9 Health Plan Recommendations on Improving Care for Children and Youth in Foster Care

California Association of Health Plans

The California Association of Health Plans' 24 member Medi-Cal managed care plans (MCPs) providing coverage to more than 10.5 million Californians , propose a set of recommendations that will serve to improve care for children and youth in foster care, including youth transitioning out of foster care until age 26. These recommendations are offered for consideration as part of DHCS' California Advancing and Innovating Medi-Cal (CalAIM) Foster Care Model of Care Initiative.

Recommendation 1

Enroll all Medi-Cal children and youth in foster care into the Medi-Cal managed care delivery system.

Children and youth in foster care may benefit from stability in their medical home, and access to the case management services/coordination of benefits available in MCPs. While some view the Fee-for-Service (FFS) delivery system as a preferred provider organization (PPO) plan (i.e., any care without authorization), many cite challenges finding specialists who will see children and youth in foster care, with providers citing payment issues and concerns. The managed care delivery system will allow development of the expertise needed to improve outcomes and reduce the fragmentation under the FFS delivery system.

Under the managed care delivery system, MCPs can achieve the following:

- **Coordinate health care for members**, consulting with medical directors to ensure integrated care and appropriate planning.
- **Participate in staffing and multidisciplinary team meetings**, such as child and family team meetings, to address member specific health issues and facilitate appropriate transitions from inpatient and residential care to the community as appropriate.
- **Engage with and support providers**, including developing innovative reimbursement strategies such as value-based reimbursements, and facilitating unique provider collaborations.
- **Form unique partnerships with community agencies**, bringing innovative programs to communities, invest and support initiatives around employment, housing, education, food security, transportation and other social determinants of health
- Provide health education and support to families of origin, foster parents, kinship caregivers, youth, and providers.
- **Be an active part of the system of care for children and youth in foster care**, developing relationships with county-based child welfare services and other locally-based child welfare service providers.

Special Considerations for Recommendation 1 Requiring Additional Discussion, If Adopted

- DHCS and MCPs will need to collaborate to develop standards of care and quality of services for this population.
- DHCS, MCPs, and other stakeholders will need to collaborate to discuss having increased data for the purposes of quality improvement and ensuring the needs of children and youth in foster care are being met, and to address challenges due to the carve-out and lack of real-time data.
- If children and youth in foster care are changed from one foster home to another, an effort should be made to keep their MCP plan/medical home consistent, to maintain some level of continuity of care, to the extent reasonable and possible. Special consideration will be needed for out-of-county placements.
- MCPs support efforts to include the youth voice in the planning process, use of peer advocates and peer support, increased communication at all levels to members and caregivers, and to identify more opportunities to involve children and youth in foster care to increase and support early transition planning.
- Children and youth in foster care not part of the MCP prior to placement will need consideration in terms of what their transition will look like once reunified with parents/family.
- DHCS and MCPs could work together to consider the best approach for transitioning this population into managed care. This should include considerations for MCP readiness by geography and considerations for the number of members transitioning at one time within a County. Also taking into consideration the availability of County staff to participate in multidisciplinary team meetings, such as child and family team meetings, to facilitate the initial transitions appropriately to address member specific health issues /needs.
- MCPs look forward to further conversations on how we can utilize the Family Urgent Response (FUR) system as an opportunity to coordinate care to ensure members are linked to the appropriate system.

Recommendation 2

Every MCP and plan partner to have a designated MCP Foster Care liaison coordinator on staff.

Children, families, and counties may benefit by there being a single point of contact within the MCP with expertise in the foster care system/a key contact to help coordinate health care needs. The designated staff member would have institutional knowledge (Medi-Cal, foster youth), be dedicated to work with county agencies, attend county advisory meetings, and develop relationships within the community. For MCPs with currently established teams that work collaboratively with the local county agencies, benefits have already been seen.

Responsibilities would include:

- **Develop collaborative working relationships** with local agencies, community partners and supportive services such as: eligibility entities, juvenile services, behavioral health, county services, advocacy support groups and parents.
- **Attend monthly/bi-monthly meetings**, so the county organizations know the MCP representative.
- **Promote sharing/cross communication of resources** as well as close collaboration with local county entities.

- Address coordination of healthcare needs for members moving between counties, establish relationships with child welfare partners locally, facilitate the resolution of member specific issues.

The MCP foster care liaison is not intended to take the place of the MCP being an active participant in each foster youth's Child and Family Team (CFT), to ensure proper communication and coordination and child and family centered planning with child welfare and county behavioral health partners.

Special Considerations for Recommendation 2 Requiring Additional Discussion, If Adopted

- MCPs would need the flexibility to recruit/hire at the level that works for their population (i.e., an MCP might choose to have this be a nurse case manager vs a social worker, due to the many medical problems these children have (especially the neonates, or medically fragile kids). Preference would be given to candidates with lived experience.
- Clearly defined county roles and responsibilities is essential (see Recommendation #5).
- Share these contacts to create access and support coordination of services (medical, prescription and behavioral health) at the time of transfer to the new county (see Recommendation #6).

