Foster Care Model of Care - CA Alliance Recommendations

The CA Alliance of Child and Family Services (CA Alliance) appreciates the Department of Health Care Services' (DHCS) and the Department of Social Services' (CDSS) recognition that youth involved in, and at risk of being placed in the child welfare system deserve a specially tailored and coordinated system-level approach to ensure access to high quality medical, dental, and behavioral health services.

As has been pointed out in numerous proposals and recommendations provided through the CalAIM Foster Care Model of Care Workgroup, only 73.3% of youth in foster care received timely access to medical care in 2019, 66% received timely access to dental care [1], and less than half (42%) of children with open child welfare cases in 2018 received any Specialty Mental Health Services through their Mental Health Plan (MHP).

It is important to note the comparison of foster youths' access to these services against other children and youth in the MediCal system particularly given research linking poverty to child welfare involvement [2]. Data provided through the Department of Healthcare Services (DHCS) Performance Outcome System (POS) indicates that 4.3% of children in the MediCal system received Specialty Mental Health Services in 2018 [3]. And only 1.5% of children in MediCal Managed Care Plans (MCPs) received a mental health service [4]. Due to a lack of disaggregated data, it is not possible to review data for individual MCPs to understand if some do better than others at ensuring that children and youth receive necessary mental health services. This point is crucially important as we rethink services for foster children and youth (as well as for youth in the probation system) and consider ways to provide services more broadly in MediCal to reduce the number of youth placed in foster care overall. With early intervention and greater access to services that are culturally and linguistically respectful and responsive, and are provided at the right time, in the right place and in the right amount, we can work to reduce the number of children entering the foster care system in California and create greater stability for families.

[1] https://www.kidsdata.org/topic/2204/foster-medical-care/table#fmt=2738&loc=2,127,347,1763,331,348,336,171,321,345,357,332,324,369,358,362,360,337,327,364,356,217,353,328,354,323,352,320,339,334,365,343,330,367,344,355,366,368,265,349,361,4,273,59,370,326,333,322,341,338,350,342,329,325,359,351,363,340,335&tf=124
[2] https://partnersforourchildren.org/sites/default/files/Poverty%20and%20Child%20Welfare%20Involvement%205-3-16.pdf
[3] https://www.dhcs.ca.gov/services/MH/Documents/OCW00-20180625-Statewide-SUP-Final.pdf
[4] https://www.dhcs.ca.gov/services/MH/Documents/00-20190304-Statewide-SUP-Final.pdf

The [twelve Guiding Principles] for the Foster Care Model of Care (FCMOC) Workgroup focus on building on existing reforms, improving timely access and continuity of care, creating a trauma-informed system that identifies and reduces disparities, and includes family and youth voice. In addition, they highlight the importance of family centered care that supports caregivers, ensures that children and youth receive services in the least restrictive environment, and with knowledgeable providers. And finally, the principles outline the need for accountability in the system and establishment of streamlined and standardized processes that reduce the complexities of reporting.

With these principles in mind, the CA Alliance has reviewed the various proposals and potential structures proposed through the Workgroup. Below we have outlined some of the most critical elements of a model of care for youth at risk of being placed in, are currently in foster care, and former foster youth. We then provide options for a structure that will address these elements.

It is important to note that any structure designed to meet the needs of foster youth, those at risk, and former foster youth, must consider that existing systems have been built on institutionally biased and/or racist historical structures, intentional or not. The number of Black and Latinx youth in care in 2018 was 23% and 21% respectively, and it is likely that between 5-10% are LGBTQ youth [5]. As we design the most responsive system to both address the current needs and to reduce the number of youth in foster care long term, we must ensure that we are addressing long standing race, ethnic, sexual orientation, gender identity and expression (SOGIE) related disparities that exist in our current systems.

While there is no question that a large percentage, perhaps as large as 1/3 of children and youth in foster care, have identified chronic healthcare needs, the American Academy of Pediatrics reports that up to 80% enter the foster care system with a significant mental health need [6]. As we learn about the short- and long-term health effects of Adverse Childhood Experiences (ACES) through the CA Surgeon General's work, it is clear that trauma-informed behavioral health interventions coupled with strong coordination of care are urgently needed for all children, youth and their families in both Child Welfare and Juvenile Justice systems, as well as former foster youth. With this lens, the CA Alliance has focused primary attention on identifying elements of a behavioral healthcare system to best address the needs of current and former foster youth.

