Improving California's Health Care Delivery System for the Child Welfare-Involved Population: Concepts and Considerations

Developed by Aurrera Health Group at the request of the California Departments of Health Care Services (DHCS) and Social Services (CDSS)

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Mission driven. Forward thinking.

Background and Introduction

In 2019, the California Department of Health Care Services (DHCS) conducted a year-long, statewide listening tour to understand from stakeholders what works and does not work in the Medi-Cal program, initially focused on care coordination, but expanding to address a broad set of concerns brought by plans, providers, counties, consumers, advocates, and other stakeholders. The fragmented delivery system serving children and youth in child welfare was a common concern, since these children experience a much higher burden of chronic medical conditions, behavioral health conditions, developmental disorders and unmet social needs; ensuring children get the right care at the right time can take intense advocacy and care coordination, especially when out-of-home placements cross county lines. About half of these children are in the fee-for-service (FFS) system, and there is no accountable entity to ensure an adequate network of primary and specialty care, no requirements for timely appointments, and no single point of contact to help ensure robust care coordination between medical and dental care, behavioral health, and social services. While this coordination role is often played by public health nurses, this role is often under-resourced and is not consistently available for all children across the state. Many expressed a desire for a single point of contact, available even when children or youth cross county lines, to help address issues and solve problems. Difficulty obtaining services for children and youth with developmental delay—which can stem from prenatal substance exposure, trauma, and other medical and mental health conditions—was a frequently-cited example, as families must navigate a confusing array of medical, behavioral, and educational systems in order to get the right evaluation, educational plan, and treatment plan.

The CalAIM Foster Care Model of Care Workgroup ("the Workgroup") was established as an opportunity for stakeholders to provide feedback on how children and youth involved or formerly involved in child welfare ("the child welfare-involved population") receive health care services through Medi-Cal and to develop recommendations for system change.[1] More specifically, the Workgroup was charged with developing recommendations that address:

1. How the health care delivery system for the child welfare-involved population should be organized to better integrate and coordinate medical, behavioral, dental, and social services;

2. Desired outcomes for the child-welfare involved population and the measures that could be used to assess performance in achieving these outcomes; and
3. The core suite of services that should be available to the child welfare-involved population.

Unlike the approach in other CalAIM workgroups, DHCS did not start the Workgroup with a draft set of solutions. Instead, DHCS asked the Workgroup to adopt a charter and set of core principles, hear from other states about how they solved similar problems, and present potential solutions for DHCS and the California Department of Social Services (CDSS) to consider. The Workgroup received a joint proposal from California's County Behavioral Health Directors Association (CBHDA) and County Welfare Directors Association (CWDA) addressing the third policy challenge identified above, setting forth a recommended set of mandatory minimum benefits, advocating automatic eligibility for the child-welfare involved population for specialty mental health services (SMHS) and substance use disorder (SUD) services, and addressing other considerations, including but not limited to workforce development and training.[2]

The California Child Welfare Council's (CWC) Behavioral Health Committee also submitted draft recommendations to the Workgroup which address the second policy challenge identified above—the desired outcomes and how to measure performance in achieving them—as well as the third, the core suite of services.[3] The CWC's Behavioral Health Committee proposal additionally addresses eligibility for SMHS, use of Family First Prevention Services Act (FFPSA) funds, interagency collaboration, and workforce development, among other issues.

Most recently, the Workgroup received recommendations from the California Association of Health Plans, setting forth nine proposals designed to improve care for child welfare-involved children and youth. These include, among others, a requirement to enroll all children and youth in foster care in Medi-Cal managed care, to require every managed care plan (MCP) to have a designated foster care liaison coordinator on staff, and to create county-specific foster care memorandums of understanding (MOUs) to improve data sharing between MCPs, county mental health plans (MHPs), and relevant county agencies and community partners.

In addition, the Workgroup received recommendations from the National Health Law Program (NHeLP), which review the pros and cons of three managed care options: a statewide integrated child welfare plan, regional integrated plans, and integrating all services within the existing managed care model. NHeLP recommends DHCS move forward with regional integrated plans, as this option balances the maintenance of local relationships with the accountability of a new model of managed care, focused on the needs of children and youth in child welfare.

