Medi-Cal's Foster Care Strategies

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Executive Summary

The Department of Health Care Services (DHCS) is building upon years of foster care reform efforts to ensure that children and youth involved with the child welfare system have streamlined access to reliable, high-quality, integrated, trauma-informed, strength-based, patient-centered, and family-centered care. This document reviews activities being undertaken by DHCS, including activities in partnership with the California Department of Social Services, to help meet this goal. These efforts reflect policy changes and benefit expansions underway through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, and additional ongoing efforts to ensure that this care happens seamlessly, and includes medical, behavioral, dental, social services, and educational systems.

Medi-Cal can promote this care through:

- **Special Features for Children and Youth Receiving Foster Care in Medi-Cal Managed Care Plans (MCPs)**:
  - Managed care enrollment in new Single Plan counties
  - Enhanced Care Management (ECM) and Community Supports
  - Dedicated Foster Care Liaison on MCP staff
  - Enhanced DHCS and CDSS Oversight
- **Enhanced Benefits Structure for All Children and Youth Receiving Foster Care**:
  - Initial behavioral health assessment
  - Evidence-based in-home and family therapies for all children involved with child welfare
  - New Activity Stipends
  - Strengthened statewide standards for medical necessity determinations (utilization review) and clinical guidance for service levels for intensive home-based services (IHBS) and therapeutic behavioral services (TBS)
  - Aligned use of the Child and Adolescent Needs and Strengths (CANS) tool across child welfare and specialty mental health
  - Coordination between the Family Urgent Response System (FURS) and the new statewide mandatory Medi-Cal Mobile Crisis benefit

- **Addressing Equity**
    - Equity-focused implementation plans
    - Culturally responsive care
    - Equity-focused data reporting
- **Increased Accountability, Oversight and Compliance:**
    - New performance expectations for MCPs
    - New performance expectations for Mental Health Plans
    - New performance expectations for Child Welfare Systems
    - New local performance expectations and incentive pool

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Purpose

DHCS, through Medi-Cal, has made strengthening California's behavioral health system a key priority, particularly for individuals with the greatest needs. For children receiving foster care, these initiatives are being pursued through multiple vehicles:

- **The California Advancing and Innovating Medi-Cal (CalAIM) initiative**, which takes concrete steps to bring meaning to "whole person care," including by establishing Enhanced Care Management (ECM) and Community Supports (discussed in greater detail below) for the most vulnerable beneficiaries. Children and youth involved in child welfare are a key population of focus for these efforts.

- **The California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration**, a new Medicaid Section 1115 demonstration that DHCS is pursuing to expand access to and strengthen the continuum of mental health services for individuals enrolled in Medi-Cal living with severe mental illness (SMI) or serious emotional disturbance (SED) that includes several core initiatives directed at children and youth.

- **Additional initiatives** to strengthen services and supports for children and youth involved in child welfare, such as ongoing efforts to align the CANS across systems, and direct contracts with Kaiser across 32 counties.

The purpose of this document is to review DHCS' various Medi-Cal strategies to strengthen the child welfare system, some of which are being implemented through CalAIM, some through the CalBH-CBC Demonstration, and additional elements through other initiatives.

Background

Children and families involved in child welfare must navigate several complex and fragmented systems – medical care, behavioral health, social services, intellectual and developmental services, education, and the justice system – and this is most challenging for children in out-of-county placements. There are multiple entities accountable for components of care and supervision, often resulting

in a fragmented experience. Children receiving foster care deserve seamless access to needed care, with a single entity accountable to sharing data and improving outcomes. Separation from parents – even in cases of abuse or neglect – is extremely traumatizing, and the experience of trauma increases the risk of mental illness onset, substance use disorders, and poor health outcomes. Yet half of children and youth receiving foster care do not receive any specialty mental health services (SMHS) which could help address the trauma and prevent the development of later health conditions.

The Foster Care Model of Care Workgroup met between June 2020 and April 2021 and was charged with providing recommendations on how to better deliver coordinated services for children and youth involved with child welfare. The workgroup, co-led by DHCS and CDSS, adopted a charter and guiding principles (see the Appendix), reviewed models from other states, and gave input on a variety of proposals put forward by associations and the State. Examples from Washington and Arizona highlighted the advantage of a single entity accountable for providing or coordinating all care, integrating behavioral health and medical care, and having clear accountability to quality metrics. Workgroup members also highlighted unique structures to California, such as realignment, that influence the ability to adopt models that have been successful in other states.

