Children and Youth in Foster Care:

Health Care Delivery Models in Washington, Arizona, and New Jersey for Children and Youth Involved with the Child Welfare System

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Aurrera Health Group is a mission-driven health policy and public affairs consulting firm based in Sacramento, California. www.aurrerahealth.com

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I. Summary and Key Takeaways

To inform its consideration of whether California should implement a new or different model of care for current and former foster children or youth, children or youth entering or at risk of re-entering the foster system, and the families and caregivers of these children and youth, DHCS, CDSS, and the CalAIM Foster Care Model of Care Workgroup ("the Workgroup") have expressed an interest in learning about the models used in other states. The Workgroup specifically identified Washington, Arizona, and New Jersey as three states with models of particular interest.

To assist DHCS, CDSS, and the Workgroup in its effort to understand these states' models, Aurrera Health Group has prepared the following summary and analysis. The summary and analysis are informed by presentations provided by Washington and Arizona at the Workgroup meeting on August 21, 2020, an interview with a former leader of the New Jersey Department of Children and Families Children's System of Care, and additional research of publicly-available material.

Washington, Arizona, and New Jersey all provide some version of a statewide healthcare delivery system for children or youth involved with the child welfare system. In short, the three states' respective models are as follows.

- Washington has a single statewide integrated Medicaid managed care plan for children and youth involved with child welfare, including youth in extended foster care or who are alumni of foster care.

- Arizona has a single statewide Medicaid managed care plan, overseen by the state's child welfare agency that provides physical health services exclusively to children or youth in out-of-home care. The state intends to carve behavioral health services into this arrangement in 2021.

- New Jersey has a single statewide behavioral health delivery system, overseen by a division within the state's Department of Children and Families that serves all children or youth with significant behavioral health needs or intellectual or developmental disabilities. Physical health services are provided by separate mainstream Medicaid managed care plans.

A table providing the structure of each state's model is included at the end of this document, and more detailed information and analysis are provided below.

Although the three states differ substantially in their approaches to providing care to children and youth involved with the child welfare system, the individuals who presented to the Workgroup on behalf of Washington and Arizona, and the former state

official with whom we discussed New Jersey's approach, did emphasize some of the same themes or lessons around models of care and approaches to reform. These include:

- The importance of stakeholder engagement and buy-in to any major system reforms.

- The value of building a model that represents a partnership between Medicaid, child welfare, and behavioral health agencies and stakeholders.

- The capacity for a single entity, focused solely on the needs of a discrete population of children or youth, to develop the capacity and expertise needed to improve outcomes.

- The need to invest in data-sharing and data integration systems that permit a single accountable entity to leverage data from Medicaid, child welfare, and behavioral health systems, if possible.

- The value of a phased, iterative approach to system redesign.

II. State Models

A. Washington

In 2016, Washington launched a single statewide Medicaid managed care program for children and youth involved or formerly involved in the child welfare system known as Apple Health Core Connections (AHCC). At its inception, AHCC provided all Medicaid-covered physical health services, pharmacy, vision, and treatment for mild-to-moderate behavioral health conditions. In 2019, services for moderate-to-acute behavioral health conditions were carved into the arrangement, making AHCC responsible for the full continuum of Medicaid-covered mental health and substance use disorder (SUD) treatment for enrollees.[1] AHCC is funded through a combination of Medicaid and block grant/wraparound dollars.

AHCC exclusively serves children or youth who are: (1) in out-of-home placements; (2) receiving adoption support; (3) in extended foster care (ages 18-21); (4) alumni of foster care (ages 18-26); or (5) reunited with their parents for one year post-dependency. Children or youth who fall into one of these categories are required to enroll in AHCC. The only exceptions are children or

[1] *See* presentation of AHCC to the CalAim Foster Care Workgroup.

youth who are American Indian or Alaskan Native, who have the option to receive coverage through the state's fee-for-service (FFS) program, and youth who fall into categories (3) or (4), who may enroll in mainstream Medicaid managed care plans for physical health care services (but are still required to receive behavioral health services through AHCC).[2] Current enrollment in AHCC exceeds 24,000 children and youth, with an average enrollee age of 10.[3]

AHCC is administered by Coordinated Care of Washington, Inc., which is an affiliate of Centene, a national publicly-traded company operating Medicaid managed care plans in 24 states.[4] Coordinated Care of Washington also administers a mainstream Medicaid managed care plan in many regions of Washington through which it provides physical health care services and the full continuum of Medicaid-covered behavioral health services.[5]

