



Children and Youth in Foster Care: Background and Current Landscape August 2020

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I. Medicaid for Children and Youth: The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit

The Medicaid program's benefit for children and adolescents is known as Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). EPSDT provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act.

The EPSDT benefit is more robust than the Medicaid benefit for adults and is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of EPSDT is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting. States share responsibility for implementing the benefit, along with the Centers for Medicare & Medicaid Services (CMS). States also have broad flexibility to determine how to best ensure such services are provided, as well as to determine the individual medical necessity criteria within their State for the services.

EPSDT entitles enrolled infants, children and adolescents to any treatment or procedure if that treatment or service is necessary to “correct or ameliorate” defects and physical and mental illnesses or conditions, as long as it is a Medicaid covered service. This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders (SUDs); as well as treatment for vision, hearing, and dental diseases and disorders.

Children and youth in foster care who receive federal Social Security Act Title IV-E payments are categorically eligible for Medicaid in every state. Under the federal Affordable Care Act (ACA), youth formerly in foster care and under age 26 are also eligible for Medicaid, regardless of their income. While there is no special health-care coverage for families with child welfare involvement, the ACA provides new opportunities for lower-to-middle income and other families who may not have had reliable health insurance in the past. Tax credits and subsidies are also available to help make insurance more affordable for families.¹ More recently, the federal SUPPORT for Patients and Communities Act of 2018 prohibits states from terminating Medicaid eligibility for juveniles under age 21 or youth in foster care under age 26 while incarcerated.

In California, children and youth are enrolled into foster care-linked Medi-Cal subject to the court's custody determination. As of March 2020, children and youth with Adoption/Foster Care aid codes² represent 0.014% (176,734) of all certified Medi-Cal eligible individuals in the state

¹ https://www.childwelfare.gov/pubPDFs/health_care_foster.pdf

² 03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U, 4A, 4E, 4F, 4G, 4H, 4L, 4M, 4N, 4S, 4T, 4W, 5K, 5L (Source: <https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast-Facts-March2020.pdf>, Appendix 1)



(12.4 million) and 0.034 % of all certified Medi-Cal eligible children under age 21 in the state (5.1 million).³

Children in foster care are not required to enroll in a Medi-Cal Managed Care Plan (MCP), *unless they reside in a county with a County Organized Health System (COHS)*, where enrollment in a Medi-Cal MCP is mandatory.⁴ As such, many children in foster care in California receive Medi-Cal services through the Medi-Cal fee-for-service (FFS) system. According to DHCS, approximately 55% of children in an out-of-home child welfare or probation placement are enrolled in an MCP and 45% receive services from the FFS system.⁵

A child in foster care may be voluntarily enrolled in a MCP only when the county child welfare agency with responsibility for the care and placement of the child, in consultation with the child's foster caregiver, determines that it is in the best interest of the child to do so and the department determines that enrollment is available to the child.

State law specifies MCP enrollment and disenrollment requirements for children in foster care placed out-of-county. Specifically:

- Whenever a child in foster care is placed in an out-of-county placement, the county child welfare agency with responsibility for the care and placement of the child must determine, in consultation with the child's foster caregiver, if the child should remain in, or enroll in, a MCP in the county where the child will be placed *or* in the county with responsibility for the care and placement of the child (as long as the department determines that enrollment is available for the child). Similar requirements apply when a child in a COHS county is placed out-of-county.⁶
- Department of Health Care Services (DHCS) has established urgent disenrollment procedures for MCPs for children in foster care in out-of-county placements (within 2 working days of a request for disenrollment made by the child welfare services agency, the foster caregiver, or other person authorized to make medical decisions on behalf of the child).
- MCPs are required to process and pay appropriately documented claims submitted by out-of-plan providers for services provided to children in foster care in out-of-county placements while they are Medi-Cal members of the plan. MCPs may require prior

³ The term "certified eligible" includes beneficiaries who have been determined eligible for Medi-Cal based on a valid eligibility determination. Source: Department of Health Care Services, June 2020. Medi-Cal Monthly Eligible Fast Facts, March 2020 as of the MEDS Cut-off for June 2020. DHCS. Chief Medical Information Officer Approval number CMIO-19-0396.

⁴ WIC, Section 14093.09

⁵ At any point in time, there are approximately 60,000 children who are in an out-of-home, child welfare or probation supervised placement. Source: California Child Welfare Indicators Project (CCWIP), University of California at Berkeley, available online at: <https://ccwip.berkeley.edu/>.

⁶ WIC, Section 14093.10



authorization for nonemergency services consistent with the plan's established policies and procedures.

The Medi-Cal EPSDT benefits described below are available to all eligible, enrolled children and youth, including children and youth in foster care.

A. Benefits Administered by Medi-Cal Managed Care Plans

Description: For Medi-Cal managed care enrollees under age 21, Medi-Cal MCPs are required to provide and cover all medically necessary EPSDT services (including services which exceed the amount provided by local educational agencies, regional centers, or local governmental health programs), unless otherwise carved out of the MCP's contract, regardless of whether such services are covered under California's Medicaid State Plan, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.⁷

The determination of whether a service is medically necessary or a medical necessity for an individual child must be made on a case-by-case basis, considering the specific needs of the child.

MCPs are responsible for the following benefits and services:⁸

- Outpatient mental health services for individuals that do not meet the medical necessity criteria for SMHS:
 - Individual/group mental health evaluation and treatment (psychotherapy)
 - Psychological testing when clinically indicated to evaluate a mental health condition
 - Outpatient services for the purpose of monitoring drug therapy
 - Psychiatric consultation
 - Outpatient laboratory, supplies and supplements
 - Screening, Brief Intervention, and Referral to Treatment for alcohol use disorders
- Use the current American Academy of Pediatrics' (AAP) Bright Futures periodicity schedule and guidelines when delivering the EPSDT benefit, including screening services, vision services, and hearing services
- Preventive services, including screenings, designed to identify health and developmental issues as early as possible
- Appropriate diagnostic and treatment services initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up
- All medically necessary Medi-Cal covered FDA-approved drugs, including psychotherapeutic drugs

⁷ [DHCS All Plan Letter 19-010, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, August 14, 2019](#)

⁸ [DHCS, Medi-Cal Managed Care Boilerplate Contracts.](#)