DHCS, recognizing Medicaid's importance in transforming the experience of children receiving foster care, has launched several initiatives to transform the Medi-Cal program. These initiatives are based on a whole person/whole family approach, designed to improve the experience and outcomes for children and families navigating complex systems, and to build on the numerous efforts to improve the foster care system that were already in motion.

CalAIM seeks to: (1) Identify and manage comprehensive needs through whole person care approaches and social drivers of health; (2) Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform; and (3) Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

A core principle of the foster care strategies -- and in CalAIM more broadly – is to standardize, simplify and streamline systems to ensure individuals and families receive the care they need without barriers. One of the key behavioral health policy changes in CalAIM is to simplify access to SMHS for children experiencing trauma due to involvement in child welfare. In the new CalAIM access criteria for SMHS, effective January 1, 2022, all children in child welfare (in out-of-home placement and/or with an open case) will meet criteria for an assessment in the SMHS program based on the trauma, grief, and loss associated with child welfare involvement. They do not have to demonstrate impairment or diagnosis in order to qualify for an assessment and medically necessary SMHS. Under CalAIM, DHCS also implemented a "no wrong door" policy that facilitates access to appropriate mental health services, no matter where the beneficiary starts accessing care. In addition, under CalAIM, DHCS is implementing a

statewide Youth Screening Tool for Medi-Cal Mental Health Services, which will ensure that children and youth with child welfare involvement are directly referred for a SMHS assessment if they or an individual acting on their behalf contacts the access line for their Medi-Cal Managed Care Plan or county Mental Health Plan seeking help. And, as mentioned at the beginning of this strategy document and discussed in detail below, ECM is a core component of CalAIM.

The CalBH-CBC Demonstration supports statewide practice transformations and improvements in the county-administered behavioral health system to better enable counties and providers to strengthen the continuum of community-based services and evidence-based practices, to improve the quality of care delivered in residential and inpatient settings, and to strengthen transitions from these settings to the community. Several components of this that will improve the quality of care for children receiving foster care include the development of Centers of Excellence (COEs) and offering incentives to counties for meeting key performance thresholds. COEs can provide orientation, training, coaching, mentoring, fidelity monitoring and other supports needed to build and sustain capacity in delivering evidence-based practices through a culturally sensitive lens. For example, DHCS anticipates that COEs may provide support to counties and providers in delivering evidence-based practices for children and youth, including services for which coverage is already clarified (e.g., Intensive Care Coordination, Intensive Home-Based Services) and services for which coverage will be clarified (e.g., Functional Family Therapy, Parent-Child Interaction Therapy, and Multisystemic Therapy). In addition, DHCS intends to incentivize county MHPs and Drug Medi-Cal Organized Delivery System counties to build a robust quality improvement program, to improve performance on quality measures, and to reduce disparities in access and outcomes. Performance improvement measurements will also include rates specific to populations experiencing disparities in behavioral health care access and outcomes, to include children and youth. Under the CalBH-CBC demonstration, DHCS also proposes to cover Activity Stipends for youth in child welfare to support activities that support emotional and social wellbeing.

