

Fact Sheet

EPSDT Home and Community Based Services Mental Health Services: Settlement Agreement in *Katie A. v Douglas*

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Overview

Mental health is an essential component in any child's healthy development in order to thrive at home, in school and in the community, and to lead a productive life as an adult. Yet mental health problems can substantially interfere with that development and later success. Children's mental health problems are common and well documented in the United States. One in five children from birth to age 18 has a diagnosable mental disorder.¹ One in 10 youth has serious mental health problems that are severe enough to impair how they function at home, in school or in the community.²

A much higher proportion of children and youth have mental health problems when they are in the child welfare and juvenile justice systems. Research shows a high prevalence of mental health disorders (and developmental delays) among children and youth in the child welfare system. Fifty-percent of children and youth in the child welfare system have mental health problems.³ As many as 80 percent of all youths involved with child welfare agencies have emotional or behavioral disorders, developmental delays, or other indications of needing mental health

¹ President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, report available at <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/downloads.html> (last visited Dec. 14, 2011).

² *Id.*

³ Barbara J. Burns et al., *Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey*, 43 J. Am. Acad. Child. & Adolescent Psychiatry 960, 960-970 (Aug. 2004).

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intervention.⁴ Children and youth in the child welfare system with mental health problems are less likely to be placed in permanent homes.⁵ They are more likely to experience a placement change than children without a mental health disorder.⁶ They are more likely to be placed out of home in order to access services.⁷ They are more likely to rely on restrictive or costly services such as juvenile detention, residential treatment, and emergency rooms.⁸ Youth in residential treatment centers, 69 percent of whom come from the juvenile justice and child welfare systems, have extremely high rates of mental and behavioral health disorders compared to the general population.⁹ While it is apparent that the child welfare system often does not adequately identify or treat children and youth with mental health needs, and thus does little, if anything, to improve the wellbeing of children and youth who come into foster care, children who are abused or neglected are also more likely to have medical or developmental conditions. In fact, one study found that children with chronic medical or developmental conditions experience an even higher level of involvement with child welfare, including an increased likelihood of removal from parental care and a prolonged stay in foster care, compared to their peers.¹⁰

To make matters worse, in 2001 the General Accounting Office (GAO) issued a report that illustrates the tragedy that result when thousands of desperate parents seeking help for their mentally ill children are forced to place their children into the child welfare or juvenile justice systems each year so that they

⁴ *Id.* See also Janice L. Cooper et al., Nat'l Center for Children in Poverty, *Addressing the Mental Health Needs of Children in the Child Welfare System: What Every Policymaker Should Know* 8 (Sept. 2010).

⁵ Cheryl Smithgall et al., Chapin Hall Center for Children, University of Chicago, *Behavioral Problems and Educational Disruptions among Children in Out-of-home Care in Chicago* 22 (2005). See also Andrew Zinn et al., Chapin Hall Center for Children, University of Chicago, *A Study of Placement Stability in Illinois* (2006); See also Jung Min Park and Joseph P. Ryan, *Placement and Permanency Outcomes for Children in Out-of-Home Care by Prior Inpatient Mental Health Treatment*, 19 *Research on Social Work Practice* 42, 42-51 (2009).

⁶ Zinn, Andrew, *supra* note 5. See also Jung Min Park and Joseph P. Ryan, *supra* note 5.

⁷ Michael S. Hurlburt et al., *Contextual Predictors of Mental Health Service use Among Children Open to Child Welfare*, 61 *Archives of General Psychiatry* 1217, 1217-1224 (2004).

⁸ Rep. Henry A. Waxman and Sen. Susan Collins, U.S. House of Representatives, Committee on Government Reform, Minority Staff Special Investigations Division, *Incarceration of Youth Who are Waiting for Community Mental Health Services in the United States* (2004). See also Kathleen J. Pottick et al., *Youths Living Away from Families in the US Mental Health System: Opportunities for Targeted Intervention*, 32 *J. Behav. Health Servs. & Res.*, 264, 264-281. See also Gunnar Almgren and Maureen O. Marcenko, *Emergency Room Use among Foster Care Sample: The Influence of Placement History, Chronic Illness, Psychiatric Diagnosis, and Care Factors*, 1 *Brief Treatment and Crisis Intervention* 55, 55-64 (2001).

