Foster Care Model of Care Workgroup: Assessing Different Managed Care Options for Foster Youth in California

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California's Advancing and Innovating Medi-Cal (CalAIM) a multi-year initiative of the California Department of Health Care Services (DHCS) initiated in 2019 to improve the quality of life and health outcomes of Medi-Cal beneficiaries through delivery system, program and payment reform across the Medi-Cal program. CalAIM will also guide the state's renewal of the Medi-Cal 1115 and 1915(b) waivers, which will expire in 2021 (based on an expected approved extension from the federal government). The CalAIM Foster Care Model of Care Workgroup was established to create a long-term plan for how children and youth in foster care receive health care (physical health, mental health, substance use disorder (SUD) treatment, and oral health) and social services.[1] The workgroup is tasked with determining whether new system of care should be developed and, if so, what it should be.

This brief outlines 3 options that the National Health Law Program (NHeLP) believes should be considered for a new foster care model of care delivery system for Medi-Cal eligible children and youth involved with the child welfare system, including a brief description of the model, and the pros and cons of each option. This brief does not address which specific children and youth should be included in this model -- for example, children receiving adoption assistance or former foster youth -- but believe it should at least include children and youth with an open child welfare case. Such decisions would need to be made prior to adopting any of the models outlined below. In this brief we also provide a recommendation as to which option we believe offers the greatest opportunity for effective delivery of care to this population of children and youth, taking into consideration the disruption to the current way services are delivered. While

additional options are certainly available, NHeLP believes the options presented in this paper are the most appropriate ones to consider in light of the existing barriers presented by the current Medi-Cal delivery system and the needs of the foster care population.

I. Managed Care and Foster Youth

A. Health Needs of Foster Youth

Youth in foster care have unique health care needs due to their complex histories of trauma and often poor access to appropriate services prior to entering care. Studies have found that up to 45 or 50 percent of children have a chronic physical health problem, such as asthma, malnutrition, or obesity.[2] In addition, the American Academy of Pediatrics reports that up to 80 percent of children entering the child welfare system have significant mental health needs and 40 percent have significant oral health issues.[3] The U.S. Department of Health and Human Services' (HHS) Children's Bureau has found that youth in foster care have higher rates of developmental disorders, certain medical disorders (including vision disorders and teeth and jaw disorders), and behavioral health problems (including attention deficit and adjustment disorders).[4] As a result, the Children's Bureau reports that these young people are twice as likely to require in-patient treatment for a behavioral health problem.[5]

Youth who are involved in the child welfare system have a higher likelihood of having experienced adverse childhood experiences (ACEs), which in turn increase children's risk for physical and mental illnesses. For instance, childhood poverty contributes to health illnesses in several ways, including by increasing exposure to toxic stress. Youth in foster care are more likely to have experienced poverty, as it is well-documented that poverty correlates with increased child welfare system involvement.[6] As a result, youth involved in the child welfare system experience health disparities due to their experiences of poverty. Similarly, youth in the foster care system have a higher rate of mental health issues than non-foster youth, resulting from history of trauma, frequently changing home situations, difficult family relationships, and inadequate access to mental health services and medications.[7]

In addition, the American Academy of Pediatrics also identifies the impact of racism as a "core social determinant of health," noting that it is linked to chronic stress and disparities in mental health problems in children and adolescents. A disproportionate number of youth in foster care are youth of color; only 5.4 percent of youth in California are Black, while over 21 percent of youth in foster care in the state are Black; 48 percent of youth in California are Hispanic/Latino, but they make up 50 percent of youth in foster care; by contrast, white children, who make up over 28 percent of youth in California, constitute only 22 percent of youth in foster care.[8]

Unfortunately, there is limited published data available to identify what specific health care services are being provided to children and youth in foster care in California. For example, data from the Lucile Packard Foundation for Children's Health reports the rates of timely

physical and dental exams for youth in foster care in California by county.[9] In 2018, DHCS published its most recent report on SMHS utilization for children and youth with an open child welfare case.[10] In addition, DHCS prepares an annual presentation on behavioral health quality of care measures for youth in foster care and children in Medi-Cal, including measure on ADHD care, follow-up after hospitalizations, psychosocial care, concurrent antipsychotic measures, and metabolic monitoring.[11] None of these reports compares how different plans or delivery systems are serving this population, which information is critical for planning how to more effectively identify and meet their needs.

B. California's Current Complex Managed Care System

Most states, including California, have moved away from the traditional fee-for-service (FFS) Medicaid delivery system to managed care systems.[12] More than two-thirds of all Medicaid beneficiaries nationally receive most or all of their care from risk-based managed care organizations that contract with state Medicaid programs to deliver comprehensive Medicaid services to enrollees.[13] There are also multiple types of managed care arrangements, including comprehensive risk-based managed care organizations and/or primary care case management (PCCM) programs. While managed care organizations are the predominant form of Medicaid managed care, millions of other beneficiaries receive at least some Medicaid services, such as behavioral health or dental care, through limited-benefit risk-based plans, known as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs).

In California, 83 percent of Medi-Cal enrollees receive most of their health care services through a Medi-Cal managed care plan (MCP), including many populations with unique needs, like seniors and people with disabilities.[14] California's model is more complicated than most other states', as the Medi-Cal program utilizes numerous models of managed care,[15] including the Two-Plan Model,[16] the Geographic Managed Care Model (GMC),[17] County Organized Health System (COHS),[18] as well as Regional Expansion,[19] Imperial, and San Benito

(Voluntary) Models. Some populations are either exempt from mandatory managed care enrollment, or have the option to voluntarily enroll in certain models. Specifically, children and youth involved in the foster care system are not required to enroll in managed care plans (MCPs) in most counties, although in COHS counties managed care enrollment is mandatory for youth in foster care. DHCS reports that 55 percent of foster youth in California currently receive health care services through a managed care program, either voluntarily or by virtue of residing in a county with a COHS Medi-Cal plan.[20]

In addition to excluded populations, some Medi-Cal covered *services* of particular importance to children in the foster care system are also excluded from the MCPs' contracts. Specifically, Specialty Mental Health Services (SMHS) are "carved out" as a category of services and are delivered by county-operated mental health plan (MHPs) instead of through MCPs or FFS.[21] Almost every county has its own MHP.