- All medically necessary Medi-Cal covered FDA-approved drugs, including psychotherapeutic drugs
- Minor Consent Services to enrollees under age 18, for which minors do not need parental consent to access, and are related to: (1) Sexual assault, including rape; (2) Drug or alcohol abuse, for children ages 12 or older; (3) Pregnancy; (4) Family planning; (5) Sexually transmitted diseases, for children ages 12 or older; and (6) Outpatient mental health care, for children ages 12 years or older who are mature enough to participate intelligently and where either (a) there is a danger of serious physical or mental harm to the minor or others, or (b) the children are the alleged victims of incest or child abuse.
- Comprehensive Medical Case Management services, including coordination of care for all medically necessary EPSDT services delivered both within and outside the MCP's provider network. MCPs are also responsible for the coordination of carved-out and linked services and referral to appropriate community resources and other agencies, regardless of whether the MCP is responsible for paying for the service
- A program with services for Children with Special Health Care Needs (CSHCNs), defined as "those who have or are at increased risk for a chronic physical, behavioral, developmental, or emotional conditions and who also require health or related services of a type or amount beyond that required by children generally." MCP programs for CSHCNs must include:
 - Standardized procedures for the identification of CSHCNs, at enrollment and on a periodic basis thereafter
 - Methods for ensuring and monitoring timely access to pediatric specialists, sub specialists, ancillary therapists, and specialized equipment and supplies
 - Methods for ensuring that each CSHCN receives a comprehensive assessment of health and related needs, and that all medically necessary follow-up services are documented in the medical record, including needed referrals
 - Case management or care coordination for CSHCN, including coordination with other agencies which provide services for children with special health care needs (e.g. mental health, SUD, Regional Center, CCS, local education agency, child welfare agency)
 - Methods for monitoring and improving the quality and appropriateness of care for children with special health care needs

MCPs are also responsible for numerous other benefits and services, including but not limited to:

- Services provided in the most integrated setting appropriate and in compliance with Americans with Disabilities Act
- Medically necessary Behavioral Health Treatment (BHT) services
- Targeted Case Management (TCM) services, including referrals to a Regional Center (RC) or local governmental health program
- Appointment scheduling assistance and necessary transportation, including non-emergency medical transportation and non-medical transportation to and from



medical appointments for the medically necessary EPSDT services they are responsible for providing

Structure and Finance: DHCS contracts with health plans that are responsible for providing all Medi-Cal services included under the contract. Plans are required under state and federal law to maintain an adequate Medi-Cal provider network to ensure that each member has a primary care physician and must report on quality and access measures. California has six managed care models:

- COHS, a health plan created and administered by a county board of supervisors. Within a COHS county, all managed care enrollees are in the same plan (22 counties)
- Two-Plan Model, which includes a publicly run entity (a local initiative) and a commercial plan (14 counties)
- Geographic Managed Care (GMC), a mix of commercial and nonprofit plans that compete to serve Medi-Cal beneficiaries (2 counties)
- Regional Expansion Model, with two commercial plans in each county (18 counties)
- Imperial Model, with two commercial plans in Imperial County.
- San Benito (Voluntary) Model, with one commercial plan

MCPs may subcontract with other entities to fulfill the obligations of the contract. Many MCPs have subcontracted with a managed behavioral health care organization (MBHO) to support the administration of their mental health coverage responsibilities.

Plans are paid a fixed amount each month, per member enrolled in the plan. Rates are based on categories of aid, which correspond to Medi-Cal-eligible populations and vary by county and plan.

1. Coordinating with Outside Entities

MCPs are required to coordinate with other outside entities when there is overlapping EPSDT responsibility. Specifically, MCPs are required to:

- Assess what level of EPSDT medically necessary services the member requires
- Determine what level of service (if any) is being provided by other entities
- Coordinate the provision of services with the other entities to ensure that MCPs and the other entities are not providing duplicative services, and that the child is receiving all medically necessary EPSDT services in a timely manner.

2. Coordinating with Regional Centers



MCPs are required to establish a Memorandum of Understanding (MOU) with each local regional center to facilitate the coordination of services for members with developmental disabilities, including Autism Spectrum Disorder.

3. Coordinating with School-Linked Child Health and Disability Prevention (CHDP) Services

MCPs are required to maintain a "medical home" and ensure the overall coordination of care and case management of members who obtain Child Health and Disability Prevention (CHDP) services through the local school districts or school sites. Additionally, MCPs must:

- Establish one or a combination of various specified cooperative arrangements with the local school district or school sites
- Identify referral protocols/guidelines between the MCP and school sites, including screening for the need of CHDP services, strategies for MCP follow-up and documentation of services provided, any innovative approaches to assure access to CHDP services and coordination with and support for school based health care services.

4. Coordinating with Substance Use Disorder (SUD) Treatment

MCPs are required to assist their members in locating available SUD treatment service sites. To the extent that treatment slots are not available within the plan's service area, the MCP must pursue placement outside the area. The MCP must continue to cover and ensure the provision of primary care and other services unrelated to SUD treatment, and to coordinate services between primary care providers and SUD treatment programs. Additionally, MCPs are required to execute an MOU with the county department for alcohol and SUD treatment services.

5. Coordinating with Specialty Mental Health Services (SMHS)

MCPs are required to establish a MOU with the county Mental Health Plans (MHPs) in their jurisdictions. MOUs must address:

- Referral protocols between plans, including:
 - How the MHP will provide a referral to the MCP when the MHP determines a beneficiary's mental illness would be responsive to physical health care-based treatment
 - How the MCP will provide a referral to the MHP when the MCP determines SMHS covered by the MHP may be required
- The availability of clinical consultation, including consultation on medications, for beneficiaries whose mental illness is being treated by an MCP.
- Management of beneficiary care, including procedures to exchange information.



- Procedures for providing beneficiaries with services necessary to the treatment of mental illnesses covered by the MHP when those necessary services are covered by the MCP:
 - Prescription drugs and laboratory service
 - Emergency room facility and related services other than SMHS
 - Home health agency services
 - Non-emergency medical transportation
 - Services to treat the physical health care needs of beneficiaries receiving psychiatric inpatient hospital services
 - Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a beneficiary's medical problems based on changes in the beneficiary's mental health or medical condition.
- A process for resolving disputes between the MHP and the MCP.

Authorities:

- <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf>
- DHCS/Medi-Cal MCP Contract
- Title 22 California Code of Regulations (CCR), Section 51473.2 (a), Minor consent services
- Welfare & Institutions Code (WIC), Sections 10725, 14124.5, 14008, 14008.5, 14010

B. Benefits Provided in Fee-For-Service (FFS) System

Description: In the FFS system, health care professionals and facilities meet state licensing and certification requirements, provide services to beneficiaries, bill the state for the services, and are generally paid at rates set by the state. It is the enrollee's responsibility to find a health care provider who accepts Medi-Cal.

Structure and Finance: The DHCS Provider Enrollment Division (PED) is responsible for the timely enrollment and re-enrollment of eligible FFS health care providers in the Medi-Cal program.

Authorities:

- WIC, Sections 14132.03(a), 14189

C. Benefits Managed by Counties

1. The Child Health and Disability Prevention (CHDP) Program

Description: In California, the CHDP program administers the Early and Periodic *screening* component of the federally mandated EPSDT benefit for individuals under the age of 21 who are enrolled in the Medi-Cal fee-for-service health care



In addition to health assessments, CHDP provides care coordination and case management to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Local CHDP programs carry out community activities which include planning, evaluation, and monitoring, informing, providing health education materials, provider recruitment, and quality assurance. Local CHDP programs are also responsible for oversight of the HCPCFC, described later in this document.

Structure and Finance: CHDP is operated at the local level by each county health department and three cities. CHDP health assessments are provided by enrolled private physicians, local health departments, community clinics, MCPs, and some local school districts. DHCS publishes Statewide Maximum Allowances for provider reimbursement.

