FULFILLING MEDI-CAL'S PROMISE

EXTENDING HOME AND COMMUNITY-BASED MENTAL HEALTH SERVICES TO JUVENILE JUSTICE-INVOLVED YOUTH IN CALIFORNIA

YOUNG MINDS ADVOCACY

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FOREWORD

Two-thirds to three-quarters of the youth involved in the California juvenile justice system may have a diagnosable psychiatric condition. In order to meet the mental health needs of these youth, it is imperative that California's juvenile justice system improve its mental health interventions. In order to stop our juvenile detention facilities from being de facto mental health institutions, California's public mental health system must invest in a truly comprehensive community-based service array.

Recognizing the critical gap in California's existing service array for juvenile justice-involved youth, Young Minds Advocacy, with the support of the Zellerbach Family Foundation, set out to evaluate what it would take to extend access to intensive home and community-based services, including intensive care coordination (ICC) and intensive home based services (IHBS).

Just as our staff prepared to publish this white paper, in response to Young Minds' request, the California Department of Health Care Services (DHCS) publicly acknowledged for the first time that ICC and IHBS are allowable services under the Medicaid Act and, pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate, must be provided to all Medi-Cal beneficiaries under the age of 21 for whom these services are medically necessary. The affirmative determination by DHCS that these critical services must be made available to all Medi-Cal youth means that thousands of low-income youth in California can no longer be denied intensive mental health services that could help them live and thrive in their own home and communities. The demand letter from Young Minds Advocacy and the DHCS response are attached in the Appendix.

As DHCS and its county partners take the necessary steps to build capacity to provide ICC and IHBS to all eligible youth, this white paper can provide information to help stakeholders effectively ensure that youth involved in the juvenile justice system can access these crucial services when needed.

We applaud DHCS for taking action to come into compliance with federal law and to meet California's obligations to youth and families in need. We look forward to working with stakeholders and the Department to ensure that ICC and IHBS are promptly made available to youth involved in California's juvenile justice system.

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EXECUTIVE SUMMARY

Juvenile Justice-Involved Youth Have Significant Mental Health Needs Yet Don't Get the Care They Need.

Mental health is a critical issue for today's youth. Adolescents and young adults are 3-4 times more likely to experience a mental illness than any other health condition, including diabetes and asthma. Young people involved in the juvenile justice system are among those at the highest risk for unmet mental health needs in our communities. While the incidence of serious mental health conditions among adolescents and young adults is generally found to be between 10% and 20%, studies estimate that as many as 70% of young people involved in the juvenile justice system may have a diagnosable mental illness.

Once involved in the juvenile justice system, however, many youth with mental health needs face considerable barriers to receiving adequate care. Despite the high incidence of mental illness, the juvenile justice system is poorly equipped to meet young people's needs. Screening and assessment are lacking, treatment options in juvenile halls and prisons are very limited, and youth with mental health needs are seldom diverted to more appropriate settings.

Extend Access to Intensive Community-Based Mental Health Services to Juvenile Justice-Involved Youth.

Experts generally agree that juvenile justice-involved youth with serious mental health needs are more effectively served in the community or at home instead of in juvenile correctional facilities. Services such as intensive care coordination (ICC) and intensive home and community-based services (IHBS) foster better outcomes, help prevent recidivism, and are more cost effective than services delivered in institutional and congregate care settings. Home and community-based treatments also have the advantage of qualifying for federal Medicaid reimbursement, covering roughly half the cost of healthcare services and administrative expenses involved in serving Medi-Cal eligible youth.

A significant number of juvenile justice-involved youth are Medi-Cal eligible. As Medi-Cal beneficiaries, these young people have a legal entitlement to a comprehensive array of healthcare services, including ICC and IHBS. The groundbreaking reform lawsuit, *Katie A. v. Bonta*, resulted in a settlement that ensured that California's child welfare population would be provided access to these services through their Medi-Cal eligibility. To date, youth without an open child welfare case have been unable to access *Katie A.* services. Extending access to ICC and IHBS to juvenile justice-involved youth who are Medi-Cal eligible would fill an important gap in the

provision of vital mental health services. Among the roughly 46,500 youth involved in the juvenile justice system, nearly 25,000 are likely eligible for Medi-Cal.

California Has a Legal Obligation to Provide ICC and IHBS to All Elligble Youth.

California participates in Medicaid, a federal program that provides medical and other remedial services to low-income people. To receive federal matching funds for its Medicaid program, known as Medi-Cal, California must comply with federal rules and regulations, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements for recipients under 21 years old. EPSDT services broadly include screening and diagnosis to identify illnesses or conditions and any treatment necessary to improve identified ailments. ICC and IHBS are EPSDT covered services that California must provide to any Medi-Cal beneficiary under age 21 who meets medical necessity criteria for these services. This includes juvenile justice-involved youth, even though they were not members of the plaintiff class in the *Katie A.* lawsuit.

Thousands of Juvenile Justice-Involved Youth May Be Eligible for ICC & IHBS.

While a substantial share of all juvenile justice-involved youth are likely eligible for Medi-Cal, a smaller (albeit not insignificant) population may have a medical need and are thereby eligible for ICC and IHBS. In order to qualify to receive a service through the Medi-Cal program, a young person must have, among other things, a determination from a qualified mental health provider that the requested service is medically necessary in order to treat or improve their mental health condition. Known as "medical necessity," this criterion determines whether eligible youth have a right to receive a particular service under California's EPSDT entitlement.

While medical necessity is determined on an individualized basis, youth who meet criteria for ICC and IHBS tend to be those with more intensive mental health needs. Research indicates that as many as 27% of young people involved in the juvenile justice system nationally experience mental illness severe enough to significantly impair their ability to function at home, in school or within the community. Termed serious emotional disturbance (SED), youth with this level of acuity often need the intensity of care offered by services such as ICC and IHBS in order to avoid hospitalization or out-of-home placement. As such, the SED rate among juvenile justice-involved youth is an appropriate proxy for estimating the share of young people within the system who might need ICC and IHBS.

As services based in the home and community, ICC and IHBS are not typically provided to Medi-Cal beneficiaries living in congregate care facilities, such as group homes. According to the most recent placement data available, an estimated 2,200 juvenile justice-involved youth live in group homes

and are likely ineligible to receive ICC and IHBS. Based on these estimates, however, approximately 4,500 juvenile justice-involved youth who are eligible for Medi-Cal need ICC and IHBS.

Providing ICC & IHBS Would Incur Modest Cost to the State.

DHCS's *Katie A.* implementation reports provide a vehicle for estimating the cost of providing ICC and IHBS to juvenile justice-involved youth. The number of juvenile justice-involved youth who are eligible for Medi-Cal and likely qualify to receive ICC and IHBS is estimated to be 4,516. Multiplying this number by the number of juvenile justice-involved youth who likely qualify to receive ICC and IHBS (4,516) yields an expected yearly total cost of $20.7 million to expand *Katie A.* services to all eligible juvenile justice-involved youth. Because EPSDT services are cost-shared by the federal government, California's annual cost would be about $10.4 million—but only if every eligible child is served. At present, about one in five eligible foster youth actually receive ICC/IHBS.

Counties Are Required to Provide ICC & IHBS as Part of Their Obligations Under the 2011 Realignment.

Beginning in 2011, California shifted fiscal responsibility for several "public safety" programs, including the Medi-Cal Specialty Mental Health Services (SMHS) program, from the state General Fund to the counties. To finance these programs, the state provides a dedicated portion of state sales and use tax revenues. Shifting a combination of obligations and funding is consistent with California's Constitution, which generally prohibits the state government from requiring local agencies to provide new or increased level of services without also providing the necessary funding.

A state mandate that county Mental Health Plans extend ICC and IHBS to all Medi-Cal beneficiaries who meet medical necessity criteria may raise questions about whether the state is imposing an unfunded mandate in violation of the Constitution. However, our analysis shows that the federal compliance exception to unfunded mandates applies to expanding ICC and IHBS eligibility. As such, counties will likely need to provide additional ICC and IHBS services using their existing Realignment funds. Questions of how to finance California's public mental health systems, however, are rarely decided without controversy. Further developments regarding how programs are financed in a post Realignment environment may be expected.

Conclusion

Investing in intensive home and community-based mental healthcare now will help increase the capacity of California's juvenile justice and mental health systems to meet the needs of thousands of youth involved in these systems. More importantly, extending access to these essential services will lead to a brighter outlook and better outcomes for young people with serious mental health needs, their families, and our communities.

INTRODUCTION

Young people involved in the juvenile justice system are among those at the highest risk for unmet mental health needs in our communities. In some cases, youth become involved in the juvenile justice system as a means of accessing needed mental health services.[1] After exhausting all other options, and with no place else to turn, many families make the heart-breaking choice of committing their children to the one system that can't refuse them. In other instances, behaviors related to unmet mental health needs result in criminal charges and juvenile justice involvement.

Once involved, however, many youth with unmet mental health needs face considerable barriers to receiving adequate care and, as a result, become stuck in the juvenile justice system. Far too many youth are detained and remain in secure facilities because more appropriate community-based mental health services are unavailable. Other young people return to the community without appropriate services and supports in place to meet their mental health needs and quickly recidivate.