[5] https://www.nclrights.org/wp-content/uploads/2013/07/LGBTQ_Youth_California_Foster_System.pdf

[6] Healthcare Issues for Children and Adolescents in Foster Care and Kinship Care, https://pediatrics.aappublications.org/content/136/4/e1142#sec-9

Essential Elements of Foster Care Model of Care

Eligibility

1. Ensure the EPSDT entitlement is met for all children and youth receiving MediCal services. While this recommendation is broader than the prescribed population, it is also how California will reduce the number of children and youth entering, and in, the foster care and probation systems. The number of children in foster care has remained consistent for the past 10 years, and to achieve the vision of CCR and the new federal Family First Prevention Services Act (FFPSA), early intervention and prevention are more important than ever. This also aligns with the guiding principles of youth and family voice and reducing racial disparities in our health systems. Family members need to access medical, dental, and behavioral healthcare services for their children, and for themselves, as early as possible, and in the right dosage, without barriers to accessing care. This supports guiding principles #7 and 9, focused on early intervention and using the least restrictive approach to care as possible.

2. Establish a condition-based eligibility category for Medi-Cal managed care and specialty mental health interventions. We applaud the CalAIM proposal to move away from diagnosis-based eligibility ("medical necessity") and towards a system in which a youth's eligibility for services is based upon their level of impairment and/or biopsychosocial factors. This shift away from diagnosis-dependent eligibility is mandated by federal law, which requires states to provide all services that are "necessary" to "correct or ameliorate" a child's mental health "condition."

Robust adherence to this federal mandate is critical because it will enable providers to intervene early when they can alleviate the effects of stressful circumstances or events that -- if left unaddressed -- are likely to cause mental health problems. We know, for example, ACEs correlate with developmental delays, behavior problems, and poor long-term health outcomes. Yet, the current diagnosis requirements prevent providers from addressing these factors until the youth's mental health has deteriorated to the point of meeting criteria for a mental health disorder. The FC MOC guiding principle #7 highlights the importance of identifying needs as early as possible, and this element ensures that social determinants of health that impacts so many youth and families at risk of system involvement get their needs identified and addressed as early as possible.

3. Presumptive eligibility for foster youth. Several previous documents presented by CWDA/CBHDA, and the Child Welfare Council's Behavioral Health Committee outline the need for presumptive eligibility for foster youth as it relates to their behavioral health needs. Considering the trauma suffered by any youth who has been removed from their

family home, we recommend that DHCS and DSS make every effort to minimize barriers to comprehensive care for this population. Presumptive enrollment of foster youth in the MHP would further this goal by ensuring that each youth receives a comprehensive assessment conducted by a Specialty Mental Health Service (SMHS) provider. Compared to MCP providers, MHP providers have a better understanding of the full range of SMHS available, and therefore are better equipped to connect the youth to all appropriate services. Mandated EPSDT services can be continued regardless of where a youth lives. In addition, if a foster youth develops a mental health condition that requires more intensive services, they will be able to access that care more quickly if enrolled in the county mental health plan. Given that every foster child's child welfare worker should be completing a CANS, for many of these youth, the initial CANS assessment will have been completed.

For children at risk of foster care, an initial screening can be provided using Adverse Childhood Experiences: leveraging the Surgeon General's ACEs Aware Initiative to implement immediate referrals from pediatricians to behavioral health providers for children at imminent risk of child welfare involvement. Children who present with a threshold ACEs score (or using an algorithm that addresses severity) and Related Life Events Screener (PEARLS) tool) should be automatically referred to Specialty Mental Health Services when necessary to address their behavioral health needs.

We recommend that foster youth would be presumptively enrolled in the MHP behavioral health system, *with an opt out to access services in the MCP delivery system*, which may be the case if the youth has a pre-existing relationship with an MCP provider. This also addresses the workgroup's guiding principle #9 – Children and youth receive services in the least restrictive environment – since early screening for behavioral health needs will help to reduce the number of youth that must "fail up" for more intensive services.

4. Once eligible, always eligible. To ensure a foster youth's stability throughout their care as well as once they are reunified or are transitioning out of care, taking a "once eligible, always eligible" approach to accessing care is essential. Rather than go through extensive reassessments, and tell their story over again and again, a child who has been placed in foster care will have ongoing challenges with trauma responses, anxieties and other behavioral health issues that will need intervention throughout the course of their youth and young adulthood. Having electronic records that provide background for providers will improve care coordination and making services available ongoing for this small population will certainly reduce the number of former foster youth who find themselves incarcerated, homeless, or become addicted to substances.