Authorities:

- Health and Safety Code, Sections 104395, 105300, 105305, 120475, and 124025 through 124110.
- Title 17 CCR, Sections 6800 through 6874
- Title 22 CCR, Sections 51340 and 51532
- [CHDP Provider Manual](#)
- [Local Program Guidance Manual](#)

2. **Specialty Mental Health Services**

Description: DHCS contracts with counties which serve as MHPs to deliver SMHS to Medi-Cal beneficiaries who meet medical necessity criteria. Outpatient SMHS include:

- Rehabilitative mental health services, including:
 - Mental health services (assessment, plan development, therapy, rehabilitation)
 - Medication support services
 - Day treatment intensive
 - Day rehabilitation
 - Crisis residential
 - Crisis intervention
 - Crisis stabilization
- Targeted case management
- Psychiatric inpatient hospital services
- For children and youth under age 21: therapeutic behavioral health services (TBS), as well as intensive care coordination (ICC), intensive home-based services (IHBS), and therapeutic foster care (TFC) – Described further below under “Pathways to Wellbeing”

To qualify for SMHS, beneficiaries must meet the standard statewide SMHS medical necessity criteria, including having a covered diagnosis, demonstrating



- Crisis stabilization
- Targeted case management
- Psychiatric inpatient hospital services
- For children and youth under age 21: therapeutic behavioral health services (TBS), as well as intensive care coordination (ICC), intensive home-based services (IHBS), and therapeutic foster care (TFC) – Described further below under “Pathways to Wellbeing”

To qualify for SMHS, beneficiaries must meet the standard statewide SMHS medical necessity criteria, including having a covered diagnosis, demonstrating specified impairments, and meeting specific intervention criteria. Medical necessity criteria differ based on coverage and age criteria established for youth under age 21, adults, and outpatient or inpatient services.¹⁰

Structure and Finance: In 2011, the state shifted funding and service responsibility to the counties for a host of law enforcement, social services, and behavioral health services. With a new dedicated revenue source (sales taxes), the responsibility for the following mental health and SUD services previously funded with State General Fund monies was transferred to counties: Medi-Cal SMHS; Drug Medi-Cal; Drug Courts; Perinatal Drug Services; Other SUD Services.

Counties are required to use moneys received from 2011 Realignment, as well as 1991 Mental Health Realignment and Mental Health Services Act (MHSA) funds (to the extent permissible under the Act), to meet their MHP obligations. Counties do not receive separate distributions of 2011 Realignment revenues for each of the above behavioral health programs and services. Instead, the revenues are deposited monthly by the State Controller into each county’s Behavioral Health Subaccount, from which each county must budget and manage the full set of services.

To provide legal and financial protections to the state and counties under 2011 Realignment, Proposition 30 amended the State Constitution and describes each of the services realigned to counties, the financial resources provided, and protections against new, unfunded mandates on counties for the programs realigned to them. In particular, Article 13 of the State Constitution now requires the state to provide new funds for any new state laws or regulations, executive orders, or administrative directives that increase costs of local services and programs included in 2011 Realignment. The state must also provide 50% of needed funds for changes to federal statutes, regulations, or federal judicial or administrative proceedings that increase costs of local services included in 2011 Realignment (e.g., CMS Medicaid Managed Care Rule).

Authorities:

- Section 1915(b) Specialty Mental Health Services Waiver

¹⁰ Title 9 CCR, Sections 1830.205 and 1830.210



- Title 9 CCR, Division 1, Chapter 11
- Mental Health Plan (MHP) Contract
- WIC Sections 14680 – 14685.1 and 14700 – 14726
- Government Code, Section 30025 et seq.
- Title 9 CCR, Sections 1810.100 – 1850.535
- California Constitution, Section 36 of Article XIII

(a) Coordinating with Managed Care Plans (MCPs)

In addition to required MOUs between county MHPs and MCPs, state regulations (Title 9, Section 1810.415) require MHPs to make clinical consultation and training, including consultation and training on medications, available to a beneficiary's health care provider for beneficiaries whose mental illness is not being treated by the MHP or for beneficiaries who are receiving treatment from another health care provider in addition to receiving SMHS from the MHP. Specifically, each MHP is required to:

- Arrange appropriate management of a beneficiary's care, including the exchange of medical information, with a beneficiary's other health care providers or providers of SMHS (maintaining confidentiality of medical records)
- Coordinate with pharmacies and MCPs as appropriate to assist beneficiaries to receive prescription drugs and laboratory services prescribed through the MHP, including ensuring that any medical justification of the services required for approval of payment to the pharmacy or laboratory is provided to the authorizing entity in accordance with the authorizing entity's procedures.

Additionally, if the MHP determines that the beneficiary does not meet medical necessity for SMHS, the MHP must refer the beneficiary to:

- A provider outside the MHP, which may include a provider with whom the beneficiary already has a patient-provider relationship or the MCP in which the beneficiary is enrolled;
- A provider in the area who has indicated to the MHP a willingness to accept MHP referrals, including federally qualified health centers, rural health clinics, and Indian health clinics; or
- An entity that provides assistance in identifying providers willing to accept Medi-Cal beneficiaries, which may include the health care options program, the local CHDP program, provider organizations, or other community resources available in the county of the MHP.

The MHP is not required to ensure the beneficiary's access to physical health care based treatment or to ensure the beneficiary's access to treatment from licensed mental health professionals for diagnoses not covered by the MHP.



(b) Coordinating with Child Welfare

AB 2083 of 2018 requires each county to develop and implement a Memorandum of Understanding (MOU) outlining the roles and responsibilities of various local entities that serve children and youth in foster care who have experienced severe trauma. The legislation is focused on the following systems: child welfare, county behavioral health, regional centers, county offices of education, and probation.

3. Drug Medi-Cal Services

Description: Medi-Cal enrollees with a SUD have long been served through the “standard” Drug Medi-Cal program (DMC), which covers a limited set of services, primarily outpatient counseling and methadone maintenance. The DMC Organized Delivery System (DMC-ODS) demonstration program substantially expanded the benefit in participating counties, covering a broad continuum of SUD treatment and support services.

Individuals under age 21 are eligible to receive Medicaid services pursuant to the EPSDT benefit. Under this federal benefit, beneficiaries can receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under federal Medicaid authority. Nothing in the DMC-ODS demonstration program overrides any EPSDT requirements. Medical necessity for an adolescent (someone under age 21) is determined using the following criteria: a) Must be assessed to be at risk for developing an SUD, and b) Must meet the American Society for Addiction Medicine (ASAM) Criteria adolescent treatment criteria.¹¹

Structure and Financing: DHCS contracted with counties to administer and pay for the standard DMC program. Additionally, “any willing provider” may contract directly with DHCS. County participation in DMC-ODS is voluntary. Counties participating in the DMC-ODS serve as MCPs (technically, “prepaid inpatient health plans”) responsible for ensuring that all Medi-Cal beneficiaries living in their county have access to the SUD treatment services they need when they need them, and that the providers are qualified and trained to deliver evidence-based care, including medication management and care coordination. Counties have the authority and responsibility to contract directly with qualified service providers to deliver care under county direction, which has meant that counties can better assure the quality of providers in their network. Under the DMC-ODS demonstration program, counties also can offer providers “other than state plan rates,” which typically means higher rates.¹² Counties utilize

¹¹ <https://www.chcf.org/wp-content/uploads/2018/08/MediCalMovesAddictionTreatmentToMainstream.pdf>

¹² <https://www.chcf.org/wp-content/uploads/2018/08/MediCalMovesAddictionTreatmentToMainstream.pdf>



2011 sales tax revenues from the Behavioral Health Subaccount to pay for DMC services.

