January 13, 2023

Michelle Baass, Director
California Department of Health Care Services
1501 Capital Avenue
Sacramento, CA 95814

Tyler Sadwith, Deputy Director, Behavioral Health
California Department of Social Services
1501 Capital Avenue
Sacramento, CA 95814

Submitted via email: CalBHCBC@dhcs.ca.gov

RE: CWDA RESPONSE TO THE PROPOSED CALIFORNIA BEHAVIORAL HEALTH COMMUNITY-BASED CONTINUUM DEMONSTRATION CONCEPT PAPER

The County Welfare Directors Association (CWDA) appreciates the opportunity to review and provide additional feedback on the draft California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration proposal. We support the goals of the proposal to strengthen California's behavioral health system for children and youth across California, and specifically for child welfare system-involved youth, through cross-system coordinated services to ultimately improve health outcomes. CalAIM and CalBH-CBC are pivotal initiatives that will improve services and outcomes for children, youth and their families served by the child welfare services system.

We are pleased that the Department incorporated some of our earlier recommendations in this current draft concept paper, specifically our proposal for joint visitation and assessments by a Specialty Mental Health Service (SMHS) provider and child welfare worker prior to the child's entry into the foster care system. This joint work supports implementation of the Integrated Core Practice Model (ICPM) and aligns with the current research that "demonstrates when services are integrated, collaborative and actively engage and partner with children, youth, and families they are most effective in meeting the complex needs of children and families involved in multiple, government-funded service organizations."[1]

CWDA appreciates and is supportive of several other components of the proposal and accompanying investments, including having a foster youth liaison in managed care plans

[1] https://www.cdss.ca.gov/inforesources/the-integrated-core-practice-model

(MCPs), activity stipends for foster youth, and funding for child and family team meetings for family maintenance cases (noted in the CDSS Local Estimates binder[2]). We look forward to working with the Administration to further develop the implementation policies for those proposals.

RECOMMENDATIONS

We have two main themes to our feedback below. First, cross-system collaboration and coordination serve as the foundation of not only the ICPM, but also the broader CalAIM initiative and AB 2083 Systems of Care mandates. We feel the CalBH-CBC proposal can be strengthened by more explicitly articulating how the Demonstration elements, and specifically how MCP efforts, will integrate into the broader AB 2083 local Systems of Care work which includes child welfare, probation agencies, behavioral health, regional centers and education agencies. The AB 2083 Systems of Care are working together to plan services for foster children and those at risk of foster care through delivery of comprehensive primary, secondary and tertiary services, with a specific focus on supporting foster youth with complex needs. This proposal presents an important opportunity to leverage those efforts to improve services specifically for child welfare involved youth and families.

Second, we believe that meeting the behavioral health needs of low-income children, youth and families, and specifically children served by the child welfare system, requires a ***bold*** approach that both ensures children receive the services to which they are already entitled, while also testing new approaches and innovations that holistically serve children, youth and families across systems. The CalBH-CBC proposal represents a historic opportunity to leverage federal funding and a course for life-long improvement of social, emotional and physical well-being for children and youth. We encourage DHCS to articulate a pathway that sets forth a commitment to strengthening existing services, ensures the EPSDT entitlement is met, and embraces innovative approaches that meets the needs of children and youth more holistically, and which articulates more concretely how this will be accomplished through the Demonstration. The plan should acknowledge the gaps in services and other disparities faced by children, youth and families of color and those who identify as LGTBQ+ in accessing those services, and articulate a plan to address those disparities to build more culturally responsive systems of care.

Expand Access Criteria to Parents: We greatly appreciate your Department's work to increase access to Specialty Mental Health Services (SMHS) through modifications in the access criteria as conveyed through BHIN 21-073. While child welfare-involved children now have automatic access to SMHS, their parents must still meet higher standards in order to treat their own mental health or substance use services. While some clinicians have found ways to provide some services under a family treatment option, this option is inconsistently

[2] https://www.cdss.ca.gov/Portals/9/Additional-Resources/Fiscal-and-Financial-Information/LOcal-Assistance-Estimates/2023-24/estimate-methodologies.pdf (See page 563 of the PDF).

applied and may not be applicable to every situation. A child's healthy growth and development, from both a physical and a mental health perspective, is completely dependent upon the child's attachment to and support from a caring and responsive primary caregiver. For families in reunification, who often struggle with their own prior traumas and current mental health and/or substance use issues, having immediate and timely access to SMHS is critical and would allow children to reunify more quickly. It also may prevent family separation altogether. Federal, state and county costs can be greatly reduced if we can better support the family as a unit. We appreciate the implementation of the dyadic benefit under CalAIM which similarly allows the provision of mental health services to parents of young children. In this vein, we urge DHCS to consider providing *automatic* eligibility for SMHS to the parent of a child welfare-involved child or youth when mental health and/or substance use issues are present, which these can be identified through the initial (proposed) joint visitation by child welfare and a SMHS provider.