The authority for this bifurcated mental health system came about through a 1915(b) Medi-Cal waiver, originally granted in 1995 and continually renewed since, which specifically waives Medi-Cal beneficiaries' right to freedom of choice of providers for these specialty services. As a result, all Medi-Cal beneficiaries, including children and youth in foster care, must receive all SMHS through the county MHP.[22] It is important to note that SMHS cannot be accessed through FFS Medi-Cal. Similarly, SUD services must also be accessed through the Drug Medi-Cal Organized Delivery System (DMC-ODS) program in certain counties that are part of California's Section 1115 waiver (Medi-Cal 2020) or through the County Drug Medi-Cal Program (DMC) in counties not participating in the waiver.[23] There are also limited non-specialty mental health services and minimal SUD services available from the MCP.[24]

Federal Medicaid law prohibits states from requiring youth in foster care to enroll in managed care programs.[25] However, states can require the enrollment of foster youth into a MCP through either an 1115(a) demonstration or 1915(b) waiver.[26] Several states, including Washington, have used waivers to authorize mandatory managed care enrollment for foster youth.[27] In fact, such waivers have allowed California to require all foster youth to be enrolled in COHS plans in select counties, and require all foster youth to receive SMHS through a single county MHP.

C. Benefits of a Managed Care Delivery System for Foster Youth

While the FFS delivery system may give beneficiaries greater choice (in most counties) to select their Medi-Cal provider for medical services and non-specialty mental health services, there are numerous limitations to such a delivery system. First, the availability of providers and specialists who accept Medi-Cal FFS has diminished over time both because of the increased managed care penetration and because the FFS reimbursement rates are so low. California's Medi-Cal payment rates for FFS (and managed care) are among the lowest Medicaid rates in the country.[28] While California's Medicaid program has the largest enrollment in the nation, spending per state resident ($2,091) was lower than New York ($3,900), Massachusetts ($2,495) and Pennsylvania ($2,195).[29]

The managed care delivery system provides greater accountability to ensure beneficiaries have access to necessary Medi-Cal covered services. While beneficiaries can and do in some cases experience difficulty accessing care through a managed care delivery system, regardless of the managed care model, in a managed care system there are specific

obligations and consumer protections required of plans, established through both federal and state laws and regulations. These include network adequacy, timely access to care standards, grievance and appeal rights, data sharing, quality measures, information and outreach, transportation assistance, and others.[30] Additionally, states can impose additional accountability on MCPs through plan contract provisions, including collection and sharing of data, as well as quality measures. None of these standards exist in the FFS delivery system.

Importantly, the MCPs' obligations include providing and coordinating the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for all beneficiaries under age 21, including providing preventive services, including screenings, designed to identify health and developmental issues as early as possible.[31] EPSDT is an entitlement for all Medi-Cal eligible children under age 21, and the State, specifically DHCS, has the direct obligation to provide or arrange for each child to get these services in the FFS delivery system. However, the State does not have the oversight, infrastructure or staffing in place to meaningfully provide or arrange for these required services for the over 5 million children and young adults enrolled in Medi-Cal. Plans have greater infrastructure to oversee their provider networks and are also subject to specific federal and state managed care laws and regulations that are intended to provide additional accountability and consumer protections for enrollees.

With respect to EPSDT screening services, MCPs are required to ensure that all children and youth are screened utilizing the AAP Bright Futures periodicity schedule and guidelines, and provide children and youth with all medical and non-SMHS services that meet medical necessity.[32] Additionally, beginning on January 1, 2020, DHCS began paying MCP providers $29 per trauma screening for children enrolled in Medi-Cal.[33] MCPs must provide their members with appropriate referrals for diagnosis and treatment of conditions identified in EPSDT screens without delay and are responsible for ensuring that members under age 21 have timely access to all medically necessary EPSDT services. Under their contracts, MCPs also must coordinate with entities outside of the plan for all necessary care, including carved-out SMHS or referral to appropriate community resources and other agencies, regardless of whether the MCP is responsible for paying for the service.[34] Plans must also provide appointment assistance, transportation, language access assistance and translation, as well as inform members and their families/primary caregivers about EPSDT, including the benefits of preventive care, the services available under EPSDT, where and how to obtain these services.[35]

MCPs' obligation to provide centralized care management and coordinated services are intended to enable quick referrals and information-sharing between providers. This coordination is critical when serving foster youth, many of whom have multiple health conditions, need access to both primary and behavioral health care, and need to have their care coordinated with entities outside the plan, including MHPs, DMC, the child welfare agency, and possibly other agencies that serve the child (e.g., Regional Centers, Local

Education Agencies, etc.).

MCPs are also required to ensure an adequate network of providers -- including a sufficient number, mix, and geographic distribution -- and to provide a directory for enrollees to identify a provider.[36] If a qualified professional is not available within the network, MCPs must arrange for a provider outside the network at no cost to the beneficiary.[37]

This provision is particularly important in allowing the unique needs of foster children and youth to be met regardless of where they reside. MCPs must also adhere to timely access standards for youth determined to need Medi-Cal services,[38] and are required to provide continuity of care when beneficiaries are moving from FFS Medi-Cal into a managed care plan for the first time, or moving from one MCP to another.[39] MCPs must also collect and report data, adhere to quality assessment and performance improvement measures and follow transparency rules.[40] Finally, unlike in the FFS delivery system, beneficiaries in MCPs are entitled to file grievances, and to request Independent Medical Reviews in certain plans, if they are denied care or otherwise disagree with the MCP's decision about their care.[41] Overall, the accountability of managed care organizations, along with the opportunities for enforcement of access to care and consumer protections, make managed care delivery preferable to FFS for foster children and youth.

D. The Need for Increased Accountability to Provide Health Care Services to Foster Youth

While California adopted a managed care delivery system for most of its Medi-Cal eligible populations, it has not done enough to make any of its Medi-Cal plans accountable for the services they are obligated to provide. Additional oversight and accountability by DHCS is necessary to ensure children and youth under age 21 enrolled in managed care, including those in foster care, receive the screening and treatment services they need and to which they are entitled under EPSDT.[42] While a managed care system should provide more accountability concerning access and quality, California's Medi-Cal system is not currently serving children and youth in foster care as it should. One of the shortcomings of the existing Medi-Cal delivery system is that managed care contracts do not include enough clarity and specificity about the unique needs of foster youth. Should the state seek to enroll the remaining foster youth mandatorily in a MCP through any of the three options outlined below, additional accountability measures are needed to ensure that all plans, including MCPs and MHPs, provide this population with the services and support they need. This will require either a new separate contract specifically tailored to the delivery of services to foster children and youth (Options 1 and 2 below), or an amendment to existing MCP (and MHP) contracts that call for specific accountability to this population (Option 3 below). Specific additional provisions that should be required,[43] regardless of the option chosen, are provided in *Appendix A* to this brief.