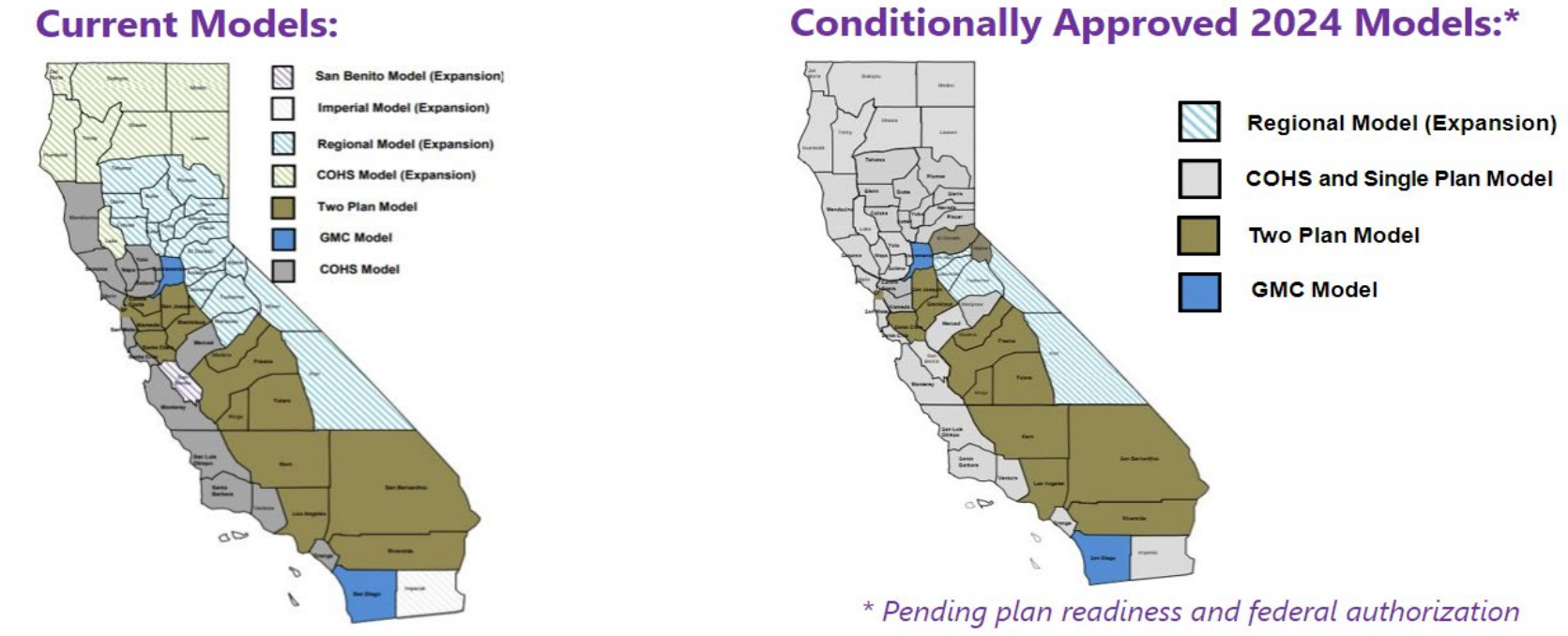
Additionally, Assembly Bill (AB) 2724 (2022) authorized DHCS to establish a direct contract with Kaiser as a Medi-Cal managed care plan in 32 counties. Children and youth in foster care will be able to enroll in Kaiser in these counties and their coverage, health information, and access to the provider network will more seamlessly transition if their placements change among those 32 counties. This provides a step toward a more seamless system in which children and youth in foster care will experience the least amount of disruption when they face changes in placement across some counties.

The sections that follow describe DHCS's foster care strategies in greater detail.

New Special Features for Children and Youth Receiving Foster Care in Medi-Cal Managed Care Plans (MCPs)

1. ***Managed Care Enrollment in New Single Plan Counties.*** It is important that children and youth receiving foster care have access to well-coordinated and managed health care. To that end, DHCS is moving toward greater use of managed care for foster children. Enrollment in managed care is currently voluntary for children in foster care except in eight counties where Medi-Cal managed care is provided by a single County Operated Health Systems (COHS) (See Figure 1 below, left side). The number of counties with COHS and single plans is growing. With the planned MCP model change in 2024, approximately 13,276 children and youth in foster care in counties transitioning to COHS and Single Plan models will be moved to mandatory managed care. DHCS has conditionally approved Medi-Cal managed care model changes in 17 counties, including 12 transitioning to a COHS model and 3 implementing a new county-led Single Plan model (see Figure 1, right side). Participation will be optional for family members of participating children.

Figure 1. Map of current models of managed care as well as conditionally approved 2024 models



2. ***ECM and Community Supports***.[1] At the center of CalAIM is ECM and Community Supports. Together, these two Medi-Cal managed care plan benefits are designed to provide high-risk members and their families with whole person care that extends into health-related social needs. The child welfare-involved population, including children and youth currently receiving foster care as well as children and youth previously receiving foster care in California or another state within the last twelve months, are eligible for ECM as long as they are enrolled in managed care. MCPs are required to contract with community-based providers to deliver ECM services.

   Effective July 1, 2023, when ECM goes live for children and youth receiving foster care, the enhanced care manager ("ECM Provider") will be the single point of contact for children, youth and their families, and will be accountable to coordinate all services: medical, dental, behavioral, developmental and intellectual disability services, sexual and reproductive health and social services, working with county behavioral health, child welfare services, educational systems, and Regional Centers. The ECM Lead Care Manager will serve as an "air traffic controller," knowing every component of the child or youth's needs and services and ensuring they are coordinated.