The origins of AHCC can be dated to 2008 when state policymakers from Washington interviewed Texas about its specialized statewide Medicaid managed care plan for children and youth involved with the child welfare system. Ultimately, policymakers in Washington came to believe that this type of plan—solely focused on children and youth involved with child welfare—could be effective in improving outcomes. In 2012, Washington took the next step in the policy development process, soliciting feedback from stakeholders to inform the development of a Request for Proposal (RFP) for a single statewide plan that would exclusively serve children and youth involved with child welfare. After a competitive bid process, Coordinated Care of Washington was selected as the winning bidder. From 2014 to 2015, representatives from Coordinated Care and officials from Washington's Medicaid and child welfare agencies went on a statewide "roadshow," visiting local child welfare and behavioral health agencies and other stakeholders across the state to discuss the implementation of AHCC. The state and plan officials who presented to the Workgroup credited this roadshow as critical to engaging stakeholders and earning their buy-in. In 2019, they conducted another roadshow, this time to gain stakeholder investment in the integration into AHCC of services for moderate-to-acute behavioral health conditions.

The state and plan officials who presented to the Workgroup identified several additional challenges and lessons learned in connection with AHCC that may be of interest to DHCS, CDSS, and the Workgroup as it considers potential models for California.

[2] Additional information on AHCC is available here.
[3] *See* presentation of AHCC to the CalAim Foster Care Workgroup.
[4] *See* Information provided on Centene's website, available here.
[5] *See* information provided on Coordinated Care's website here.

First, they noted that before the launch of AHCC, when children and youth involved with child welfare moved from one county to another, Washington, like California, had difficulty ensuring continuity of their care and services. They also encountered issues with clearly defining roles and responsibilities among the myriad organizations and entities involved in providing and overseeing these children and youth's care. According to the presenters from Washington, AHCC has largely solved this problem for AHCC enrollees, at least concerning medical services, because AHCC is now responsible for all Medicaid-covered physical health services, behavioral health services, pharmacy, and vision for its enrollees, regardless of where the enrollee resides within the state.

The presenters from Washington also reported that the integration of intensive behavioral health services into AHCC has led to improvements in care coordination. With the full spectrum of Medicaid-covered behavioral health services carved in, AHCC has been able to efficiently coordinate care for enrollees who receive such services.

The presenters from Washington also emphasized the importance of integrating the expertise and participation of organizations, agencies, and professionals from the worlds of child welfare and specialty behavioral health to supplement Coordinated Care of Washington's experience in traditional physical health services and delivery systems. To break down silos and ensure open communication between AHCC and child welfare agencies, AHCC now has liaisons that work with the child welfare system to help resolve issues and ensure that enrollees are receiving the non-Medicaid-covered services and supports they need. AHCC continues to work on increasing the integration of child welfare into its processes and systems.

Improving data sharing and integration, particularly between the child welfare system and AHCC, continues to be an area of focus for state and plan officials. The presenters stressed that effective data sharing between AHCC and child welfare systems is critical to AHCC performance. AHCC uses child welfare data to obtain up-to-date contact information for enrollees, to inform its risk-stratification analyses on its enrollee populations, and to support more effective care coordination for enrollees.

Another challenge identified by presenters was helping other system stakeholders adjust to and embrace the change in roles and responsibilities that accompanied the implementation of AHCC. For example, many stakeholders expressed apprehension about the potential loss of connections and institutional knowledge in the shift from a system driven by local authorities to one with a

significant statewide role for AHCC. In response, AHCC has worked hard to develop strong relationships with local authorities and learn from their years of experience administering child welfare and behavioral health systems.

The presenters also noted that it was important for AHCC to develop positive relationships with child welfare workers across the state, some of whom were concerned initially about how the entry of AHCC would impact their roles in the system. To address this concern, AHCC has tried to build positive working relationships with child welfare workers and provide clarity around their respective roles and responsibilities. More generally, the presenters reported that it has taken time and effort for AHCC to persuade system stakeholders and enrollees to see AHCC as an ally. Because of these challenges, and the need to provide adequate time for stakeholder communication and coordination, the presenters stressed the value of a phased and iterative approach to reform.

Current areas of focus for AHCC include integrating the health plan into more child welfare processes and working to address issues of equity in service delivery and enrollee outcomes.

B. Arizona

Arizona has a specialized statewide plan, known as the Comprehensive Medical and Dental Program (CMDP), that provides physical and dental services exclusively to children and youth in out-of-home care. Arizona state statute requires that CMDP be managed by the state's child welfare agency, the Department of Child Safety. Although CMDP is managed by a state agency, it functions like the state's other Medicaid managed care organizations (MCOs); it is governed by a contract with the state Medicaid agency and paid under a risk-based capitated model.[6] Currently, there are approximately 13,000 children and youth enrolled in CMDP. The plan is mandatory for all children and youth in out-of-home care.

