DISCUSSION DRAFT

State Policy for Improving Access to Timely and Effective Mental Health Services for Foster Children Placed Outside of the County of Jurisdiction

Rev. May 29, 2015

Goal:

To improve access to timely and effective mental health services for all foster children placed outside of the county of child welfare and/or probation mental health jurisdiction, in another county.

Guiding Principles:

1. Transfer policy whereby the mental health authorization, treatment, and payment is transferred to the host county mental health plan should be aligned with permanency goals. Transfers must be done in a child-focused and family-focused manner, which requires a policy with flexible parameters
2. The tenets and suggested practices of the Katie A. Settlement Agreement and the proposed Continuum of Care Reform (CCR) efforts with respect to child and family teams should be embedded in this policy.
3. A child and family team is a central, driving force in this effort and should be convened as soon as possible following the guidelines in the Katie A Core Practice Model.
4. Both child welfare and mental health systems need to work collaboratively to build trauma-informed systems of care.
5. Child welfare and mental health systems will include youth and family voices and choices in decisions about their care.
6. The policy must ensure that crossing county boundaries does not compromise service delivery.

Context:

The State, County Behavioral Health Directors Association (CBHDA), County Welfare Directors Association (CWDA), and the Chief Probation Officers of California (CPOC) believe that a multi-pronged approach is needed to address this long-standing challenge. The State and counties share responsibility to reduce barriers and provide access to mental health services for foster children placed out-of-county.

The policy takes into account the recent programmatic and fiscal changes impacting the child welfare, probation and mental health programs. The policy also considers the child's best interests for safety, permanency and well-being. Recent program/fiscal changes include:

- Katie A. Court Settlement and Core Practice Model
- The CCR Recommendations
- 2011 Realignment

Proposal Components:

1. **Screening and Assessment** – Consistent with California's intent for the child welfare system as expressed in the January 2015 Continuum of Care Reform report and Katie A Core Practice Model, DHCS and CDSS will collaborate with CWDA, CBHDA, CPOC, and other key stakeholders to provide timely behavioral health screening and assessment for all foster children. Screening and assessment should be trauma-informed and cover a range of potential needs including developmental disabilities, prenatal

neurotoxin exposure, substance abuse (for older youth), mental health, and other domains.

In addition, guidelines are being developed by the DHCS concerning services by health care/managed care plans and county mental health plans, with respect to defining mild to moderate versus high need, and specialty vs. non-specialty mental health services. The guidelines will be provided to health care providers for making referrals to county mental health when foster children are screened as needing specialty mental health services.

2. **Authorization and Services** – The following changes will improve access to mental health services for foster children placed out of county:
   a) In cases of emergency, the responsible agencies shall take the child to where the emergency services are available.
   b) Upon assessment of the child with a mental health need, the child and family team will determine if transfer of authorization and services should proceed based on the input of the child (as appropriate), his/her family, and caregiver representative (e.g. relative, foster parent, FFA or group home), the county of jurisdiction child welfare/probation case manager and county of jurisdiction mental health plan. The assessment and authorization shall occur within 4 business days following the referral to the county behavioral health department. Absent a child and family team, the determination of transfer of mental health authorization and services would be made by the following entities: jurisdiction county mental health plan and family; the county child welfare agency and/or the probation agency. In either case, the determination will be based on the child's case plan objectives (which is inclusive of the treatment plan), and decisions will be made in the best interests of the child and family.
      - If the transfer of authorization and services proceeds, the Host County MHP (HC-MHP) will assume responsibility for the authorization and provision of, and payment for, medically necessary Medi-Cal specialty mental health inpatient and outpatient services, and thus bear the financial and compliance risk.
      - If the Jurisdiction County Mental Health Plan (JC-MHP) maintains the case, that county will continue to be responsible for the authorization and provision of, and payment for, medically necessary Medi-Cal specialty mental health inpatient and outpatient services.
      - If there is a disagreement between counties regarding transfer of authority or services authorized, then a decision will be made by the responsible county placing agency (CWS or Probation), in consultation with the child and family team (if one exists), within 48 hours. State and county agencies will identify the appropriate dispute resolution process.
      - The county child welfare, probation, and/or mental health representative of whichever county holds responsibility for the authorization, provision, and payment for mental health services shall be a member of the child and family team, as he/she is a critical member in meeting the goals of the child and family service plan, consistent with the CCR Recommendations and Katie A Core Practice Model.

   c) As Continuum of Care Reform (CCR) is implemented, group homes will continue to transition to short-term, intensive treatment models. These group home providers must have the ability to provide mental health treatment services directly to

foster children in their care. In addition, as Therapeutic Foster Care (TFC) is implemented, and as the CCR recommendations for Treatment Foster Family Agencies (FFAs) move forward, these agencies also must be certified as Medicaid providers. These agencies then would serve as Medi-Cal subcontractors of County MHPs and be able to request authorization for services from the responsible MHP, and to provide those specialty mental health services directly to the foster children in their care.

d) The State will work with stakeholders to develop a statewide training for determining medical necessity for mental health services for children in foster care, so that there is more uniformity in establishing eligibility for services.

3. **Administrative and Financing Issues**
   a) DHCS commits to analyzing the appropriate method(s) necessary to most quickly implement a policy to allow for the transfer of authorization and provision of services from the county of jurisdiction to the host county, based on the process outlined in 2 above (e.g., revise regulations, issue an Information Notice, and/or amendment to the MHP Contract). In the event a Medi-Cal Mental Health Plan contract amendment is needed, DHCS will collaborate with CBHDA to develop the relevant language.
   b) In the MEDS database, DHCS will add an indicator when the county of residence needs to be added.

4. **Capacity and Accountability** – The State and counties are doing the following:
   - The State is implementing the Katie A Shared Management Structure so that DHCS and DSS can work with county mental health plans and county child welfare/probation agencies to identify capacity issues locally to coordinate services for children with mental health needs. Pursuant to data-sharing agreements, the State and counties will share data to track outcomes and identify potential gaps in access to services.
     - Contingent on CMS approval, the implementation of the Medi-Cal 20/20 Waiver offers opportunities to assist with workforce capacity issues. DHCS may be able to allocate waiver funds to entities that have experience administering loan repayment programs, such as the Health Professions Education Foundation (a 501(c)(3) under OSHPD). DHCS could stretch waiver funds across a larger number of health professionals including child and adolescent psychiatrists if it used a matching grant approach similar to that used by the State Loan Repayment Program (administered by the Health Professions Education Foundation).
   - Auditors will receive training so that audit practices are consistent with program requirements for the authorization and payment of treatment services for foster children placed out-of-county.