⁹ Nan Dale et al., *Characteristics of Children in Residential Treatment in New York State*, 86 *Child Welfare* 5, 5-27 (2007).

¹⁰ Cordelia C. Robinson and Steven A. Rosenberg, *Child Welfare Referrals to Part C*, 26 *J. Early Intervention* 284, 284-291 (Jul. 2004).

may obtain the mental health services they need.¹¹ Many of these families have exhausted their life savings and health insurance only to face the major dilemma of surrendering their parental rights and tearing apart their families in order to obtain mental health treatment for their troubled children. The GAO report estimated that, in 2001, parents were forced to place more than 12,700 children in the child welfare or juvenile justice systems as the last resort for those children to receive needed mental health care treatment.¹² Placement out of the child's home also increased the risk for mental health problems for young children. Infants who experience maltreatment and placement in foster care faced the greatest risk for emotional and behavioral problems. Infants in foster care had longer placements, higher rates of reentry into foster care (experiencing recurrent maltreatment and disruption of family bonds), and high rates of behavioral problems, developmental delays, and health problems.¹³

In July 2002 a federal class action lawsuit, *Katie A. v. Bonta*, was brought on behalf of a class of plaintiffs in or at risk of foster care¹⁴ in California who need individualized mental health services and supports. Plaintiffs principally alleged that defendants failed to provide Medicaid-eligible children in foster care, or at imminent risk of being placed in foster care, with the mental health services they needed and to which they were entitled under the Medicaid Act. The named plaintiffs were five Medicaid-eligible children in the foster care system who needed more intensive mental health services due to their serious mental and emotional disabilities and the resulting challenging behaviors. The lead plaintiff, Katie A. herself, was removed from home at age four and experienced 37 different moves or placements in foster care, including 19 psychiatric hospitalizations, by the time she was fourteen years old. Nearly ten years after the case was filed, and after extensive litigation and a lengthy settlement negotiation through the assistance of a court appointed Special Master, a landmark settlement in the case has been reached that will hopefully result in tens of thousands of children receiving the kinds of necessary intensive home and community-based services and supports they need to succeed in life. This

¹¹ Gov't Accountability Office, *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services.*, Report GAO-03-397 1 (Apr.2003), <http://www.gao.gov/new.items/d03397.pdf>.

¹² *Id.*

¹³ Steven D. Blatt et al., *A Comprehensive, Multidisciplinary Approach to Providing Health Care for Children in Out-of-home Care*, 76 Child Welfare 331, 331-347 (1997). See also Child Protective Servs., Dep't of Health & Human Servs., National Survey of Child and Adolescent Wellbeing: CPS Sample Component Wave 1 Data Analysis Report 4 (2005), available at http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/cps_sample/cps_report_revised_090105.pdf.

¹⁴ Foster care begins when a child is removed from his or her parents or guardians and placed under the responsibility of a state child welfare agency. Removal from the home can occur because of physical abuse or neglect. It can also occur when a child's own behavior or condition is beyond the control of his or her family or poses a threat to their community. Foster care may be provided by a family member, caregivers previously unknown to the child, or a group home or institution.

issue brief describes that settlement and the important new services that are now mandated to be provided to these children under EPSDT as a result of that settlement agreement with the state of California.

Background

While it is well established that children and youth in the foster care system have a higher rate of serious mental health problems due to abuse, neglect and abandonment, challenges associated with meeting the mental health needs of these children and youth in the child welfare system are numerous. Despite the fact that these children are entitled to services and supports to meet their social and emotional-related needs, too often they do not receive them. The reasons range from failure by the child welfare agency to screen or assess children, to failure to provide adequate mental health services, or the appropriate services. As a result of these failures, children and youth with mental and emotional disorders languish in foster care, often in group homes, residential treatment centers or other congregate care facilities as their behaviors deteriorate without effective services and supports.