Authorities:

- [Special Terms and Conditions](#)
- [Intergovernmental Agreement](#)

D. Reform Initiatives and Other Medi-Cal Programs

The items described below (in chronological order) are some of the key, statewide initiatives and reforms over the past two decades designed to improve mental health services for children and youth, including children and youth in foster care.

1. Children’s System of Care (CSOC) and the Ventura Model¹³

Pioneered in Ventura County in the mid-1980s, California established a nationally-recognized, widely published care model called “Children’s System of Care (CSOC).” The CSOC model sought to integrate mental health care, social services, educational programs, and juvenile justice programs for children with serious emotional disturbances.

In 1987, the model was authorized for expansion through AB 377 (Wright) in three additional counties (San Mateo, Santa Cruz, and Riverside), with funding for evaluation. The evaluations conducted by UC San Francisco researchers found the program effectively achieved its goals: a) to ensure that the target population was served as intended; (b) to reduce reliance on restrictive levels of care, especially state hospital and group homes; (c) to reduce the likelihood of re-arrests for youth involved in the juvenile justice system; and (d) to improve the educational performance of target population youth in school settings.

In the model, a series of planning steps are used to create service plans and case management procedures, and administrative structures are also created to allow coordination and monitoring of services provided the children and youth. Specifically, the CSOC model includes:¹⁴

“...Additional case management designed to access and coordinate services across sectors of care. ...(Counties) provide a type of special therapeutic day treatment in the schools or school-based outpatient treatment. With respect to the social services sector, all three counties provide some type of in-home service to foster parents that assists these parents in maintaining the youth in foster

¹³ For additional information, see: <https://www.cibhs.org/sites/main/files/file-attachments/socmanual.pdf>

¹⁴ Rosenblatt, Abram & Attkisson, C. & Fernandez, Alberto. (1992). Integrating systems of care in California for youth with severe emotional disturbance II: Initial group home expenditure and utilization findings from the California AB377 Evaluation Project. *Journal of Child and Family Studies*. 1. 263-286.



home placement in order to prevent moving youth to a more restrictive residential environment or level of care.

...(T)he counties also now make placement decisions through interagency committees, which combine the expertise and experiences of staff from the various child service sectors (most notably, probation/juvenile justice, mental health, social services, and education). These placement committees also help control out-of-home placements by reviewing jointly whether a given out-of-home placement is appropriate. As necessary, mental health personnel may work with personnel from other sectors or within facilities run by other sectors to resolve acute clinical crises."

In 1992, AB 3015 established the Children's Mental Health Services Act (WIC, Sections 5850-5886). Over the years that followed, the Legislature appropriated millions of dollars each fiscal year to implement the model throughout the state.¹⁵ By the end of the decade, the Budget Act of 2000 provided a \$15 million GF augmentation for "full statewide implementation" of the Children's System of Care Program.¹⁶ The following year, a downturn in the economy led to a \$2 million reduction to AB 3015 children's mental health services.¹⁷ The Budget Act of 2002 reduced CSOC funding by half, eliminating \$19.7 million from the program.¹⁸ In 2003, the Budget Act maintained funding for CSOC at \$20 million.¹⁹ But in 2004, funding for CSOC was eliminated.²⁰

In 2004, California voters passed Proposition 63, also known as MHSA. MHSA funds distributed to counties include "Community Services and Supports (CSS)." MHSA statute directs counties to use CSS component funds for programs and services described in the Children's Mental Health Services Act the Children's Mental Health Services Act (commencing with WIC, Section 5850).²¹ Specifically, MHSA state regulations require CSS component mental health programs to incorporate "the principles of the Children's Mental Health Services Act in WIC 5850 et. seq."²²

The federal Community Mental Health Services Block Grant (MHBG) program, which granted California approximately \$92.8 million in 2019²³, provides funding to establish or expand an organized community-based system of care for providing non-Medicaid mental health services to children with serious

¹⁵ https://www.cibhs.org/sites/main/files/file-attachments/socm_phas2so1.pdf?1431968391

¹⁶ <https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr00-02.pdf>

¹⁷ <https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr01-05.pdf>

¹⁸ <https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr02-05.pdf>

¹⁹ <https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr03-06.pdf>

²⁰ <https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr04-09.pdf>

²¹ WIC, Section 5892(a)(5)

²² CCR Title 9, Section 3610(a)(2)

²³ <https://www.samhsa.gov/sites/default/files/grants/2019-new-continuation-grant-awards-by-state.pdf>



emotional disturbances (SED). Some counties utilize MHBG funds to implement the Children's System of Care program.

2. California Children's Services (CCS) Program

Description: The California Children's Services (CCS) program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools. Medi-Cal is required to refer all CCS-eligible clients to CCS for case management services and authorization for treatment.

The explicit legislative intent of the CCS program is to provide necessary medical services for children with CCS medically eligible conditions whose parents are unable to pay for these services, wholly or in part. The statute also requires the DHCS and the county CCS program to seek eligible children by cooperating with local public or private agencies and providers of medical care to bring potentially eligible children to sources of expert diagnosis and treatment.

Structure and Finance: The CCS program is administered as a partnership between county health departments and DHCS. In counties with populations greater than 200,000, county staff perform all case management activities for eligible children residing within their county. This includes determining all phases of program eligibility, evaluating needs for specific services, determining the appropriate provider(s), and authorizing for medically necessary care. For counties with populations under 200,000, the DHCS Children's Medical Services (CMS) Branch provides medical case management and eligibility and benefits determination through its regional offices located in Sacramento and Los Angeles.

Currently, approximately 70% of CCS-eligible children are also Medi-Cal eligible, so Medi-Cal reimburses their care. The cost of care for the other 30% of children is split equally between CCS Only and CCS Healthy Families. The cost of care for CCS Only is funded equally between the State and counties. The cost of care for CCS Healthy Families is funded 65% federal Title XXI, 17.5% State, and 17.5% county funds.

The funding source for a county CCS program is a combination of monies appropriated by the county, State General Funds, and the federal government. AB 948, the realignment legislation passed in 1992, mandated that the State and county CCS programs share in the cost of providing specialized medical care and rehabilitation to children with physical handicaps through allocations of State



General Fund and county monies. The amount of State money available for the CCS program is determined annually through the Budget Act.