II. Options for a New Foster Youth Model of Care

Administrative Integration of physical and behavioral health services is an important goal to achieve better outcomes for children and youth in the foster care system.

The current fragmented Medi-Cal delivery system does not achieve effective delivery of needed health care services. Currently, 24 MCPs must coordinate Medi-Cal covered services for their members with 56 MHPs and DMC programs that deliver Medi-Cal covered SMHS and SUD services in each county without a formal arrangement (contract). Achieving integration statewide for this population would require legal changes to mental health funding laws established under 1991 and 2011 Realignment or voluntary contracting arrangements between the MCPs and county MHPs. The options below would each seek to achieve that administrative integration. Additionally, all of the options presented suggest that dental services could also potentially be integrated with the other covered benefits but oral health care delivery is not addressed in more detail in this brief.

Option 1: Single statewide foster youth-specific plan, with medical, behavioral health and dental services fully integrated ("the Washington Model"), and counties given the "right of first refusal" to provide and administer all behavioral health benefits.

Description:

All children and youth in the state involved in the foster care system (with an open child welfare case) will receive integrated physical and behavioral care services, and potentially also oral health care, through a single MCP that provides statewide integrated services. Several states use this model: Washington's Apple Health Core Connections,[44] Texas' STAR Health,[45] and Illinois' Youth Care. County MHPs currently providing SMHS and SUD services in each county would be given the right of first refusal to administer and provide all behavioral health services through a subcontract with the MCP; the single statewide MCPs would be responsible for all Medi-Cal covered services, and subcontract with the MHPs for all behavioral health services at the county's election, or another entity if the county does not elect to.

Pros/Benefits:

- *Integrated Plan Responsibility*: Establishes a single, statewide integrated MCP that contracts with DHCS and is administratively responsible for all Medi-Cal services, assuming full integration of responsibility for all carved out behavioral health services; improves coordination between physical, behavioral health screening and services and potentially dental care; allows for centralized data collection and sharing; allows simplified administrative monitoring and oversight by the state; and makes one plan

accountable for meeting the all Medi-Cal requirements, including quality and performance measures. At the same time, allowing the county MHPs to provide all behavioral health services through a subcontract with the statewide MCP would simplify and integrate the delivery of the behavioral health benefit under one plan.

- *Statewideness*: A single MCP operates across the state so children and youth who experience placement moves from one county to another will not experience coverage disruption or a change of plans; MCP can partner with the child welfare state agency -- DSS -- for coordination of child-welfare services and health care through a single MOU or agreement (while partnering with county child welfare agencies in each county).
- *Population-specific*: Provides a customized contract specific to the health care and related needs of children/youth in foster care; sufficient population size will more likely attract a plan that would invest in care to this specific population; the MCP can develop and maintain expertise and experience, as well as establish best practices, to address the specific needs of this population; given the specific focus on foster youth it will be easier to integrate with existing child welfare processes and requirements.

Cons/Obstacles:

- *Existing county-based systems*: Child welfare services currently are administered at the county level; coordination by a single MCP with each individual county child welfare agency would be very challenging.
- *Carved out SMHS/DMC services*: The current carve-out of SMHS and SUD in state law, as well as in the Medi-Cal waivers, and would be difficult to untangle, even just for this population. Therefore, aligning the full benefit, including SMHS, would likely require a partnership between the counties and the single MCP. There are options to do that. Even so, there would remain the challenge: the single statewide MCP would have to coordinate service delivery of behavioral health services with 56 different county MHPs and DMC programs.
    - Although challenges would remain because MCPs and MHPs are currently reimbursed and financed differently, MCPs and MHPs could agree under existing law to voluntary arrangements in which the MCP would retain contract responsibility for all Medi-Cal covered services and then could subcontract with a county MHP for all behavioral health service under each of the Medi-Cal managed care models. [46]
    - DHCS could require the single MCP to allow MHPs to have the right of first refusal in each county to administer and provide all behavioral health services through a subcontract with the MCP. Under this scenario the MCP would be responsible by contract for all Medi-Cal covered services for foster children and youth, but would subcontract with the MHPs for all behavioral health services at the county's election. This would achieve administrative integration for all Medi- Cal services for this population. (The viability of this

arrangement is discussed more fully in Option 2 below.)

  - Even under this scenario, however, the single statewide MCP would have to coordinate service delivery of SMHS and SUD services with 56 different county MHPs and DMC programs. A single statewide MCP might determine such county specific arrangements too complicated or burdensome to take on.

- *COHS members*: Existing COHS Medi-Cal plans, which are local community health plans, would lose existing foster care children and youth who are currently mandatory managed care members, since COHS plans would not have the ability to bid on a statewide contract to provide Medi-Cal services to this population.
- *Local Initiatives (LI) contracting:* Existing LI Medi-Cal plans, which are also local community health plans, would lose foster care children and youth who are currently voluntary members of their plans, since LI plans would not likely be able to bid on a statewide contract to provide Medi-Cal services to this population. (Even if a multi-county LI could be formed through the joint action of more than one county Boards of Supervisors, it would be difficult, if not impossible, to do statewide.)
- *Existing local relationships*: A statewide MCP serving all foster children and youth might not have existing relationships with counties, including county MHPs and child welfare agencies, or with providers and community based organizations, across all parts of the state. Building these relationships would be challenging -- Washington has reported that one challenge they have faced is the length of time to get things done with multiple agencies and stakeholders.
- *Changing Managed Care Plans/Providers:* Children coming into the child welfare system would likely have to disenroll from their existing MCPs in order to enroll in the single statewide foster care MCP, jeopardizing continuity of care. Since most children in California are currently mandatorily enrolled in Medi-Cal managed care, this would increase disruption by requiring plan changes for all children coming into or leaving the child welfare system. Additionally, foster children and youth in MCPs or FFS Medi-Cal could have a disruption in their physical health care service providers unless continuity of care with existing providers is required (as it is today).

Option 2: Regional (i.e. a county or groups of contiguous counties) managed care plans with medical, behavioral health and dental services integrated, and counties given the "right of first refusal" to provide and administer all behavioral health benefits.

