in September 2005 the parties are still not in agreement on a benchmark for TBS utilization or on other alternative measures that could be used to ensure that the judgment is implemented in material respects and that class members have appropriate access to TBS and other necessary services in all MHPs of the defendants Medi-Cal program.

34. The defendants make at least three arguments as to why TBS benchmarks should not be set. First, the plaintiffs don't have the authority, secondly, it would impose a perverse incentive on "clinician's judgment" and thirdly, there is no generally accepted standard for TBS utilization. Exhibit 9, Defendant's brief on out-of-county placements.

35. The court has found that TBS services are underutilized for eligible class members and that increased utilization of TBS services by class members is necessary unless alternative data can be provided that shows that class members are having their intervention and treatment needs addressed through alternative means to fulfill the purpose of the judgment in material respects.

36. The special master has not been able to find alternative data that would show that class members are having their mental health needs appropriately

addressed and therefore clinicians are simply choosing other interventions and services from the service array. To the contrary the special master has directly observed in some counties that access to TBS services is limited by capacity, lack of information and clarity on eligibility criteria, frustration with difficulty in accessing mental health services and weak management and oversight at the MHP level. In addition, the current utilization data are below the level Dr. Vandenberg recommended and Dr. Richard Clarke affirmed in their affidavits. In addition, they are below what the special master would expect to find if clinicians were able to use the service based on the clinical needs of the child and not have to be constrained by lack of capacity, a time consuming and complicated approval process which varies significantly across counties, limitations in use by the mandated eligibility criteria, managements concerns with regard to risk of audit liability and mixed messages regarding priority for use of the service. Some providers of TBS services also recently received contracts that limit the capacity to a fixed number and further reduce the flexibility to provide the necessary TBS service that by definition is a service where timely delivery is of the essence.

37. The Surgeon General's Children's Mental Health Conference has found that growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them. "It is time that we as a Nation took seriously the task of preventing mental health problems and treating mental illnesses in youth." Surgeon General's Conference on Children's Mental Health, 2000, Exhibit 16.

38. The current prevalence figures are that 20% of youth have a diagnosable disorder, 9-13% have Serious Emotional Disorder (SED) with substantial functional impairment, and 5-9% have SED with extreme functional impairment. Dr. Robert Friedman, Presentation to the National Council of

1 Legislatures July 2004, Exhibit 13. Dr. Friedman, the Director of the Children's
2 Mental Health National Research and Training Center, Florida Mental Health
3 Institute, is one of the leading authorities on prevalence research and community-
4 based children's mental health services.

5 39. When the prevalence figures are applied to the California EPSDT
6 Eligible population they show that for 3,348,482 eligible children, approximately
7 669,696 (20%) would have diagnosable mental health conditions, 334,848 (10%)
8 with SED with functional impairment and 217,651 (6.5%) with SED with extreme
9 functional impairment. These figures would actually be higher for the Medi-Cal
10 population because it is a vulnerable population with more association with poverty
11 and the related constellation of problems found in these families. It also includes the
12 foster care population and many children in juvenile justice that have incidence of
13 mental health disorders that are 50% or higher. The defendant is currently providing
14 services to approximately 182,106 children. The defendants point out that the
15 prevalence figures are not exact and are only proxies for the actual occurrence but
16 the point of the Surgeon General's Report on children is that the proxy is the best
17 scientifically supported data we have with wide professional concurrence and that
18 children are being woefully underserved by all responsible agencies. In addition,
19 these figures are used for evaluation, planning and projection purposes by both
20 researchers and program administrators across the country.

21 40. TBS is designed to be an intensive in-home intervention that can be
22 structured to address the presenting needs of the child and family to keep the child
23 stable at home, in foster care or an alternative living arrangement. TBS is also to be
24 used to assist a child to step down from a more restrictive environment. TBS is
25 required to use a variety of behavioral and cognitive behavioral techniques including
26 cognitive behavioral therapy, cognitive restructuring, and use of hierarchies and
27 graduated exposure. Examination of the current evidence based practices shows that,
28

in fact, these are intervention techniques that have some level of empirical support including the specifically defined population of children at risk of out-of-home placement or more restrictive placement. TBS is well structured to deliver a range of well supported evidence based strategies and is primarily dependent on providers being supported to develop even greater skills in these empirically supported techniques. Exhibit 14 presents a table from the report of the Children's Evidence Based Practices Expert Panel that was submitted to Washington State's DSHS Children's Division, Children's Administration, Juvenile Rehabilitation Administration and Mental Health Division that shows the various techniques and various levels of support that have been demonstrated empirically. Exhibit 15 also contains a complete report, "Summary of Effective Interventions for Youth with Behavioral and Emotional Needs," from the Hawaii Child and Adolescent Mental Health Division produced in fall 2004 that shows similar support and also demonstrates what a state children's mental health system can produce with comprehensive data that can be used for data-based decisions by management and to help shape practice and utilization of empirically supported services by clinicians.