Authorities:

- Health and Safety Code, Section 123800 et seq.
- Title 22 CCR, Section 51013

3. The Local Education Authority (LEA) Billing Option Program (BOP)

Description: The Local Education Authority (LEA) Billing Option Program (BOP) was established in 1993, in conjunction with the California Department of Education (CDE). The LEA BOP reimburses LEAs (school districts, county offices of education, charter schools, community college districts, California State Universities and University of California campuses) the federal share of the maximum allowable rate for approved health-related services provided by qualified health service practitioners to Medi-Cal enrolled students. Under LEA BOP, the mental health services that are reimbursable include psychological assessments; psychosocial status assessments; psychology/counseling treatment (individual and group); nutritional counseling; and targeted case management services. LEAs may also choose to contract with the local MHP to provide SMHS.²⁴

Structure and Finance: In California, LEAs fund the state share of Medicaid expenditures utilizing a Certified Public Expenditure (CPE) methodology. Federal Financial Participation (FFP) funds for Medicaid expenditures are available for two types of services: direct medical services (referred to as “health services” or “direct services” in this report) and administrative activities. The reimbursement for administrative activities is available through the School-Based Medi-Cal Administrative Activities (SMAA) Program.

Authorities:

- WIC, Section 14132.06 and 14115.8
- Title 22 CCR, Sections 51190, 51270, 51360, 51491, 51535.5

4. Pathways to Wellbeing (“Katie A.”)

In 2011, the settlement agreement of the Katie A. v. Bonta lawsuit (Katie A.) resulted in the collaboration of the California Department of Social Services (CDSS) and DHCS developing child, family and team engagement approaches and best practices related to SMHS. In 2013, the departments released the [Pathways to Mental Health Services Core Practice Model Guide](#) in support of these integrated approaches. That document provided a comprehensive framework for counties to address the mental health needs of children and

²⁴ https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/LEA_Report_FY2017-18.pdf



The Katie A. settlement agreement approved by the court in 2011 required State child welfare and mental health leaders to work together to establish a sustainable framework for the provision of an array of services that occur in community settings and in a coordinated manner.²⁶ Additionally, MHPs now offer the following intensive services as EPSDT benefits:²⁷

Intensive Care Coordination: An intensive form of TCM that facilitates assessment of, care planning for, and coordination of services for children and youth and includes a CFT. ICC is intended for children and youth who are involved in multiple child-serving systems, have more intensive needs, and/or whose treatment requires cross-agency collaboration.

Intensive Home-Based Services: Individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's or youth's functioning. These interventions are aimed at: helping the child/youth build skills for successful functioning in the home and community, as well as improving the family's ability to help the child/youth successfully function in the home and in the community. IHBS is expected to be of significant intensity to address the mental health needs of the child or youth, consistent with the child's or youth's client plan, and will be predominantly delivered outside an office setting, and in the home, school, or community.

Therapeutic Foster Care: A short-term, intensive, highly coordinated, trauma-informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. TFC should not be the only SMHS that a child or youth receives. Children and youth receiving TFC also must receive ICC and other medically necessary SMHS, as set forth in the client plan. Similar to ICC and IHBS, there must be a CFT in place to guide and plan TFC service provision.

5. **EPSDT Performance Outcome System/Mental Health Services Performance Dashboard**

SB 1009 of 2012 required DHCS to establish an EPSDT Performance Outcomes System to improve outcomes at the individual and system levels and will inform fiscal decision making related to the purchase of services. With input from an expert task force and advisory committee, DHCS selected the Pediatric Symptom Checklist and the CANS tools to measure child and youth functioning. County MHPs are required to administer the tools and report data to DHCS, using the tools. Since that time, reporting and activities were moved under the scope of the MHS Performance Dashboard.

²⁶ <https://cdss.ca.gov/inforesources/foster-care/pathways-to-well-being>

²⁷ https://cdss.ca.gov/Portals/9/Medi-Cal_Manual_Third_Edition.pdf?ver=2018-01-24-144144-470



and will inform fiscal decision making related to the purchase of services. With input from an expert task force and advisory committee, DHCS selected the Pediatric Symptom Checklist (PSC-35) and the Child and Adolescents Needs and Strengths (CANS) tools to measure child and youth functioning. County MHPs are required to administer the tools and report data to DHCS, using the tools. Since that time, reporting and activities were moved under the scope of the MHS Performance Dashboard.

6. **Presumptive Transfer of Medi-Cal Specialty Mental Health Services (SMHS) for Youth in Foster Care Placed Out-Of-County (AB 1299)**

AB 1299 of 2016 established “presumptive transfer” for youth in foster care placed out-of-county. It requires a prompt transfer of the responsibility for providing or arranging and paying for SMHS from the county of original jurisdiction to the county in which the child or youth in foster care resides. Presumptive transfer is intended to provide children and youth in foster care who are placed outside their counties of original jurisdiction timely access to SMHS, consistent with their individual strengths and needs, and Medicaid EPSDT requirements.²⁸

Children and youth removed from the home and care of their parents and placed in protective custody, or foster care, are legal dependents or wards of the juvenile court in the county where the removal occurred. The county that establishes dependency or wardship of a child or youth is the county of original jurisdiction and is referred to as the “county of original jurisdiction” for the purposes of presumptive transfer. In June 2018, joint DHCS and CDSS guidance to counties described methods to comply, including procedural flowcharts, notification requirements, exceptions and waivers, implications for Child and Family Teams.²⁹

7. **California Children’s Services (CCS)– Whole Child Model**

Description: SB 586 of 2016 authorized DHCS to establish the Whole Child Model (WCM) program in designated COHS or Regional Health Authority counties to incorporate CCS-covered services into a Medi-Cal MCP contract. The goals are improved care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

Today, children with CCS-eligible conditions are enrolled in both the CCS FFS and managed care delivery systems. As such, they receive their services in two (or more) separate systems that do not always coordinate and communicate

²⁸ https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN-18-027%20Presumptive%20Tranfer/MHSUDS_Information_Notece_18-027_Presumptive_Transfer.pdf

²⁹ https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN-18-027%20Presumptive%20Tranfer/MHSUDS_Information_Notece_18-027_Presumptive_Transfer.pdf



effectively. This can result in additional complexity for families to navigate access to care among other care coordination issues. Under the Whole Child Model, DHCS intends to eliminate this bifurcated system, strengthening overall care coordination for the beneficiary and their family resulting in better overall health outcomes and better access to care. Beneficiaries and their families will benefit from a single point of care coordination.³⁰

Structure and Finance: DHCS convened a CCS Advisory Group to inform the implementation of the WCM, which continues to meet. There are 21 counties and 5 health plans participating in the WCM, with implementation phased in between July 1, 2018 and July 1, 2019. Health plans coordinate the beneficiary's full scope of health care needs, inclusive of primary preventive care, specialty health, mental health, education, and training rather than multiple entities coordinating these efforts separately.

Authorities:

- WIC, Sections 14093.06, 14094.2 through 14094.20,
- Health and Safety Code, Sections 123835, 123850

8. Adverse Childhood Experiences (ACEs) Aware Initiative

Description: Established under AB 340 of 2017, Adverse Childhood Experiences (ACEs) Aware is an initiative led by the Office of the California Surgeon General and DHCS to give Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs. The goal is to detect ACEs early and connect patients to interventions, resources, and other support that can improve the health and well-being of individuals and families. Effective January 1, 2020, DHCS began paying Medi-Cal providers for conducting ACE screenings for children and adults up to age 65 with full-scope Medi-Cal. The Office of the California Surgeon General and DHCS are partnering with organizations across the health care system and California's communities to ensure that these providers have the training, tools, and resources they need to effectively incorporate ACE screening into patient care.