The Aurrera Health Group, on behalf of DHCS and CDSS, prepared this discussion paper to complement those submitted by CBHDA/CWDA, the CWC Behavioral Health Committee, the California Association of Health Plans, and NHeLP. The paper addresses the question of how the health care delivery system for the child welfare-involved population could be organized to better integrate and coordinate medical, behavioral, dental, and social services, provide children and youth with a single continuous point of contact to help address issues and solve problems, and ensure adequate access to specialty care. It presents a number of concepts for modifying or transforming the existing health care delivery system to achieve these aims.

This discussion paper is divided into four sections. Section One lays out several of the key problems the Workgroup and state are trying to solve—fragmented delivery systems, lack of a single permanent point of contact to address issues and solve problems, and challenges in accessing specialized services. Section Two identifies three potential approaches to re-organizing or modifying the state's current delivery system model for child welfare-involved children and youth to help address these problems. Section Three discusses one potential approach—the development of a specialized managed care plan for the child welfare-involved population. And Section Four discusses two alternative approaches—one that would permit counties to alter their delivery systems for behavioral health services, and one that would entail more modest changes to the existing Medi-Cal managed care and FFS systems.

1. The Current System: A Fragmented Delivery Systems; No Single Permanent Point of Contact for Children and Youth to Help Solve Problems; and Challenges in Access to Specialized Services.

During DHCS's year-long statewide listening tour on what works and does not work in the Medi-Cal program, a common theme in the feedback provided by child-welfare involved

children and youth and their parents and caregivers was frustration with a fragmented system of care coordination and the lack of a single point of contact within the system to help address issues and solve problems for children and youth. Another challenge consistently raised by child-welfare involved children and youth, parents and caregivers, CDSS personnel, and other stakeholders within the system is difficulty accessing needed specialized care – whether medical, behavioral, educational, or related to needed social services.

For child-welfare involved children and youth—many of whom require a range of physical, behavioral, and social services—coordination among service providers is critical. And yet, no single entity is responsible for assuming this critical function for this population. As a result, all too often health and social service providers and systems fail to communicate and share information, to effectively coordinate services, and to align on a strategy for maintaining or improving a child's health and well-being and supporting the child's permanency goals.

Child welfare-involved children and youth also lack a single continuous point of contact that they (or their parents and caregivers) can turn to for help addressing issues and solving problems, such as difficulty finding a needed specialist (medical, behavioral, or related to developmental delay), or communicating with a particular provider. This problem is particularly acute for children and youth who move from one county to another once, or even multiple times, and thus, could most benefit from a single continuous point of contact charged with helping the child or youth navigate multiple health and social service systems.

Another challenge with the current delivery system is access to needed care, particularly specialty physical and behavioral health care. According to the University of Massachusetts Medical School, 25 to 33 percent of children in foster care have three or more chronic health issues, 25 to 30 percent have failed hearing and vision tests and as many as 60 percent have developmental/learning disabilities.[4] The American Academy of Pediatrics (AAP) has classified children in foster care as a population of children with special health care needs. AAP also notes that fully one third come into foster care with a chronic health condition that has often gone undiagnosed and untreated.[5] Parents and caregivers, county social workers and other county staff, CDSS personnel, and many other stakeholders report spending hours trying to facilitate a child or youth's access to specialty services, or to ensure the services were coordinated with each other. Importantly, delays in access to specialty care, disruptions in care, and the inability

to access needed care adversely affect a child's physical and mental health and well-being, which in turn affects a child's placement stability and success.