   Many children and youth receiving foster care who will be eligible for ECM may already be receiving some level of care management through other programs or benefits such as Intensive Care Coordination (ICC) or Intensive Home Based Services (IHBS). In many of these instances, ECM will be additive, improving management of care across delivery systems, and comprehensively addressing unmet medical and/or social needs. MCPs are also expected to contract with existing programs that provide care management services to ECM Populations of Focus and could serve as ECM Providers.[2] For example, If a child or youth is enrolled in both ECM and Intensive Care Coordination, California Wraparound or Health Care Program for Children in Foster Care (HCPCFC) and their existing wraparound coordinator is a contracted ECM Provider, then the managed care plan may assign that care manager as that child's ECM Provider, at the child or caregiver's preference.[3] County welfare departments or county behavioral health departments will be able to contract with managed care plans to serve as an ECM Provider, as long as they demonstrate the capacity to meet the requirements to be an ECM Provider.[4]

[1] ECM is a Medi-Cal Managed Care benefit and only available to Members enrolled in Managed Care. As of July 2022, about 69 percent of children involved in child welfare are enrolled in Managed Care.

[2] For more information on ECM policies, see the ECM Policy Guide.
[3] Additional operational guidance can be found in the ECM Policy Guide.
[4] For more information ECM provider requirements, see the ECM & Community Supports Provider Standard Terms & Conditions.

ECM Providers are responsible for the coordination of and referral to community and social support services, including but not limited to services offered by the MCP such as Community Supports, to meet the needs of the Member.[5] CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria includes children and youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the past 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months.

A child or youth involved in child welfare and enrolled in the Medi-Cal managed care plan can also qualify for Community Supports. DHCS offers 14 pre-approved Community Supports services. Examples of Community Supports services[6] that may specifically be beneficial to foster children and youth include:

- Day Habilitation Programs.
- Respite Services
- Medically Tailored Meals/Medically-Supportive Food.
- Environmental Accessibility Adaptions (Home Modifications).
- Asthma Remediation

3. ***Dedicated Foster Care Liaison on MCP Staff.*** Through work undertaken in tandem with the CalBH-CBC demonstration, DHCS will require each managed care plan to assign a foster care liaison to enable effective oversight and delivery of ECM. The foster care liaison will have expertise in child welfare services, county behavioral health services, and other sectors, ensure appropriate ECM staff attend Child and Family Team meetings, and ensure managed care services are closely coordinated with other services. The Foster Care Liaison will be a management level position at the MCP with responsibility to oversee the ECM providers providing services to child welfare involved children and youth in their case load, provide technical assistance to MCP staff as needed, and serve as point of escalation for care managers if they face operational obstacles when working with county and community partners. DHCS will develop standards and expectations for this role to ensure consistency for all MCPs.

[5] For more information on Community Supports, see the Community Supports Policy Guide.
[6] For more information on pre-approved Community Supports services, see the Community Supports Policy Guide.

4. ***Enhanced DHCS and CDSS Oversight.*** As part of both CalAIM and the upcoming CalBH-CBC initiative, DHCS and CDSS are enhancing oversight and monitoring of managed care plans, county behavioral health and child welfare departments.

Enhanced Benefits Structure for All Children and Youth Receiving Foster Care

Building on existing initiatives and requirements, including Early and Periodic Screening Diagnostic and Treatment (EPSDT), the foster care strategies are designed to simplify and improve care for children and youth receiving foster care across the full scope of Medi-Cal benefits. These include the full array of inpatient and outpatient services, including medical visits, surgeries, diagnostic tests, drugs, hospitalization and therapy, and services provided under EPSDT. As noted above, children and youth receiving foster care will be eligible for the ECM benefit, Community Support services as defined in CalAIM, and activity stipends, as defined above.

In addition, the foster care strategies include clarification of key forms of evidence-based practices that must be provided to children and their families. The services will be trauma-informed and evidence-based, designed to support both biological families/families of origin and resource families.

Telehealth offers a unique opportunity to deliver personalized, low-barrier access to services for children and youth across geographic divides. Telehealth allows the continuation of trusted relationships with clinicians, counselors, enhanced care managers, or other supports, regardless of whether a child is placed out of county. Telehealth allows more frequent touchpoints as it eliminates transportation and other logistical barriers. It allows flexibility to support family therapy for children where in-person visits may not be feasible or advisable (potentially including parents who are incarcerated or out of state.) Telehealth can also allow connections linking children, youth, and families to culturally responsive services that may not be available locally. Services through a virtual service platform will be available once this platform is launched through the Children and Youth Behavioral Health Initiative.