Structure and Financing: ACE screenings are not mandatory. Medi-Cal providers are encouraged to screen Medi-Cal pediatric and adult patients. Medi-Cal providers can receive payment for providing qualified ACE screenings since they are now a Medi-Cal-covered benefit. Eligible Medi-Cal providers who conduct qualifying ACE screenings can be paid up to \$29 in the FFS delivery system and no less than \$29 in the medical managed care delivery systems.

Authorities:

- <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-018.pdf>

³⁰ <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-WCM-FAQ-2019.pdf>



II. California Child Welfare Services

Children under age 18 are brought into the child welfare services system when an allegation of maltreatment has been substantiated and it is determined that family maintenance or reunification services are necessary for the safety and well-being of the child(ren).

All county Child Welfare Services (CWS) offices host a Child Abuse Reporting Hotline where social workers receive referrals from mandated reporters or concerned members of the community. When a call is received, the Hotline worker collects information from the caller and uses a required hotline assessment, the Structured Decision Making (SDM) tool, to help make a determination whether an investigation is warranted. Next:

- If the Hotline worker determines the information provided does not meet the definition of abuse, neglect or exploitation and an investigation is not indicated, the referral is closed (or “evaluated out”).
- If the Hotline worker assesses the information and determines it is sufficient to initiate an investigation, the referral is sent to an Emergency Response social worker and, depending on potential danger to the child, occurs either immediately or within 10 days of the referral.
 - If the investigation social worker determines that there has been some abuse, neglect or exploitation, and risk and safety issues cannot be ameliorated without intervention, they will obtain a warrant for removal unless exigent circumstances exist. The worker must then file a petition to the court and within 48 hours a detention hearing will occur to remove the child to be placed into foster care with Family Reunification services.
 - If the investigating social worker believes the child can remain safely in the home with court and child welfare oversight, they will recommend Family Maintenance services.

State law (commencing with WIC Section 601) authorizes courts to accept petitions to take jurisdiction over children. Children and families can be served either while the child is in foster care or while the child remains home with court oversight. To be eligible, the child/youth must meet the definition of candidates for foster care. This includes any youth who are at imminent or serious risk of removal and placement into a foster care setting should preventative services fail, and certain requirements must be met.

A. Continuum of Care Reform Initiative

Introduced in 2015 with AB 403, with follow-up legislation in subsequent years, is premised on significantly reducing the use of group homes and congregate care with the vision that all children and youth in foster care are loved by and living with resource families, which include and prioritize relatives.

1. Child and Family Teams (CFTs)



CFTs are described through a joint letter with CDSS (ACL 16-84) and DHCS (Mental Health Substance Use Disorder Services Information Notice 16-049) and are integrated throughout the Pathways to Well-Being Core Practice Model described earlier. A CFT is a group of individuals that includes the child or youth, family members, professionals, community supports, and others as identified by the family who have a vested interest in the child and family's success. The purpose is to identify supports and services needed to achieve permanency, enable a child to live in the least restrictive setting and promote normal childhood experiences.

The CFT must occur within the first 60 days a child comes into care and on a regular basis thereafter. County Interagency Placement Committees (IPCs) are comprised of representatives from the county placing agencies, county mental health and others who have shared responsibility for the well-being and safety of the child. Pursuant to WIC, Section 4096, IPCs must approve any placement into a Short-Term Residential Treatment Program (STRTP), certain group homes, and certain out-of-state residential programs. ACL 17-122 outlines the procedures and requirements of an IPC.

2. **Child and Adolescent Needs and Strengths (CANS) Assessment Tool**

Pursuant to AB 403 and Continuum of Care Reform (CCR), CDSS selected the CANS as the functional assessment tool to be used with the CFT process to guide case planning and placement decisions. As described earlier, DHCS has also selected the CANS, as well as the Pediatric Symptom Checklist, to measure child and youth functioning.³¹

The CANS is a multi-purpose assessment tool developed to assess well-being, identify a range of social and behavioral healthcare needs, support care coordination and collaborative decision-making, and monitor outcomes of individuals, providers, and systems. Completion of the CANS assessment requires effective engagement using a teaming approach. The CANS must be informed by CFT members, including the youth and family. The CANS assessment results must be shared, discussed, and used within the CFT process to support case planning and care coordination.

The CANS must be completed prior to the completion of the family case plan, and the CANS results are intended to inform the CFT in several key areas, including but not limited to:

- Determining if the child, youth, or Non-Minor Dependent (NMD) has unmet behavioral health or substance use needs
- Making placement decisions
- Informing the Level of Care protocol
- Determining educational needs

³¹ <https://cdss.ca.gov/Portals/9/ACL/2018/18-09.pdf>



County placing agencies and MHPs must share with each other completed CANS assessments and their resulting identified outcomes for children assessed and/or served by both agencies to avoid unnecessary duplication and overassessment of children and youth.³²

B. Health-Related Initiatives for Children and Youth in Foster Care

1. Health and Education Passport

Description: Under state law, when a child is placed in foster care, the case plan for each child must include a summary of the health and education information or records, including mental health information or records, of the child. The summary may be maintained in the form of a “health and education passport,” or a comparable format designed by the child protective agency. The health and education summary shall include, but not be limited to:

At minimum, the health and education summary must include:

- Names and addresses of the child's health, dental, and education providers
- The child's grade level performance, the child's educational progress, the child's school record, assurances that the child's placement in foster care accounts for proximity to the school in which the child is enrolled at the time of placement
- The number of school transfers the child has already experienced
- A record of the child's immunizations and allergies
- The child's known medical problems
- The child's current medications, past health problems and hospitalizations
- A record of the child's relevant mental health history, the child's known mental health condition and medications
- Any other relevant mental health, dental, health, and education information concerning the child determined to be appropriate.

Within 30 days after initial placement of a child into foster care, the child protective agency is required to provide the caretaker with the child's current health and education summary. For each subsequent placement, the child protective agency must provide the caretaker with a current summary within forty-eight hours of the placement.

Caregivers are required to obtain a medical appointment for their children in foster care within the first month of receiving the children into their homes.

³² <https://chhs-data-prod.s3.us-west-2.amazonaws.com/uploads/2019/09/Specialty-Mental-Health-Services.pdf>



Caregivers are required to obtain a medical appointment for their children in foster care within the first month of receiving the children into their homes.

Structure and Finance: The primary sources of federal funding for CWS are authorized in Title IV-E, Title IV-B, and Title XIX of the Social Security Act. These funds are passed through to the states, and in California, the funds are further distributed to the counties. In addition, CWS programs partially utilize Title XIX, Child Abuse Prevention and Treatment Act (CAPTA), State Children's Trust Fund (SCTF), Proposition 10, and Proposition 98 funds. Under 2011 Realignment, counties use dedicated sales tax revenues to administer adoption Services, foster care, and child welfare services.

