Attachment: CalAIM CalBH-CBC – CWDA/County Comments on Draft Concept Paper

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1	Introduction Overview – Capacity Building	DHCS references the *Assessing the Continuum of Care for Behavioral Health Services in California (2022)* which identified needs for children, youth and families as a basis for the recommendations in the proposal.	The proposal does not address some of the critical gaps identified in the Assessment report. For example: • Only five of the 58 counties report operating a CRTP for youth, 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." (page 108). That Assessment report does not specifically address service gaps for foster youth, but foster youth often are impacted because of their trauma experiences that make them more likely to need the types of services examined through the Assessment. We recommend more specifically addressing the gaps identified in the report, or at least acknowledging there continue to be gaps, and articulating a plan for addressing those gaps, including for children/youth in mental health crisis and for Residential SUD programs. Note the CYBHI Infrastructure Grants will certainly begin to help address those gaps, but those are one-time funds and voluntary by County MHPs and providers; gaps may still remain after those grants are issued. The one-time funding nature may have dissuaded providers from applying. Can there be an assessment of where gaps remain after the grants are issued, and commitment made in the concept paper to developing a plan with stakeholder input to fill those remaining gaps?

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			We also recommend adding the findings from the Foster Youth Focus Groups, conducted as part of the Model of Foster Care Workgroup.
7	CMS Letter on demonstration opportunities	References a 2018 letter that allows states to adopt innovative delivery systems.	CMS recently issued another letter in August 2022, "*Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth*" with numerous examples of initiatives across states to improve access and quality of services worthy of consideration, with input from stakeholders.
8	Community-based care	1st paragraph states: "DHCS recognizes that a comprehensive continuum of community-based care for Medi-Cal beneficiaries living with SMI/SED, inclusive of housing supports and other community supports, ensures that residential care and inpatient care are available when medically necessary and clinically needed to stabilize and transition adults, children and youth to community-based care."	Can you please explain how having comprehensive community-based care ensures that residential care and inpatient care are available? It seems something is missing here.
9	#4 County option to enhance community-based supports	County MHPs could opt into providing certain community-based services.	Additional feedback provided below but overall, concern is that this is not a statewide option. Some youth will be excluded based purely on whether their county opted in or not, which undermines equal access to service efforts and is likely to exacerbate existing inequities in service access.
9	#5 County option to implement the IMD Waiver	County MHPs could opt into the IMD waiver to allow for FFP for youth in IMDs.	Same concern as above. Note this directly impacts foster youth placed into STRTPs. Declining capacity in STRTPs has resulted in more ejects/rejects of foster youth and inability to access care and services they are entitled to receive under EPSDT and Title IVE, even when certified as needed by a Qualified Individual pursuant to FFPSA requirements.
9	Target Population	Last paragraph states, "In identifying the key elements of the demonstration, DHCS	Foster youth are not specifically listed in this paragraph and should be. DHCS convened the Behavioral Health Model of

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		also dedicated particular attention to the needs of populations that experience a disproportionate impact of behavioral health conditions, including children and youth, individuals who are experiencing or at risk of homelessness, and individuals who are justice-involved (Figure 2)."	Foster Care Workgroup, and those meetings were ended with the release of this proposal, presumably to address the specific and acute needs of foster youth. We recommend that foster youth (including candidates of foster care) should be specifically identified as a target population and strategies articulated clearly for meeting their needs. The strategy should at minimum, align with the pending AB 2083 Gaps Analysis and Recommendations Report that is due out shortly.
15	Strengthening the Statewide Continuum of Community-Based Services - Evidence-based programs	"DHCS proposes clarifying statewide coverage requirements and ensuring access to at least three specific evidence-based services that can be delivered at home or in the community under current Medi-Cal coverage authority: multisystemic therapy, functional family therapy and parent-child interaction therapy."	We appreciate that DHCS plans to issue guidance to counties that clarifies and streamlines Medi-Cal coverage of and reimbursement for these three specific services. However, there are many other therapies and services that may warrant similar guidance, including equine and art therapy, and supervised visitation with a SMHS provider (often used in child welfare cases). It is unclear if additional guidance on other evidence-based practices will receive similar guidance, and if counties and stakeholders will be able to provide input to ask for guidance on additional practices. We are also unclear if there will be a way to track whether the guidance will lead to increased use of the practices and we recommend some mechanism to track for this. One shortcoming of the current process for tracking SMHS delivery is that it does not track how some SMHS (specifically TCM & outpatient mental health services) are delivered nor their effectiveness. For example, one:one counseling session through referral to a third party vendor (such as Beacon) is very different from PCIT. Quality and delivery methods matter for kids and families – yet none of this is currently tracked or reported and we think should be.