The clarified benefits and services include:

1. ***Initial Behavioral Health Assessment.*** As part of the Foster Care Model of Care Workgroup, the County Behavioral Health Directors Association of California and the County Welfare Directors Association proposed a joint home visit with the child welfare worker and a specialty mental health provider for every child or youth entering the child welfare system. DHCS proposes to clarify that a specialty mental health provider should accompany the child welfare worker during the home visit, within 30 days of substantiating an allegation of abuse or neglect and upon the child's entry into the child welfare system. The specialty mental health provider would do a comprehensive behavioral health assessment to identify mental health and/or substance use conditions related to the child and/or the family, identify necessary social supports, and then connect the child

and family (both the biological family/family of origin and the resource family, as appropriate) to any needed clinical or community services. As part of the CalBH-CBC Demonstration, DHCS proposes to develop standards and requirements for the behavioral health assessment and cross-agency collaboration.

The goal is to ***start SMHS and SUD treatment services at the time of entry into the child welfare system,*** instead of depending on child welfare worker referrals. Currently, only half of children receive at least one specialty mental health service, and the data shows many drop-off from referral to actual service). This proposal is synergistic with (but not duplicative of) the Family First Preventive Services Act (FFPSA), since the joint visit will allow the child welfare social worker and the SMHS provider to collaborate on offering any federally approved "well supported" FFPSA services as enumerated in the Title IV-E Prevention Services Clearinghouse that the family could be eligible to receive in support of family health and permanence.

2. ***Evidence-Based Family Therapy for All Children Involved with Child Welfare*.** The CalBH-CBC Demonstration is designed to expand and strengthen the continuum of community-based care, especially for children, youth, and their families. While a comprehensive set of community-based services for children and youth are currently coverable under Medi-Cal pursuant to the EPDST mandate, DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement of specific evidence-based practices statewide. DHCS proposes clarifying statewide coverage requirements and ensuring access to at least three specific evidence-based services that can be delivered at home or in the community under current Medi-Cal coverage authority: Multisystemic Therapy, Functional Family Therapy, and Parent-Child Interaction Therapy. These services are known to help reduce the institutionalization of high-risk children and youth, including those who are involved in the juvenile justice system and those who have been removed from their homes, experienced homelessness, or confronted other major disruptions. DHCS' guidance will include specific service definitions, provider qualifications, implementation requirements and dedicated billing codes to incentivize provider delivery and monitor utilization and performance. With the COEs, resources will be available to support county and provider implementation of these and other services with fidelity to service models and reflecting the cultural factors and diversity of California children and youth.
    - Multisystemic Therapy (MST). MST is an evidence-based intensive family and community-based intervention for children and young people aged 11-17 who are at risk of out-of-home placement in either care or custody due to a history of arrest or behavioral health issues. DHCS intends to issue guidance to counties that clarifies and streamlines Medi-Cal coverage and reimbursement of MST as a bundled service for qualifying children and youth.
    - Functional Family Therapy (FFT). FFT is a family-based prevention and intervention program for high-risk youth between the ages of 11 and 18 that addresses complex and multidimensional problems with a flexibly structured and

culturally responsive practice. DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for FFT.

- Parent-Child Interaction Therapy (PCIT). PCIT is an evidence-based, short-term treatment designed to teach parents strategies that will promote positive behaviors in children and youth who exhibit disruptive or externalizing behavioral problems. DHCS intends to issue guidance to counties that clarifies Medi-Cal coverage and reimbursement for PCIT.

DHCS will continue engaging stakeholders and exploring opportunities to issue guidance on Medi-Cal coverage of other therapeutic supports. In addition, DHCS will engage stakeholders on opportunities to incorporate community-defined practices and cultural adaptations of evidence-based practices to ensure culturally and linguistically centered services given the rich diversity in California's communities.

3. ***New Activity Stipends.*** Many children and youth in child welfare do not have access to the activities that support physical health, mental wellness, healthy attachment and social connections – all protective factors that promote resilience and prevent mental illness and substance use disorders. In response, DHCS intends to develop a new benefit for children aged 3 and older in the child welfare system to be used for activities to promote social and emotional well-being and resilience, manage stress, build self-confidence, and counteract the harmful effects of trauma.[7] These payments would support activities not otherwise reimbursable in Medi-Cal, such as mindfulness-based stress reduction, movement activities, sports, leadership, nature activities, music and art programs, and other activities to support healthy relationships with peers and supportive adults. DHCS intends to request federal expenditure authority to support the activity stipends in the CalBH-CBC Demonstration application, which will be administered by CDSS and county child welfare agencies.