Description:

Children and youth involved in the foster care system would receive integrated physical and behavioral care services, and potentially also oral health care, through a plan covering multi-county regions, or single-county "regions" for large counties. Providing SMHS and SUD services in each county in a region would be given the right of first refusal to administer and provide all behavioral health services through a subcontract with the MCP; regional MCPs

would be responsible for all Medi-Cal covered services, and subcontract with the MHPs for all behavioral health services at the county's election.[47] If the MHP chose not to provide the behavioral health services, the MCP would be responsible to provide or arrange for those services directly or through a subcontract with another entity.

Pros/Benefits:

- *Regional coverage*: Allows for continuity of care and plan enrollment when youth move out-of-county to neighboring counties due to placement changes; a single contracting MCP can partner with the child welfare county agencies in the region for coordination of child-welfare services and health care through an MOU or agreement; regional contracts may be attractive to existing MCPs already providing services in the region because contracts will be for a larger foster youth population than one individual county where the population may be too small to consider viable; fewer foster care specific MCPs would allow DHCS to focus oversight on fewer plans statewide. All existing plans, including COHS and LIs plans, could bid in regions where they already maintain Medi-Cal managed care contracts; if a COHS or LI plan wants to expand into a contagious county in a region where they currently do not have a contract, they could seek that authority.[48]
- *Existing local relationships*: Existing relationships in counties - including county MHPs, DMC programs, child welfare agencies, providers and community based organizations, social services and local education agencies - can be maintained or built upon in a regional approach; if the MCP is responsible for all Medi-Cal covered services for children and youth in foster care, but must subcontract with the MHP to provide all of the behavioral health services this population, data-sharing, service delivery and tracking, and meeting quality outcomes would be easier to achieve, while maintaining existing behavioral health provider networks.
- *Population-specific*: Like Option 1, this option provides a customized contract specific to the health care and related needs of children and youth in foster care; a foster care specific population focus makes it easier to integrate with existing child welfare processes and requirements.

Cons/Obstacles:

- *Existing county-based systems*: Given the fact that child welfare services are administered at the county level, coordination by the regional MCP with each county child welfare agency could be more challenging; if a particular large county (e.g. Los Angeles) were its own region, this would not be a concern but foster youth placed in nearby counties would still potentially experience a change in their MCP or behavioral health

service provider under the existing presumptive transfer process.

- *Carved out SMHS/DMC services*: Like with Option 1, the existing carve-out of SMHS and SUD benefits in state law would be difficult to untangle. Aligning all benefits under the regional MCP, including behavioral health services, would likely require a partnership between the regional MCPs and counties; the regional MCPs still would have to coordinate service delivery of behavioral health services with the different county MHPs and DMC programs.
    - A regional MCP that is responsible for all Medi-Cal physical and behavioral health services could enter into a voluntary contract with either a single county MHP, or a multi-county regional MHP to arrange for or provide the behavioral health benefits for foster children and youth in that region.
    - If a particular large county with a COHS or LI were its own region (e.g. Los Angeles), this option might be more feasible, since relationships and agreements already exist between the current MCP and county MHP and DMC-ODS programs today.
- *COHS/LI Expansion*: Some COHS or LIs that currently participate in Medi-Cal managed care in only one county would need to form commissions with neighboring counties and negotiate new contracts if they chose to bid on managed care contracts for foster youth outside of their county. Failure to do so might result in COHS or LI plans losing existing Medi-Cal members that are in foster care or have an open child welfare case; if an existing COHS, LI or Regional Model plan currently covers multiple counties that form such a "region", this option would also not present a barrier.
- *Existing local relationships*: In a regional MCP, the plan that secures the contract might not have existing relationships with certain counties -- including county MHPs or child welfare agencies, or with providers and community based organizations -- making implementation more challenging, but not insurmountable; if a particular county were its own region (e.g. Los Angeles), or if an exciting COHS, LI or Regional Model currently covers multiple counties, this may also not present a barrier as the regional MCP may already have existing relationships and provider contracts in place.

Option 3: Existing managed care plan models, with medical, behavioral health and dental services integrated, and counties given the "right of first refusal" to manage all behavioral health benefits.

Description:

Children and youth in foster care would receive care through an existing MCP in the county where they reside. If they are not in a county where they are already required to mandatorily enroll in managed care, they would be required to enroll in an MCP. This option would be the closest to the existing model for some foster youth, as MCP contracts in place today would govern these enrollees. The most significant change would be that physical/medical, behavioral health, and potentially oral health services, would be integrated under the MCP's administrative responsibility but existing county MHPs in each county would be given the

right of first refusal to provide all behavioral health services through a subcontract with the MCP. If the MHP does not elect to provide the behavioral health services, the MCP would be responsible to provide or arrange for those services directly or through a subcontract with another entity or plan.

Pros/Benefits:

- *Existing county-based child welfare systems*: Foster care and health care services should potentially be easier to coordinate through a managed care structure, rather than in a FFS delivery system; child welfare services administered at the county level would be more easily coordinated with the existing MCP(s) in each county much the way they are today, yet with added accountability through contract amendments (*See Appendix A*).
- *Continuity of Managed Care Plans:* Foster children and youth would not be required to disenroll from their current MCP when they enter or leave the child welfare system; given more than half of children and youth in foster care in California are enrolled in managed care currently, this would decrease disruption caused from changing plans, as might be required in Option 1 or 2 if the statewide or regional MCP is not the same as the youth's existing MCP.
- *Integrated behavioral health services*: As with Options 1 and 2, counties could elected to provide all behavioral health services through a voluntary subcontracting arrangement with the MCPs, although the direct accountability for all services would be through the MCP contracts with DHCS. This would simplify and integrate the delivery of the behavioral health benefit under one plan. The current MCPs already have existing relationships with counties through required MOUs that must be in place to coordinate the delivery of behavioral services, so moving to administrative integration under this option could be achieved more easily.
- *Local Initiatives (LI) and COHS contracting:* Existing COHS and LI Medi-Cal plans would not lose foster care children and youth who are now members, and would not have to take additional joint action through county board of supervisors to bid on new statewide or regionally based population specific contracts.
- *Existing local relationships*: Existing MCP relationships with counties, including county MHPs, child welfare agencies, and with providers and community-based organizations, would continue and not be disrupted.

Cons/Obstacles:

- *Current Realignment Funding*: The same fiscal and legal challenges discussed above under Option 1 and 2 exist here, so this remains a barrier to achieving administrative integration.

