Foster Care Model of Care Workgroup (FCMCWG) - Discussion Framework and Questions

Workgroup Date: February 26, 2021

The Workgroup on February 26, 2021 will review a "straw dog" combined proposal for a foster care model of care. DHCS and CDSS have not selected these as final recommendations, nor do we know yet if all components are feasible. The purpose of today is to understand how a combined proposal could meet the guiding principles of the workgroup, understand how it could work, where there could be challenges, and what considerations need to be addressed when recommendations are ultimately selected. This is our opportunity to "stress test" this model. We want to focus on integration, accountability, and structural changes needed for this model to be successful.

For the purposes of this discussion, please envision a model that combines the four proposals you have seen in earlier meetings:

1. **Streamlined access to specialty mental health services** (amending medical necessity): Children in child welfare are at increased risk of developing mental health conditions due to experience of trauma. Medi-Cal policy is proposed to be revised to ensure "automatic access" to a specialty mental health assessment, and then which services are needed would be based on the mental health needs of the individual child or youth.

2. **Expanded set of services for children and families** (CWDA/CBHDA proposal): This proposal would incorporate the following into an expanded set of benefits for children and families in child welfare:
   a. *Front-End Minimum Mandatory Scope of Behavioral Health Services:*
      i. Trauma-informed, Resiliency-building Therapeutic Services for Children and Families
      ii. Broaden eligibility for Intensive Care Coordination (ICC)
      iii. Individual Child and Family Therapy
      iv. Therapeutic Relationship-Building Services for Families
      v. Broaden Eligibility for Therapeutic Behavioral Services (TBS)
      vi. Intensive Home-Based Services (IHBS)
      vii. Substance Use Disorder (SUD) Services
      viii. Family Reunification Partnership Program (potential best practice)
      ix. Peer Supports

x. Adopt "Full-Service Partnerships" and "Wraparound Programs" for Families (including parents) in the Child Welfare Services System.

c. Inclusion of Z and V Codes

d. Crisis or Urgent-Oriented Services

3. **Regional managed care** (modified "option 2" from the NHELP proposal)**.** The State selects a small group of regional child welfare plans through a competitive bidding process. The contracts would have the following requirements for each plan:
    a. Robust expertise in the specific needs of children in the child welfare system
    b. Detailed agreements with local child welfare departments and county mental health plans to ensure close coordination of care, including managed care representation at Child and Family Team meetings
    c. Accountability for a set of outcomes measures specific to the child welfare population
    d. Requirement for a mobile personal health record for each member, easily accessible to providers across sectors
    e. Responsibility for all medical care
    f. Enhanced care management (with counties having the first right of refusal to be the subcontractor, as long as they meet the robust minimum requirements)
    g. Specialty mental health and SUD treatment would remain the responsibility of counties
        i. All children in the child welfare plan would have automatic access to specialty mental health (changes to medical necessity)
        ii. Children choosing to access non-specialty mental health services in managed care networks would still have that option
        iii. Voluntary carve-in of administrative responsibilities for specialty MH and SUD could be feasible, with plans subcontracting to county providers for MH and SUD services

    Children involved in child welfare would be mandated into a regional plan, with opt-out exemptions reviewed on a case-by-case basis.

4. **Enhanced relationships and stronger collaboration between managed care plans, local systems, providers, and the youth and families** (modified components from the CAHP proposal). Opportunity for enhanced relationships and stronger collaboration which is key to improving health and ensuring the needs of children and youth in foster care are being met. Components include:

    a. Participate in staffing and multidisciplinary team meetings such as Child and Family team meetings;
    b. Provide health education and support to families of origin, foster parents, caregivers, youth, and providers;
    c. 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;
    d. Designated Foster Care Liaison Coordinator as the key point of contact.

With these four elements combined, what do we need to consider to know what we need to ensure is in place going forward? The following questions can guide our discussion.

Discussion Questions:

1. How could the combined proposal ensure more equitable outcomes?

2. How could a regional managed care plan better coordinate and integrate social services? (e.g., participate in Child and Family Team meetings, work to find alternatives to residential care)

3. What are the keys to success for a regional managed care model? What key policies would need to be in place for this model to deliver better access and better outcomes?

4. What results should a regional managed care plan be expected to deliver?

5. What must a regional managed care plan include to ensure and advance racial equity? How should the regional managed care plan be accountable to meet targeted outcomes to address and advance racial and health equity?

6. What are the biggest challenges for a regional managed care model? How would we ensure the needs of children, families, and caregivers are consistently met and they have access to quality health care across all regions?

7. Given that specialty mental health and SUD services would still mostly be provided on a county-by-county basis, what statewide accountability systems would need to be in place to ensure all counties provide the core suite of services, and services are all available regardless of their county of placement? What are the keys to ensuring appropriate communication and coordination of care between the counties and a regional managed care plan?

8. How would the state most effectively integrate existing resources, such as public health nurses, into an integrated managed care approach?

9. What would the enhanced care management (ECM) benefit look like in a regional managed care model? How could current intensive case management services be improved with additional funding from a managed care ECM contract (including what could the public health nurse service include if more funding were available in the ECM model)? When would ECM be better delivered by a non-county subcontractor?

10. How do we assure that an integrated managed care approach addresses access to special services and special needs, such as the following:
    a. Need for dental services (including care under anesthesia, orthodontic)
    b. Services for medically fragile children
    c. Need for confidential sexual and reproductive health care services
    d. Need for gender-affirming care
    e. Services for individuals with developmental disabilities?