California's foster care system was no different. According to a 2001 report by the Little Hoover Commission, more than 50,000 children in foster care who need mental health services did not get them.¹⁵ The Commission observed that "while [these] children may be eligible for an array of services, the system for delivering those services is so fragmented, anemic and disorganized that it regularly fails to meet the needs of these children."¹⁶ The Commission also found that mental health services for children needed to be expanded, but the State lacked appropriate standards on the care and services that should be available.¹⁷ In October 2003, a RAND Corporation study listed California as one of three states nationwide which offer the least mental health care to children in need.¹⁸ Every day thousands of foster children were needlessly confined in locked hospital wards and other institutional facilities or placed in large group homes. Yet these children could remain in their own homes and communities if only they were provided the full range of mental health services to which they are entitled under federal law. The *Katie A. v. Bonta* lawsuit was filed on July 18, 2002 on behalf of a class of children to address this longstanding problem. Plaintiffs claimed that by depriving plaintiffs of necessary mental health services, defendants violated the EPSDT provisions of the federal Medicaid Act, 42 U.S.C.

¹⁵ State of Ca. Little Hoover Commission, *Young Hearts & Minds: Making a Commitment to Children's Mental Health* 22 (Oct. 2001) (nearly 70% of children in foster care system in California "will experience a mental health problem"); *see also* Ca. Mental Health Planning Council, *California Mental Health Master Plan: A Vision for California* (Mar. 2003), at DHS000600 (depending on the study, the estimate for "the proportion of children entering the foster care system with significant mental health problems ranges from 35 to 85 percent").

¹⁶ *Id.*

¹⁷ *Id.* at 10.

¹⁸ Roland Sturm et al., *Geographic Disparities in Children's Mental Health Care*, 112 *Pediatrics* 308 (Oct. 2003), available at <http://pediatrics.aappublications.org/cgi/reprint/112/4/e308.pdf>.

§§1396d(a)(4)(B); 1396d(r)(5); 1396a(a)(10)(A); and 1396a (a)(43)(C). They also asserted that defendants failed to provide mental health services in the most integrated setting appropriate to the needs of class members, in violation of Americans with Disabilities Act, 42 U.S.C. §12132, 28 C.F.R. §35.130 and Section 504 of the Rehabilitation Act, 29 U.S.C. §701 *et seq.*

Early on in the litigation, the Court certified a statewide class consisting of the following children and youth:

“a class of children in California who: (a) Are in foster care or are at imminent risk of foster care placement, and (b) Have a mental illness or condition that has been documented or, had an assessment already been conducted, would have been documented, and (c) Who need individualized mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary services in the home or in a home-like setting, to treat or ameliorate their illness or condition.” For purposes of the case, ‘imminent risk of foster care placement’ means that within the last 180 days a child has been participating in voluntary family maintenance services or voluntary family reunification placements and/or has been the subject of either a telephone call to the Child Protective Services hotline or some other documented communication made to a local Child Protective Services agency regarding suspicions of abuse, neglect or abandonment.”

The Class includes children living either with their parents or relatives or in any of a variety of foster care placements, such as group homes or foster homes.

As of July 1, 2004, over 85,000 children were in child welfare-supervised foster care in California.¹⁹ Approximately half of the children spent between six to 36 months in foster care; one in four stayed for 42 months or longer.²⁰ The U.S. Surgeon General and the state’s respected Little Hoover Commission agree that foster children must have available the full range of treatment services.²¹ The President’s New Freedom Commission on Mental Health issued its report in January 2003 noting that effective, state-of-the-art treatments vital for quality care and recovery are now available for most serious mental illnesses and serious emotional disorders.²² The mental health field has developed *evidence-based practices* (EBPs) and *emerging best practices* — a range of treatments

¹⁹ Barbara Needell et al., Univ. Ca. Berkeley Ctr. for Soc. Servs. Res., 1998-2004 July 1 Caseload Children in Child Welfare Supervised Foster Care by Placement Type in California (2004).