- *Absence of Statewideness*: With an option that build on the current system of managed care that is county specific and inconsistent, children and youth who experience placement moves from one county to another will experience the same disruptions and change of plans they do today; coordination of child-welfare services and health care services will continue to be inconsistent and not uniform.
- *No population-specific contract*: Under this model, as currently, there would be no customized contract specific to the health care and related needs of children/youth in foster care; the plan's ability and incentive to develop and maintain expertise and experience, as well as establish best practices, to address the specific needs of this population, would potentially be lower without more resources and specific accountability; amendments to existing contracts would address some concerns re accountability to the foster care population, but given the small number of foster youth in some small or rural counties, the incentive of MCPs to meet their specific needs will be limited.

III. Recommendation

While there certainly are benefits to each of the above options, there are drawbacks to all of them as well. Given that, selecting one option over another involves weighing the pros and cons of each based on a variety of factors. Selecting the best option should be based on what model is most likely to serve the needs of children and youth in the child welfare system, and not only on what is least disruptive to the current system in the short term, although system functionality and capacity is relevant.

While having a single statewide managed care plan that specifically serves the health, behavioral health, and oral health needs of foster children and youth across the state may at first appear to be the simplest and most effective model, given that most services these children and youth use are currently county-run or- administered, including child welfare services, SMHS, SUD services, education and others, a regional or county MCP model would be a preferable option to ensure strong local relationships are built and remain in place.

Both Options 2 and 3 meet this regional/county standard. We recommend Option 2 over Option 3 for the following reasons:

1. ***Regional foster care specific contracting achieves the goal of having specific obligations and accountability to serve the unique needs of the foster care population*.** Existing MCP and MHP contracts have no specific focus on children and youth involved in the child welfare system. While amending existing contracts to add additional requirements for this population could work under Option 3, it would be less effective than having a fewer regionally based contracts that specifically address this population, including through adequate rates, specialized

provider networks, specific requirements for screening, service delivery, care coordination, continuity of care, data sharing and tracking, and quality measures and outcomes. (See Appendix A for recommended additional contract provisions that are necessary.) These are all critical elements to effectively and adequately serve these children and youth and integrate their health services with other services provided by child-serving systems, such as the child welfare agency.

Under Option 2, MCP contracts that are regional and focused solely on the foster care population would also be easier for state agencies (DHCS, DMHC and CDSS) to regulate and monitor. MCPs in place today already cover regions that comprise contiguous counties, and these plans could contract regionally to serve children and youth in the child welfare system. For example, Partnership Health Plan now holds the contract as the MCP to serve 14 Northern California counties - Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity and Yolo - through a COHS plan. Similarly, the 18 rural counties under the Regional Model of managed care -- where beneficiaries now choose between two commercial MCPs, Anthem Blue Cross and California Health & Wellness -- could be another region for a new foster care specific contract. Larger counties like Los Angeles, could be single-county regions. Under Option 3 – even with amendments to the existing MCP contracts in each county -- oversight and regulation would likely continue as it does today without enough specific focus on the needs of foster youth.

2. ***Regional contracting to serve the foster care population would allow counties with few foster youth to be part of a larger region.*** Larger enrollment would make it more feasible for a plan to invest resources and develop expertise and relationships necessary to provide appropriate, competent care to this vulnerable population. This approach would also allow foster youth who may frequently move between contiguous counties to remain enrolled in the same regional MCP, protecting continuity of care and provider relationships, and allowing the youth's care coordination and medical home to remain intact. This would serve the goal of maintaining relationships and established

   procedures between the regional MCPs and various county agencies, including the MHP/DMC programs, as children/youth in foster care move due to placement changes.

   Currently, outside of the COHS counties, child welfare social workers can choose to enroll foster youth in MCPs or to have them remain in FFS Medi-Cal and look for providers on their own or with the help of the county child welfare agency. MCPs currently have little incentive to develop a specialized approach or additional services or expertise to serve this population, and current MCP or MHP contracts do not require such an investment. Under Option 3, these children and youth would continue to be enrolled in a variety of MCPs, and might have to change plans when

their placements change. Without large numbers of foster youth enrolled, existing MCPs are unlikely to develop targeted approaches to meet their needs. The MCPs lack of focus on the specific needs of foster children and youth is often cited by advocates as a reason that managed care should not be mandated for this population.

3. ***A regional contracting approach that makes a single MCP responsible for all Medi-Cal covered services for this population, but allows the county MHP/DMC program to provide all behavioral health services, would allow county MHPs/DMC programs (and existing network providers) to continue to administer and arrange for the delivery all of the behavioral health services to this population through a subcontract with the MCP.*** This formal subcontracting arrangement would require the MCP, MHPs, and DMC programs to work jointly to address data-sharing, service delivery and tracking, and achieve quality outcomes - all of which are existing barriers to coordinated care under the current SMHS/SUD carve out where only a variety of ineffective MOUs exist.[49] This arrangement would also simplify the responsibility for all behavioral health services under one plan and avoid the confusion that exists today by dividing responsibility for behavioral health services between plan types for SMHS and non-specialty mental health services.[50]

   A regional approach to contracting in Option 2 could also work if the MCP is required to build and maintain relationships with child welfare and other social services agencies, local education agencies, and community-based organizations, even though they are county operated or managed. Requiring additional accountability through contracts would result in more integration or better coordination of these services. Under Option 3, this would require formal relationships with many more plans – 24 MCPs total statewide – which makes it more challenging. For example, in GMC counties (Sacramento and San Diego), foster care children and youth could be enrolled in one of six different plans, making coordination between each MCP and county MHP/DMC program even more difficult and burdensome.

4. ***A regional contracting approach could be rolled out over time, as regions are ready, rather than all at once.*** This would allow DHCS and other regulators to conduct readiness assessments to ensure consumer protections are in place. Such a readiness determination is necessary to ensure a smooth transition and appropriate planning, as is needed with any managed care expansion or transition. Under Option 3, a rollout would require DHCS assessing the readiness of all 24 MCPs (and 56 MHPs), which would likely not be as feasible outside of its normal audit review processes without additional staffing resources.