To a great extent, all three of these issues—fragmented delivery systems, lack of a single continuous point of contact to help solve problems, and challenges accessing needed care—stem from the structure of the state's existing delivery system for child welfare-involved children and youth, in which responsibility is shared among the state's MCPs, FFS Medi-Cal, the county-based MHPs and substance use treatment programs (Drug Medi-Cal Organized Delivery System (DMC-ODS) and Drug Medi-Cal), and the county-based child welfare system. The result is that no single entity or delivery system is responsible for ensuring that child welfare-involved children and youth receive consistent care coordination, a single continuous point of contact available to help address issues and solve problems, and timely access to all needed medical, behavioral, dental, and social services. This discussion paper presents three approaches to addressing this issue.

2. Overview of Potential Approaches to Delivery System Reform

In the course of its work, the Foster Care Workgroup has devoted considerable attention to the question of how the health care delivery system for the child-welfare involved population could be changed to achieve better outcomes for this high-need population. The topic was specifically addressed in the August Workgroup meeting, where the Workgroup received presentations from Washington and Arizona on their managed care delivery systems for the child welfare-involved population, and in October, when the Workgroup discussed whether and how such models could be adapted to California. Outside of the Workgroup setting, leadership within DHCS and CDSS have done additional work to explore the question of how California's existing health care delivery system could be changed to better meet the needs of the child welfare-involved population.

Through these conversations, both inside and outside the Foster Care Workgroup setting, a number of health care delivery system concepts have emerged for consideration. Broadly, these concepts fall into one of three categories:

(1) Concepts that involve the creation of a new separate specialized Medi-Cal MCP devoted exclusively to the child welfare-involved population ("a child welfare plan").

(2) Concepts facilitating voluntary integration of behavioral health and physical health services, or integrating all behavioral health services into the county MHP.

(3) Concepts that would enhance the current Medi-Cal managed care or FFS system to better meet the needs of the child welfare-involved population and their parents and caregivers.

3. A Child Welfare Plan

One option would be to introduce a new Medi-Cal managed care entity with its own procurement and plan contract designed to serve the child welfare-involved population (referred to in this paper as "a child welfare plan.") A growing number of states have adopted this approach and today, at least 9 states have some version of a child welfare plan. These states include Washington and Arizona, as well as Georgia, Wisconsin, Illinois, Texas, Florida, West Virginia, and Tennessee.[6] The next addition to this group will likely be Ohio, which in November of this year issued a request for proposals (RFP) for a child welfare plan, with a planned go-live date of January 2022.[7]

Although in many of these states, all or the majority of behavioral services are carved in to the state's child welfare plan contract, California could not mandate this approach, as the California Constitution gives counties the authority to manage behavioral health services through realignment. However, the state could assign to a child welfare plan coverage of all Medi-Cal covered physical health benefits, dental benefits, and the mild-to-moderate behavioral health benefit; could require the plan to demonstrate expertise and programming specific to child welfare, including substantial responsibilities for care coordination and care management; and could require the plan to work closely with county mental health and child welfare systems to ensure well-coordinated care. Counties could voluntarily contract with the child welfare plan to administer the specialty mental health and substance use disorder (SUD) treatment benefit, either just for the child welfare-involved population, or as part of a broader integration effort for all their members. Where a county exercised this option, DHCS could require the plan to contract with or otherwise maintain the existing network of county-operated SMHS and SUD treatment providers, where available.

A child welfare plan—organized as a single statewide plan or as a small number of regional plans—offers a number of potential strengths when compared to the existing,

fragmented structure of delivery systems for child welfare-involved children and youth. Key among these strengths are the potential to:

(1) Improve accountability by consolidating responsibility for medical care and the coordination of all other services into one statewide child welfare plan or a small number of regional plans;

(2) Allow the state to more effectively track performance and outcomes for the child welfare-involved population and implement policies to drive performance improvements;

(3) Support the development of organizational expertise in managing the complex and significant health care and social service needs and multi-system involvement of this population; and

(4) Host a personal electronic health record or health information exchange to allow all providers and care coordinators access to complete, real-time information.

We discuss these potential strengths in more detail below.