Cover services not otherwise reimbursable that promote healing: Most recent trauma research has found a mind-body connection to healing.[3] Brain research has found that traumatic stress results in injuries to the brain that result in loss of memory, balance issues, numbness in the body, etc. Therapy often needs to be accompanied by body-healing activities to help re-establish neural connections that will help individuals coping with trauma to heal. These include activities such as yoga, acupuncture, chiropractic services and massage. We recommend that these activities should be authorized through MCPs and County MHPs as a benefit for children and their parents/primary caregivers who are healing from trauma, in addition to any other traditional therapies. We feel these should be authorized and funded separate and apart from the activity stipends, which are intended to promote enrichment and social activities that also serve a valuable purpose in child and youth development. We also encourage the Demonstration to clarify coverage for equine and art therapies to facilitate greater access to those therapies.

Articulate improvement targets upfront, with stakeholder involvement, and provide resources to meet these targets: DHCS states its intent "to work with counties to strengthen the community-based care continuum, supporting behavioral health delivery system transformation through incentives, robust technical assistance and oversight." (pg 21). DHCS also plans to engage counties and other stakeholders in the design of a "transparent monitoring approach," and notes that it "may amend" its contracts with County MHPs to accomplish certain goals including "establish key performance expectations and accountability standards." This relatively vague language leaves stakeholders in the dark as to what those expectations and accountability standards will be, if any, and whether there will be a stakeholder role in this process. We urge DHCS to set an expectation that this Demonstration project will increase penetration rates to SMHS for foster youth, given changes in access criteria pursuant to BHIN 21-073. Specifically, we should expect higher utilization of services specifically designed for foster youth including Intensive Care

[3] See for example the research and findings of Bessel Van Der Kolk, MD, "The Body Keeps the Score." https://www.besselvanderkolk.com/resources/the-body-keeps-the-score

Coordination (ICC), In-Home Based Services (IHBS), and Therapeutic Behavioral Services (TBS). Foster youth stepping down from emergency rooms, hospitals or other in-patient settings often lack access to partial hospital programs. These and other SMHS must be readily available statewide to foster youth and families in need. We also urge DHCS to articulate how it will work with the Department of Social Services (DSS) to align CANS (Child and Adolescent Strength and Needs) tools and to utilize CANS assessment data (and any other assessments) to track access to SMHS and outcomes for foster youth, and articulate statewide expectations for service delivery based on CANS Assessments (i.e. high CANS score as an indicator of a need for certain SMHS). To support this recommendation, we also urge DHCS to work with county MHPs to assess their capacity needs and barriers, including but not limited to workforce and training needs, and to provide targeted funding and other resources and support as needed to meet these goals.

Proposed service array must be expanded statewide, and not at county option: The Demonstration proposes certain optional, community-based services such as FACT, ACT and temporary housing, while noting (pg 13) "for those under age 21 counties already must provide all medically necessary services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate." However, as noted in DHCS's own Assessment Report[4], critical gaps remain. For example:

- Only five of the 58 counties report operating a Children's Crisis Residential Treatment Program (CRTP), with no county offering more than one youth-oriented CRTP (pg 89).
- The majority of California counties lack available residential beds specifically for youth (75 percent, 45 respondents). One respondent noted, "The absence of SUD services in my world is so absolute and complete I don't know where to begin to discuss gaps." (pg 108).

Recent and significant investments to build infrastructure through the Children and Youth Behavioral Health Initiative are greatly appreciated; however, the proposed Demonstration misses an important opportunity to articulate how the above (and other) gaps will be addressed. County child welfare agencies (CWS) are seeing an increase in youth entering care due to significant unmet needs, and CWS are struggling to find services to meet their needs. Two specific populations we feel need to be addressed that will help reduce entries into foster care, and provide more effective services to foster youth in care, include:

(1) Youth with co-occurring mental health and intellectual/developmental disabilities (I/DD): Current services are too often siloed for this population. Children and youth with I/DD and behavioral issues often are referred for Applied Behavioral Analytics (ABA) services for behavior modification, but this does not treat their underlying mental health needs. Mental health practitioners may refuse to serve children with I/DD because they do not believe the child will be responsive to treatment. This can

[4] https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf (January 10, 2022).

result in extreme feelings of frustration that lead to aggressive or angry outbursts, and a resulting child welfare referral. We recommend that DHCS set an expectation that SMHS be delivered when a CANS or other assessments indicates a likely need, and that specially-trained SMHS providers should work in concert with ABA service providers to align behavior modifications to the mental health treatment plan. One potential way to accomplish this is to augment Regional Center services to include mental health clinicians.