Today, children and youth enrolled in CMDP receive behavioral health services from the Regional Behavioral Health Authorities (RBHAs). The RBHAs operate as MCOs and receive payment on a risk-based capitated basis. However, Arizona plans to carve behavioral health services into CMDP effective April 1, 2021. Upon integration, the Department of Child Safety will subcontract the management of CMDP to a separate MCO on a full-risk basis, with the MCO to be determined through a competitive bidding process.[7] The MCO will have access to foster care

[6] *See* presentation of Arizona Medicaid to the CalAim Foster Care Workgroup.
[7] *See id.*

and physical claims data, as CMDP does today, as well as behavioral health claims data.

In her presentation to the Workgroup, the Deputy Director of Arizona's Medicaid Program stated that the goals of the integration of behavioral health into CMDP are to improve clinical outcome measures and the administrative experience for enrollees. She also stated that integration should improve enrollee experience by, for example, reducing the number of hotlines and transportation vendors enrollees must work with from two (one for CMDP and one for the enrollee's behavioral health MCO) to one. She also noted that under the current system, disputes sometimes arise between CMDP and each of the behavioral health MCOs about which entity is responsible for paying for a particular healthcare service. Once behavioral health is integrated into CMDP, these disputes should be eliminated, as should any potential delays or disruptions in service that may result from such disputes. Another goal of the integration is to improve behavioral health outcomes for children and youth in out-of-home care. Although CMDP has excelled in providing physical health services to its enrollees, there is significant room for improvement on the behavioral health side. The state believes that an integrated plan will have the tools and incentives it needs to achieve better outcomes in this area.

The integration of physical and behavioral health services for children and youth in out-of-home placement is part of Arizona's larger effort to move toward integrated physical and behavioral managed care plans for all enrollees, even those with the most complex needs.

C. New Jersey

Unlike Arizona and Washington, New Jersey does not have a single specialized Medicaid managed care plan for children or youth involved in the child welfare system. It does, however, have a single statewide delivery system for behavioral health services for children or youth with significant behavioral health needs or intellectual or developmental disabilities (I/DD), including those involved with the child welfare or juvenile justice systems. This delivery system, known as the Children's System of Care (CSOC) is overseen by a division within the New Jersey Department of Children and Families by the same name (CSOC) that was formerly known as the Division of Child Behavioral Health Services.[8] The CSOC is managed by a contracted system administrator, PerformCare, which is affiliated

[8] *See* information provided here; *see also* approved Section 1115 Medicaid waiver at 71-72 of the PDF, *available* here.

with AmeriHealth Caritas, a Pennsylvania-based company that operates Medicaid managed care plans in eight other states and the District of Columbia.[9] The CSOC is funded through a combination of Medicaid dollars, child welfare funds, juvenile justice funds, and additional state funds.[10]

Under the CSOC, services are provided to children or youth with significant behavioral health needs or I/DD, regardless of income, insurance status, or Medicaid eligibility. However, for certain services, children or youth (or their parents or caregivers) must complete a Medicaid application to determine the child's eligibility to receive Medicaid as secondary insurance or to receive state funds to cover the cost of certain behavioral health services.

The services provided by the CSOC generally fall into one or more of the following categories. A brief description of each service is provided below.

- Mobile Response and Stabilization Services (MRSS) for Youth in Crisis Emergencies. Under the CSOC, face-to-face crisis response is delivered within one hour of notification to stabilize behavior and prevent removal from the home. MRSS is available 24 hours a day, 7 days a week. Stabilization services may be authorized for up to eight weeks.

- BioPsychoSocial Assessment. Where the CSOC administrator needs more information to assess a child or youth's needs, a clinician conducts an in-person BioPsychoSocial Assessment of the child or youth. This assessment is scheduled within three days of a child or parent's call and conducted within one week thereafter.

- Care Management Services. Under the CSOC, care management is performed by county-based, nonprofit organizations known as care management organizations. Using the wraparound model, these organizations conduct face-to-face care management and service planning for youth with moderate to complex needs and their families, including through the coordination of child/family team meetings and the implementation of individual service plans.

- Intensive In-Home or Intensive In-Community Services. These include behavioral assistance, social-emotional learning services, clinical and

[9] *See* information provided here.
[10] *See* the presentation from PerformCare at 9, 12, *available* here. Note that this presentation appears to date from 2013 or 2014. It is possible that the funding sources for the CSOC have changed since then, although the budget analysis here indicates that it continues to be funded by a combination of state and federal sources.

therapeutic interventions, applied behavioral analysis, and individual support services, among others.

- Substance use treatment services. SUD services arranged by CSOC include outpatient individual and group counseling, and withdrawal management, among other services.

- Out-of-home treatment. These include services provided in treatment homes, group homes, residential treatment centers, specialty residential services, and psychiatric community homes.