(1) Improved Accountability through Reduction in the Number of Accountable Entities

In creating a child welfare plan, the state would consolidate responsibility for physical health services and the coordination of medical, behavioral, dental, and social services under a single statewide plan or small number of regional plans. Currently, responsibility for physical health services is distributed among the state's many MCPs—each of which is responsible for a relatively small number of child welfare-involved children and youth—and the state's FFS system. Responsibility for care coordination is shared among the state's multiple health care and social service delivery systems. Due to lack of clarity as to the roles and responsibilities of these respective systems, and the sheer number of entities involved, care coordination too often falls to parents and other caregivers, and state and county personnel, who typically lack the time, resources, or authority needed to effectively assume this role.

With a child welfare plan, there would be a single entity accountable to each individual child welfare-involved child or youth (and his or her parents and caregivers), with responsibility

for ensuring access to needed services, including specialty services. The plan, in its role as a care coordinator, would be responsible for making sure that all of a child or youth's providers are communicating as needed and aligned in their approach to sustaining or improving the child or youth's well-being and permanency. Through the plan contract, the state could require that the plan assign each enrollee a single care coordinator or care manager, who would be for enrollees (and parents and caregivers) the sole point of contact for information about accessing services and help resolving problems. Notably, with a statewide plan, this point of contact would remain the same regardless of a child or youth's county of residence. With regional plans, the single point of contact would only change if the child or youth moved outside the region (and DHCS could require those points of contact to coordinate closely when a move resulted in a change of health plan). The result would be that child welfare-involved children and youth would have a single point of contact to turn to for help, including in the period immediately after a move to another county, in which children and youth are typically confronted with new medical, behavioral, and social service systems to navigate, and may need assistance finding local providers or continuing services with their existing providers.

Finally, a child welfare plan would be held to managed care standards, including the requirement to have an adequate network of primary and specialty care providers and behavioral health providers, as well as timely access standards, requiring availability of primary care appointments within 10 business days of the request, and specialty care appointments within 15 days of the request. These standards do not apply to the FFS delivery system.

(2) Better Performance Tracking and New Levers for Driving Performance Improvement

The establishment of a single statewide child welfare plan or small number of regional plans would also support more effective tracking of service utilization and outcomes for child welfare-involved children and youth. The child welfare plan would have access to all physical health claims data for the child welfare-involved population in the region or state (depending on the plan model). This would be a significant improvement over the current system, where physical health claims data is distributed among the state's many MCPs, as well as the FFS system. In addition, to fulfill its care coordination function, the plan would also be responsible for obtaining information regarding utilization of behavioral, dental, and social services by plan enrollees. The plan could be contractually obligated to obtain this information, assuming

adequate support from the state in the elimination of any barriers to such information-sharing. The plan could then offer a new valuable source of data and information to the state and stakeholders regarding service utilization and outcomes for the child welfare-involved population taken as a whole. With appropriate data controls and verification mechanisms, the state could ensure that the data the plan reported out was comprehensive and reliable.

In addition, the establishment of a child welfare plan would give the state a host of policy tools with which to ensure adequate access to services, increase quality, and drive improvements in outcomes. Through CalAIM, DHCS is developing a plan contract that will ensure coordinated, high-quality, whole-person care for all Medi-Cal enrollees, including those with significant medical, behavioral, or social needs. Among other new services and requirements, the contract will include a new enhanced care management (ECM) benefit that will ensure intensive and comprehensive care management for high-need enrollees, including children or youth with complex physical, behavioral, development, or oral health needs. The child welfare plan contract would take the MCP contract to be implemented under CalAIM as its foundation—including the ECM benefit, network adequacy requirements, and financial incentives tied to performance and outcomes—but include modifications and enhancements designed to meet the unique needs of child welfare-involved children and youth.

(3) Development of Expertise in Managing Care for the Child Welfare-Involved Population

One other potential advantage of the child welfare plan is that it would establish a single accountable entity, subject to a strong incentive to develop expertise in managing care for the child welfare-involved population. Under the current delivery system, no single health care entity (e.g., MCP, MHP, DMC-ODS program) has enough child welfare-involved enrollees to give this population the sustained focus and investment it requires.