These poor outcomes reflect the failings of the public mental health system. The traditional approach to meeting the mental health needs of children with serious behavioral and emotional disorders has been to (1) provide medication management and outpatient therapy or (2) institutionalize youth in group homes or psychiatric facilities. **This service approach is often ineffective, expensive, and results in damaged lives, broken families, and extinguished hopes.**

This white paper examines the needs of youth[2] involved in California's juvenile justice system and analyzes the inadequacies of our public mental health system in providing appropriate mental healthcare for these young people. The paper explores how to expand intensive home and community-based services that are now provided to child welfare-involved youth to similarly situated young people involved in the juvenile justice system. These services include Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) provided through California's Medi-Cal Specialty Mental Health Services Program (SMHS). As part of our analysis, the paper considers California's legal obligation under state and federal Medicaid law to provide ICC and IHBS to all Medi-Cal eligible youth for whom these services are medically necessary. Finally, this report estimates who might benefit from full implementation of the law within the juvenile justice population and at what cost to the state.

MENTAL ILLNESS IS A CRITICAL UNMET CHALLENGE

Youth and Mental Health

Mental health is a critical issue for today's youth. Children, adolescents, and young adults are 3-4 times more likely to experience a mental illness than any other chronic health condition, including diabetes and asthma.[3] Moreover, the incidence of mental illness among children has the potential to reverberate throughout a child's entire life: half of adult illnesses begin in adolescence, and three-quarters arise by age 24.[4]

Timely and intensive treatment can make a profound difference in a youth's life.[5] However, as many as 80% of adolescents with diagnosable mental health needs fail to receive the services necessary for their conditions.[6]

The mental health needs of young people do not disappear with age; rather, they compound to reduce young people's life chances as they transition into adulthood, where the effects of childhood mental illness continue to be felt.

A lack of timely treatment not only fails to alleviate the symptoms and impairments of mental illness, but can also lead to worse health outcomes overall. Without treatment, youth can experience more severe and frequent symptoms of mental illness that, over time, are more likely to become resistant to treatment.[7] For example, a delay in seeking treatment for schizophrenia has been shown to be related to aggravated symptoms and adverse reactions to medications, along with increased hospitalization and suicide risk.[8]

The mental health needs of young people do not disappear with age; rather, they compound to reduce young people's life chances as they transition into adulthood, where the effects of childhood mental illness continue to be felt. Even among youth with less acute mental health conditions, a lack of treatment leads to increased chances of dropping out of school, unemployment, and involvement in the criminal justice system.[9] As many as half of youth with a mental illness drop out of school,[10] and more than half of all high school dropouts have a diagnosable psychiatric disorder.[11] Even the life span of those with mental illness is affected. Individuals living with mental illness die nearly nine years earlier than the general population, typically due to highly preventable health conditions such as diabetes and tobacco use.[12]

Greater Incidence of Mental Illness Among Youth Involved in the Juvenile Justice System

The prevalence of mental illness is even more pronounced within the juvenile justice system. Juvenile justice-involved youth experience much higher rates of mental illness than the general population. **While the incidence of serious mental health conditions among adolescents and young adults is generally found to be between 10% and 20%, studies estimate that as many as 70% of young people involved in the juvenile justice system may have a diagnosable mental illness.**[13]

Juvenile Justice Facilities Acting as De Facto Mental Institutions

High rates of youth with mental illness in the juvenile justice system are among the consequences of failure by other child-serving systems to provide appropriate and timely mental healthcare. When mental illness goes untreated, many young people experience a deterioration in their ability to function at home, in schools, and within the community. This could include disruptive, destructive, or violent behavior that can lead to police involvement and arrest. It is also common for youth with unmet mental health needs to self-medicate through substance abuse. These behaviors can cross the threshold of delinquency and, as a result, far too many youth become involved in the juvenile justice system.[14] In other instances, youth are committed to the juvenile justice system in order to access care otherwise unavailable through public and private mental health providers.[15]

Regardless of how youth enter the system, many remain in detention due to a lack of appropriate community-based mental health treatment. In many communities, juvenile justice detention centers have become the de facto placement in lieu of appropriate treatment.[16] Lacking treatment options, some children are placed in detention without having any charges pending. Others remain detained because there are no alternative appropriate placements.[17, 18] A study by Congress concluded that, on a daily basis, around 2,000 youth nationwide are held in detention every day solely for this reason.[19]

Similarly, a 2007 study conducted by the Chief Probation Officers of California (CPOC) found that youth with mental disorders remained in placement an average of 18 days longer than those without mental disorders.[20] By keeping these youth in detention longer, county juvenile justice systems incurred an average of $7,210 more per youth in facility costs alone.[21] When taking into account additional costs to the system, the CPOC study estimated that youth with mental illness cost $18,800 more than other youth in detention.[22]

Despite the high incidence of mental illness, the juvenile justice system is poorly equipped to meet young people's needs. Screening and assessment are lacking, treatment options in juvenile halls

CONTEXT

understanding the extent of need for services

most common[i]

MENTAL HEALTH CONDITIONS

1. DISRUPTIVE DISORDERS — 46.5 PERCENT
2. SUBSTANCE ABUSE DISORDERS — 46.2 PERCENT
3. ANXIETY — 34.4 PERCENT
4. MOOD DISORDERS — 18.3 PERCENT

CO-OCCURRING DISORDERS

of these, 79 PERCENT met the criteria for two or more diagnoses[v]

of these, 60 PERCENT met the criteria for an additional substance use disorder[v]

while the incidence of serious mental health conditions among youth involved in JUVENILE JUSTICE is 70 PERCENT[vi]

27 PERCENT have a serious emotional disturbance[vii]

15 PERCENT[iii] of detained youth receive treatment while detained

ONLY 8 PERCENT[iii] received treatment within 6 months after detention

11 percent of detained youth had attempted suicide at some point in their lives[ii]

MANY JUVENILE-JUSTICE INVOLVED YOUTH ATTEMPT SUICIDE

There were 205 suicide attempts and 1 suicide in CA juvenile detention facilities (2013)

90 percent of youth involved in the **juvenile justice system** have experienced TRAUMA[iv]

30 percent of youth involved in the **juvenile justice system** meet the criteria for POST-TRAUMATIC STRESS DISORDER[iv]

i. Jennie Shufelt and Joseph Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study*, Nat'l Center for Mental Health and Juvenile Justice 2 (June 2006).

ii. California Board of State and Community Corrections, Juvenile Detention Survey Profile Survey 2013 1st-4th Quarter Survey Results.

iii. Linda A. Teplin, et al, *The Northwestern Juvenile Project: Overview*, Office of Juvenile Justice and Delinquency Prevention Juvenile Justice Bulletin 11 (Feb 2013).

iv. Carly B. Dierkhising, et al., *Trauma Histories Among Justice-Involved Youth: Findings from the National Child Traumatic Stress Network*, National Center for Child Traumatic Stress 3 (July 16, 2013).

v. Jennie Shufelt and Joseph Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study*, Nat'l Center for Mental Health and Juvenile Justice 3 (June 2006).

vi. Substance Abuse & Mental Health Servs. Admin., *Community Conversations About Mental Health: Information Brief* 21 (July 2013).

vii. Kathleen Skowyra and Joseph Cocozza, Nat'l Cent. For Mental Health & Juvenile Justice, *A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System* 8 (2006).

and prisons are very limited,[23] and youth with mental health needs are seldom diverted to more appropriate settings.[24, 25] The use of medication and punishment, rather than treatment, is far too common, and family contact is significantly limited. Together, these circumstances can lead to isolation, disengagement, and worsening mental health symptoms.[26] In most communities, juvenile justice staff receive little training about the mental health needs of the young people they supervise in probation, detention, and correctional settings, or how mental disorders can impact behavior. Without adequate training, juvenile justice staff frequently turn to ineffective or punitive strategies for dealing with behaviors related to mental illness.

ADDRESSING UNMET NEEDS

Extend Access to Intensive Care Coordination & Intensive Home Based Services, through California's Medi-Cal Program, to Juvenile Justice-Involved Youth.

A significant number of juvenile justice-involved youth are Medi-Cal eligible based on income or foster care status. Young people who are Medi-Cal beneficiaries have a legal entitlement to a comprehensive array of healthcare services, including intensive community-based mental health services such as the treatments at issue in the groundbreaking reform lawsuit, *Katie A. v. Bonta*. The *Katie A.* settlement ensured that California's child welfare population would be provided access to intensive home and community based services through their Medi-Cal eligibility. However, only youth invoveld with the child welfare system were members of the plaintiff class in *Katie A.*, and other Medi-Cal youth have not had access to the resulting services, including intensive care coordination and intensive home-based services.

Extending access to ICC and IHBS services to juvenile justice-involved youth who are Medi-Cal eligible would fill an important gap in the provision of vital services to this population. Experts generally agree that juvenile justice-involved youth with unmet mental health needs are more effectively served within the community instead of in juvenile correctional facilities.[27] **Services such as intensive care coordination and intensive home-based services foster better outcomes for these youth, help prevent recidivism, and are more cost effective than services delivered in institutional and congregate care settings.**[28] Treatment outside the correctional system also has the advantage of qualifying for federal Medicaid reimbursement, which covers roughly half the cost of healthcare services and administrative expenses incurred by Medi-Cal beneficiaries.[29]

The balance of this white paper explores how to operationalize the goal of delivering intensive home and community-based services to youth who are at risk of, or already involved in, the juvenile justice system. We begin by describing

California's legal obligation to provide intensive community-based mental health services to all Medi-Cal eligible youth for whom these services are medically necessary, including those involved in the juvenile justice system. The authors then estimate the number of young people involved in the juvenile justice system likely eligible for Medi-Cal and in need of these intensive mental health services. Finally, the paper projects the anticipated costs and administrative measures needed to extend *Katie A.* services to all eligible juvenile justice-involved youth.