Recommendation 3

MCP Foster Care liaisons, County social workers, County Mental Health, and community and peer partners to meet regularly with community partners to share strengths and opportunities for improvement and program standardization.

Enhanced relationships/strong collaborations with MCP Foster Care liaisons, County social workers, County Mental Health, and community and peer partners (placement partners, agencies and community-based organizations serving foster youth) is key to improving health for this population. MCPs support regular communication and collaboration across all entities benefiting this population, including convening Joint Operations Committee (JOC) meetings with community and peer partners. Regular meetings will facilitate the following:

- Sharing of information
- Enhanced relationships
- Address barriers and develop resolutions to system-wide issues
- Build momentum for implementation of best practices.

Special Considerations for Recommendation 3 Requiring Additional Discussion, If Adopted

- This potentially could be done in the context of a "learning collaborative." CAHP could be a good resource to facilitate this learning collaborative. Otherwise, perhaps DHCS could do so.
- Stakeholder impact imperative for formulating evidence-based clinical and social approach to program and willingness to pivot as identified.
- Public health nurses (PHNs) through the Health Care Program for Children in Foster Care (HCPCFC) public health nursing program located in county child welfare service agencies and probation departments should be engaged in this process as well

Recommendation 4

DHCS to ensure Fee-For-Service providers understand they will be reimbursed for care provided to children and youth in foster care regardless of residency county (short-term fix), and align the eligibility reporting software to reflect the beneficiary's residency county (long-term fix).

The Medi-Cal provider website only reflects the child's "subscriber county" (i.e., the county from which the child originated and is not reflective of the county in which the child resides, also referred to as origin county) making it challenging for providers to know if the child is located in their county. This confuses providers and foster care families and can create access to care issues at the point of service. MCPs report that providers who are accustomed to billing the MCP may be apprehensive to see FFS children and youth in foster care due to the need to bill the State directly for services and concerns around associated payment. MCPs have this information in their file; however, providers only see the subscriber county on the website when an individual is in an FFS window.

Short-term recommendation: DHCS to provide clearer, foster care-specific guidance for providers assuring them that as long as a child is Medi-Cal eligible, the claim will be paid regardless of the county code/residency county (i.e., the county in which the child resides and where the child can access services, also referred to as the placement county).

Long-term recommendation: DHCS to update the Medi-Cal provider website with the child's residency county to minimize this confusion for providers.

Special Considerations for Recommendation 4 Requiring Additional Discussion, If Adopted

- Seeking to minimize the adversity of out of county placements is a complex cross delivery system issue because resolution for one system may create harms in another. *We support a focused conversation on out-of-county placements with all delivery systems participating to develop joint recommendations on this complex issue.*
- Addressing beneficiary eligibility barriers that can impact the ability of an MCP to identify these members and engage the members quickly into care, such as:
  - The need for the immediate assignment of a foster care aid code upon removal from the home. MCPs report that when a child is removed from their home, it would be helpful for the aid code to be updated as close to real-time as possible; sometimes this happens in a few days, at other times it can take much longer.
  - In instances where children and foster youth are Medi-Cal and California Children's Services (CCS) Program-eligible, MCPs report that even when the CCS eligibility is known, when the CCS eligibility is maintained by another county, the MCP is not aware that it is being maintained in a county other than the MCP county. This is critical information for MCPs and serves as a barrier to care coordination. Perhaps a supplemental file with complete data can be shared with MCPs.
  - MCPs' understanding is that DHCS is in the process of adding a former foster youth (FFY) flag in the MEDS system and are supportive of this.

Recommendation 5

MCPs, in partnership with DHCS, and MHPs to collaborate to create county-specific foster care Memorandums of Understanding (MOUs) to gather and share data, clarify and support business responsibilities including, but not limited to, juvenile justice, behavioral health, social services and county health care agencies.

MOUs are needed for data-sharing, being able to speak with counties, and helping to ensure privacy issues are addressed. There is changing personnel at both MCPs and counties, and data-sharing is not uniform amongst counties. This concept is in alignment with the goal of moving towards a more consistent and seamless system inclusive of all agencies serving the foster community. It will be imperative for community entities (not governed by DHCS) to obtain clarification, guidance and expectations.

MOUs exist today with other community/county partners. Although functional and having achieved successful outcomes for the populations, there are limitations to this approach as it is a shared responsibility – not solely on the MCP.

Special Considerations for Recommendation 5 Requiring Additional Discussion, If Adopted

- Will need extreme clarity around data sharing transparency and rights to communication to make this work.
- Will need clarification and consideration related to specialty providers (medical, behavioral health, etc.) that may not be in the MCP's network nor know how the MCP will collaborate.
- Further discussion around Requests for Information (ROIs) will be required to facilitate improved coordination of care.
- This effort should leverage the work currently being done under Assembly Bill 2083 (Chapter 815, Statutes of 2018). MCPs are not a required participant in statute, but are very interested in participating in/leveraging this process so there is no duplication of work efforts.

Recommendation 6

Develop an easily accessible, shared list of MCP Foster Care liaisons, appointed County Social Workers assigned to the MCPs. This would serve to facilitate and encourage communication between the MCPs and counties to curtail access to care challenges as children and youth in foster care navigate care across county lines.