By contrast, a statewide child welfare plan or small set of regional plans would have a singular focus—effectively managing care and improving outcomes for the child welfare-involved population. Moreover, the plan contract would be structured, both in its substantive requirements and payment arrangements, to drive improvements in the delivery and management of care for the child welfare-involved population.

There is even potential that a child welfare plan, subject to rigorous contractual requirements and well-designed financial incentives, could help drive innovation in care delivery and care management for this population. This could take the form, for example, of the development of centers of excellence—or groups of providers with demonstrated expertise in treating the child welfare-involved population—eligible for enhanced reimbursement or value-based payment. Innovation could also come in the form of increased use of telehealth visits for child welfare-involved children or youth with specialty providers where in-person access to services cannot be reasonably obtained.

(4) Host a Personal Electronic Health Record or Health Information Exchange

The current fragmented delivery system creates substantial data sharing challenges, and as a result, primary care and specialty providers often see children with incomplete information, especially after placement changes, which can compromise the quality and safety of care. Few providers seeing children in foster care have access to current care plans, medical history (e.g., diagnoses, hospitalizations, diagnostic study and lab results, etc.), vaccine records, dental records, case management contact information, Child and Adolescent Needs and Strengths (CANS) survey results, or information on relevant educational issues. A single statewide child welfare plan could host a personal health record for all children in child welfare, allowing access to timely and accurate clinical and social data for all treating providers (medical, behavioral, social services, and educational) at the point of care. In the current fragmented system, an integrated personal health record would be difficult to achieve, but a single plan (or a small group of regional plans) could ensure information follows the child at all points of care.

A child welfare plan—with its potential to increase accountability, enhance performance management and outcomes tracking, support the development of expertise, and improve information sharing—would represent a significant change from the existing system. It would have to be developed and implemented with extensive stakeholder input and participation, which would require time and dedicated resources. Developing a child welfare plan would also be a major undertaking for the state, which would need to seek legislative approval and secure federal approval for the plan, issue an RFP, develop a contract, and manage a procurement process, among other administrative functions. All that said, it has the potential to drive meaningful improvements in health and social outcomes for the child welfare-involved population. Lessons could be learned by reaching out to additional states with child welfare

plans to hear more about their experience. The experiences of Florida and Texas could be particularly instructive as they, like California, are both geographically large and racially diverse states.

4. Other Approaches to Delivery System Reform

A second category of options would maintain the current managed care structure but permit counties to alter their behavioral health delivery systems, either by carving SMHS or SUD services into the MCP contract for the child welfare-involved population, or by carving the mild-to-moderate behavioral health benefit into the MHP contract for the child welfare-involved population, allowing all behavioral health services to be delivered by one entity. Under existing state constitutional and statutory law governing county program realignment, either option would have to be implemented by counties on a voluntary basis.

Carve-In of SMHS or SUD Services into the MCP Contract

A carve-in to the MCP contract of SMHS, SUD services, or both, would theoretically offer MCPs the opportunity to better coordinate and integrate physical health care and a wider continuum of behavioral health care for the child welfare-involved population. The carve-in could also enable MCPs to better address data-sharing challenges and improve care coordination and care management. In addition, the carve-in could reduce the number of systems that the child welfare-involved population must navigate, which could improve access and utilization. In implementing counties, the carve-in would also reduce the number of health care entities accountable for the child welfare-involved population, which may in turn allow for more effective performance monitoring and oversight by the state and county. To preserve the existing provider network and ensure adequate access, the MCP could be required to offer a contract to all providers participating in the local SMHS or Medi-Cal SUD delivery system.

On the other hand, there would be a learning curve for MCPs, all of whom would be assuming responsibility for new behavioral health services and provider networks for the first time. This learning curve could be particularly steep for the MCPs that have outsourced administration of the mild-to-moderate behavioral health benefit to behavioral health organizations (BHOs), leaving the plans themselves with little to no experience covering behavioral health services in Medi-Cal. In addition, the number of children and youth in child

welfare would still be a very small proportion of the plan's overall membership, which may make it difficult for plans to prioritize the needs of this population among competing demands.