4. ***Strengthened Statewide Standards for Medical Necessity Determinations (Utilization Review) and Clinical Guidance for Services Levels for Intensive Home-Based Services (IHBS) and Therapeutic Behavioral Services (TBS).*** Currently, there is substantial county-by-county variation regarding who is eligible for IHBS and TBS services, and what service level is indicated based on the need of the child or youth. DHCS is currently updating the Medi-Cal Manual for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) Services and will use this opportunity to strengthen expectations and requirements for these critical services.

[7] To align with CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria, DHCS proposes to include children and youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the last 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months.

5. ***Aligned Use of the Child and Adolescent Needs and Strengths (CANS) Tool*** across child welfare and specialty mental health by (1) ensuring that both child welfare and behavioral health providers are using the same CANS tool with the same modules; and (2) inclusion of CANS benchmarks in the cross-sector incentive pool. These actions will ensure that the CANS tool is administered in the same way, whether done by a specialty mental health provider or by a child welfare worker, so that outcomes can be tracked over time. Robust outcome measurements will allow the State to incentivize outcomes. In addition, under the CalBH-CBC, DHCS proposes to build on the current SMHS requirement for using the CANS tools for children and youth aged 6-20 for performance data reporting purposes to help guide level-of-care determination and inform treatment planning for select intensive SMHS. This process will include a stakeholder input process.

6. ***Coordination Between the Family Urgent Response System (FURS) and the New Statewide Mandatory Medi-Cal Mobile Crisis Benefit*****,** which will launch in January 2023. FURS is a coordinated statewide, regional, and county-level system designed to provide collaborative and timely state-level phone-based response and county-level in-home, in-person mobile response during situations of instability, to preserve the relationship of the caregiver and the child or youth. As outlined in emerging policy guidance on the new mobile crisis benefit that will go live as early as January 2023, as part of the implementation of the new mobile crisis benefit, Medi-Cal behavioral health delivery systems will need to describe how mobile crisis teams will coordinate with FURS.

Addressing Equity:

Racial inequities exist throughout the child welfare system, with Black, Indigenous, and People of Color children disproportionately referred into the system and placed out of the home. A commitment to addressing inequity is an essential part of the new foster care strategy:

1. ***Equity-Focused Implementation Plans***. Before implementing CalBH-CBC Demonstration activities, opt-in counties may be required to submit and secure DHCS approval of an implementation plan. DHCS is proposing that county implementation plans include equity-centered strategies for expanding services and supports for populations disproportionately affected by SMI/SED or for whom gaps in care are particularly notable, including children and youth, especially those involved in the child welfare system, among other populations.

2. ***Culturally Responsive Care***. DHCS will continue to seek stakeholder feedback related to Medi-Cal coverage of culturally responsive evidence-based practices. In addition, under the CalBH-CBC demonstration, COE can provide orientation,

training, coaching, mentoring, fidelity monitoring and other supports needed to build and sustain capacity in delivering evidence-based practices through a culturally sensitive lens. DHCS will engage stakeholders on opportunities to incorporate community-defined practices and cultural adaptations of evidence-based practices to ensure culturally and linguistically centered services given the rich diversity in California's communities.

3. ***Equity-Focused Data Reporting***. All data dashboards, currently under development, will be required to show data broken down by race, ethnicity, and gender. When reliable data is available, data will also be displayed by sexual orientation and gender identity (not feasible now due to inconsistent data collection).

Increased Accountability, Oversight and Compliance:

Consistent with CalAIM and as part of CalBH-CBC, DHCS and CDSS are establishing a cross-sector incentive pool with an accountability framework grounded in continuous quality improvement principles which includes a robust compliance program, quality monitoring and improvement standards, and reporting in a new public dashboard, based on integrated data sources across the three systems – managed care, county behavioral health, and county child welfare systems.

As part of the cross-sector incentive pool, the State will set benchmarks and hold all systems – MCPs, MHPs and child welfare systems (CWS) – accountable to meet the benchmarks. The new cross-sector incentive pool would be designed to align systems and reward improvement in outcomes, based on process utilization and quality outcomes. An accountability framework would include a robust quality monitoring and compliance program to ensure that MCPs, MHPs, and CWS will have the following elements: standards and procedures; oversight; training and communication; monitoring and auditing, and authority necessary to enforce standards and apply corrective action plans or sanctions when necessary.

Following issuance of guidance and to facilitate shared implementation and accountability at the local level (between MCPs, MHPs, CWS), DHCS and CDSS will require a memorandum of understanding (MOU) between the systems, to ensure the systems share data, and work together to improve outcomes that require collaboration across systems, including process measures (such as appropriate cross-sector attendance at CFT Meetings), utilization measures (such as the population receiving all appropriate medical, dental, and behavioral health screenings and interventions) and outcome measures (such as shorter intervals until placement stability, shorter time to reunification). These agreements will be informed by stakeholder engagement.

