

The Foster Care Subcommittee of the CMHDA Children's System of Care Committee has identified the provision of mental health services to foster children placed out-of-county as an area of particular interest relative to the change opportunities being offered by the California Welfare Redesign and the Mental Health Services Act (MHSA) implementation. In the summer of 2004, the subcommittee formed an interdisciplinary workgroup to identify barriers to meeting the mental health needs of this group of youth and to propose potential strategies to eliminate barriers to their mental health care.

Twenty-seven individuals attended two workgroup sessions. Representatives included advocates, county mental health professionals, providers, DMH representatives and other stakeholders. Input from California Department of Social Services and Probation is not included in the report as their representatives were not able to attend the workgroup meetings. Nonetheless, the information in this report is considered to be an important step in preparation for system change planning that may take place at the local and state levels in the near future.

The report provides a summary of issues in four key areas and offers recommendations for CSOC and CMHDA member consideration:

- **Medi-Cal Benefit Eligibility and Service Reimbursement**
- **Inter-County Administration of Services**
- **Access to Mental Health Services**
- **Care Management and Interagency Coordination**

Background

More than 700,000 children come in contact with California's child welfare system each year. Many of those youth are placed in foster care, with over half being children under the age of five (see Attachment A – CDSS Fact Sheet). In 2004, 86,000 children were in foster care in California. *Most are supervised by county child welfare services departments and are referred to as "welfare supervised". A small portion are the responsibility of county probation departments and are referred to as "probation supervised".* CDSS data from 2002 indicate that of the 97,919 youth in out-of-home placement, 93% came from child welfare caseloads and 7% came from county probation caseloads. These youth are often referred to as the "out-of-home" placement population that has been a major focus of the Children's System of Care over the past 20 years. A brief overview of the two groups of youth is provided below:

9% group homes 25% foster family agencies 38% relative homes 4% other homes 16% foster family homes 8% guardian homes	88% group homes 3% foster family agencies 4% relative homes 3% other homes 2% foster family homes
33.3% African American 33.3% Hispanic 33.3% White	26% African American 36% Hispanic 33% White 5%Other
56% ages 0-10	81% ages 15-18
21% out-of-county/state	51% out-of-county/state

National research studies have demonstrated that foster care youth are at a significantly greater risk of mental illness, while the care delivery systems often are fraught with structural problems that impede access to effective service (Foster Care Policy Brief, Rosenbach, 2001). Those problems include:

- **Lack of continuity of health benefits** - These children often have greater disruptions in Medicaid health benefits compared to other Medicaid funded populations according to reviews of several state programs;
- **State-level variation in the structure of Medicaid programs** – The variations in Medicaid expenditures across states suggest that states differ in the use of Medicaid to serve children in foster care, despite states having flexibility in how they use Medicaid to pay for services for children in foster care and the capability to fund a comprehensive continuum of care, ranging from screening and assessment to follow-up treatment and ongoing therapies.
- **Lack of a broad based concept of care coordination** – Due to the complexities of the various systems involved in the lives of these children, care coordination policies and protocols are particularly essential for these children, yet they are frequently not clearly defined and are poorly enforced.

These areas of national policy concern were confirmed by the Foster Care Subcommittee, and are considered to be of particular importance in California, given the number of children who are placed out-of-county and where inter-county dynamics add yet another layer of complexity to an already complex situation. CDSS data indicates that in July 2002, 24% of the welfare supervised children placed with relatives (43% of placements), and 7% placed with foster families or guardians (46% of placements) are placed out-of-county or out-of-state, presenting a unique challenge to county Mental Health Plans responsible for insuring children with Medi-Cal benefits have access to appropriate mental health services. For probation supervised youth, while a much smaller number, over 50% are placed out-of-county, presenting a particular access issue for this group of youth, many of whom are placed in lower level group home settings. Further, while over half of foster care youth are reunited with parents, 16% are adopted according to CDSS data. The Foster Care Subcommittee identified this group within the out-of-county placed group of youth, as a group whose unique long-term needs require distinct consideration.

Medi-Cal Benefit Eligibility and Reimbursement

This area addresses current policies regarding how youth in the foster care system in California are made eligible for Medi-Cal health benefits and how specialty mental health services are reimbursed.

Issues:

- ***County-tied Medi-Cal Eligibility*** - In California, when foster care youth are placed out-of-county by their county of origin into a different county, a “host county”, their Medi-Cal stays with the county of origin. This causes numerous complications for both counties of origin and host counties in ensuring access to services.
- ***Different Eligibility Rules*** - Social Security Insurance regulations and policies may differ from Medi-Cal regulations. For example, with Social Security Insurance a child’s original address (county of origin) can change to the site of service delivery (host county). Given the occurrence of both chronic health problems and mobility of this population (in 2000, for those in placement over 12 months, 35% experienced three or more placements), it is not uncommon for this population to have disrupted Medi-Cal eligibility as a result of benefit changes.
- ***Access to Eligibility Information*** - Value Options is not allowed access to MEDS file data (DHS has authority over this data and Value Options is

for mental health services for youth placed out-of-county, and then for assuring proper reimbursement for the federal and matching share of the services claimed.

Inter-County Administration of Services

This section addresses the various policies and practices of county departments and agencies across the state relating to the administrative management of mental health services provided to out-of-county placed youth.