5. Consider using an Alternative Benefit Plan (ABP) to provide a full array of behavioral health services for former foster youth. As foster youth are aging out of the system, and for those in extended foster care, the array of behavioral health services diminishes significantly from the EPSDT services available until age 21. Often the most effective services (e.g. peer support, Wraparound) are no longer widely available. These youth must learn to navigate a completely new system at a time when they are at their most vulnerable. The Centers for Medicaid and Medicare provide an option for states to develop ABPs to address the needs of specific populations. "Under ABPs, states may provide a benefit that is defined by a reference to an overall coverage benchmark, rather than a list of discrete items and services… ABPs can be targeted to certain Medicaid groups, including former foster youth." [7] This addresses guiding principle #2, particularly the focus on ensuring former foster youth have access to timely and appropriate access to care.

Access, Continuity and Coordination

6. Full array of services, including substance use services, must be available. Foster youth and their families must be able to access the full array of Specialty Mental Health Services (SMHS), including Substance Use services. This will require more service providers having the ability to contract with MHPs for the range of services including ICC, IHBS, TBS, Medication Support, Mental Health Services and Case Management. Given the requirement outlined in FFPSA for Short Term Residential Therapeutic Programs (STRTPs) to provide aftercare services, STRTPs will need to contract to provide Wraparound for youth leaving their facilities.

Substance Use services have not been available in California through EPSDT (unless a youth has a co-occurring mental health disorder), despite their being part of the federal entitlement. While the DMC-ODS system has helped increase access in some counties, the state needs to ensure that there is access to substance use services in all regions of the state and allow for reimbursement through both the DMC-ODS system and through EPSDT billing. For many older foster youth, this can be the primary issue that results in placement changes and instability. These services must be developed and must be reimbursed at the rates as other EPSDT services; having EPSDT providers dually contracted to provide DMC-ODS services would be a natural step towards more integrated services.

7. Continuity and coordination of care through intensive care coordination (ICC). The lack of continuity and coordination of care for foster youth across systems is a

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[7] Congressional Research Office, "Medicaid Coverage for Former Foster Youth Up to Age 26". https://fas.org/sgp/crs/misc/IF11010.pdf

primary concern that must be addressed through this visioning process. With well over 50 MediCal Managed Care Plans and Commercial Plans serving the MediCal population, and 56 MHPs providing SMHS, plus those still receiving fee for service (FFS) MediCal, foster youth are easily lost without a strong advocate to navigate these systems on their behalf. Former foster youth are often at even greater risk given that they are often living on their own, attempting to become independent but still needing access to these critical services to maintain stability.

Expanding Intensive Care Coordination, as outlined in the CWDA-CBHDA Joint Behavioral Healthcare Vision for Child Welfare document could address the gap in coordination that now exists. The integration of the Child and Family Team (CFT) structure that already exists through the Child Welfare system will be important to use as the model for coordination and use of the Child and Adolescent Needs and Services (CANS) assessment tool across Child Welfare, Probation, and Behavioral Health, can ensure that all members of the team, including Regional Centers and Education, who must be engaged to ensure stability, access to services, and continuity while child is in the foster care system.

For those foster youth or former foster youth that may opt to receive their behavioral health services through an MCP, the Enhanced Care Management (ECM) and In Lieu of Services (ILOS) can serve to provide these care coordination services, as outlined in the revised CalAIM proposal. In developing the most comprehensive system of care for foster youth, allowing ILOS to be provided through the MHPs would ensure that ICC and ILOS are working together to support youth, in the same way they are expected to work together through the MCPs.

Any structure created must incorporate the work already being done through AB 2083, which requires that, at both state and local levels, agencies serving foster youth – child welfare, behavioral healthcare, regional centers, education, juvenile justice, and community-based organizations – must work collaboratively to ensure continuity and coordination of care. Healthcare and dental organizations will need to be integrated into this process so that this part of a youth and family’s care is considered. The framework established by the Integrated Core Practice Model, and the ongoing implementation of Child and Family Teams (CFT) should include health and behavioral healthcare partners for all foster youth. Using ICC provided through MHPs and contracted providers also increases the likelihood that services will also be provided in a culturally responsive and linguistically accessible manner.