Appendix A

The following guiding principles were adopted by the Foster Care Model of Care Workgroup and are included here for reference.

Recommendations for a New Model of Care: Guiding Principles

1. Builds upon existing foster care reform efforts, such as the Integrated Core Practice Model and AB 2083 model of care, and the Continuum of Care Reform.
2. Provides timely and appropriate access to care for children and youth in out-of-home placements and former foster youth, up to age 26 years. Coordination across child-serving systems should be increased and appropriate services should be available to meet the needs of this vulnerable population.
3. Ensures that children and youth have continuity of care through maintaining trusted relationships and preserving connection to family, community, and culture.
4. Meets the needs of diverse children, families, caregivers, and youth through a trauma-informed health delivery system that focuses on recovery and resiliency.
5. Identifies and reduces disparities and ensures that identified needs are addressed and supportive services are provided in a culturally responsive manner, including race, ethnicity, language, sexual orientation, and gender identity perspectives.
6. Values youth/family voice and choice in preserving and furthering California's investment in a child- and family-centered approach to care planning and decision-making
7. Identifies needs as early as possible. The needs of children, youth, and families in the foster system and of those entering or at risk of re-entering the child welfare services system must be addressed and met comprehensively and expeditiously.
8. Assesses and treats the health needs of children and families entering or at risk of re-entering the foster system.
9. Children and youth receive services in the least restrictive environment. The participants of Child and Family Teams (CFTs), including the placing agency, county behavioral health representatives, as well as other health providers, must base placement and services recommendations on the specific needs of children/youth and families with a goal of supporting children and families in the least restrictive and most family like setting possible.
10. Ensures children and families receive services provided by knowledgeable providers who are apprised of the proper resources available to address their needs. Providers should be trained in collaboration across child-serving systems, including county and contracted provider networks, and should recognize the specific needs a child in the foster system and their family may have. Additionally, the child-serving systems should receive training to understand the role each sector plays

in addressing attachment, permanency, and trauma-related needs of children and their families/caregivers, which aligns with the intent of the AB 2083 model of care.

11. Establishes streamlined and standardized processes to unify (or at least closely coordinate) systems, to prevent duplication and eliminate complexity of reporting.
12. Ensures accountability, and that processes and tools are in place to monitor and be adapted as needed, based on outcomes and child, family, and community engagement.
13. Ensure the development of an intensive ongoing training framework dedicated to establishing clinical models to address the specific needs of foster youth and their families/caregivers.

Appendix B

Whole Person/Whole Approach:
The State is launching several new efforts to support the whole person/whole family approach to care. The following interventions are designed to support healthy families through providing access to coverage, integrated services, and treatment. Some initiatives listed below are focused on the child welfare population; others are designed to ensure all children are offered help before a problem grows to the point of threatening family integrity and safety. Implementation dates are listed in bold.

1. **Implementation of Family First Prevention Services Act** offering evidence-based prevention services to support families at risk of out-of-home placement. ***October 2021.***

2. **Family Urgent Response System**: promoting stable family placements and intervening quickly if risk of disruption. ***July 2021***

3. **Programs Addressing Access to Services for All Populations,** with potential to decrease family stress and avoid child welfare involvement:
    a. **Children and Youth Behavioral Health Initiative:**
        i. **Virtual Services Platform**: this statewide virtual platform will provide screening, tools and supports for ALL young people through age 24 and their caregivers. It creates a universal point of entry, with a tiered mode: the most effective, least resource-intensive treatment is delivered first, with referrals to managed care plans and county behavioral health for higher level of service, with navigation tools to help connect people to support and services. An e-consult/e-referral system will also be built in, to allow primary care providers to receive support and consultation, to better manage behavioral health conditions. ***2024***.
        ii. **Expanding Evidence-Based Practices (EBPS) Statewide**: an expert workgroup will identify evidence-based practices, which could include evidence-based family therapies to support healthy parenting and resilience. ***Fiscal year 2022-23.***
        iii. **Dyadic Services,** a new benefit providing behavioral health screening and treatment to parents/caregivers during well infant and child exams, to identify issues that could affect the child's well-being and address them. Dyadic services ensure that well infant, child and adolescent visits to primary care providers are paired with behavioral health assessments and interventions, with the goal of identifying stressors to families before they affect the children's wellbeing and allowing trained professionals to provide real-time supports and interventions. ***July 2022.***
        iv. **Workforce:** The Department of Health Care Access and Information will be launching multiple programs to build out the workforce needed to meet the growing behavioral health needs of children and youth: expanding training of

youth peer providers, building out behavioral health training programs, awarding grants to expand the supply of behavioral health provider, and creating a new category of provider, behavioral health coaches) to significantly expand the workforce, especially in schools.