²⁰ State of Ca. Little Hoover Commission, *Still in Our Hands: A Review of Efforts to Reform Foster Care in California* (Feb. 2003) (hereafter *Still in Our Hands*).

²¹ U.S. Pub. Health Serv. Office of the Surgeon General, Dep’t of Health & Human Servs., *Mental Health: A Report of the Surgeon General* (1999), *available at* <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

²² *Id.*

and services whose effectiveness is well documented.²³ Two of those practices are treatment foster care (also called “therapeutic foster care” or “TFC”) and wraparound services.²⁴

Wraparound has been described as “a family-focused, strengths-based program where intensive and comprehensive social, mental health and health services are ‘wrapped’ around children and their families (biological, adoptive and/or foster families) to reinforce natural family supports.”²⁵ California State guidance describes wraparound programs as family-centered, needs-driven, strength-based, individualized, unconditional, community-based, comprehensive, flexible, collaborative, outcome-based, promoting self-sufficiency, and cost-effective.²⁶ Wraparound has become a widely used organizing framework and prominent practice model through which community-based services for a broad range of populations with complex needs are delivered and is available through nearly 1000 initiatives in nearly every state.²⁷ The philosophical principles of Wraparound have long provided the basis for understanding this innovative and widely-practiced service delivery model. This value base for working in collaboration and partnership with families extends from wraparound’s roots in programs such as Kaleidoscope in Chicago, the Alaska Youth Initiative, and Project Wraparound in Vermont.²⁸ These principles are also consistent with what has been described by federal funding agencies like the Substance Abuse & Mental Health Services Agency (SAMHSA) and in literature for years as “system of care” principles. Some of the key principles are: family voice and choice, team based decision-making, collaboration, community-based, individualized and strength-based services.²⁹

Similarly, TFC, according to the Surgeon General, is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders. Care is delivered in private homes with specially trained foster parents. The combination of family-based care with specialized treatment interventions creates “a therapeutic environment in the context of a nurturing family home.” ... Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In

²³ Substance Abuse and Mental Health Administration, *The President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America: Executive Summary* 68 (Jan. 2003).

²⁴ *Id.*

²⁵ Lynne Marsenich, Ca. Institute for Mental Health, *Evidence-Based Practices in Mental Health Services for Foster Youth* 15, 35 (Mar. 2002).

²⁶ C. Dep't of Social Services, *All-County Information Notice No. I-28-99* (April 7, 1999), http://www.dss.cahwnet.gov/getinfo/acin99/I-28_99.pdf.

²⁷ Eric J. Bruns et al., *Intervening in the lives of youth with complex behavioral health challenges and their families: The role of the wraparound process*, 46 *American Journal of Community Psychology* 314, 314–331 (2010).

²⁸ Eric J. Bruns et al., *National Wraparound Initiative*, Portland State Univ., *Ten principles of the wraparound process* (2004).

²⁹ *Id.*

addition, therapeutic foster parents are given a higher stipend than that given to traditional foster parents, and they receive extensive pre-service training and in-service supervision and support.³⁰

For foster children, especially those with serious mental health needs, the full range of treatment services must include wraparound services and therapeutic foster care. Wraparound and TFC are intensive and comprehensive mental health services that, among other things, are designed to meet the individualized needs of these children. In fact, California's leading mental health research institute has identified "[o]nly two intervention models [that] have demonstrated effectiveness in the treatment of foster children – the wraparound service strategy and therapeutic foster care."³¹ It found wraparound to be one of the few mental health interventions for which there is "strong" evidence of efficacy, with significant expert support and many scholarly articles describing its benefits.³²

Based upon the results of a number of studies, the Surgeon General found that youth in TFC "showed more improvements in behavior and lower rates of institutionalization and the costs were lower than those in other settings."³³

Yet these services were not clearly covered by Medicaid in California and thus not available, other than through pilots, developed solely at the will of the county. The litigation sought to make those services available to class members in California under the Medicaid EPSDT mandate.