(2) Substance Use and Mental Health Treatment for Youth: As noted in the DHCS Assessment Report, SUD services are simply, and critically, lacking for youth -- especially for foster youth who require a residential-based setting. This is due to the bi-furcation of contracting and disparate rates to providers, with SUD contract rates often lower than SMHS rates. We appreciate the efforts underway through CalAIM to administratively integrate SUD and mental health services; however, this is a multi-year effort and pending the 1915(b) waiver renewal expected January 2027.[5] Until then, we urge this Demonstration to identify specific strategies to improve access to and delivery of services to youth with SUD needs through both residential and community-based options. This should include an increase in SUD rates paid to providers, joint SMHS/SUD contracts, and allowing SMHS service providers to bill for any SUD treatment service provided concurrently with mental health treatment.

Implementing a Patient-Centered Medical Home for Foster Youth: The concept paper acknowledges that this Demonstration does not implement a comprehensive approach to meeting the needs of foster youth, yet we believe that the Demonstration can and should make a more concerted effort to support all youth who are in foster care or at risk of foster care if services are not provided timely and comprehensively to them and, as noted above, their families. The Centers for Medicare and Medicaid Services (CMS) recently urged states to adopt care delivery models such as patient-centered medical homes and health homes to increase integration of primary and mental health services and to address child/youth needs earlier.[6] Such an approach may not only improve well-being but also help strengthen families and avoid foster care referrals altogether.

Under CalAIM, children and youth with the most complex medical and social needs, including foster youth, will become eligible for Enhanced Care Management (ECM) and Community Supports beginning July 1, 2023. We appreciate the focus on foster youth but we also continue to have questions and some concerns that we hope can be resolved through additional focused conversations with stakeholders.

---

[5] https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx
[6] https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf (pg 10)

Pursuant to the ECM updated policy guide,[7] "in instances where the Member's California Wraparound Care Coordinator or HCPCFC Public Health Nurses is also their ECM Provider, ECM services could be provided where the Member receives California Wraparound or HCPCFC services." We appreciate that a HCPCFC Public Health Nurse (PHN) or the foster child's Wraparound provider may serve in the capacity of an ECM provider and believe these entities should be the MCPs' preferred provider of ECM services for foster children. Otherwise, ECM is likely to introduce a new entity as a formal system partner in the child and family's child welfare case, an entity not connected to the current cross-systems AB 2083 work, even though AB 2083 is designed to serve the very same youth with complex needs. This has the potential to cause confusion for youth and families and potential duplication of efforts.

Additionally, if an external CBO is selected to be an ECM provider, that ECM provider would be required to utilize existing child welfare assessments and perform any additional assessments independently, pursuant to the ECM policy guide (pg 40). It is unclear from the proposal how the ECM provider would be authorized to obtain this assessment information given strict child welfare confidentiality laws, and how these other assessments will be integrated into child welfare case planning. We think this should be clarified.

We also have concerns that ECM rates will be inadequate to allow county HCPCFC PHNs and existing Wraparound providers for foster children to contract with MCPs, given the high acuity of needs among foster youth and their families and the staffing required to meet their needs. Reimbursement rates to ECM providers need to be commensurate with the level of needs of this population and the staffing needs of the provider, to meet those needs, so that both community-based providers (CBOs) and county entities (especially in rural counties or other areas that have service gaps) can serve as ECM providers.

Lastly, it appears that foster youth who remain in fee-for-service will be ineligible for the ECM benefit, and the Demonstration does not articulate an approach to ensure foster youth in fee-for-service are not left behind. This is a gap we recommend at least acknowledging for future work, if not addressing in the final version.

We stand ready to engage with the Department and stakeholders to discuss ways to strengthen the ECM proposal for foster children with complex medical and social needs and potentially explore and test other patient-centered models that can meet the unique needs of this population.

---

[7] https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide.pdf (starting page 39)

Dental Services Not Addressed by this Proposal: While it may not be the vehicle for addressing dental services, county child welfare agencies experience significant delays and barriers to ensuring foster youth have access to dental care to meet dental needs. Children in foster care have higher rates of dental problems, and one-third of children in care have not had a dental visit in the past year (Finlayson et al., 2018).[8] We urge DHCS to consider options for increasing access to quality dental care for foster children and stand ready to partner with you and other stakeholders to address this issue.

Thank you for this opportunity to comment and we look forward to additional conversations in the near future.

Sincerely,

Cathy Senderling-McDonald, Executive Director
County Welfare Directors Association (CWDA)

cc: Jacey Cooper, Chief Deputy Director Health Care Programs & State Medicaid Director, DHCS
Kim Johnson, Director, California Department of Social Services (CDSS)
Jennifer Troia, Chief Deputy Director, CDSS
Angie Schwartz, Deputy Director, Children and Family Services Division, CDSS

Attachment: Chart with additional feedback

---

[8] https://www.childwelfare.gov/pubpdfs/health_care_foster.pdf