b. **Population Health Management Program:** Implements a series of robust requirements for health plans designed to ensure that all children enrolled in Medi-Cal managed care receive whole-person care across the continuum of care, from wellness and prevention through to addressing complex needs. ***January 2023 and ongoing***
c. **Postpartum Coverage:** DHCS will allow a full year of post-partum Medi-Cal coverage for all women, supporting the well-being of both the woman and child. The goal is to ensure women have access to needed medical and behavioral health services during the critical first year of an infant's life. This extension of post-partum coverage for a full year will be available for all women and will not require any particular diagnosis. ***April 2022.***
d. **Implementing ACES Aware**: supporting universal trauma screening in primary care settings, identification of unmet needs, and referral to services. This program trains and incentivizes primary care providers to ask important questions to identify trauma, and to intervene before the trauma leads to problems that could threaten family stability. ***Current and ongoing.***
e. **988 Hotline and Mobile Crisis Response Teams:** Offering robust crisis response through implementation of the federal 988 hotline and coordinating with mobile crisis response services, allowing de-escalation of crises before they lead to child welfare referrals. ***Current and ongoing****.*
f. **Behavioral Health Continuum Infrastructure Project:** expanding access to mental health and substance use disorder treatment. This project will provide grants to support building new or expanding existing treatment facilities, to ensure access to prompt treatment is available across the state at all levels of care. The goal is to ensure children, youth and families can receive services locally, especially in regions with inadequate treatment infrastructure. ***Current and ongoing****.*
g. **Behavioral Health Quality Improvement Program:** supporting counties through training, technical assistance, and incentives, building a stronger behavioral health delivery system. This program allows DHCS to provide financial incentives to counties as they make progress towards implementing new statewide initiatives. ***Current and ongoing.***
h. **Medi-Cal's Strategy to Support Health and Opportunity for Children and Families:** exploring strategies to work across agencies to coordinate existing and emerging initiatives for children health. This includes initiatives to increase preventive and primary care, eligibility and enrollment enhancements, and behavioral health services and MCP accountability and engagement to identify and reduce health disparities. The strategies will align with these efforts. ***Current and ongoing.***
i. **Children's Preventive Services Report:** assesses the provision of preventive services and used to identify and monitor appropriate utilization of preventive services, including blood lead testing, for children in Medi-Cal managed care. This report builds accountability to ensure children receive key preventive services. ***Current and ongoing.***

j. **Behavioral Health Workforce Investments**: investing in expanding the behavioral health workforce through training, stipends, and workforce development (through the Department of Healthcare Access and Information, formerly known as OSHPD). This project aims to address workforce shortages, including for services focused on children and youth. ***Fiscal year 2021-22.***

k. Implementation of Peer Support Services Benefit: New Medi-Cal benefit covering new provider type and new services. **July 2022.**

Appendix C: Child Welfare Populations: Eligibility for Services

Note: the new enhanced behavioral health benefits (expanding eligibility for intensive home-based services and therapeutic behavioral health services, and the new family therapy benefit) would be available to all children in Medi-Cal.

BH services for all children and youth are based on their needs, after the completion of the assessment

Populations		**Numbers (CDSS data)**	**Joint home visits**
Substantiated Allegations	After disposition hearing substantiates allegations, pending placement decisions	72,373 hotline cases; assume 2/3 already on Medi-Cal (5-year pre-COVID average)	X
	Family Maintenance (open case, not removed from home)	22,712 (5-year pre-COVID average)	X
	Out of home placement	21,292 new entries, (5-year pre-COVID average) 54,373 total out of home (FY 2021-22)	X
	Family members of children in family maintenance and out of home placements[8]	TBD	
	Non-minor dependents (18-20)	7,503	NA
	Child Welfare involved, post-adoption	85,939 (FY 2021-22)	NA

[8] For the purpose of eligibility for the special population MCP, DHCS proposes to allow biologic family members (family of origin) to opt into the plan if they share a household with the involved child or youth and are either a parent/guardian (the role primarily responsible for the child) or a sibling (regardless of genetic relationship). This benefit would not be available for resource families.