California's Legal Obligation to Provide Intensive Community-Based Mental Health Services to all Medi-Cal Eligible Youth

EPSDT Entitlement

California participates in Medicaid, a federal program intended to provide medical and other remedial services to low-income people.[30] To receive federal matching funds for its Medicaid program, known as Medi-Cal, California must follow certain guidelines set up by the Social Security Act, Medicaid's implementing legislation, as well as related rules and regulations.[31] One such requirement is the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to all Medi-Cal eligible children under 21 years old.[32] These services must include screening and diagnosis to identify illnesses or conditions and any treatment necessary to improve such ailments.[33]

Medical Necessity Requirement

Medicaid requires that participating states cover any services or treatment necessary to correct or ameliorate a Medicaid-eligible youth's illness or condition.[34] Generally, a service is considered medically necessary if a young person needs it in order to help improve or reduce a functional impairment resulting from a diagnosed health condition.[35] Determination of what is medically necessary must be made on an individualized basis and in light of the youth's overall situation and long-term needs.[36]

The Medicaid Act's Rehabilitation Option

Medicaid authorizes certain services to be covered by participating states' medical programs, and included among these are rehabilitative services and services designed to reduce disability and restore a patient's maximum functioning.[37] This component of the Medicaid program, known as the Rehabilitation Option, is optional for states. Similar to the Medicaid program itself, however, once a state opts into the Rehabilitation Option, its requirements are mandatory. California has opted into Medicaid's Rehabilitation Option.

The Rehabilitation Option specifically allows for flexibility in the location of services, including providing services in both home and community settings. This flexibility in how services are provided and the requirement to maximize a consumer's functioning demonstrate how medical

necessity under the rehabilitation option is based on how well patients function, rather than strictly on their medical diagnosis.[38] Services specifically covered by the Rehabilitation Option are centered around facilitating the consumer's ability to live independently within the community.[39] Avoiding institutionalization is a basic goal of rehabilitative services.[40] Home and community based services are provided to promote success in this arena, and may be deemed medically necessary and thus covered under Medicaid. Additionally, California's Medi-Cal rules support providing services in the setting and manner most appropriate to the consumer's needs and treatment plan.[41]

Medicaid Coverage of *Katie A.* Services

EPSDT services include treatment for mental health conditions.[42] Successful treatment of these conditions often requires services such as case management and coordination, and individualized services delivered at home or in a home-like setting.[43] These services may be necessary for the success of a youth's mental health treatment and, as such, must be covered by Medi-Cal.

On this basis, the *Katie A.* lawsuit sought and ultimately secured coverage of ICC and IHBS as Medi-Cal covered services.[44]

History of *Katie A. v. Bonta*

The *Katie A. v. Bonta* lawsuit was filed in 2002 against the state of California and Los Angeles County, the largest foster care system in the country.[45] The plaintiffs alleged that California was failing to provide foster youth with sufficient mental health services, to which they are entitled under federal Medicaid law.[46] Under the provisions of the Social Security Act, foster children are automatically eligible (also known as "categorical eligibility") for Medicaid on the basis of their placement in foster care or receipt of foster care services.[47]

The *Katie A.* plaintiffs alleged that California's foster care system was failing to provide necessary mental health services to the children that it served, and as a result, put children at risk of institutionalization rather than supporting their treatment at home and in their communities.[48] The plaintiffs argued that as many as 85% of foster children have serious mental health conditions, yet thousands fail to receive necessary treatment.[49] Citing universal agreement by mental health experts, the plaintiffs explained that children with intensive mental health needs require an individualized array of services. The suit alleged that all of these services are mandated by federal law.[50]

The plaintiffs settled with Los Angeles County in 2003, and with the state in 2011.[51] The landmark state settlement agreement initiated a new approach for providing mental health services and supports to foster youth in California. It ensured that children with more intensive mental health needs, a group known as the *Katie A.* subclass, would be provided with specific services, including Intensive Care Coordination and Intensive Home Based Services. ICC and IHBS are intensive, individualized services intended to meet the needs

of children with the most serious mental health needs and prevent their removal from their homes, or hasten their return to the community from institutional and congregate care placements.[52]

Katie A. Services

Successful treatment of mental health conditions often requires services such as case management and coordination, and individualized services delivered at home or in a home-like setting.[53] These services may be a necessary part of a young person's mental health treatment plan and, as such, are required by federal Medicaid law and covered in California under the Medi-Cal program as a result of the *Katie A.* settlement.

Intensive Care Coordination is a case management service that facilitates mental health care planning and coordination of treatment services and supports. ICC is typically delivered in community-based settings, but can also be especially beneficial for youth transitioning out of institutional placements, group homes, and hospitalization.[54]

Intensive Care Coordination is distinct from other types of case management services in its focus on organizing, matching and monitoring services among service providers and across child-serving systems.[55] The intensive care coordinator provides a single point of accountability for developing and implementing the youth's care plan and is responsible for ensuring that services are accessible, coordinated, and delivered in a manner that meets the young person's individual needs and strengths.[56]

Intensive Care Coordination is often a critical mental health service for young people who are engaged in multiple child-serving systems, including the juvenile justice system. Young people with intensive mental health needs often require multiple services and supports in order to succeed. **Coordinating multiple services is a complex task in itself and is made more challenging when navigating among several agencies. When any one of these key interventions is unavailable, a young person may experience treatment failure.** ICC ensures that needed services are not only available and accessible to youth and their families, but also are delivered according to a consistent and coordinated treatment approach, avoiding the harm caused by providers working at cross purposes.

Intensive Home-Based Services are intensive interventions built around the individual youth's strengths and needs that are delivered in the most natural setting possible. IHBS services are designed to address the mental health conditions that interfere with a youth's ability to successfully function at home and in the community. These services are intended to help young people develop functional skills needed to improve their ability to care for themselves, regulate their behavior, and manage their symptoms. Services may also be provided to family members to educate them about their child's mental health disorder, to teach them how to manage symptoms, and to support the overall treatment efforts.[57]

Intensive Home-Based Services are especially beneficial to youth at risk of, or transitioning home from, out-of-home placement. **The delivery of intensive services and supports in home and community settings provides young people with continued access to existing natural supports that are unavailable in institutional or group home facilities.** Importantly, IHBS build the capacity of adults who care about youth to effectively respond to their individual needs. By working with youth in their home environments, providers are able to identify real time concerns impacting youth and fashion specific strategies to help them develop the skills they need to have positive relationships with their families and others in their communities.

Overall, intensive home and community-based services have myriad advantages in treating youth with unmet mental health needs. The Center for Medicare and Medicaid Services (CMS) has issued guidelines detailing the significant potential for success using home and community-based services.[58] Quality of life along with social, functional, and emotional strengths have all been shown to improve when home and community-based services were implemented.[59] ICC and IHBS services were highlighted in particular as approaches that led to significantly improved outcomes for youth.[60] **Both research and federal guidelines have consistently reported that basing treatment within the home and community can greatly improve the lives of young people in need of intensive services.**

Katie A. Subclass

Pursuant to the terms of the *Katie A.* settlement agreement, eligibility for ICC and IHBS was limited to child welfare-involved youth with more intensive mental health needs. This population of Medi-Cal eligible youth is known as the *Katie A.* subclass, all of whom are Medi-Cal beneficiaries with an open child welfare case.[61] Subclass members may include children living at home while their families receive protective services ("family maintenance case").

Following the formal end of the statewide *Katie A.* lawsuit in December 2014, California has continued to provide ICC and IHBS as Medi-Cal funded specialty mental health services. However, state policy issued by the Department of Health Care Services (DHCS) still limits eligibility for these services to those Medi-Cal beneficiaries who meet criteria for membership in the *Katie A.* subclass.[62] Whereas DHCS may have had authority to implement and restrict access to ICC and IHBS as prescribed by the *Katie A.* settlement agreement while the lawsuit was pending, nothing in the law or regulations presently authorizes DHCS to deny access to Medicaid-covered medically necessary services for eligible young people.

Accordingly, California has a present legal obligation under the Medicaid Act's EPSDT benefit and Rehabilitation Option to provide intensive home and community-based services, including ICC and IHBS, to any Medi-Cal beneficiary under age 21 who meets medical necessity criteria for

these services. This includes juvenile justice-involved youth, regardless of whether or not they are members of the *Katie A.* subclass.

Juvenile Justice-Involved Youth and Medi-Cal Eligibility

Youth involved in the child welfare system face similar challenges and adversities as those involved in the juvenile justice system. As a starting point, foster youth have similar incidence of mental health disorders, with as many as 85% of the population experiencing unmet mental health needs.[63] In addition, both populations experience comparable rates of trauma, maltreatment, poverty, and other childhood risk factors.[64] Other similarities include special education needs, school advancement challenges, and substance use disorders.[65] Given the overlapping needs of both populations, it is reasonable to assume that juvenile justice-involved youth would experience many of the same benefits from receiving intensive home and community-based mental health services as foster youth.

Many juvenile justice-involved youth could receive intensive services through California's Medi-Cal system if the state, consistent with the federal EPSDT entitlement, extended access to ICC and IHBS beyond child welfare-involved youth. Among the reported 46,538 youth involved in the juvenile justice system,[66] almost 25,000 are likely eligible for Medi-Cal, as described in greater detail below.[67]

There are two main ways for youth involved in the juvenile justice system to qualify for Medi-Cal: (1) by court ordered declaration of wardship, or (2) through the usual means-test eligibility process.