MCPs support sharing/cross communication of resources as well as close collaboration with local county entities. Actions that streamline communications across MCPs/counties/surrounding counties will help ensure appropriate care for children and youth in foster care. Integral to this success is sharing information and building momentum to adopt best practices. Some MCPs have already embarked on this and are working on a similar process.

Special Considerations for Recommendation 6 Requiring Additional Discussion, If Adopted

- Need to further discuss best way to manage, share list.
- Consider leveraging existing lists and resources in place today to improve information-sharing. An example of a list that could be leveraged is the list that all county entities are required to include on their websites and that the California Department of Social Services (CDSS) also includes on its website: https://www.cdss.ca.gov/inforesources/foster-care/presumptive-transfer/county-points-of-contact.

Recommendation 7

MCPs support children and youth in foster care being included as an Enhanced Care Management (ECM) target population.

Given the fact that children and youth in foster care may experience multiple placements, maintaining the physical and behavioral health history of the child is a critical role for MCPs. Through the ECM care manager, the MCP can contribute to the overall coordination for these children.

Special Considerations for Recommendation 7 Requiring Additional Discussion, If Adopted

- We will need to understand how this would avoid duplicating case management activities already paid for by Medicaid through the MHP.
- We will also need to ensure that any recommendations that come out of the DHCS Foster Care Model of Care Workgroup process are consistent with DHCS' CalAIM ECM workgroup process. We will need to understand what system would need access to the current ECM system used by care managers to coordinate and communicate care efforts.

Recommendation 8

Include school-based health clinics (SBHCs) in the MCP network to allow children and youth in foster care to get their care where they go to school to increase access to care.

SBHCs have extensive expertise in pediatric care. *If SBHCs include a behavioral health component, they can help address the behavioral health needs of children and youth in foster care in the school setting.* Behavioral health staff can often help provide guidance to educators as to how to manage behavioral health issues. Schools are a source of stability for children and youth in foster care making it easier for students to access services through SBHCs.

Currently, few SBHCs are assigned primary care providers in the MCP system for the students served, nor are they able to provide services 24/7, as is required of other full-care providers. However, about two-thirds of the SBHCs are affiliated with or run by health care organizations (like federally qualified health centers (FQHCs)) that are already in-network providers in the MCP system. SBHCs are uniquely positioned to provide access to health care to all youth at schools, not just children and youth in foster care. MCPs encourage future SBHCs to be affiliated with an FQHC, or a perhaps similar county entity (if not already done), so that the services they render can be easily identified in encounter data, included for HEDIS, followed up with by MCP Foster Care liaisons, etc. Otherwise, providers could be working at cross purposes or duplicating services.

If there is a way to identify services that are being offered by a SBHC, then the MCP's Foster Care liaisons and school liaison could ensure that a SBHC representative (clinician, therapist, etc.) is included in any Interdisciplinary Care Team meetings or efforts to optimize the coordination of services rendered to these high-risk youth. This could also apply to county clinic mobile services, outreach, or community health workers being utilized by a county's public health agency so that all entities serving these youth have their care coordinated by the MCP.

Special Considerations for Recommendation 8 Requiring Additional Discussion, If Adopted

- It will be important to discuss barriers related to encounter data as encounter data isn't always readily available and to work with DHCS to develop recommendations/processes to address the barriers.
- It is extremely difficult to determine who to contact at the schools to coordinate care. Encourage MCP Foster Care liaisons to conduct outreach to SBHCs in MCP's service area to ensure they are "connected" to the MCP's network.
- It will be imperative for community entities (not governed by DHCS) to obtain clarification, guidance and expectations. Obtaining an MOU with SBHCs would be beneficial.
- It will be important to help school administrators understand the opportunities for Medi-Cal claiming and reimbursement to leverage critical federal Medicaid matching funds.
- We need to be cognizant of the potential for children and youth in foster care to experience triggers at school and that other students can stigmatize youth if they know they are foster youth.

Recommendation 9

Build upon Whole Person Care Pilots (WPC) Program best practices to develop a Universal Consent Form.

Being able to share information about children and youth in foster care is a difficult and major issue. *Improved data sharing between coordinating entities (MCPs, child welfare entities, behavioral health providers, schools, and the court system) is necessary.* A Universal Consent Form could help address the following identified challenges:

- Privacy laws have the potential to hinder the exchange of medical and behavioral health information between the MCP and County Mental Health resulting in barriers to coordinating services.
- Transferring a case to the county leads to a delay of care.
- Medi-Cal Rx may result in challenges for children and youth in foster care who encounter barriers related to filling prescriptions as the MCP will no longer be responsible for authorizing medication.
- There is a need to track codes to identify members who had previously been in foster care but who have aged out or changed need codes – for the purpose of tracking health outcomes over time.

Special Considerations for Recommendation 9 Requiring Additional Discussion, If Adopted

- Clear guidance is needed from DHCS on the use and the scope of the consent.
- A process and central repository is needed to track patient revocation of the form to ensure there is not a breech in patient rights.

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