States Legal Obligation to Provide Mental Health Services to Medicaid Eligible Children in or at risk of Foster Care

Nearly all foster children are eligible to receive medical services, including mental health services, from the Medicaid program.³⁴ Medicaid is a jointly administered

³⁰ Beth A. Stroul, CASSP technical Assistance Center, Georgetown University, Therapeutic Foster Care. Vol. III: Series on community-based services for children and adolescents who are emotionally disturbed (1989); *see also* U.S. Pub. Health Serv. Office of the Surgeon General, *supra* note 29.

³¹ Lynne Marsenich, *supra* note 33, at 12,17-19.

³² *Id.* at 33, 49. *See, for example*, Barbara J. Burns et al., *Comprehensive Community-Based Interventions for Youth with Severe Emotional Disorders: Multisystemic Therapy and the Wraparound Process*, 9 *Journal of Child and Family Studies* (2000); Eric J. Bruns et al., *Adherence to wraparound principles and association with outcomes*, 14 *Journal of Child and Family Studies* 521-534 (2005); John D. Burchard, et al., *The wraparound approach, Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (Barbara Burns and Kimberly Hoagwood Eds., 2002); James T. Yoe et al., *Wraparound care in Vermont: Program development, implementation, and evaluation of a statewide system of individualized services*, 5 *Journal of Child and Family Studies* 23-37; Joseph L. Woolston et al., *Intensive integrated, in-home psychiatric services: The catalyst to enhancing outpatient intervention*, 7 *Child and Adolescent Psychiatric Clinics of North America* 615-633 (1998).

³³ U.S. Pub. Health Serv. Office of the Surgeon General, *supra* note 29.

³⁴ *Emily Q. v. Bontá*, 208 F. Supp. 2d 1078, 1088 (C.D. Cal. 2001); Children in foster care are automatically eligible for Medicaid coverage if they receive Title IV-E foster care assistance. 42 U.S.C. § 1396a(a)(10)(A)(i)(I). Foster care children who are not IV-E eligible can still qualify for Medicaid through one of the other mandatory eligibility categories, such as being recipients of

federal and state program designed to provide medical and remedial services to low-income people under Title XIX of the Social Security Act, 42 U.S.C §1396 *et seq.* Federal law requires state Medicaid programs to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age.³⁵ The services covered under EPSDT are those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a). Under federal requirements for the EPSDT programs, Medicaid must screen eligible children “to determine the existence of certain physical or mental illnesses or conditions.”³⁶ Medicaid must then provide these eligible children with vision, dental and hearing services and “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in . . . [42 U.S.C. § 1396d(a)] . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether are not such services are covered under the State [Medicaid] plan.”³⁷ Under § 1396d(r)(5), states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a).³⁸ 42 U.S.C. § 1396d(a) contains a list of 28 categories of care or service; the categories are fairly general.³⁹ States must provide all of the services listed in § 1396d(a) to eligible children when such services are found to be medically necessary.⁴⁰ A service need not be expressly listed in § 1396d(a) to be covered.⁴¹

Rehabilitation services are one such mandatory EPSDT service.⁴² Rehabilitative services are defined as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of the individual to his best possible functional level.”⁴³ The

supplemental security income benefits [42 U.S.C. § 1396a(A)(10)(A)(i)(II)] or one of the optional categories, such as being deemed “medically needy.” 42 U.S.C. § 1396a(A)(10)(A)(ii).

³⁵ 42 U.S.C. § 1396d(r)

³⁶ 42 U.S.C. § 1396d(r)(1)(A)(ii).

³⁷ 42 U.S.C. § 1396d(r)(2)-(5).

³⁸ *Katie A. ex rel Ludin v. L.A. Cnty.*, 481 F.3d 1150, 1158 (9th Cir. 2007), *rev'g & remanding* 433 F. Supp. 2d 1065 (C.D. Cal. 2006).

³⁹ *Id.* at 1154.