Wardship Qualification

In California, when a youth is adjudicated delinquent by a court,[68] roughly equivalent to being found guilty of a crime in the adult system, the juvenile court may choose to declare the youth a ward of the state.[69] In such cases, the juvenile court takes legal responsibility for the youth and assumes parental authority.[70] The court then may make decisions about the care and custody of the youth instead of his or her parents.[71] As part of this authority, the judge determines where a young person resides while under court supervision, which may include remaining at home or with a relative; placement in family foster care, in a group home or in non-secure residential treatment; or detainment in juvenile hall or probation camps.[72]

Unlike foster youth, juvenile justice-involved youth generally do not automatically qualify for Medi-Cal on a categorical basis.[73] However, when a youth involved in the juvenile justice system is declared a ward and is placed by the court outside his or her own home,[74] the youth is considered by the California Department of Health Care Services to be placed in foster care, and thereby qualifies for Medi-Cal.[75] According to the Office of the Attorney General's most recent data, an estimated 5,246 juvenile justice-involved youth in California

are eligible for Medi-Cal as wards in out-of-home placements in the community.[76]

Family Income & Public Benefits

In addition to youth who qualify for Medi-Cal as wards in out-of-home placements, juvenile justice-involved youth may be Medi-Cal eligible based on their family's income or because they are recipients of public benefits.

In order for a child to be eligible for Medi-Cal as a household member in 2015, a family must make less than 138% of the federal poverty level.[77] In addition, children living in households with income less than 266% of the federal poverty level may be individually eligible for Medi-Cal.[78]

Young people involved in the juvenile justice system may also be eligible for Medi-Cal as recipients of certain public benefits. Qualifying benefits include CalWORKS, California's welfare program, and Supplemental Security Income (SSI), the federal income supplement program available to low-income children who are blind or disabled.[79] Both benefit programs consider family income as a factor in determining eligibility.

Estimates of the number of juvenile justice-involved youth who qualify for Medi-Cal on the basis of family income or receipt of public benefits are hard to find, but this number could be substantial.[80] Anecdotal evidence from a 1999 survey of Chief Probation Officers of California estimated Medicaid eligibility due to family income in the juvenile probation population at an average of 47%.[81] Another national study found that 67.5% of juvenile justice-involved adolescents between ages 13-18 years were eligible for public health insurance.[82] These data suggest that a fairly conservative estimate of Medi-Cal eligibility based on family income may be as high as 50%.

Inmate Payment Exception

Some youth who are eligible for Medi-Cal are disqualified from receiving Medicaid funded services while detained in a secure setting. Known as the "inmate payment exception," the Medicaid act forbids federal funding, or "federal financial participation" (FFP), for medical care, including mental health services, for "inmates of a public institution."[83] A public institution includes juvenile halls and county probation camps in circumstances when youth are placed in these settings due to criminal activity either before disposition or upon sentencing.[84, 85, 86] Thus, federal Medicaid reimbursement is not generally available for services delivered to youth who are detained in a secure setting.[87]

Youth involved in the juvenile justice system remain eligible for Medi-Cal regardless of their placement. The Inmate Payment Exception only affects whether federal reimbursement through the Medicaid program is available for services delivered while the young person qualifies as an inmate in a public institution, as defined under federal law.

Additionally, the Inmate Payment Exception does not affect a young person's constitutional right to receive appropriate mental healthcare while detained. **Regardless of whether federal Medicaid reimbursement is available, both the 8th and 14th Amendments require juvenile detention facilities to provide adequate healthcare, including mental health services, to young people confined in these institutions.**[88]

The inmate payment exception does not apply to minors in a juvenile detention center awaiting placement elsewhere and minors on intensive probation in a secure treatment facility that is not part of the criminal justice system.[89] The Medi-Cal Eligibility Procedures Manual clarifies that facilities eligible for Title IV-E foster care payments and community care facilities are not considered "public institutions."[90]

Based on available data, an estimated 10,600 youth involved in the juvenile justice system may be disqualified from receiving Medi-Cal reimbursed mental health services due to the Inmate Payment Exception. This population includes 10,394 youth incarcerated in secure county facilities and an additional 241 committed to a Division of Juvenile Justice Facility following disposition of their cases by the juvenile court.[91]

However, most youth in secure county facilities will return to the community after a brief period of detainment. According to the California Board of State and Community Correction's Juvenile Detention Survey, the overall statewide average length of stay in county juvenile halls was less than a month (26 days) in 2013, the most recent year available.[92] There is some evidence to suggest that children sent to juvenile hall following court disposition stay longer in detention than the overall statewide average, however, the vast majority of these young people leave these secure settings within two months.[93] As many as 8,600 youth in county correctional facilities likely leave in this time frame.[94] **Once these youth return to the community, they are again qualified to receive Medi-Cal reimbursed mental health services, including ICC and IHBS.** Conversely, we estimate that 2,035 youth are ineligible for Medi-Cal reimbursement due to the Inmate Payment Exception.

Combining the above calculations, we conclude that almost twenty-five thousand juvenile justice-involved youth are likely Medi-Cal eligible.[95]

Juvenile Justice-Involved Youth Eligible for Intensive Services

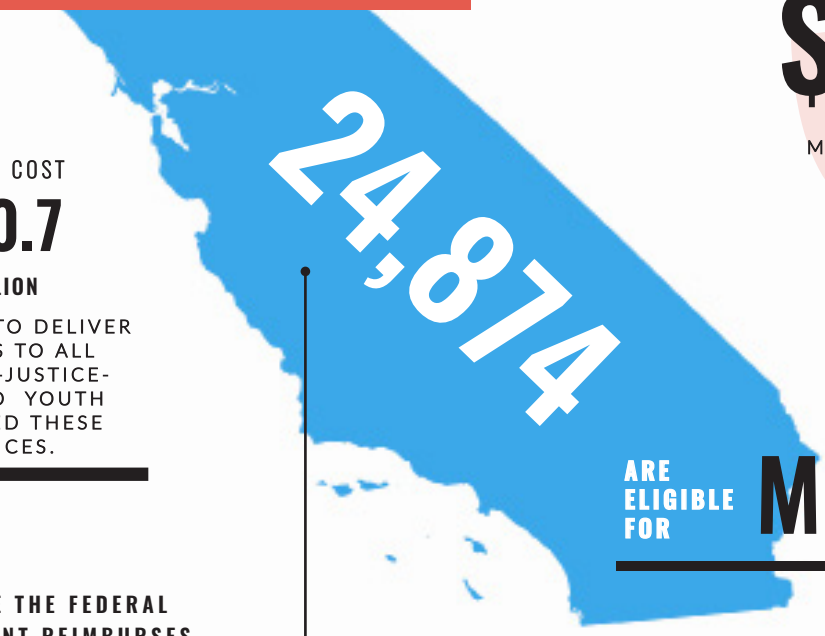
While a substantial share of all juvenile justice-involved youth are likely eligible for Medi-Cal, not all of these youth have serious mental health needs that warrant intensive services, including ICC and IHBS. **In order to qualify to receive Medi-Cal specialty mental health services, a young person must have, among other things, a determination from a qualified mental health provider that a requested service is medically necessary in order to treat or improve his or her mental health condition.** Known as "medical necessity," this

By the Numbers

in CALIFORNIA, OUT OF

46,538

YOUTH INVOLVED IN THE JUVENILE JUSTICE SYSTEM,



ARE ELIGIBLE FOR **MEDI-CAL**

IT COSTS ON AVERAGE

$4,586

PER BENEFICIARY TO DELIVER ICC/ IHBS SERVICES IN **CALIFORNIA**

IT CAN COST LOCAL GOVERNMENTS UP TO

$18,800

MORE TO INCARCERATE A YOUNG PERSON WHO IS MENTALLY ILL THAN TO INCARCERATE OTHER YOUTH

IT WILL COST

$20.7

MILLION

ANNUALLY TO DELIVER ICC/IHBS TO ALL JUVENILE-JUSTICE-INVOLVED YOUTH WHO NEED THESE SERVICES.

BECAUSE THE FEDERAL GOVERNMENT REIMBURSES THE STATE FOR HALF OF ITS MEDICAID COSTS,

CALIFORNIA'S ANNUAL COST WOULD BE ONLY

$10.4

MILLION

IF EVERY ELIGIBLE YOUTH WERE SERVED.

OF THE JUVENILE-JUSTICE INVOLVED YOUTH THAT ARE ELIGIBLE FOR MEDI-CAL,

4,516

LIKELY QUALIFY FOR

ICC & IHBS

BASED ON MEDICAL NECESSITY CRITERIA

criterion determines whether youth have the right to receive a particular service under California's EPSDT entitlement, as explained in greater detail below.

While medical necessity is determined on an individualized basis, youth who meet criteria for ICC and IHBS tend to be those with more intensive mental health needs. Research indicates that as many as 27% of young people involved in the juvenile justice system nationally experience mental illness severe enough to significantly impair their ability to function at home, in school or within the community. Termed serious emotional disturbance (SED),[96] youth with this level of acuity need the intensity of care offered by services such as ICC and IHBS in order to avoid hospitalization or out-of-home placement. Therefore, the SED rate among juvenile justice-involved youth seems to be an appropriate proxy for estimating the share of young people within the system who might need ICC and IHBS.