41. TBS is California's version of intensive in-home support using a range of empirically supported techniques. The evidence based literature finds high to medium support for these interventions for a number of disorders and populations. In my experience quality intensive in-home services are one of the most effective services in helping children remain with their families in the community. Further, professionals across the country are working to develop as much capacity as possible to deliver these services in the home and school environment because they have been demonstrated to be effective when delivered in these settings and are far less disruptive and frequently less expensive than the more restrictive options including residential services that have little empirical support.

42. It is common practice to examine utilization rates for all kinds of

services and to use the changes in utilization patterns to determine whether services such as intensive in-home services are being used more widely and instead of more restrictive and costly options. See the Hawaii Summary of Effective Interventions for Youth with Behavioral and Emotional Needs in Exhibit 12. It would not be unusual for an expected utilization rate to be set so that discrepancies from this standard can be examined to identify problems or positive examples. The information would also be provided to clinicians so they could receive feedback on whether they are providing the intervention services that are most likely to assist a child to remain in their home and school. The utilization rate recommended by Dr. Vandenberg of 5% of SED children receiving TBS services is a reasonable expectation to be used to assess whether TBS services are being accessed without major barriers and as a service that should be considered and tried for many children who are at risk of having to leaving their home or current living arrangement in the foreseeable future or who need assistance to safely and successfully step down from a more restrictive placement. In fact, it is likely an underestimate of what the utilization would be if it was a service that was widely and easily available.

Special Master Recommendation

43. Based on the findings, the special master recommends to the court that jurisdiction be extended until TBS utilization has significantly increased. The issue in front of the court is not what the ultimate utilization rate will be, but how does the court hold the defendant accountable to fulfill the purpose of the judgment and provide appropriate services and particularly TBS services to eligible class members. The court has determined that accountability for implementation is necessary. This recommendation sets a performance expectation that would show that the defendant is making substantial progress in making sure that TBS eligible class members are being thoughtfully and carefully considered for possible intervention with TBS services in all MHPs of the state and clinicians are able to

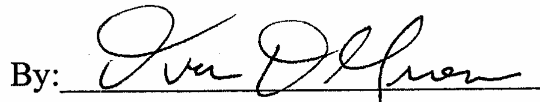
prescribe and access the service without undue delay or procedural difficulty. It is less than Dr. Vandenberg's recommendation in order to demonstrate progress within a reasonable and achievable timeline.

44. It is recommended that significant increase be defined as an overall increase in TBS utilization to between 3.5% and 4% of clients receiving EPSDT services and that the performance level will be sustained at least 12 months from the time first achieved. Further, that for any county under 3% TBS utilization, the defendant must present compelling and clear quantitative and qualitative evidence that class members have access to TBS services and are receiving appropriate alternative services and/or achieving positive outcomes. It is further recommended that if the court orders the above recommendation be implemented, that the parties be directed to readdress the remaining disputed issues and to work with the special master to develop a strategic implementation plan that will have a likely probability of significantly increasing TBS utilization within the next 12 to 24 months.

45. In order to expedite addressing under-utilization in counties with little or no utilization, it is also recommended that the Defendant be required to conduct 10 focused reviews next year with a combination of DMH and external reviewers to be identified by the special master or an independent monitor as deemed appropriate by the court. The review protocol should also be refined to include more detailed and rated findings on each child reviewed and should be drafted to reflect the composite of internal and external perspectives.

Dated: October 12, 2005

Respectfully Submitted,

By: 

Ivor D. Groves, PhD

Special Master

List of Exhibits

Exhibit 1 DMH letter No: 99-03 Attachment 2

Exhibit 2 Page 2-defendant submission to the special master regarding potential data measures.

Exhibit 3 Letter from defendants regarding meeting with Dr. Mayburg

Exhibit 4 Data chart of 03-04 and 04-05 for Penetration Rates of TBS to EPSDT Eligible and Penetration Rates of TBS and EPSDT Clients

Exhibit 5 Los Angeles County Data

Exhibit 6 Chart J form showing declining projected use of TBS

Exhibit 7-10 Are briefs for:

Exhibit 7 Extension of Jurisdiction
Exhibit 8 Clarification of Modification of Class Membership
Exhibit 9 Out-of-County Placements
Exhibit 10 TBS Utilization Benchmarks

Exhibit 11 National Survey of Children and Adolescents (n = 3,703)

Exhibit 12 Executive Summary - Evidence Based Prediction of Mental Health Services for Foster Youths

Exhibit 13 Robert Friedman Slide from Presentation for National Conference of State Legislatures

Exhibit 14 Table on Evidence Based Practices

Exhibit 15 Summary of Effective Intervention for Youth with Behavioral and Emotional Needs

Exhibit 16 Surgeon General's Conference on Children's Mental Health