IV. Conclusion

Based upon the numerous considerations outlined in this paper, and the three options presented, we recommend the State consider Option 2 as the most likely to achieve the overarching goals and uphold the principles of the Foster Care Model of Care Work Group and to meet the unique needs of California's foster children and youth and their families. While no option is the perfect solution to address all of the current problems with the existing fragmented system, and they all present their own implementation challenges, retaining the systems as they are today is not going to achieve the outcomes, equity and access we are seeking or reduce health disparities experienced by these children and youth.

Appendix A

Additional Contract Provisions Needed to Address the Needs of Foster Children and Youth

1. Screening:

- Require specific performance goals/metrics for screening foster children and youth (prevention, developmental, behavioral health, medical and dental, vision and hearing exams meeting the requirements of the AAP Periodicity Schedule), and for assessing and providing necessary medical and behavioral health services, including ACES screenings, and follow-up care.
    - Performance measures should be set for well-child examinations provided to children in out-of-home care on a timely basis.
    - Performance measures should be set for the number and percentage of youth that receive immunizations while in custody of child welfare in accordance with the Immunization Schedule.
- EPSDT required screenings and examinations must be provided within a specific timeframes for children in out of home placement. If a change in placement results in change of PCP, additional EPSDT screenings/exams may be required.

2. Care Coordination:

- Require specific care coordination and care planning elements/processes, utilizing a defined team-based planning model -- the Child and Family Team (CFT)[51] -- and measuring fidelity to the CFT practice. Care planning should be age-appropriate, consider the special needs of foster child/youth, and support the involvement of youth and family in care planning, as well as all affected providers. Coordination with a child/youth's social worker, caregiver, or parent should be required when making or recommending referrals to health care and social services.
- Provide care coordination directly or through mental health plan/provider for wraparound service provision.

3. Service Delivery and Tracking:

- Ensure all foster youth have timely access to all existing behavioral health services/SMHS, including home and community based intensive mental health services and supports.
- Ensure that enrollee entering foster care stays with their PCP if possible or that the new PCP has access to health information.
- If placement changes and the child/youth must move to new geographic area, ensure assignment of a new PCP within 72 hours of receiving notification of the new placement (sooner if their needs must be addressed within 72 hours).

- Require plans to consider expected utilization by children and youth – i.e. Transitional Age Foster Youth (TAFY) between ages 16-25, including former foster youth – with behavioral health conditions based upon national and state prevalence data.
- Provide a smooth transition of care for children and youth enrollees who lose Medicaid eligibility or coverage is suspended when incarcerated.
- Develop a comprehensive transition plan for TAFY.
- Track whether foster children and youth receive the behavioral health services identified in, and in the timeframe required by, their care plans and recommended by a qualified provider and by the CFT.
- Track the number and percentage of foster youth in out-of-home care who receive a follow-up medical, behavioral health or dental service on or before 30 days/60 days following the date an EPSDT screening determines the service is necessary.
- Track enrollment of foster youth to ensure adequate coordination of care with providers and foster parents or guardians.

4. Provider Networks:

- Require the provider network to be set based on the anticipated needs of the child welfare involved populations, including: children and TAFY with behavioral health needs, children and youth with both MH/SUD and co-occurring chronic physical health conditions, and homeless youth.
- Require the network to include providers with experience working with foster care populations or one or more of the following populations: Children, TAFY and adults with behavioral health needs, individuals involved in multiple service systems, “high risk groups” like individuals involved in juvenile justice/criminal justice systems, and individuals who are homeless.
- Require contracts with all SMHS and SUD providers in sufficient numbers and capacity to timely deliver all necessary behavioral health services (whether through MHP contracts or direct contracts with providers).

5. Continuity of Care:

- Ensure continuity of care, including for youth receiving wraparound services, SMHS/SUD services, for youth who have a current care plan when entering foster care, youth who are experiencing a change in out-of-home placement, youth who are leaving the system to return to families of origin or adoptive placements, and youth who become hospitalized or incarcerated.
- Ensure the child/youth can maintain access to existing provider relationships, and where not possible, assist the young person in transitioning to equivalent care without interruption.
- Allow child/youth to continue to receive services, including SMHS/SUD services, from non-participating providers with whom they have an existing documented relationship.
- Coordinate with child welfare workers, caregivers, and providers to ensure continuity of

services when a new enrollee moves from another MCP or FFS to the plan and coordinate with the MCP or FFS provider during transition to ensure no break in services.

- Ensure there is no break in existing mental health services or access to needed medications for child/youth entering and exiting foster care.

6. Quality & Evaluation:

- Evaluate the effectiveness of behavioral health services, whether the services adequately addressed crises, reduced placement disruptions and placements in amore restrictive care setting, reduced symptoms, improved educational progress, promoted normal and natural childhood development, and other relevant factors.
- Require evaluation of children/youth who change placement to determine the need for another PCP visit or additional behavioral health services (if change in placement results in change of PCP, additional EPSDT exams may be required).
- Develop practice guidelines that are age-appropriate, culturally-competent (including LEP, cultural background, disability, and SOGI), and consider the specific needs of foster youth, with input from youth, caregivers, families, and, for behavioral health medications, in consultation with a child psychiatrist.
- Implement quality improvement and evaluation procedures for foster youth, including: tracking enrollment of foster youth, assessing quality of care and developing interventions to improve quality, engaging in ongoing performance improvement projects, reporting performance measures and participating in external quality reviews, and implementing a grievance and appeal system that accounts for inclusion of notice to child welfare workers, foster parents or caregivers, and foster child legal representatives.
- Utilization Management staff shall include people who have experience working with one or more of the following populations: children, TAFY, and adults with behavioral health needs; individuals involved in multiple service systems; “high risk groups” like individuals involved in child welfare, juvenile justice/criminal justice systems; and individuals who are homeless.

ENDNOTES

[1] Dep't of Health Care Servs (DHCS), *Foster Care Model of Care Workgroup*, https://www.dhcs.ca.gov/provgovpart/Pages/Foster-Care-Model-Workgroup.aspx.

[2] *See* Paula Barbel, *Addressing Health Needs of Children in Foster Care,* 50 Nursing 18 (2020), https://journals.lww.com/nursing/Citation/2020/03000/Addressing_health_needs_of_children_in_foster_care.6.aspx; Nat'l Foster Youth Inst., *Health and Healthcare* (last visited Nov. 23, 2020), https://nfyi.org/issues/health- healthcare/.

[3] *See* Am. Acad. of Pediatrics, *Health Care Issues for Children and Adolescents in Foster Care and Kinship Care*, 136 Pediatrics e1131 (2015), https://pediatrics.aappublications.org/content/136/4/e1131.