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			Our other concern is that the services specifically identified for additional guidance serve very limited populations. MST and FFT focus on justice-involved youth and PCIT serves families with young children. Culturally-based interventions for black, Latino and tribal families, and therapies for homeless youth, are also lacking. Rather than specifically identifying a very limited list of services, the proposal can be strengthened by articulating how DHCS will support county MHPs and managed care plans on how they will support them to implement broader range of therapies based on individual needs, and how to leverage federal funding (including maximizing claiming to SMHS) to facilitate this. Given the focus on trauma informed services and requirement for ACES screening in Medi-Cal, we are curious why there is no mention of the ACES work and discussion of how those efforts will intersect with this Demonstration Project.
16	Strengthening the Statewide Continuum of Community-Based Services	1st paragraph: "In addition, the CalBH-CBC Demonstration may request authority from the federal government to make targeted improvements statewide for children and youth who are involved in the child welfare system."	Regarding the "may" – when will this be known? What are the triggers? What will be requested and how will DHCS engage stakeholders in the process? We believe this section should be strengthened and efforts made to identify specific area for focus for targeted improvements in the concept paper.
	Strengthening the Statewide Continuum of Community-Based Services	1st paragraph: " While the CalBH-CBC Demonstration is not intended to serve as a vehicle for implementing a comprehensive approach to responding to these recommendations, it does propose to carry out a number of recommendations delivered by the workgroup."	This is disappointing as the hope of the Model of Foster Care Workgroup was to have a comprehensive approach specific to the needs of foster youth and candidates foster care. We acknowledge that Enhanced Care Management will serve as one pathway to serve children, youth and families with complex social and medical needs, but this will leave out any foster youth in fee-for-service and their families. We also have questions and some concerns, as noted in our memo, on the ECM benefit that begins July 1, 2023. We encourage DHCS to consider testing other patient-centered models for providing

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			comprehensive services to foster youth, pursuant to federal guidance issued by CMS in August 2022.
16	Cross-Sector Incentive Pool	"DHCS proposes to establish a cross-sector incentive pool to collectively reward MCPs and county behavioral health and child welfare agencies for meeting specified outcome measures for children and youth in the child welfare system."	We support incentivize outcomes for cross systems collaboration. Although we are not 100% clear how this would be operationalized, but we would recommend Probation and Regional Center be incentivized from the beginning to ensure each system is equally invested in the outcome, in alignment with AB 2083 work, particularly since Child Welfare cannot do this work alone and achieve outcomes without the investment and involvement of the other systems. We also think co-investment from the beginning would better mirror the spirit of AB2083. The creation of a cross sector database would help with tracking a youth across the systems. A partial list of potential items to be identified for incentive pool: -Implementation of promising and evidence-based therapies and programs and tracking the location of these services (i.e. in home vs in community). -Level of participation and engagement of MCPs and MHPs in local 2083 Systems of Care work. -Intensive services (ICC & IHBS) for foster youth and other complex populations (i.e. juvenile justice, regional centers). -Reduced disparities in access to SMHS when foster children are placed out-of-county (to address presumptive transfer issues). -Intensive services that can continue after a child welfare case closes (i.e. Wraparound can continue after case closes); -More timely screening, identification, and access to physician care services to meet the needs of youth by MCPs, including access