Authorities:

- Welfare and Institution Code Section 16010, 16010.4, and 358.1
- <https://cdss.ca.gov/inforesources/caregiver-advocacy-network/health-passport>
- Title 42 United States Code section 675(5)(D)

2. **Health Care Program for Children in Foster Care (HCPCFC)**

Description: Through the HCPCFC, public health nurses under the supervision of a supervising public health nurse provide a variety of services, in consultation and collaboration with social workers and probation officers. Services include: medical and health care case planning; helping foster caregivers to obtain timely comprehensive health assessments and dental examinations; expediting referrals for medical, dental, mental health and developmental services; coordinating health services for children in out-of-county and out-of-state placements; providing medical education through the interpretation of medical reports and training for foster team members on the special health care needs of children and youth in foster care; and participating in the creation and updating of the Health and Education Passport for every child as required by law.

Structure and Finance: The CHDP program, under the direction of the DHCS Children's Medical Services Branch, works with community programs and agencies to identify the major obstacles children in foster care face in gaining access to coordinated, multidimensional services. The State Budget Act of 1999 appropriated State General Funds to CDSS for the purpose increasing the use of PHNs in meeting the health care needs of children in foster care. The enabling legislation for the HCPCFC was Assembly Bill 1111. FFP at enhanced rate of 75% is available for administrative services delivered by a SPMP.

Authorities:

- WIC, Section 16501.3 (a) through (e)
- <https://www.dhcs.ca.gov/services/HCPCFC/Pages/ResourceGuide.aspx>



3. Psychotropic Medication Utilization

The Child and Family Services Improvement and Innovation Act of 2011 required States to establish protocols for the appropriate use and monitoring of psychotropic medications with children and youth in foster care.³³ Senate Bill 484 (Beall), Chapter 540, Statutes of 2015, required DSS to establish a methodology to identify STRTPs and group homes that have levels of psychotropic drug utilization warranting additional review. The legislation also required DSS to consult with DHCS and stakeholders every three years to revise the methodology. The departments have issued “California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care.”³⁴

4. Sexual Health and Education

Senate Bill 89 of 2017 (Budget bill) is intended to ensure that youth in foster care receive comprehensive sex education and are able to access critical health care and services. The bill requires child welfare workers to verify youth in foster care have received comprehensive sexual health education that meets the requirements of the California Healthy Youth Act, as well as inform youth of their rights to access age-appropriate, medically accurate information about reproductive and sexual health care, including, but not limited to, unplanned pregnancy prevention, abstinence, use of birth control, abortion, and the prevention and treatment of sexually transmitted infections. The legislation also required CDSS to develop quality sexual health training, which must be obtained by all social workers, foster caregivers, and judges.³⁵

California also released a “Plan for the Prevention of Unintended Pregnancy for Youth and nonminor dependents (NMDs) in Foster Care” in 2016. Additionally, California Healthy Youth Act requires California public schools, including charter schools, to provide comprehensive sexual health education to all students.³⁶

5. Foster Youth Bill of Rights

Beginning in 2001 and expanded through legislation in subsequent years, all children placed in foster care have specific rights, including the right to reasonably prompt medical, dental, vision, mental health, and SUD services, and reproductive and sexual health care.³⁷

³³ https://www.childwelfare.gov/pubPDFs/health_care_foster.pdf

³⁴ <https://www.courts.ca.gov/documents/BTB24-1G-12.pdf>

³⁵ <https://fosterreprohealth.org/wp-content/uploads/2018/04/SB-89-Fact-Sheet-Website.pdf>

³⁶ Ibid.

³⁷ <https://www.cdss.ca.gov/cdssweb/entres/forms/English/pub396.pdf>; WIC, Section 16001.9



C. Additional Interagency and Reform Initiatives

The items described below (in chronological order) are some of the key, statewide initiatives and reforms over the past two decades designed to improve and better coordinate services provided across multiple agencies to children and youth in foster care.

1. Wraparound Services

CDSS describes Wraparound as a strengths-based planning process that occurs in a team setting to engage with children, youth, and their families. Wraparound shifts focus away from a traditional service-driven, problem-based approach to care and instead follows a strengths-based, needs-driven approach. The intent is to build on individual and family strengths to help families achieve positive goals and improve well-being.³⁸

Wraparound is also a team-driven process. From the start, a child and family team is formed and works directly with the family as they identify their own needs and strengths. The team develops a service plan that describes specific strategies for meeting the needs identified by the family. The service plan is individualized, with strategies that reflect the child and family's culture and preferences.

California Wraparound began in the 1990s and is intended to allow children to live and grow up in a safe, stable, permanent family environment. For children and families in the foster care system, the Wraparound process can:

- Enhance strengths by creating a strength-based intervention plan with a child and family team
- Promote youth and parent involvement with family voice, choice, and preference
- Use community-based services
- Create independence and stability
- Provide services that fit a child and family's identified needs, culture, and preferences
- Create one plan to coordinate responses in all life domains
- Focus on achieving positive goals

Authorities:

- WIC, Sections 18250 – 18258

2. Intensive Services Foster Care (ISFC)

³⁸ <https://cdss.ca.gov/inforesources/cdss-programs/foster-care/wraparound>



2. Intensive Services Foster Care

AB 404 of 2017 created ISFC as a new category of licensure to serve minor or non-minor dependents in foster care who have intensive needs such as medical, therapeutic, or behavioral needs. Under ISFC, families are intended to be supported with:³⁹

- Ongoing CFTs as needed to support placement stability
- Coordination of SMHS (agencies should be familiar with the full array and how to access the system)
- Respite care including natural supports
- Trauma informed and permanency competent services
- Ongoing problem solving and collaboration when barriers arise

3. Extended Foster Care

AB 12 of 2010, the California Fostering Connections to Success Act, as amended by AB 212 of 2011, authorizes foster care services beyond age 18 to provide additional time and support to children and youth. According to the Judicial Council of California: "The guiding principle of this extension is to provide each eligible nonminor with the opportunity to make decisions regarding his or her housing, education, employment, and leisure activities, while ensuring the availability of ongoing support and assistance when difficulties are encountered. The 6 new rules, 2 amended rules, 10 new forms (5 optional and 5 mandatory), and 1 revised form provide the guidance and structure needed to fully implement the court process for the extension of juvenile court jurisdiction and foster care services."⁴⁰

4. Commercially Sexually Exploited Children Program

In 2014, California established the CSEC Program through Senate Bill 855 (Chapter 29, Statutes of 2014), which funds counties to develop a coordinated, interagency approach to CSEC case management and service planning.⁴¹ The program has provided statewide training for county child workers and out-of-home caregivers, training for youth in foster care to help them recognize and avoid commercial sexual exploitation, and funds for counties to develop protocols and for capacity building for services to commercially sexually exploited children.⁴²

³⁹ https://www.cibhs.org/sites/main/files/file-attachments/tfc_isfc_webinar_slides_final_05_30_2018_0.pdf?1528303941