In addition to medical necessity limitations, California generally denies ICC and IHBS to Medi-Cal beneficiaries living in congregate care facilities, such as group homes. Based on the most recent placement data available, an estimated 2,200 youth involved in the juvenile justice system live in group homes and thus are ineligible to receive ICC and IHBS.[97] Based on the foregoing, we estimate that approximately 4,516 juvenile justice-involved youth who are eligible for Medi-Cal are projected to need ICC and IHBS.

WHAT WILL IT TAKE TO EXTEND SERVICES TO JUVENILE JUSTICE-INVOLVED YOUTH IN CALIFORNIA?

Per Capita Cost of Delivering ICC & IHBS

According to the latest *Katie A.* billing data spanning September 2014 through August 2015, statewide funds spent on providing ICC totaled $26,991,211, while IHBS cost $37,014,007.[98] ICC services were provided to 9,051 youth, whereas 6,848 young people received IHBS. Overall for the reporting timeframe, the average statewide cost of ICC was $2,982 per subclass member receiving services, while IHBS cost $5,405 per subclass member.[99]

When looked at in each county, ICC and IHBS costs varied widely. The cost per ICC consumer ranged from $184 in Tehama County and $306 in Kings County, to a high of $7,217 in San Francisco, followed by $5,923 in Marin County. IHBS costs per person were lowest in Shasta County, with an average of $1,412 per consumer, and Kern County was its closest competitor at $1,445. San Francisco again led counties, with an average cost of $24,137 per consumer, followed by Contra Costa County at $12,156.

Overall Cost of Expanding ICC and IHBS to Juvenile Justice-Involved Youth

Not knowing whether future recipients of *Katie A.* services will require ICC, IHBS, or a combination of both, complicates an overall cost estimate for expansion. However, DHCS's *Katie A.* billing data provide a vehicle for estimating combined ICC and IHBS costs per person, assuming that juvenile justice-involved youth will receive services that are similar in intensity and duration to foster youth. Using total ICC and IHBS costs ($64,005,218) divided by the number of subclass members (13,956), the average costs of ICC and IHBS per beneficiary is estimated at $4,586.[100]

The number of juvenile justice-involved youth who are eligible for Medi-Cal and likely qualify to receive ICC and IHBS was estimated above to be 4,516. Multiplying this by the statewide average yearly cost per recipient ($4,586) yields an expected yearly cost of $20.7 million to expand *Katie A.* services to all eligible juvenile justice-involved youth. Because EPSDT services are cost-shared by the federal government, California's annual cost would be about $10.4 million—if every eligible youth is served. At present, about one in five eligible foster youth actually receives ICC and/or IHBS.

Administrative Requirements of Extending Services

Under federal law, states are required to designate a single state agency with the responsibility for administering their Medicaid programs.[101] In California, the Department of Health Care Services (DHCS) is the designated state agency responsible for the Medi-Cal program.[102] In this capacity, DHCS has the responsibility to clarify what services are covered under California's State Medicaid Plan, subject to federal approval. The Department is ultimately accountable for ensuring that the Medi-Cal program fully complies with federal law and regulations. This authority includes the power to direct county Mental Health Plans (MHPs) to deliver particular services to Medi-Cal beneficiaries.

DHCS exercised its oversight authority to implement the settlement agreement in the *Katie A.* lawsuit by requiring MHPs to deliver ICC and IHBS to subclass members. This was accomplished using a series of policy directives,[103] known as information notices, after DHCS "determined that ICC and IHBS fall within the parameters of [the Medi-Cal Program's] existing [specialty mental health services]."[104] The Department's information notices provided instructions to guide local agencies in delivering ICC and IHBS to child welfare-involved youth.

Following the example provided by *Katie A.* implementation, DHCS has the authority to direct

county mental health plans to deliver ICC and IHBS to all Medi-Cal beneficiaries who meet medical necessity criteria. The state agency has already recognized these services are eligible for federal reimbursement as Medicaid coverable services, and determined they are covered in the existing Medi-Cal Specialty Mental Health Services benefit package.[105] The key administrative action needed to extend services to juvenile justice-involved youth as outlined herein is for DHCS to issue a policy directive that:

- Confirms that ICC and IHBS are EPSDT Medi-Cal covered services included in the Medi-Cal Specialty Mental Health Services benefit;
- As covered services, ICC and IHBS must be provided to all eligible children and youth who meet medical necessity; and
- Instructs county Mental Health Plans to promptly begin providing ICC and IHBS in accord with their obligations to serve eligible Medi-Cal beneficiaries.

This policy message could be delivered through an information notice that supersedes previous notices that limit ICC and IHBS to Katie A. subclass members.[106]

Providing ICC & IHBS is Not an Unfunded Mandate

In addition to recognizing ICC and IHBS as a benefit available to all Medi-Cal eligible youth who meet medical necessity criteria, the State must also address how these services will be funded. California's approach to funding programs administered by local and state governments is governed by a complex set of constitutional and statutory provisions. Under California's Constitution, the state government is generally prohibited from requiring local agencies to provide new or increased level of services without providing the necessary funding. The State Constitution recognizes that local agencies and school districts are entitled to reimbursements for increased costs to their budgets resulting from state mandates imposed through legislation or administrative policy directives. Local governments are required to seek reimbursement for "unfunded" state mandates by filing a claim with the Commission on State Mandates, a quasi-judicial administrative body. Until state mandate claims are resolved, local agencies are required to carry out services without reimbursement.

Starting in 2011, the state government shifted fiscal responsibility for several public safety programs, including the Medi-Cal Specialty Mental Health Services program, to the counties.[107] To finance these programs, the state dedicated a portion of state sales and use tax revenues to be deposited into a special Realignment fund. As part of this shift, local governments are only required to comply with state mandates that impose a new program, higher level of service, or otherwise increase the costs already borne for the realigned programs when and to the extent that the state provides additional funding for these new requirements.[108] In simple terms, the state is required to pay local

governments up front, rather than reimburse them after the fact, when imposing increased costs for public safety programs.

There is, however, an important exception to the unfunded mandates prohibition. Notwithstanding the changes brought about by Realignment, "the state shall not be required to provide a subvention of funds . . . for a mandate that is imposed by the state . . . to comply with federal law."[109] This federal compliance exception applies to mandates imposed by legislation, executive order, or administrative directive, as well as to increased costs resulting from state plans, waivers, or amendments submitted by the state to the federal government.

A state mandate requiring county Mental Health Plans to extend ICC and IHBS to all Medi-Cal beneficiaries who meet medical necessity criteria falls squarely under the federal compliance exception. As previously summarized, the EPSDT entitlement is a federal mandate. **In order to comply with this federal mandate, California must provide ICC and IHBS, both coverable services under the Medicaid Program, to all Medi-Cal eligible youth who meet medical necessity criteria.** When the Medi-Cal Specialty Mental Health Services (SMHS) program was realigned to the counties, the MHPs assumed responsibility for complying with this federal mandate. Under Realignment provisions, the state is not required to provide additional funding for increased costs that might result from complying with federal law by providing ICC and IHBS.

Nevertheless, questions of how to finance California's public mental health system are rarely decided without political controversy. Even though the federal compliance exemption provides a reasonably clear answer to the question of whether the state is responsible for providing additional funding, the state and local governments are still working to resolve how programs are financed in a post-Realignment environment.

Programmatic Requirements of Extending Services

There are additional programmatic requirements needed to properly implement ICC and IHBS as benefits available to Medi-Cal eligible youth involved in the juvenile justice system. Both services require an expansion in local capacity to deliver intensive community-based care. In addition, the effectiveness of both ICC and IHBS depends on a team-based approach to treatment decision-making and service delivery. This teaming component requires local child-serving systems to improve communication and coordination by breaking down agency silos and filling service gaps that impede effective care for multi-system involved youth.

It is also critical that public mental health systems have sufficient capability to monitor service quality and client outcomes. Without effective quality assurance, informed decision-making is significantly impaired. Absent data, program managers cannot know whether young people

actually get therapeutic benefit from the treatment they receive, or whether public resources are being used effectively and efficiently.

Implementation of the *Katie A.* settlement offers important lessons for future efforts to provide ICC and IHBS to juvenile justice-involved youth. One problem involved trying to "ride the bike while building it." DHCS instructed county Mental Health Plans to begin serving subclass members with ICC and IHBS in May 2013.[110] At the time, the state had not yet completed a thorough assessment of service capacity, offered very limited guidance about the new service array, and had only just begun offering training and technical assistance. Local agencies faced a steep learning curve and, in most cases, figured out how to manage this new service array through trial-and-error. The state eventually released policy guidance on recommended shared management structures between mental health and child welfare agencies in July 2014, nearly 14 months after service was to begin.[111] Another problem was caused by repeated delays in implementing data and reporting requirements. As a result, the quality assurance components of the settlement agreement were left undone when the court's jurisdiction ended in December 2014. As a result, there continues to be limited capacity to monitor whether ICC and IHBS are being provided consistent with core practice standards.

Despite these significant challenges, *Katie A.* implementation helped build programmatic infrastructure that can be leveraged when expanding services to juvenile justice-involved youth. As a starting point, most county Mental Health Plans have at least two years of experience delivering ICC and IHBS, providing a significant base level of expertise and source of leadership when services are extended beyond the *Katie A.* subclass. Additionally, a much greater depth of guidance for local agencies is available now for implementing ICC and IHBS. This includes training resources and best practices developed through regional and state learning collaboratives. There are also existing resources available within the juvenile justice system for extending ICC and IHBS. Several probation officers participated in early *Katie A.* implementation trainings and it is likely that many have already contributed as mental health treatment team members for *Katie A.* subclass members. This experience could be an important asset to local probation agencies as they prepare to collaborate with county Mental Health Plans to expand service delivery to juvenile justice-involved youth.