[4] *See* Child Welfare Information Gateway, *Health-Care Coverage for Youth in Foster Care -- And After* (2015), https://www.childwelfare.gov/pubPDFs/health_care_foster.pdf.

[5] Child Welfare Information Gateway, *supra.*

[6] *See, e.g.*, Ctr. for Juvenile Justice Reform & Chapin Hall, *Racial and Ethnic Disparity and Disproportionality in Child Welfare and Juvenile Justice: A Compendium* (2009), https://ocfs.ny.gov/main/recc/cjjr_ch_final-1.pdf.

[7] Nat'l Conference of State Legs., Mental Health and Foster Care (2019), https://www.ncsl.org/research/human- services/mental-health-and-foster-care.aspx.

[8] *Compare* KidData.org, *Child Population, by Race/Ethnicity* (2018), https://www.kidsdata.org/topic/33/child- population-race/Pie#fmt=144&loc=2&tf=108&ch=7,11,726,10,72,9,73&pdist=73 *with* KidsData.org, *Children in Foster Care, by Ethnicity/Region* (2018), https://www.kidsdata.org/topic/22/foster-in-care-race/table#fmt=19&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=108&ch=7,11,8,10,9,44&sortColumnId=0&sortType=asc.

[9] KidsData.org, *Timely Medical Exams for Children in Foster Care* (2019), 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&sortType=asc; KidsData.org, *Timely Dental Exams for Children in Foster Care* (2019), https://www.kidsdata.org/topic/2203/foster-dental-care/table#fmt=2736&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,

59,370,326,33
3,322,341,338,350,342,329,325,359,351,363,340,335&tf=124 (finding: "Over the past 20 years, the percentage of children in foster care receiving timely health exams has improved dramatically, though fewer than one in four still do not receive timely care. In 2019, 73% of children in foster care received timely medical exams, up from 11% in 1998, and 67% received timely dental exams, up from 8%.).

[10] DHCS, *Performance Outcomes System Children/Youth with an Open Child Welfare Case Report* (June 8, 2018), https://www.dhcs.ca.gov/services/MH/Documents/OCW00-20180625-Statewide-SUP-Final.pdf.

[11] DHCS, *Quality of Care in Medi-Cal: Understanding HEDIS for Children in Foster Care* (April 2020), https://www.dhcs.ca.gov/dataandstats/Documents/Quality-of-Care-in-MediCal-Understanding-HEDIS-for- Children-in-Foster-Care-042020.pdf.

[12] For state specific data, *see* Medicaid.gov, *Medicaid Managed Care Enrollment Reports*, https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.htm; *see also* Kaiser Family Foundation (KFF), *Medicaid Managed Care State Tracker*, https://www.kff.org/data-collection/medicaid-managed- care-market-tracker/.

[13] *Id.*

[14] DHCS, *Medi-Cal Monthly Eligibility Fast Facts* (Sept. 2020), https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast-Facts-June2020.pdf.

[15] DHCS, *Medi-Cal Managed Care Models* (Jan. 2020), https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf; *see also* KKF, *Medi-Cal Managed Care: An Overview and Key Issues* (Mar. 2016), http://files.kff.org/attachment/issue-brief-medi-cal-managed-care-an-overview-and-key-issues.

[16] Under the Two-Plan Model, a commercial plan and Local Initiative (LI) compete for members; LIs are local health plans that are Knox-Keene Act licensed, county-sponsored managed care plans that serve one or more counties. *See* Cal. Welf. & Inst. Code D. 9, Pt. 3, Ch. 8 ("Prepaid Plans"); Cal. Code Regs. tit. 22, § 53800 (regulating two-plan model managed care program).

[17] In a GMC Model, DHCS contracts with multiple Knox-Keene Act licensed commercial or local health plans within a single county; the GMC Model serves clearly defined geographic areas. *See* Cal. Welf. & Inst. Code D. 9, Pt. 3, Ch. 7, Art. 2.91 ("Geographic Managed Care Pilot Project"); Cal. Code Regs. tit. 22, §§ 53900-53928.

[18] A COHS is a single public local health plan established by the county board of supervisors and governed by an independent commission; Two or more counties may also jointly form a single COHS; COHS serves the entire Medi-Cal population of its region without a commercial plan competitor and enrollment is mandatory for nearly all all Medi-Cal beneficiaries. *See* Cal Welf. & Inst. Code § 14087.54(b)(1) (authorizing COHS); *see also* Nat'l Health Law Prog., *County Organized Health System Medi-Cal Plans* (Sept. 2014), https://healthlaw.org/resource/county- organized-health-system-medi-cal-plans/#.

[19] Two commercial plans in each county (18 counties).

[20] *See* DHCS, *Children and Youth in Foster Care: Background and Current Landscape* (Aug. 2020), https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-

Care-Landscape-Overview.pdf.

[21] For more information on mental health services covered by Medi-Cal, see Nat'l Health Law Prog., An Advocate's Guide to Medi-Cal Services, Chapter III (2020), Ch4.pdf

[22] County MHPs are considered PIHPs. For information about California's Section 1915(b) waiver, *see* DHCS*, Medi-Cal Specialty Mental Health Services* (Oct. 2019), https://www.dhcs.ca.gov/services/Pages/Medi- cal_SMHS.aspx. A list of county MHPs are available at DHCS, *County Mental Health Plan Information* (Jan. 2020), https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

[23] For more information on substance use disorder services covered by Medi-Cal, *see* Nat'l Health Law Prog., *An Advocate's Guide to Medi-Cal Services, Chapter IV* (2020), https://healthlaw.org/wp- content/uploads/2020/02/NHeLP-MediServicesGuide-Complete-Ch4.pdf

[24] *Id*., Ch. 3.

[25] *See* 42 U.S.C. § 1396U-2(a)(2)(A).

[26] *See Coalition for Health v. Hawaii Department of Human Services*, 365 Fed. App. 874, 876 (9th Cir. 2010).

[27] For more information, request a memo on this issue on file with the Nat'l Health Law Prog.

[28] *See* California State Auditor, *DHCS*, *Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services* 24 (Mar. 2019), https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf ("A 2017 study of states' Medicaid fee- for- service rates by the Kaiser Family Foundation found that California's rates were only 76 percent of the national average, and that only two states—New Jersey and Rhode Island—had lower rates.").