⁴⁰ <https://www.courts.ca.gov/7988.htm>

⁴¹ <https://chhs-data-prod.s3.us-west-2.amazonaws.com/uploads/2017/06/Committees/California-Child-Welfare-Council/Council-Information-Reports/CWC-2016-2017-Annual-Report-FINAL-8.29.2017.pdf>

⁴² https://calswec.berkeley.edu/sites/default/files/csec_acl_14-62.pdf



5. Children and Youth System of Care (AB 2083)

AB 2083, legislation enacted in 2018,⁴³ requires each county to develop and implement a MOU outlining the roles and responsibilities of various local entities that serve children and youth in foster care who have experienced severe trauma. The legislation is focused on the child welfare system and the following other systems, but can be expanded to include others:

- Child welfare
- Regional centers
- County offices of education
- Probation
- County behavioral health

Additionally, the legislation requires development of state MOU guidance, a process to request technical assistance from a [new State Interagency Resolution Team](#), an analysis of gaps in placement types, services, or other issues, and development of a multiyear plan for increasing capacity. The California State Association of Counties released a [memorandum](#) and [sample MOU](#) which counties can customize to meet their local needs.⁴⁴ To date, the following interdepartmental information has been released from the state:

- [AB 2083 MOU Guidance Information Notice](#)
- [AB 2083 MOU Guidance](#)
- [AB 2083 Technical Assistance Information Notice](#)

6. Family Urgent Response System

Established by AB 2043 of 2018, county child welfare, probation, and behavioral health agencies are required to establish county-based FURS for the provision of mobile crisis-response services to current or former youth in foster care and their caregivers, and requires CDSS to establish a statewide hotline to be available 24 hours per day, seven days per week to respond to caregiver or youth calls when a crisis arises.

7. Families First Prevention Services Act

Federal Families First Prevention Services Act of 2018 builds on California's CCR effort to reduce the use of congregate care. As a result, federal Title IV-E child welfare funding can now be used for certain prevention and aftercare services, as well as for eligible children and their parents to receive mental health and SUD treatment services and in-home parenting, skill-based instruction.

⁴³ https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB2083

⁴⁴ https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-022%20Integrated%20Core%20Practice%20Model%20and%20Integrated%20Training%20Guide/MHSUDS_Information_Note_18-022_ICPM_and_ITG.pdf



III. Defining the Population of Children and Youth in Foster Care

A. Reconciling the Child Welfare System (CWS) and DHCS Medi-Cal Data Systems to Clearly Identify the Focus Population

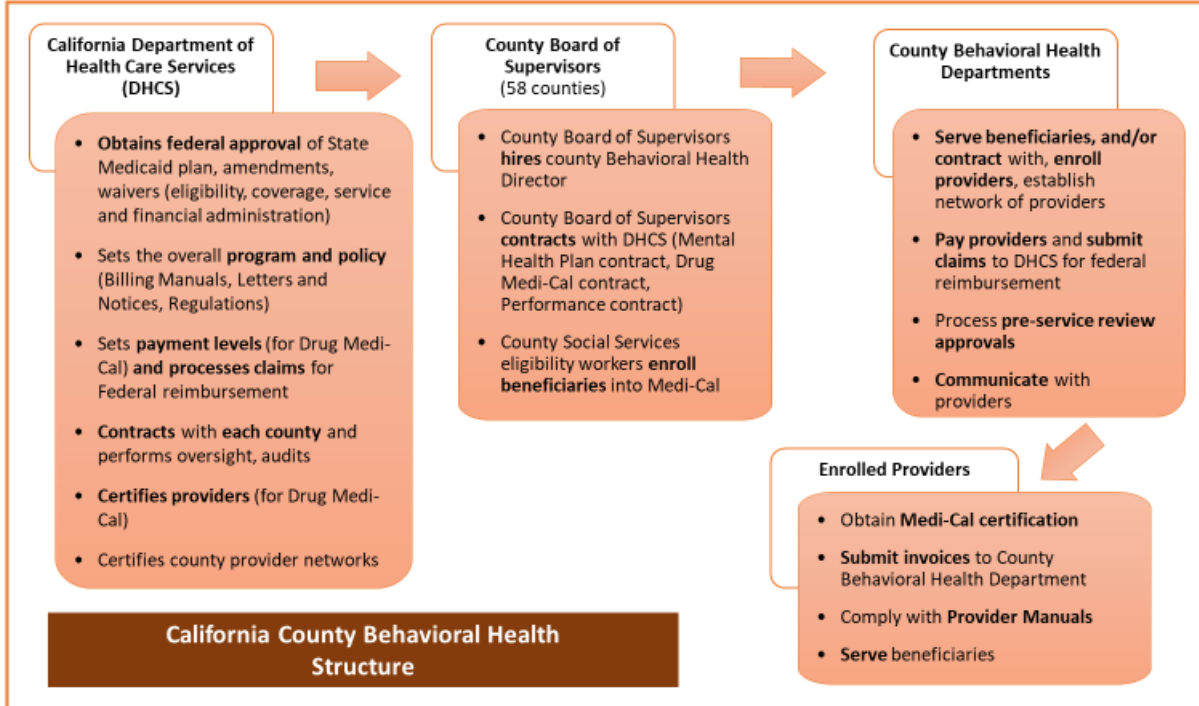
With the support of UC Berkeley, the CA Department of Social Services has established an extensive child welfare data support system as well as a Child Welfare Indicators Project that tracks everything from county caseload data to performance on indicators such as number of placement changes and well child visits. This system is designed to generate reports for child welfare administrative purposes as well as to generate critical outcome information on California's child welfare system. Similarly, DHCS has established a Medi-Cal data warehouse which brings together Medi-Cal encounter and claims data from contracted health plans, fee for service providers, the counties and FQHCs. DHCS also contracts with External Quality Review Organizations (EQRO) to monitor access, quality and the effectiveness of services delivered by contracted health plans and the county behavioral health departments to Medi-Cal beneficiaries.

Efforts have been made to reconcile the data generated by these systems to establish a methodology to track and monitor the child welfare population served by the health plans, FFS providers and the counties from a health and behavioral health service utilization perspective. Due to the fact that the data systems in question are independent and designed to capture information for use by their respective oversight entities and constituencies clear data element identification parameters for each system are needed to develop an effective data merge methodology while maintaining the integrity of the systems. It is important to define questions such as, at what point does a child go from having a child welfare "case" to becoming a child who is Medi-Cal eligible in foster care. These questions need to be resolved to address critical issues related to health and behavioral health access, compliance with existing legal settlements and care coordination and treatment consent responsibilities. To answer such questions requires cross matching the appropriate DHCS MEDS eligibility data with the appropriate DSS child welfare caseload information and then testing the results against the stated policy goals. The result of this process could be used, for example to develop and implement a mechanism to merge child welfare, health and behavioral health "caseloads" to promote the policy goal of "multi-system enrollment" and coordinated access to needed services and supports.



IV. Additional Charts

Current County Behavioral Health Structure





GAVIN NEWSOM
GOVERNOR



Current Organization of the Medi-Cal Managed Care System