⁴⁰ *Id.*

⁴¹ *Id.* at 1158. See *Parents League for Effective Autism Services v. Jones-Kelley*, 339 F. App'x 542 (6th Cir. 2009), *aff'g* No. 2:08-CV-421, 2008 WL 2796744 (S.D. Ohio July 30, 2008), *aff'g* 565 F. Supp. 2d 905 (S.D. Ohio June 30, 2008) (finding Applied Behavioral Analysis therapy to be EPSDT rehabilitative service under § 1396d(a); also discussing habilitation services); see *also*, *e.g. Collins v. Hamilton*, 349 F.3d 371, 375-76 n.8 (7th Cir. 2003) (citing 42 U.S.C. §§ 1396d(a)(4)(B) and 1396d(r) and holding “a state’s discretion to exclude services deemed ‘medically necessary’ by an EPSDT provider has been circumscribed by the express mandate of the statute”); *Ekloff v. Rodgers*, 443 F. Supp. 2d 1173, 1179 (D. Ariz. 2006) (covering incontinence supplies).

⁴² 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130 (1978). See *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass 2006) (case management and monitoring, and in-home support services for seriously emotionally disturbed children fall under § 1396d(a)(13)).

⁴³ 42 C.F.R. § 440.130(d) (1978).

Government Accounting Office (“GAO”) recognized that the rehabilitation option allows children to “obtain services in nonmedical settings, including school-based or other day treatment and home-based services.”⁴⁴

In addition to rehabilitation services, case management services is another mandatory EPSDT service.⁴⁵ Case management is composed of services which “assist individuals eligible under the [Medicaid] plan in gaining access to needed medical, social, educational, and other services.”⁴⁶ California, like many states, covers targeted case management for both adults and children with mental illnesses.

The Settlement Agreement⁴⁷

A settlement was reached after almost 2 years of intensive negotiation, led by the Special Master with a confidential negotiation work group team that consisted of the parties and a number of key stakeholder representatives, including family members, counties and providers. Plaintiffs have obtained much of what they sought in their preliminary injunction motions through the Settlement Agreement.⁴⁸ Further, the Ninth Circuit and the district court agreed that wraparound and TFC are medically necessary for children with serious mental health needs.⁴⁹

The core of the Agreement is contained in Paragraphs 19 and 20. Paragraph 19 expressly states that the four “objectives” of the Agreement are to:

- a. “Facilitate the provision of an array of services delivered in a coordinated, comprehensive, community-based fashion that combines service access, planning, delivery, and training into a coherent and all-inclusive approach;”
- b. “Support the development and delivery of a service structure and a fiscal system that supports a core practices and services model, as described in (a);”
- c. “Support an effective and sustainable solution that will involve standards and methods to achieve quality-based oversight, along with training and education that support the practice and fiscal models;”
- d. “Address the need for certain class members with more intensive needs (hereinafter referred to as “Subclass members”) to receive medically necessary mental health services in their own home, a family setting or the most homelike setting appropriate to their needs, in order to

⁴⁴ Roland Sturm et al., *Geographic Disparities in Children’s Mental Health Care*, 112 *Pediatrics* 308 (Oct. 2003), available at <http://pediatrics.aappublications.org/cgi/reprint/112/4/e308.pdf>.

⁴⁵ 42 U.S.C. §§ 1396d(a)(19), 1396n(g)(2). See *Rosie D.*, 410 F. Supp. 2d at 52-53.

⁴⁶ *Id.*

⁴⁷ A complete copy of the *Katie A.* Settlement Agreement can be found on the NHeLP website at [http://healthlaw.org/images/stories/Katie A. settlement 9.1.11 executed version.pdf](http://healthlaw.org/images/stories/Katie_A_settlement_9.1.11_executed_version.pdf).

⁴⁸ See Report Pursuant to Court’s Order Appointing Special Master at 8, lines 15-16, dated May 28, 2010 (Dkt. No.702)

⁴⁹ *Katie A.*, 481 F.3d at 1153.

facilitate reunification, and to meet their needs for safety, permanence, and wellbeing.”⁵⁰

The Agreement defines a *Subclass* of class members as consisting of “children and youth who:

(1) are eligible for full-scope Medi-Cal, (2) meet medical necessity requirements, (3) have an open child welfare services case, and (4) are currently in or being considered for either:

A. “Wraparound, therapeutic foster care or other intensive services, therapeutic behavioral services, specialized care rate due to behavioral health needs or crisis stabilization/intervention;” or

B. “[A] group home (RCL 10 or above), a psychiatric hospital or 24 hour mental health treatment facility, or has experienced [3] or more placements within 24 months due to behavioral health needs.”⁵¹ The criteria used to define Subclass members effectively identifies the children and youth with serious mental health needs, and all members of that class will have equal access to the services.