[29] California Health Care Found., *Medi-Cal Facts and Figures: Crucial Coverage for Low-Income Californians* (Feb. 2019), https://www.chcf.org/wp-content/uploads/2019/02/MediCalFactsFiguresAlmanac2019.pdf.

[30] For additional information on requirements in Medicaid Managed Care federal regulations, *see* Nat'l Health Law Prog., *Issue Brief Series* (May 2016), https://healthlaw.org/resource/issue-brief-1-medicaid-managed-care-final- regulations-and-health-equity/#.V0iZ1vkrKM8, *see also* KFF, 10 Things to Know about Medicaid Managed Care (Oct. 2020), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/.

[31] *See* DHCS, *All Plan Letter 19-010*, (Aug. 14, 2019) [hereinafter APL 19-010], https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf.

[32] *Id*.

[33] *See* Early and Periodic Screening, Diagnosis, and Treatment Program: trauma screening, Assembly Bill No. 340, Chapter 700 (2017-18) [hereinafter AB 340], https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB340.

[34] *Id*.

[35] *Id*.

[36] *See* Nat'l Health Law Prog., *Managed Care in CA Series, Issue 1: Network Adequacy*

Laws (May 2018), https://healthlaw.org/resource/managed-care-in-ca-series-issue-1-network-adequacy-laws-revised-may-7-2018/.

[37] *Id.*

[38] *Id.*

[39] *See* DHCS, *All Plan Letter 18-008*, (Jul. 10, 2018), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-008.pdf; *see* also Nat'l Health Law Prog., *Managed Care in California Series, Issue 6: Continuity of Care in Medi-Cal Managed Care* (Jan. 2016), https://healthlaw.org/resource/managed-care-in-california-series-issue-6-continuity-of-care-in-medi-cal-managed-care/#.

[40] *See* Nat'l Health Law Prog., *Issue Brief 4: Medicaid Managed Care Final Regulations: Quality and Transparency* (June 2016), https://healthlaw.org/resource/issue-brief-4-medicaid-managed-care-final-regulations- quality-and-transparency/.

[41] *See* Nat'l Health Law Prog., *Managed Care in California Series, Issue 4: Internal Grievances and External Review* (Aug. 2015), https://healthlaw.org/resource/managed-care-in-california-series-issue-4-internal-grievances- and-external-review/#.

[42] See Cal. State Auditor, supra note 28.

[43] Some of these suggested requirements are taken from Washington Apple Integrated Foster Care Contract, https://www.hca.wa.gov/assets/billers-and-providers/ahif_medicaid.pdf.

[44] *See* Wash. Health Care Authority, *Wash. Apple Health Integrated Foster Care Contract* (April 2019), https://www.hca.wa.gov/assets/billers-and-providers/ahif_medicaid.pdf*; see also* Wash. Dep't of Children, Youth, & Families, *Apple Health Core Connections* (last visited Nov. 23, 2020), https://www.dcyf.wa.gov/services/health- for-youth/apple-health; Coordinated Care, *Provider FAQs* (last visited Nov. 23, 2020), https://www.coordinatedcarehealth.com/providers/resources/core-connections-resources/provider-faqs.html.

[45] *See* Tex. Dep't of Family & Protective Servs., *STAR Health* (last visited Nov. 23, 2020), http://www.dfps.state.tx.us/Child_protection/Medical_Services/default.asp; https://www.fostercaretx.com/.

[46] *See* Anil Shankar and Diana Ung, *Voluntary Behavioral Health Integration in Medi-Cal: What Can Be Achieved Under Current Law,* Cal. Health. Care Found. 12, (Oct. 2019), https://www.chcf.org/publication/voluntary- behavioral-health-integration-medi-cal/ (although MCPs and MHPs are reimbursed and financed differently, MCPs could subcontract with a county MHP for mental health service under each of the Medi-Cal managed care models; other options are available as well; for example, a county could seek a contract to provide all medical and mental health services); *see also*, Len Finocchio et al., *Improving Mental Health Services Integration in Medi-Cal: Strategies for Consideration,* Blue Sky Consulting Group (May 2017), http://static1.1.sqspcdn.com/static/f/675504/27611440/1498768966757/BSCG_BSCF_Behavioral_Health_Integration_Report_May_2017.pdf?token=Yb7IPOd%2FHEgEwr8YuqFA0c3Tcf0%3D (discussing options counties have to contract with MCPs, who would assume financial and administrative

responsibility for services the counties currently deliver, or alternatively adopt a pilot approach wherein counties could assume responsibility for all mental health services).

[47] *Id*.

[48] In the COHS program, boards of supervisors of more than one county may establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. *See* Cal Welf. & Inst. Code § 14087.54(b)(1). Similarly, the state statutes provide for the creation of local initiatives which cover geographic "service areas" that are not limited to a single county. *See* Cal. Welf. & Inst. § 14258.

[49] *See* Kimberly Lewis, et al., *Navigating the Challenges of Medi-Cal's Mental Health Services in California: An Examination of Care Coordination, Referrals and Dispute Resolution*, Nat'l Health Law Prog. (2018), https://healthlaw.org/resource/navigating-the-challenges-of-medi-cals-mental-health-services-in-california-an- examination-of-care-coordination-referrals-and-dispute-resolution/ (examining the effectiveness of the MOUs in place statewide between MCPs and MHPs).

[50] Even if administrative integration of all services under the MCP contract is not determined by the state to be feasible due to financing or legal limitations brought about by Realignment, a regionally contracted MCP could still establish relationships with existing MHPs/DMC programs much as they do today. Yet additional accountability is needed for both MCPs and MHPs/DMC programs to adequately and appropriately serve this population.

[51] *See* CDSS, *ACIN I-71-18* (Nov. 9, 2018), https://www.cdss.ca.gov/Portals/9/ACIN/2018/I-71_18_ES.pdf (CDSS Guidance requiring the use of CFTs for children in foster care); *see also*, CDSS, *Child and Family Teams (CFTs)*, https://www.cdss.ca.gov/inforesources/foster-care/child-and-family-teams ("There is an increasing body of evidence showing that services for children and families are most effective when delivered in the context of a single, integrated team that includes the child or youth, his or her family, natural and community supports, and professionals. The Child and Family Team (CFT) process is key to the success of the Continuum of Care Reform efforts and the well-being of children, youth, and families served by public agencies and their partners. It is based on the belief that children, youth, and families have the capacity to resolve their problems if given sufficient support and resources to help them do so.").