Development of meaningful quality assurance tools may also be on the horizon in California. As a result of legislative action, DHCS is in the process of developing a statewide performance and outcomes system (POS) for California's EPSDT specialty mental health services.[112] While progress on this tool has been slow, DHCS issued it first report in February 2015 and is expected to continue to expand the frequency and depth of its analysis of system performance and client outcomes in the future.[113] At the same time, the federal government is requiring California to develop state and county data dashboards by

September 2016 on important quality assurance measures, including indicators of quality, access and timeliness of mental healthcare provided by county Mental Health Plans.[114]

Additionally, DHCS and the California Department of Social Services (CDSS) are moving forward with the Joint Management Community Team to aid in joint management and oversight and accountability specific to clients of both the mental health and social services systems. Early reports on data matching work that blends DHCS and DSS databases looks promising, and suggests that useful data should be available soon on ICC, IHBS, and implementation of the practice model used to deliver services. External Quality Review information required under Medicaid will soon be available that describes in some detail where the counties are in their implementation of the *Katie A.* settlement agreement. Presumably, these tools can also be used to monitor and evaluate progress on ICC & IHBS implementation to juvenile justice-involved youth, as well as other newly eligible groups.

CONCLUSION

WHEN YOUNG PEOPLE ACT OUT BECAUSE THEY LACK MENTAL health treatment or supports, they are often shunted into the juvenile justice system as a way to control their behavior, leaving their underlying needs unaddressed. Labeling a youth as truant or disruptive without dealing with the unmet needs in his or her life make successful outcomes much harder to achieve.

With two-thirds to three-quarters of its youth having a diagnosable mental health condition, it is imperative that California's juvenile justice system improve its mental health interventions. The various other agencies that serve this population must strengthen their coordination in care delivery as well.[115]

To avoid poor outcomes, child-serving systems must work more collaboratively to better understand the needs and strengths of youth involved in multiple systems and to more effectively coordinate delivery of services. In order to stop our juvenile detention facilities from being de facto mental health institutions, also, California's public mental health system must invest in a truly comprehensive community-based service array.

Extending access to intensive home and community-based services, including ICC and IHBS, will help fill a critical gap in California's existing service array for juvenile justice-involved youth. The required investment into these services would be relatively modest, without even considering the cost savings to the juvenile justice facilities that presently house youth with mental health needs. In addition to being a prudent fiscal policy decision, it is good risk management as many young people involved in the juvenile justice system have a legal entitlement to these services

under state and federal Medicaid law. Failure to provide required treatment exposes the State to enforcement litigation.

Investing in intensive community-based mental healthcare now will help build the capacity of California's juvenile justice and mental health systems to meet the needs of thousands of youth involved in these systems. More importantly, extending access to these essential services will help lead to a brighter outlook and better outcomes for young people, their families, and our communities.

AUTHORS

This report was written by Wesley Sheffield, Emily Bisnett, and Patrick Gardner.

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ABOUT YOUNG MINDS ADVOCACY

Young Minds Advocacy is a nonprofit organization based in San Francisco that uses strategic advocacy and communications to help young people and their families access mental health services and supports, and improve mental health system performance and accountability. For more information, visit us online at *www.youngmindsadvocacy.org*.

ABOUT ZELLERBACH FAMILY FOUNDATION

The mission of the Zellerbach Family Foundation is to be a catalyst for constructive social change by initiating and investing in efforts that strengthen families and communities.

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2 For the purposes of this white paper, juvenile justice-involved youth include those who have been cited or arrested and either are (a) participating in informal probation supervision pursuant to California Welfare & Institutions Code § 654 or (b) have had a petition filed with the juvenile court pursuant to § 601 or § 602 that has been found true (equivalent of being found guilty in the adult system).

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6 Id. at 12.

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8 See note 4, at 15.

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10 Id.

11 Id. at 10.

12 Id.

13 Id. at 11, 13; Patrick Gardner and Brian Blalock, *Juvenile Mental Health Courts and Comprehensive Legal Services through Legal Aid and Public Defender Collaboration*, Management Information Exchange Journal 31, (Fall 2013); Kathleen Skowyra and Joseph Cocozza, Nat'l Cent. For Mental Health & Juvenile Justice, *A Blueprint for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System* 1 (2006), *available at* http://www.ncmhjj.com/wp-content/uploads/2013/07/2006_A-Blueprint-for-Change.pdf.

14 Counsel of State Governors, *Criminal Justice/Mental Health Consensus Project* xii (June 2002).

15 See note 1.

16 U.S. House of Reps. Comm. on Gov't Reform, *Incarceration of Youth Who Are Waiting for Community Mental Health Services in the United States* 4-5 (July 2004).

17 Id.

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25 Id. at 18.

26 Id. at 10.

27 See note 1, 4.

28 Id. at 12; see note 19, at 31, 34.

29 Inmates who receive treatment outside the "correctional system" for more than 24 hours are eligible for Medicaid reimbursement for those inpatient services. 42 C.F.R. § 435.1010; *Clarification of Medicaid Coverage Policy for Inmates of a Public Institution*, Health Care Financing Admin., U.S. Dept. of Health & Human Services, (Dec. 12, 1997), *available at* http://csgjusticecenter.org/wp-content/uploads/2014/06/PolicyforInmatesofPublicInst1997.pdf; Sue Burrell & Alice Bussiere, Youth Law Center, *The Inmate Exception and Its Impact on Health Care Services For Children in Out-Of-Home Care in California* 13 (2002), *available at* http://www.ylc.org/wp/wp-content/uploads/The%20Inmate%20Exception%20-%20November,%20%202002.pdf.

For example, inpatient care for longer than a day at a hospital, psychiatric facility, or other facility outside the correctional system, would be eligible for Medicaid reimbursement.
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Services, (Dec. 12, 1997), *available at* http://csgjusticecenter.org/wp-content/uploads/2014/06/PolicyforInmatesofPublicInst1997.pdf.

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31 42 U.S.C. § 1396a.

32 442 U.S.C. § 1396d(a)(4)(B).

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37 42 U.S.C. § 1396d(a)(13); 42 CFR § 440.130; 9 Cal. Code of Regulations § § 1810.243, 1810.345; 22 Cal. Code of Regulations § 51176.

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39 Id.

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41 Cal. Dep't of Mental Health (DMH) Letter No.: 02-07, 2 (November 19, 2002).

42 42 U.S.C. § 1396d(r).

43 *Katie A. v Bonta* First Amended Complaint at 18 (2002).

44 *Katie A. v Bonta* Settlement Agreement at 6-7 (2011). This agreement also included other services, but further determination as to their coverage under the EPSDT umbrella was deemed necessary.

45 See note 43, at 3-4.

46 Id.

47 42 U.S.C. § 1396a(a)(10)(A)(i)(I); 42 U.S.C. § 671 (part of Title IV-E of the Social Security Act).

48 See note 43, 3-4.

49 Id. at 12.

50 Id. at 13.

51 *Katie A. v Bonta*, Bazelon Center for Mental Health Law, http://www.bazelon.org/In-Court/Current-Litigation/Katie-A.-v.-Bonta.aspx.

52 See note 44, at 6-7.

53 See note 43, at 18.

54 Cal. Dep't. Of Soc. Services and Dep't of Health Care Services, *Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS) & Therapeutic Foster Care (TFC) for Katie A. Subclass Members* 7-12 (2013), *available at* http://www.dhcs.ca.gov/Documents/KatieAMedi-CalManual3-1-13FinalWPREFACE.pdf; *see also* Katie A. Settlement Agreement, Appendix E, 33-34.

55 Id.

56 Id.; *see also note 44, at 33-34*.

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58 Ctr. for Medicaid and CHIP Servs., Ctr. for Medicare and Medicaid Servs., *Coverage of Behavioral Health Servs. for Children, Youth, and Young Adults with Significant Mental Health Conditions*, (May 17, 2003), *available at* http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf.

59 Id. at 2.

60 Id. at 3-4.

61 Youth are considered to be a member of the *Katie A.* subclass if they meet the following criteria: (1) are full-scope Medi-Cal eligible; (2) have an open child welfare services case; and meet medical necessity criteria for Specialty Mental Health Services (SMHS) as set forth in 9 California Code of Regulations § 1840.205 or 1830.210; and (4) are currently in or being consider for specified intensive services or placements, including therapeutic behavioral services, crisis services, or residential treatment.

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66 This estimate includes all cases resulting in juvenile justice court dispositions, except for those dismissed or remanded to adult court, as well as youth who were placed on informal probation without court disposition. California Department of Justice, *Juvenile Justice in California* 72, 81 (2014), *available at* https://oag.ca.gov/sites/all/files/agweb/pdfs/cjsc/publications/misc/jj14/preface.pdf.

67 Id.

A small portion of young people involved in the juvenile justice system are adults. For example, nearly 16% of all juvenile court dispositions involve individuals between ages 18 and 24. Id. at 88. An unknown portion of these young people are over age 20 and, therefore, ineligible for the EPSDT benefit, which is limited to beneficiaries under age 21 in California. To date, publicly accessible data does not distinguish between those under or over age 20. As a result, a small percentage of youth included in this white paper's estimate may include young adults who are ineligible for EPSDT services.

68 Cal. Welf. & Inst. Code §§ 601, 602.

69 Cal. Welf. & Inst. Code §§ 726, 727.

70 Elizabeth Hill, *California's Criminal Justice System: A Primer*, Legislative Analyst's Office 49-50 *available at* http://www.lao.ca.gov/2007/cj_primer/cj_primer_013107.pdf.