Issues:

- ***Provider Disincentives*** – Many providers do not have the infrastructure or resources to manage complex contractual requirements of multiple placing county Mental Health Departments. When providers do have this ability it is very expensive and not worth doing if only a few children will be served. This can put certain services out of reach for small counties, or counties regardless of size who have need for only a small number of children. The contracting processes and requirements from one county to another are not uniform and are often very complicated and time consuming thus delaying access to services. In other cases, unless there is a prior relationship between the county and the provider, a contract cannot be established in advance. Contracting may take as long as 18 months to complete. Often there are multiple restrictions for organizational providers. In some cases a county will disallow, as a contract provision, an organizational provider from treating children from another county. Finally, disallowances are cost prohibitive for providers and host counties.
- ***County Disincentives*** - Inter-county contracting can require considerable costs for both placing and placement counties. Host counties incur high infrastructure costs to provide services to out-of-county foster youth. When the county of responsibility changes, the new county may not agree to pay the costs that were initially agreed to. The new county may not pass the state share s to the host county. Various county departments do not make adequate use of funding streams nor are they as creative with funding as other counties.
- ***ASO Disincentives*** - Value Options is not allowed to contract with organizational providers to serve out-of-county children for CMHDA contracts and many counties do not make their provider lists available to Value Options.

Access to Specialty Mental Health Services

are required to be available to Medi-Cal recipients, the county-level resources for the provision of emergency and inpatient services can vary, sometimes causing delay in immediate access to emergency and crisis services for these youth.

- **County Requirements** - Nothing compels placement counties to provide services to these youth, and given the lack of local resources and the disincentives cited above relative to county-to-county contracting, many counties will not treat children from other counties, even if payment has been promised.
- **Case Management Demands** – Due to the many individuals involved in the care of out-of-county placed youth, the timely coordination of care is often compromised for those youth placed at a significant distance from placing counties.
- **Cultural Competence Demands** - There is an over-representation of children of color, especially African American and Latino children in the foster care system. Many counties may lack the culturally competent service strategies to address the mental health needs of these youth.
- **Lack of Specialized Services** – Counties often lack specialized treatment interventions designed to address issues of family reunification, adoption, and emancipation (transition age services) for this population.
- **Lack of Self Help, Prevention and Early Intervention** - Currently, public mental health systems do not include these specialized services in the array of services available to foster care youth.

Care Management and Interagency Coordination

This area addresses the complex and intensive coordination efforts that are necessary to meet the care needs of this population. It is an area that has received much attention over the years and never seems to improve.

Issues:

- **Information Sharing Demands** – The task of insuring timely and effective communication among a wide cast of involved players in the lives of foster care youth is challenging in the best of situations. This is further complicated for out-of-county placed youth where the policies and cooperative relationships between

practice, multiple parties hold responsibility for various aspects of a child's care. Additionally, there is not centralized responsibility and oversight – the diffusion of responsibility seems to lead to lapses in accountability and policy enforcement. Laws and regulations that do exist to manage programs for this population are not effectively enforced.

- **Lack of support for adoptive families** - Currently, after an adoption is finalized, the child's county of origin [the county in which they first entered the foster care system] continues to be responsible for all of the child's Medi-Cal services, regardless of the county of permanence, which is the county in which a child lives after being adopted. This requires children who have found permanent families and are out of the foster care system to continue to be connected to a county in which they no longer reside, have no plans of returning to, and therefore have reason to be connected. This subjects adopted children to all of the problems we know exist for out-of-county foster children, such as difficulties accessing medically necessary services.

Recommendations

The following recommendations were outlined by the Subcommittee to address the issues identified in the two discussion meetings:

1. **Modify California Medi-Cal Eligibility for Foster Care Youth and Qualified Adopted Youth** - CMHDA should approach the State Departments of Mental Health and Social Services to seek changes in Medi-Cal eligibility requirements for foster care and qualified adopted youth. The purpose would be to insure continuity of Medi-Cal eligibility and access to care regardless of youth residence within the state. The solution should identify both counties of origin and host counties to allow appropriate tracking and cost reconciliation. ***In particular, there needs to be a special proposal developed to change the county Medi-Cal code to the host county, also the county of residence of the adopted parents, when the adoption is final.***
2. **Modify Reimbursement System for Specialty Mental Health Services for Foster Care Youth and Qualified Adopted Youth**– CMHDA should approach the State Department of Mental Health and Social Services to seek changes in the current system of reimbursement to counties that provide mental health services to children placed in their counties by other counties. The purpose would be to insure

3. ***Establish Formal County-to-County Protocols for Service Coordination, Treatment Authorization and Care Management of Foster Care and Qualified Adopted Youth*** – CMHDA counties should establish standard formal protocols within and between counties to insure clear roles and responsibilities, treatment authorization and oversight, emergency and crisis plans, and ongoing communication, among placing agencies, providers and caregivers of foster care and qualified adopted youth placed out-of-county. This agreement would set the conditions for delivering mental health services to children and youth regardless who need assistance in a host county. Included in this population are: a) children/youth residing in another county, driving into the host county for services; b) those children/youth who are from one county, but were adopted in another county; and c) children/youth from other counties who are placed in relative foster care, foster family care, or group homes within a host county.

4. ***Establish Standards for Minimum Service Array Needed to Meet the Needs of Foster Care Youth in California***- In collaboration with foster care consumers, families, providers, agency representatives and advocates, CMHDA should facilitate the development of minimum standards and services that should be available to meet the needs of foster care youth, including a summary of best and promising practices in addressing treatment, permanent placement, and developmental needs of foster care youth.