This structure must also allow for ICC to be provided regardless of the county a youth is residing in, so that children and youth placed out of county continue to have the necessary continuity of care and time to ensure that a clear transition plan is in place if

a long-term resource family placement is occurring. These ICC providers will assist in addressing issues related to presumptive transfer of youth and will work closely with the foster care public health nurses and educational foster care liaisons. This addresses guiding principles #1, 2, 3, 9, and 10.

8. Integration of community-based services throughout the system. Any model of care that seeks to address the diverse health and behavioral health needs of foster youth must, at its core, be integrated into community. It is vital that services for children and families (and particularly behavioral health services) are provided in community-based settings that are easily accessible and are culturally and linguistically responsive. Community-based organizations (CBOs) provide field-based services in homes, in schools, and throughout communities, meeting children and families where they are, and ensuring that transportation is not a barrier to access services. CBOs are well positioned to address specialized needs for LGBTQ and transgender youth. With a diverse workforce that includes parent partners and peer advocates, CBOs are positioned to be responsive to the unique needs of foster youth and can link them to services in their communities. This addresses guiding principles #5, 9, and 10.

9. Family centered care. Research has demonstrated the connection between a caregiver's own wellbeing and their children's. Additionally, the need for foster and relative caregivers to understand the trauma that foster children have experienced is essential to addressing their health and behavioral healthcare needs long term. Whether it is biological family members or foster caregivers, the importance of addressing the needs of the whole family cannot be understated. When parents are stable and supported, their children do better [8]. As the Foster Care Model of Care is considered, establishing a family-centered intervention that includes models such as Certified Behavioral Health Clinics (CCBHCs), as well as the fiscal structures that allow for service providers to bill for a "family intervention" will help to both reduce any stigma the youth may feel, and center the intervention of the family unit rather than on the child. Additionally, having services that support caregivers specifically, so that issues related to their own anxiety, depression, or substance use issues can be addressed.

CCBHCs are responsible for directly providing (or contracting with partner organizations to provide) nine types of services [9], with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination and integration with physical health care. Because these clinics are led by behavioral health providers, and require partnerships with healthcare, they bring expertise in reaching and engaging

[8] https://www.apa.org/monitor/2017/09/cover-resilience
[9] National Council for Behavioral Healthcare Organizations. What is a CCBHC? https://www.thenationalcouncil.org/wp-content/uploads/2017/11/What-is-a-CCBHC-11.7.17.pdf?daf=375ateTbd56

those with behavioral health needs. Having behavioral health be the “front door” for youth and families and ensuring a robust set of mental health and substance use services available on an as needed basis, can engage families who might otherwise be reluctant to reach out for services. Developing service systems such as CCBHCs and ensuring access to care for all members of a family, will meet guiding principles #1, 4, 8, 9 and 10.

10. Specialized care requires a statewide approach. For youth in the foster care system that present complex care needs, whether they are medical or behavioral or both, having access to statewide approaches and resources is critical to ensuring that care is available. With the recent decision to decertify out of state facilities where 130 foster and probation youth were placed, it has become clear that using a coordinated approach at the state level is the most effective way to identify placement options that are available, or to build an individualized program to meet a youth’s needs. Having one entity that can serve as a clearinghouse for resources for youth needing intensive services could reduce the time and effort that is spent in caseworkers placing and replacing youth in programs that do not meet their needs, or whose needs far exceed any programs that currently exist in the continuum. This element addresses the guiding principles #1, 9 and 10.

11. Use of current structures in CCR (CFTs, AB 2083) to ensure interagency collaboration. Since the design of California’s Continuum of Care Reform (CCR) for foster youth, several vital interagency structures have been put in place. These have taken years of multisystem collaboration, training and technical assistance and still being operationalized. However, where these efforts have been successful, they have had good results in increasing access to care, engagement parents and youth, and communication between partner organizations. As DHCS and CDSS look to design a FC MOC for the future, it is important that these developing elements are central to any new system that includes health and dental care. Rather than adding additional methods of coordination, integrating healthcare into this system that exists, and ensuring that additional partners such as public health nurses and educational liaisons are included in CFTs, and interagency work being done through AB 2083. This addresses guiding principles #1, 3, 5, 6, and 10.

12. Statewide hotline available to foster youth and caregivers to ensure access. To ensure that at any point in time there is a state level intervention available, we suggest a statewide hotline staffed by health and behavioral health specialists that can assist youth and families in accessing services in their community. This would need to be staffed specifically for the purpose of assisting callers with administrative questions about MediCal, as well as understanding the various systems at the local level that

interact and may need to be engaged to best address a youth's medical, dental, or behavioral health needs.