71 *Juvenile Justice Hearings*, The Super. Ct. of Cal., Cnty. of Santa Clara, http://www.scscourt.org/self_help/juvenile/jjustice/process.shtml (last visited Mar. 10, 2015).

72 Marcus Nieto, *County Probation Camps and Ranches for Juvenile Offenders* 9 (November 2008) *available at* https://www.library.ca.gov/crb/08/08-016.pdf.

73 42 U.S.C. § 1396a(a)(10)(A)(i)(IX).

74 Qualifying placements include "a relative's or non-relative's home as well as a ranch, institution, group home, or a facility which offers 24-hour non-medical care and is not under the criminal justice system." Cal. Dep't of Health Care Services, *Medi-Cal Eligibility Procedures Manual* 6D-2 (2001), *available at* http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Article6-InstitutionalStatus.pdf.

75 Id.

76 According to the most recent publication of *Juvenile Justice in California* by the Office of the Attorney General in 2014, of the youth adjudicated delinquent, 33,426 were declared wards. Following disposition, 5,246 youth were then placed out-of-home in a non-secure facility, and thus would be eligible for Medi-Cal via the foster youth qualification. See note 66, and 81. An unknown number of youth placed with relatives may also be eligible for Medi-Cal on the basis of wardship. However, existing data doesn't distinguish between youth remaining in their own homes and those placed with relatives. Id. Some youth placed with relatives may qualify for and receive foster care benefits, including Medi-Cal. Therefore, this estimate may underestimate the number of youth eligible for Medi-Cal on the basis of wardship.

A similar estimate was reached through the California Child Welfare Indicators Project's website, which indicated that the number of children in foster care under the supervision of probation in 2014 averaged around 4,468. California Child Welfare Indicators Project, http://cssr.berkeley.edu/ucb_childwelfare/PIT.aspx. This was an average of Point In Time/Children in Foster Care data from January 1, April 1, July 1, and October 1, 2014, with an Agency Type selection of Probation, and was further broken down by placement type.

77 Federal poverty levels (FPL) are based on family size. For example, the 138% FPL for a three-person family in 2015 is $2,311 monthly or $27,725 annually. *Do You Qualify For Medi-Cal Benefits?*, Cal. Dept. of Health and Human Services, http://www.dhcs.ca.gov/services/medi-cal/Pages/DoYouQualifyForMedi-Cal.aspx (last visited Mar. 10, 2015).

78 Federal poverty levels (FPL) are based on family size. For example, the 266% FPL for a three-person family in 2015 is $4,454 monthly or $53,440 annually. Department of Health Care Services, *All County Letter 15-14* (March 11, 2015).

79 22 Cal. Code of Regulations § 50201.

80 The best guess of Medicaid eligibility via family income for the juvenile probation population found was from a 1999 survey of 57 Chief Probation Officers. The estimates of eligibility ranged from 15-99%, with an average estimate of 47%, but this was based on perception, not data, as documentation of this information did not exist. Sue Burrell & Alice Bussiere, Youth Law Center, *The Inmate Exception and Its Impact on Health Care Services For Children in Out-Of-Home Care in California* 4 (2002).

81 Id.

82 Carly B. Dierkhising, et al., *Trauma Histories Among Justice-Involved Youth: Findings from the National Child Traumatic Stress Network*, National Center for Child Traumatic Stress 3 (July 16, 2013).

83 42 U.S.C § 1396d(a)(29)(A); 42 C.F.R. § 441.13; 42 C.F.R. § 435.1009; Cal. Welf. & Inst. Code § § 14053(b)(1), 14131.

84 42 C.F.R. § 435.1010.

85 Id.; U.S. Dept. of Health & Human Services, Health Care Financing Admin., *Clarification of Medicaid Coverage Policy for Inmates of a Public Institution* (Dec. 12, 1997), *available at* http://csgjusticecenter.org/wp-content/uploads/2014/06/PolicyforInmatesofPublicInst1997.

pdf. In a perhaps relevant recent development, the Affordable Care Act has a different definition of which inmates are excluded from eligibility for the new health care exchanges, and thus when the incarcerating government becomes responsible for health care. Incarcerated individuals awaiting disposition of their charges remain eligible for enrollment in an exchange's health plan. While the Act deals with health care exchanges rather than Medicaid, the different line drawn by the ACA may signal a shift in federal policy on when FFP is available. Patient Protection and Affordable Care Act § 1312(f)(1)(B).

86 22 Cal. Code of Regulations § 50273(a).

87 See note 88, at 14, fn. 60. CMS representative confirmed that the deciding factor of whether FFP is available is not being found "guilty" but rather whether or not the individual is residing or will reside in a correctional facility.

However, inmates who receive treatment outside the "correctional system" for more than 24 hours are eligible for Medicaid reimbursement for those inpatient services: 42 C.F.R. § 435.1010; Health Care Financing Admin., U.S. Dept. of Health & Human Services, *Clarification of Medicaid Coverage Policy for Inmates of a Public Institution* (Dec. 12, 1997), *available at* http://csgjusticecenter.org/wp-content/uploads/2014/06/PolicyforInmatesofPublicInst1997.pdf; Sue Burrell & Alice Bussiere, Youth Law Center, *The Inmate Exception and Its Impact on Health Care Services For Children in Out-Of-Home Care in California* 13 (2002), *available at* http://csgjusticecenter.org/wp-content/uploads/2014/06/PolicyforInmatesofPublicInst1997.pdf; see note 80, at 13.

For example, inpatient care for longer than a day at a hospital, psychiatric facility, or other facility outside the correctional system, would be eligible for Medicaid reimbursement. See note 80, at 13.

88 Youth Law Center, *Medicaid for Youth in the Juvenile Justice System* 3 (August 2006).

89 22 Cal. Code of Regulations § 50273(c).

90 See note 74.

91 See note 66, at 81.

92 California Board of State and Community Corrections, Juvenile Detention Survey Profile Survey 2013 1st-4th Quarter Survey Results.

93 Husky & Associates, Inc., Alameda County, California Comprehensive Study of Juvenile Justice System 1.4 (Dec 31, 2004).

94 Because data indicate that youth are typically detained for less than two months, the authors estimated that, when averaged over the course of a year, roughly two-twelfths of the total population of young people sent to secure detention facilities are disqualified by the Inmate Payment Exception from receiving Medi-Cal reimbursed mental health services on any given day. In order to include these relatively brief periods of disqualificaiton from Medi-Cal reimbursement in our methodology, we have excluded 17% (approximately 1,900 wards) of the population sent by the juvenile court to secure county facilities post deposition in our estimate of the number of young people who are likely eligible of Medi-Cal within the junvenile justice system.

The authors estimation also excluded the entire population of youth sent to a Division of Juvenile Jstuice (DJJ) facility, which are operated by the California Department of Corrections and Rehabilitation. Youth sent to DJJ facilities typically "have the most serious criminal backgrounds and most intensive treatment needs," and, therefore, tend to stay in detention settings for long periods of time. California Department of Corrections & Rehabilitation, *Division of Junvenile Justice*, Dec. 2, 2015, http://www.cdcr.ca.gov/Juvenile_Justice/index.html. For example, the average length of stay for all DJJ facilities in 2014 was 36.7 months. California Department of Corrections & Rehabilitation, Population Overview 2014 (Dec. 31, 2014) *available at* http://www.cdcr.ca.gov/Reports_Research/docs

research/Population_Overview/POPOVER2014.pdf.

95 Eligible youth include 8,600 incarcerated youth, plus 30,655 non-wards and wards living at home mulitplied by 50 percent, plus 5,256 wards in out-of-home placement for a total of 24,884. (Totals may not add up due to rounding).

96 See note 1, at 8; Jennie Shufelt and Joseph Cocozza, *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study*, Nat'l Center for Mental Health and Juvenile Justice 4 (June 2006) *available at* http://www.ncmhjj.com/youth-with-mental-health-disorders-in-the-juvenile-justice-system-results-from-a-multi-state-prevalence-study/.

97 This estimate is based on Child Welfare Indicators Project Data, using an average of Point In Time/Children in Foster Care data with an Agency Type selection of "Probation" sorted by "Placement Type" from January 1, April 1, July 1, and October 1, 2014. California Child Welfare Indicators Project, http://cssr.berkeley.edu/ucb_childwelfare/PIT.aspx. Because it is generally assumed that all of these youth are Medi-Cal eligible as wards in out-of-home placements, as explained above, these young people are still eligible for other Medi-Cal Specialty Mental Health Services while living in group home settings.

98 Cal. Dep't of Health Care Services, *Katie A. Specialty Mental Health Services Report - 12 Month Rolling Report* 6 (Run on 9/8/15), *available at* http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/SMHS_REPORT12MONTHROLLING-2015-09-08.pdf.

99 Id. at 6-7. This estimate used the *Katie A.* implementation reports published by DHCS. The particular report used the rolling report covering September 2014 through August 2015 and pulled on September 8, 2015 can be found at http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/SMHS_REPORT12MONTHROLLING-2015-09-08.pdf. This report tabulated individual county reports into statewide data, as well as listing individual counties' reported numbers. This paper's estimate was arrived at by direct calculation from the numbers provided therein. For example, the average cost of ICC per subclass member

was found by dividing the costs approved for ICC found on page 9 by the numbers of unique consumers of ICC found on page 10. Some county-specific data was not available for privacy reasons, and thus the ranges may be somewhat inaccurate, but those numbers were included in the statewide numbers.