In addition, the carve-in could threaten to disrupt the strong relationships many county child welfare departments have built with their local specialty mental health and SUD provider systems, and the important work these groups have undertaken together as part of the Child and Youth System of Care initiative. If a county were to opt-in to the carve-in, it would want to ensure that the system improvements and connections achieved through implementation of AB 2083 (Children and Youth System of Care) were not lost in the delivery system change. This risk could be mitigated by requiring MCPs to contract with all county-operated or currently county-contracted providers, so while the administration of the benefit would shift, the providers and existing relationships would not.

Carve-In of the Mild-to-Moderate Behavioral Health Benefit into the MHP Contract

The state could also afford counties the option to have their MHPs assume responsibility for the mild-to-moderate behavioral health benefit from the MCPs. Eliminating the bifurcation of responsibility for behavioral health services between MCPs or FFS and the MHPs could also simplify and streamline the behavioral health delivery system for child welfare-involved children and youth. This, in turn, could allow the MHPs to more effectively coordinate behavioral health services for this population, better track the performance of contracted behavioral health providers, support more effective data-sharing among providers, and spur improvements in system performance and outcomes. Combining the administration of the mild-to-moderate benefit and the SMHS benefit could also improve access to and increase utilization of SMHS for the child welfare-involved population by, for example, making the process of referral and linkage to SMHS easier.

It is worth noting, however, that the carve-in of the mild to moderate benefit into the MHP contract may not make a meaningful impact, as DHCS is proposing to change the medical necessity criteria for specialty mental health services such that out-of-home placement, or a high score on a trauma screening tool, would be sufficient to justify entry into the specialty mental health system. Should this change take effect, all child welfare-involved children or youth would have the option of accessing behavioral health services through the county MHP, including those who would previously have been limited to the behavioral health services and

network provided by the child or youth's MCP or the FFS program, depending on the child's enrollment. In addition, an unintended consequence of a mild-to-moderate carve-in to the MHP contract could be that some children and youth would experience a narrower set of treatment options, as they would no longer have access to providers contracted with the MCP but not the MHP, and parents/caregivers would potentially obtain behavioral health in a different system than their children. This could specifically limit access to behavioral health providers embedded in primary care settings, such as community clinics or Kaiser Permanente.

Other Modifications to the Current Medi-Cal Managed Care or FFS Systems

A third category of concepts include enhancements to the existing Medi-Cal managed care or FFS programs that would not shift responsibility for covered services. In the table below, we identify five such proposals that have been discussed by the Workgroup and identify some potential strengths and open questions for each. Some of these proposals are the same as or very similar to recommendations put forward by CBHDA/CWDA, the CWC's Behavioral Health Committee, the California Association of Health Plans, and NHeLP.

Many of the proposals included below could be combined with each other, as well as with the proposal to develop a child welfare plan or voluntary behavioral health integration. In addition, some of these combinations could be implemented incrementally and may be synergistic over time. For example, the development of a child welfare plan would provide a natural platform for the establishment of new performance and outcomes measures. Likewise, a new value-based bundled payment arrangement could be developed in connection with the child welfare plan contract and available to providers who meet state criteria for designation as child welfare providers of excellence.

Table 1. Other Proposed Modifications to the Current Medi-Cal Managed Care or FFS Systems

Proposal	Strengths	Open Questions
(1) Require each MCP to have a manager or team with specific expertise in the child welfare-involved population	• Could improve care management for the child welfare-involved population • Could push MCPs to build capacity and expertise to meet the unique needs of the child welfare-involved population	• Concern about duplication of the intensive care coordination services provided as a SMHS and the current role of public health nurses • Would not address fragmentation in the current system
(2) Create a bundled payment model to support providers treating the child welfare-involved population, either in FFS or Medi-Cal managed care	• Could incentivize more providers to develop centers of excellence • Could be designed to drive advancements in whole-person care, and encourage greater integration of physical and behavioral health services or a wider set of behavioral health services	• Could require an increase in MCP capitation rates • Could require an increase in budget for FFS expenditures
(3) Increase the number of public health nurses within the FFS system	• Could improve care management and care coordination, leading to increased utilization of needed services	• Concern about duplication of the intensive care coordination services provided as a SMHS • Would not address fragmentation in the current system • Would require a new funding source, and/or modifying the existing funding structures