To effectuate these objectives, the State has agreed, among other things, that two newly defined services, *Intensive Care Coordination* (“ICC”) and *Intensive Home Based Services* (“IHBS”), are reimbursable under the Medicaid Act, and that they will further explore the extent to which Therapeutic Foster Care (“TFC”) services are also covered under the Medicaid Act.⁵² They will also facilitate the provision of ICC and IHBS and, if covered by Medicaid, TFC services, to Subclass members.⁵³ All of the components of these services can be covered under EPSDT as rehabilitative services or case management or targeted case management services. See discussion, *supra*. In fact, the negotiation work group developed the definitions of these services (see Appendix “D” and “E” of the Agreement) and the State has already amended the State Plan (and received approval from the federal Centers for Medicare and Medicaid Services) to ensure the components of these new services could be covered. In delivering these services, providers will work as a team with the child and family and with representatives of the involved public agencies, and will coordinate the delivery of mental health services and other supports, consistent with the wraparound principles.

To support this effort, the State has committed to developing, promoting and circulating a “core practice model” that would be utilized by all agencies and individuals who serve class members and their families. Again, consistent with the wraparound principles, the core practice model is designed to guide the provision of mental health services to class members in a coordinated, comprehensive and community-based fashion and includes values, goals and

⁵⁰ Settlement Agreement, at ¶19(1).

⁵¹ *Id.* at ¶19(1).

⁵² *Id.* at ¶20(a).

⁵³ *Id.*

principles that promote working with families and care providers as a team. One key principle is that the State will strive to provide children and youth who require intensive mental health services with treatment in their homes, foster homes, or independent living programs so that they can avoid hospitalization or placement in group homes or other institutions, and avoid being removed from their biological families in the first instance. For children with intensive or complex needs, the core practice model provides for the delivery of services through a formal *Child and Family Team*.⁵⁴

The State will also develop and circulate a Medicaid documentation manual that will inform and instruct providers how to provide and bill ICC, IHBS and TFC services to Medicaid, consistent with the core practice model.⁵⁵ The State must also develop an implementation plan within the first 6 month period of the Settlement Agreement that addresses how the services and the core practice model will be brought to scale statewide.⁵⁶

There are other key features of the Settlement that will serve to reform the child welfare and mental health systems and ensure better coordination of the state and county governance agencies responsible for serving these children and youth. The State will support this model by creating a joint agency management structure to develop policy and program direction consistent with the core practice model.⁵⁷ The policies and program directions will promote mental health services that: (1) are individualized and tailored to the strengths and needs of each family and child; (2) assures family voice, choice and preference throughout the process; (3) are geared to ensuring that children will have permanency and stability in their living situations; and (4) are culturally competent and are a blend of formal and informal resources designed to assist the families with success transitions.⁵⁸ The State will also develop a training curriculum to support use of the new core practice model by child welfare and mental health staff.⁵⁹ In addition, the State has agreed to develop a process to identify class members in order to firmly link them to necessary mental health services.⁶⁰ It will establish a team to collect data on service delivery and outcomes.⁶¹ Within six months after final Court approval of the Agreement, the parties must develop an implementation plan to fulfill the obligations of the Agreement.⁶² Through a stipulated judgment in the case, the Court retains jurisdiction over this case for 36 months (starting December 5, 2011) to enforce the Agreement.⁶³

⁵⁴ *Id.* at Exh.1, Appendix C (describing core practice model).

⁵⁵ *Id.* at ¶20(b).

⁵⁶ *Id.* at ¶20(l).

⁵⁷ *Id.* at ¶20(d).