100 Id. at 6.

101 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10.

102 Welf. & Inst. Code § 10740; 22 Cal. Code of Regulations § 50004.

103 Cal. Dep't of Health Care Services, MHSD Information Notices No. 13-03; 13-10; 13-11; 13-13; 13-19; 14-036.

104 Cal. Dep't of Health Care Services, *Section 1915(B) Waiver Proposal 2015-2020* 19 (June 10, 2015).

105 Id.

106 Cal. Dep't of Health Care Services, MHSUDS Information Notice Nos. 13-11 1 (May 3, 2013), 14-036 2 (Oct. 16, 2014); See note 54, at 3.

107 Mac Taylor, *2011 Realignment: Addressing Issues to Promote Its Long-Term Success*, California Legislative Analyst's Office 1-5 (Aug. 19, 2011).

108 *See* California Constitution Article XIII § 36(c)(4)(A).

109 California Constitution Article XIII § 36(c)(4)(E); S.B. 1020 § 4 (2012); Gov't Code § 30026.5.

110 Dept. of Health Care Services, Implementation of Claiming for Intensive Care Coordination and Intensive Home-Based Services in the Short-Doyle/Medi-Cal Claims Processing System for Dates of Service Beginning January 1, 2013, MHSD Information Notice No. 13-11 (May 3, 2013) *available at* http://www.dhcs.ca.gov/formsandpubs/Documents/13-11.pdf.

111 *Joint Management Task Force Recommendations* (July 28, 2014) *available at* http://calswec.berkeley.edu/sites/default/files/uploads/jmt_recommendations_report_7-28-14.pdf; Cal. Dep't of Health Care Services, *Response to the Joint Management and Fiscal Task Force Recommendations* (2014) *available at* http://www.dhcs.ca.gov/Documents/Shared_Mgmt_Annc.pdf.

112 Welf. & Inst. Code § 14707.5.

113 Cal. Dep't of Health Care Services, *Performance Outcomes System for Medi-Cal Specialty Mental Health Services for Children and Youth*, Stakeholder Advisory Committee Presentation (Feb 27, 2015) *available at* http://www.dhcs.ca.gov/individuals/Documents/StakeholderAdvisoryCommittee/SAC_Presentation_02_27_15.pdf.

114 Centers for Medicare & Medicaid Services, Letter to Mari Cantwell, Approval of 1915(b) Medi-Cal Specialty Mental Health Services (SMHS) Waiver (June 24, 2015) *available at* http://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915(b)_Waiver_Amend_01_10_14.pdf.

115 Portland State University, Research and Training Center on Family Support and Children's Mental Health, *Prevalence of Psychiatric Disorders in Youth in Juvenile Detention* 1 (Feb. 2003).

GLOSSARY of ACRONYMS and ABBREVIATIONS

CalWORKS	California Work Opportunity and Responsibility to Kids
CDSS	California Department of Social Services
CMS	Centers for Medicare and Medicaid Services
CPOC	Chief Probation Officers of California
DHCS	California Department of Health Care Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment Services
FFP	Federal Financial Participation
ICC	Intensive Care Coordination
IHBS	Intensive Home Based Services
MHP	Mental Health Plan
POS	Performance and Outcomes System
SED	Serious Emotional Disturbance
SMHS	Medi-Cal Specialty Mental Health Services
SSI	Supplemental Security Income

VIA ELECTRONIC MAIL AND U.S. MAIL

May 20, 2015

Jennifer Kent, Director
California Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Dear Director Kent,

The Department of Health Care Services (DHCS) administers medical assistance programs under Title XIX of the Social Security Act, including the Specialty Mental Health Program, authorized under section 1915(b) of the Act. In order to receive federal matching funds for this program and others, California must adhere to federal Medicaid requirements and implementing regulations, including 42 C.F.R. §§ 430 et seq. In particular, federal law requires California to cover certain mandatory services, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, for Medicaid-eligible children under the age of 21. 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(a)(4)(B). Pursuant to Medicaid's EPSDT provisions, California is required to provide screening services to identify defects, conditions, and illness. California must then arrange for or provide the necessary diagnostic and treatment services to correct or ameliorate those conditions, whether or not such services are covered under the state plan. 42 U.S.C. § 1396d(r)(1), 42 C.F.R. § 441.56(b), 42 U.S.C. § 1396d(r)(5).

The EPSDT mandate is a comprehensive entitlement to medical assistance for eligible children and young adults. In 2007, the Ninth Circuit held that, "under the EPSDT provisions, states have an obligation to cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a)." *Katie A. v. Bonta*, 481 F.3d 1150, 1158 (9th Cir. 2007).

Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) are included among the array of comprehensive treatment services allowable under the Medicaid Act. California has received federal Medicaid reimbursement for ICC and IHBS delivered to *Katie A.* subclass members, all of whom are Medi-Cal beneficiaries, since 2013. Several other states deliver one or both of these services as part of their Medicaid program, including Washington, Massachusetts, Connecticut, Ohio, Montana, Indiana, and Wisconsin. Additionally, the Center for Medicare and Medicaid Services (CMS) has issued guidelines detailing home and community-based mental health services that significantly enhance positive outcomes for children and youth, specifically citing intensive care coordination and intensive in-

home services as critical and allowable benefits under state Medicaid programs. *See* Coverage of Behavioral Health Servs. for Children, Youth, and Young Adults with Significant Mental Health Conditions, Ctr. for Medicaid and CHIP Servs., Ctr. for Medicare and Medicaid Servs. 3-4 (May 17, 2013).

Notwithstanding the foregoing, on information and belief, California is denying access to ICC and IHBS to children who are full-scope Medi-Cal and for whom these services are medically necessary, solely because these children are not members of the *Katie A.* subclass. Moreover, on information and belief, county Mental Health Plans that are charged with implementing the EPSDT Specialty Mental Health Program and arranging for or providing ICC and IHBS to eligible youths, are refusing to provide these Medicaid-covered services based on state policy guidance and information that restricts services to *Katie A.* subclass members. The result is that Medi-Cal children for whom ICC and/or IHBS are medically necessary are being unlawfully denied access to these Medicaid-covered services.

Whereas DHCS may have had authority to implement (and restrict access to) ICC and IHBS services as prescribed by the *Katie A.* Settlement Agreement during the pendency of the Federal District Court's jurisdiction over the state, nothing in the Agreement or under law or regulations presently authorizes DHCS to deny access to Medicaid-covered, medically necessary services, for eligible youths.

We, therefore, demand you take action in the next sixty (60) days to end the unlawful prohibition on providing ICC and IHBS as Medi-Cal covered specialty mental health services available to all eligible Medi-Cal beneficiaries for whom these services are medically necessary.

We further demand that DHCS expeditiously issue a policy statement or similarly enforceable guidance that supersedes and corrects all other policy statements, notices, information, or guidance that is, or may be interpreted as being, inconsistent with the federal mandate requiring that ICC and IHBS must be provided to all eligible children for whom these services are medically necessary.

Thank you for your prompt attention to this matter.

Sincerely,

Patrick Gardner, JD
President

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

November 12, 2015

Mr. Patrick Gardner
President
Young Minds Advocacy
275 5th Street
San Francisco, CA 94103

SUBJECT: Response to October 14, 2015 Correspondence

Dear Mr. Gardner,

Thank you for your October 14, 2015 letter requesting clarification of Department of Health Care Services (DHCS) policy now that court jurisdiction has ended in the Katie A. matter.

Federal Medicaid law requires states to provide Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) to beneficiaries under the age of 21 who are eligible for the full scope of Medicaid services as medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. This requirement obligates states to provide Medicaid-covered services whether specified in the state plan or not. (See Mental Health Services Division (MHSD) Information Notice No. 13-01; see also 42 U.S.C. § 1396a(a)(43) and 42 U.S.C. § 1396d(r).) Under the Medi-Cal Specialty Mental Health Services Waiver, Mental Health Plans (MHPs) are responsible for providing, or arranging for the provision of, specialty mental health services for eligible beneficiaries. (See MHSD Information Notice No. 13-01.) Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) are allowable services under the Medicaid Act and, as such, can be provided through the EPSDT benefit.

With the end of court jurisdiction over the Katie A. matter, DHCS agrees it is worthwhile to, and will, issue an Information Notice to MHPs clarifying that EPSDT services have included ICC and IHBS services that can be provided to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for those services. DHCS will clarify that membership in the Katie A. subclass is not a prerequisite to receiving ICC and IHBS. The notice will supercede any prior Information Notices to the extent they conflict.

We would like your input on the proposed Information Notice described above. We anticipate having a draft of the Information Notice one month from the date of this letter. We will expect to receive any input from you within two weeks of providing you the proposed notice.

The Department also intends to compile a list of existing guidance that may benefit from similar clarification and, if appropriate, prepare proposed revisions to this other guidance within approximately 12 weeks from the date of this letter. Changes to certain documents will require collaboration with the California Department of Social Services. We will also ensure that the Katie A. Community Team as well as the County Behavioral Health Directors Association of California (CBHDA) are advised of changes to the guidance before any is published. We anticipate that obtaining appropriate review of the proposed revised guidance may take more than 12 weeks to complete, but will endeavor to reach a final result as expeditiously as possible.

We look forward to continuing to work collaboratively with you and other Katie A. stakeholders to address any concerns with the ongoing implementation of these Katie A.-related services.

Sincerely,

Kara Read-Spangler
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