- Support for families and caregivers through a Family Support Organization. Through the CSOC, family support organizations offer peer-based support services from parents or caregivers who have raised a child with complex behavioral health needs or I/DD.[11]

Each CSOC-covered service has its clinical criteria that are used to determine whether a child or youth is eligible for the service.[12] All CSCOC providers have access to a single electronic health record system that supports timely access to and sharing of information.[13]

The CSOC does not arrange for outpatient individual or group behavioral health treatment services provided at a provider's office, clinic, or other healthcare facilities, or traditional inpatient care.[14] These are typically arranged and paid for by a child or youth's Medicaid managed care plan or private insurance plan.

In our conversation with the former leader of the CSOC, she emphasized several elements of the CSOC model that she believed were critical to its success. First, she noted that the CSOC grew out of a focused effort by the state to reduce the number of children in institutional settings, in part by communicating to behavioral health providers that the state intended to significantly shift its purchasing from inpatient to outpatient behavioral health services. As a result, from its inception, the CSOC has supported the state's behavioral health providers but also challenged them to partner with the state on a system transformation designed to improve care and outcomes for children and youth with significant behavioral health needs. At times, that has meant pushing providers to adopt new evidence-based practices or use data to track and

[11] *See id.*
[12] The clinic criteria are available here.
[13] The shared electronic health record system is called CYBER. More information about CYBER is available in the PerformCare provider training here.
[14] *See* CSOC Youth and Family Guide, *available* here.

improve their performance. Today, for example, the CSOC provides its contracted providers with data dashboards that display the provider's performance on key metrics and provide a comparison against state targets. The CSOC adopted the same supportive but challenging posture toward local child welfare authorities—seeking their input and buy-in on system-wide change, but also pushing them to make changes needed to improve outcomes and strengthen accountability, including through increased use of data.

The former leader of the CSOC we interviewed also stressed the value of having child welfare, behavioral health, and Medicaid agency involvement in the development, oversight, and administration of the system. In her view, the traditional encounter-based system used by Medicaid added rigor to the CSOC and the opportunity for more effective outcomes measurement and increased accountability. However, she believed that if the system were driven primarily by Medicaid, with minimal involvement from behavioral health and child welfare systems, it would lack the expertise needed to effectively serve children and youth with behavioral health challenges. One example of the cross-system collaboration she identified as key to the CSOC's success has been New Jersey's establishment of child health units in each of the child welfare offices across the state, staffed by nurses who work with caseworkers, foster parents, and other caregivers to ensure that children and youth involved in child welfare are screened for and then connected to the services they need.[15]

[15] For more information on New Jersey's Child Health Units, *see* Center for Health Care Strategies, Making Medicaid Work for Children in Child Welfare: Examples from the Field (June 2013), available here.

III. Chart: State Medicaid Delivery System Models

Physical Health Services	Behavioral Health Services	Key Attributes
WASHINGTON		
• Delivered by a single statewide risk-based MCO that serves only youth and children who are in out-of-home placement, receiving adoption support, reunited with their parents for one year post-dependency, in extended foster care (ages 18-21), or alumni of foster care (ages 18-26) • MCO also operates a mainstream integrated Medicaid plan in WA • MCO is affiliated with Centene, a national Medicaid insurer	• Services for mild-to-moderate behavioral health conditions covered by MCO since the launch of the plan in 2016 • In 2019, behavioral health services for moderate-to-acute behavioral health conditions were carved into the MCO contract	• Specialized statewide MCO for a broader group of children and youth involved or formerly involved with child welfare • At first, providing physical and mild-to-moderate behavioral health services; now provides a full continuum of behavioral health services • Plan administered by MCO affiliated with a national insurer
ARIZONA		
• Delivered by a single statewide risk-based MCO that serves children and youth in out-of-home care only • MCO is administered by the state's child welfare agency under contract with the state's Medicaid agency	• Currently delivered by risk-based MCOs known as regional behavioral authorities (RBHAs) • Effective 4/21, behavioral health will be integrated into the single statewide MCO that provides physical health services to children and youth in out-of-home care • The child welfare agency will subcontract to another MCO to run the plan on an at-risk basis	• Specialized statewide MCO for children and youth in out-of-home care • Other children involved in child welfare not included in the plan • MCO will cover all Medicaid-covered behavioral health services in 2021 • MCO administered by a state child welfare agency under contract with Medicaid agency

Physical Health Services	Behavioral Health Services	Key Attributes
NEW JERSEY		
• Delivered by one of five mainstream MCOs, all of which are offered statewide	• Delivered by an administrative services organization (ASO) under the oversight of the state's child behavioral health agency • Serves youth (and their families) with significant behavioral health needs, intellectual/developmental disabilities (I/DD), or autism • ASO contracts with care management organization to provide wraparound services for youth and families with moderate to complex needs	• Physical health services provided by mainstream MCOs • Services for all children with significant behavioral health needs, I/DD, or autism provided through a single statewide system • System administered by ASO under contract with child behavioral health agency