⁵⁸ *Id.* at Exh. 1, Appendix B (describing principles of core practice model).

⁵⁹ *Id.* at ¶¶20(e)-(f).

⁶⁰ *Id.* at ¶ 20(i).

⁶¹ *Id.* at ¶20(h).

⁶² *Id.* at ¶ 21.

⁶³ *Id.* at ¶30; *See* Stipulated Judgment dated December 5, 2011 (Dkt. No.779)

One of the significant features of this Settlement Agreement is that the State will create a systemic and integrated practice shift that promotes a family-centered, individualized approach to serving all Class members. The core of this litigation was that State defendants failed to identify and make services available to treat the mental health needs of Class members.⁶⁴ As explained above, the State has agreed to develop a practice model that provides a framework, guidelines and approaches to identifying, linking and coordinating mental health services for the Class, consistent with good child welfare principles. In the long-term, Class members and all children and youth involved with the child welfare system will benefit from this practice shift.

The Settlement Agreement in *Katie A.* is the most recent litigation in a series of cases over the past decade that have targeted the inadequacies of the mental health services for children and youth under Medicaid. See *Katie A. v. Bontá*, Stip. Order Re Final Approval of Class Settlement, dated July 16, 2003 (Dkt. No. 128) (approving settlement on behalf of a class of foster youth who need mental health services that requires Los Angeles County to identify foster youth and children who need mental health services, to expand wraparound services, and to provide those services in child and family teams); *J.K. v. Eden*, No. Civ. 91-261-TUC-JMR (D. Ariz. June 26, 2001) (approving class-action settlement that in part requires the state to provide Medicaid eligible children with mental health services tailored to the child and family and in the most appropriate setting); see also *Rosie D. v. Romney*, 474 F. Supp. 2d 238 (D. Mass. 2007) (ordering defendant state agencies to implement a plan to, among other things, provide behavior health screenings and services to a class of children suffering from serious emotional disturbances as defined by Individuals with Disabilities Education Act). While those cases have also addressed intensive home-based mental health services, this Settlement is unique in that it: (1) clearly and specifically identifies and defines three key Medicaid services (ICC, IHBS and TFC) in a clear and simple manner, (2) broadly covers the kinds of services and supports necessary to meet the needs of children and youth, and (3) directly ties these services to the practice model by which they must be delivered to be effective.

Conclusion and Recommendations

This Settlement Agreement offers the opportunity for other states to clearly follow the wisdom of California, and ensure that critical and effective services like wraparound and TFC are provided to children and youth in the foster care system, as well as, in other systems, including juvenile justice and special education, as medically necessary services that must be provided as part of the state's EPSDT mandate. Importantly, it also directly furthers goals of the 1999 *Olmstead v. L.C.* decision to provide services in the most integrated setting possible — services in communities rather than in institutions, as the ADA requires, and at lower cost.

⁶⁴ See First Amended Complaint ¶147 (filed December 20, 2002).

Recommendations:

- 1) Determine whether your state covers home and community based mental health services for children in or at risk of foster care either through its Medicaid state plan or through a separate EPSDT benefit.
- 2) Even if EPSDT covered intensive care coordination and home-based services and supports are already authorized under your state plan or other similar authority, determine if these services are being provided to all Medicaid eligible children, when medically necessary, to maintain the child at home or in a home-like community setting, or to return the child to their home or community from an institution or congregate care setting.
- 3) Work directly with foster care, juvenile justice, and special education attorneys or advocates to identify children in your state who are in need of these services and advocate for these services in juvenile courts, special education hearings or other forums where these services might be directly authorized or mandated by a court order.
- 4) The National Health Law Program is serving as co-counsel in a number of cases involving children's mental health services throughout the country. Contact NHeLP to assist you or other advocates in learning about the opportunities this settlement presents for your state, through either co-counsel arrangements or technical assistance.

For more information about the *Katie A.* settlement, contact Kim Lewis, Managing Attorney at NHeLP's California office, at (310) 736-1653, or email her at: lewis@healthlaw.org.