Accountability, Transparency and Administrative Processes

13. Develop strong oversight, transparency, and accountability mechanisms to promote equitable access and to reduce disparities across counties. DHCS and DSS can play a leadership role in developing a robust accountability infrastructure for foster children and youth, with a focus on continuous quality improvement. This should take the form of standardized data collection, tracking, and performance outcomes tools across the state, so stakeholders can know what services youth are getting, where they are getting them, and what the outcomes are. The current DHCS Performance Outcomes System is not sufficient as it is currently used. We also have insufficient data on utilization of behavioral health services among the MCPs. The elements outlined in the CWC Behavioral Health Committee which include a) Identify a clear and simple set of core statewide goals, with corresponding outcomes for youth, parents and families involved in or at risk of becoming involved in the child welfare system, b) Develop and enhance the infrastructure necessary to collect, synthesize and monitor outcome data, c) Develop and mandate a robust quality improvement process for children's behavioral health statewide, would begin to address the current gaps. Ensuring that any foster youth data collection is consistent between MCPs and MHPs will also be important.

Additionally, the disproportionate numbers of Black, Native American, and Latinx youth in foster care requires a new type of oversight and mechanisms for innovative solutions. This could be developed through a statewide advisory committee comprised of subject matter experts, practitioners, community-based organizations, counties, family members, youth and others with lived experience that could address the inherent disparities in our public child and family serving systems. This addresses guiding principles #4, 5, 10 and 12.

14. Ensure streamlined administrative approaches. Our current systems providing health and behavioral healthcare have created enormous administrative burdens on providers that are borne out of a compliance driven approach to care. Of utmost importance as we design a model for foster youth is to create statewide standards that meet federal laws, and do not add additional state or county requirements. Similarly, MHPs should work with the state and CBOs to develop standardized contracting, credentialing, authorization, and service documentation for children and youth so that providers are spending more time with children and families than they are on paperwork.

As it relates to the Foster Care Model of Care, using telehealth, designing electronic health records that can be accessed for youth moving between counties, and identifying care navigators that will follow a youth throughout their stay in foster care are important steps toward ensuring continuity and coordination of care.

According to the American Academy of Pediatrics, "use of web-based health records or use of the patient portal in the electronic health record, in particular, have incredible potential to decrease the health information gap among professionals caring for children and adolescents in foster care." [10] This addresses guiding principles #2 and 11.

Additional Recommendations on Structure of the Foster Care Model of Care

1. Regional MCPs provide healthcare services. A regional system of MCPs that provide health and dental services to foster, at risk and formed foster youth, will reduce the complexity of the current managed care system that is so often challenging to access. These regional MCPs would have foster care liaisons who would gain knowledge and experience in the unique needs of foster youth, and would interact with the MHPS, Child Welfare, Juvenile Justice, Regional Centers and Education when health issues need to be addressed through these systems. This would significantly reduce the number of MCPs serving foster youth, and these regional MCPs should be structured to include elements outlined in the CA Association of Health Plans Recommendations. Dedicated Foster Care Liaisons, Memorandums of Understanding for data sharing, and Use of Enhanced Care Management for youth opting to be served in MCPs are essential components to be included in the system.

2. All foster youth are assessed for behavioral health through their MHP with option to access through an their MCP. Given the number of children and youth who require a broader array of behavioral healthcare services than is available through MCPs, as well as the number of structures already in place to assist in coordination among child-serving agencies, we recommend that an initial screening and assessment occur through the MHP. Additionally, the universal use of CANS as the assessment tool for children and youth in the foster and probation systems allows for only one agency to complete this tool, rather than a foster youth having to receive different assessments in multiple systems.

3. Foster youth with complex needs access statewide coordination. Creating a statewide approach to addressing the needs of foster youth with complex needs seems essential to reduce multiple placement failures and moves that exacerbate their trauma.

[10] https://pediatrics.aappublications.org/content/136/4/e1142#sec-39

In terms of serving those kids with complex needs, state could consider a model like the CA Children's Services - this approach would help defray the expense to any one system and might insure that highly specialized and innovative treatments can be accessed for youth for whom currently available services are insufficient. Developing a "specialty care designation" for a provider or network that is specifically designed and funded to serve foster youth with the most complex needs could be considered.