Proposal	Strengths	Open Questions
(4) Define new MCP measurement outcomes specific to the child welfare population	• Could spur improvements in system performance • Could be combined with enhanced performance monitoring requirements, which would help inform identification of strengths and areas for improvement	• Robust outcomes measurement would require additional investments in data collection and sharing • Challenge of drawing conclusions about the performance of individual MCPs based on outcomes data, given the number of systems providing care for this population and the challenge of coordination between them • Dearth of validated, meaningful measures (most health care measures focus on utilization, as opposed to patient-reported outcomes of well-being, recovery, avoiding harm, and achieving goals)
(5) Mandating enrollment for all children and youth in foster care into Medi-Cal managed care (behavioral health remains a carve-out unless counties volunteer to carve in)	• Could decrease the challenges faced by families trying to find a primary care or specialty provider, as FFS has no accountable entity ensuring sufficient provider networks and timely access • Would also allow coordination of care for services through the MCP, which doesn't currently exist through FFS • Could be combined with new expectations of managed care (e.g., concepts described above)	• Would not resolve challenges faced by out-of-county placements, requiring change in plans and disruption of provider relationships • Few if any MCPs have demonstrated robust investment in the child welfare population, and do not currently have internal expertise in their specialized needs

Conclusion

A single child welfare plan, or a small group of regional plans, has the most potential to address the profound challenges that children, youth, and families face in the current fragmented system. It would create an accountable entity to ensure a robust network of providers, timely access to care, coordinated medical, behavioral, dental, and social services, a dashboard of performance metrics, and a portable health record. If specific counties choose to partner with the plan to carve in specialty mental health services, safeguards could be put in place to maintain the current network of specialty mental health providers and the relationships built between mental health and social service providers as part of Continuum of Care Reform and to ensure utilization management practices do not prevent access to needed care. Creating a new managed care model just for children and youth in child welfare would also be the most complex solution to implement, and success would require a multi-year planning and implementation process. Lessons from other states suggest that significant changes to the health care delivery systems serving the child welfare-involved population must be implemented over time, with stakeholder input and buy-in, and adequate time for preparation and the ability to make adjustments throughout implementation. Sweeping change to the systems that serve the child welfare-involved population in California, if implemented rapidly, could introduce risk and lead to unintended consequences.

Nonetheless, there is widespread agreement that significant system change could improve outcomes for the child welfare-involved population. CalAIM provides a unique opportunity to reconsider the current health care delivery system for the child welfare-involved population, and the option to recommend a significant restructuring with the goal of meaningfully advancing outcomes for this population.

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[1] The *Foster Care Model of Care Workgroup Website* includes the complete Workgroup Charter, Guiding Principles Document, Workgroup Roster, and the agenda and all associated materials for public Workgroup meetings.
[2] CBHDA and CWDA. *Joint Behavioral Health Vision for Child Welfare*; May 5, 2020.
[3] The California Child Welfare Council. *Behavioral Health Committee Draft Policy Recommendations*; September 2020.
[4] UMass Medical School. *Foster Children Evaluation Services*.

[5] Pediatrics (The Official Journal of the American Academy of Pediatrics), Vol. 136, Issue 4 (Oct. 2015), *Health Care Issues for Children and Adolescents in Foster Care and Kinship Care*.
[6] On behalf of DHCS, the Aurrera Health Group provided to the Workgroup a memorandum discussing the health care delivery systems for the child welfare-involved populations in Arizona, Washington, and New Jersey. This memorandum was based on presentations provided by Arizona and Washington to the Workgroup on August 21, 2019, as well as additional research.
[7] For more information about the procurement in Ohio, *see* the OhioRISE website.