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			-Utilization across counties of expanded CalAIM options including community workers and peer supports, specifically for child welfare-involved families. -Access to SMHS and other mental health and SUD services for parents as well as children served by child welfare programs.
16	Cross Sector Incentive Pool	"To facilitate shared accountability among the three systems, DHCS and CDSS may require contract changes and a Memorandum of Understanding to ensure MCPs and county behavioral health and child welfare agencies share data and work together to improve outcomes."	Generally we agree this would be a great addendum to the existing MOU, particularly surrounding data sharing which is an area of collaboration that typically lags behind the other aspects of cross system collaboration. That said, CWS agencies currently are not part of these MOUs or contracts; these are only between MCPs and MHPs. Is DHCS proposing to add CWS agencies? What data would be shared? Not necessarily opposed to this but wanting to understand the details and how this would be operationalized.
16	Cross Sector Incentive Pool	"As part of these contract changes, MCPs would be required to have a dedicated Foster Youth Liaison on staff to enable effective oversight and delivery of Enhanced Care Management (ECM). The Foster Care Liaison would have expertise in child welfare services, county behavioral health services, and other sectors; ensure appropriate ECM staff attend child and family team meetings; and ensure managed care services are closely coordinated with other services. The Foster Care Liaison would be a management-level position at the MCP with responsibility to oversee the ECM providers with foster care children and youth in their caseload, provide technical assistance to MCP staff as needed, and serve as a point of escalation for care	CWDA proposed a Foster Youth Liaison at the MCP and we are very appreciative of its inclusion in the proposal. We request a modification of their duties/responsibilities, to include serving as a point-of-contact at the MCP to assist our child welfare public health nurses as needed with accessing health care services within the MCP provider network, i.e. connecting with primary care physicians and specialists, scheduling medical appointment and trouble-shooting issues, and obtaining documentation as needed. See also our memo for questions and concerns with respect to ECM providers for foster youth. In addition, we recommend addition of a special code to help identify foster youth in order to help prioritize and expedite their access to services whenever possible. Per the ECM Policy Guide, MCPs will have access to Medicaid codes already to identify these populations; an additional indicator across MCPs would further assist in accessing care and can help expedite

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		managers if they face operational obstacles when working with county and community partners."	barriers to accessing their Medi-Cal benefits when a foster child is placed out-of-county. Might also consider encouraging MCPs to consider persons with lived experience for the FY Liaison position, in additional to other professional qualifications.
16	Foster Youth Liaison	"To facilitate shared accountability among the three systems, DHCS and CDSS may require contract changes and a Memorandum of Understanding to ensure MCPs and county behavioral health and child welfare agencies share data and work together to improve outcomes. As part of these contract changes, MCPs would be required to have a dedicated Foster Youth Liaison on staff…"	As written, DHCS is not committing in its draft concept paper to a contract changes with MCPs. The addition of the Foster Youth Liaison would require a contact change. Hence we are concerned that there is no explicit commitment to require the addition of foster care liaisons.
17	Activity Stipends		Generally supportive of the goals and we look forward to working with CDSS to implement this proposal. We additionally continue to recommend that the activity stipend be allowed for children aged 0-3 and potentially this can be an adjunct to the new dyadic benefit under CalAIM (i.e. if the physician makes a recommendation for an activity stipend during the dyadic visit, the information can be shared with our CWS PHN who can initiate the activity stipend).
17	Activity Stipends – Eligible population (also applies for ECM eligible populations per the updated policy manual)[1]	Footnote indicates: "To align with CalAIM ECM Children and Youth in Child Welfare population of focus eligibility criteria, DHCS proposes to include children and	We appreciate this expansive population of focus and wanted to note that children in AAP are covered, but not children who have achieved permanency through Guardianship. These are typically relative caregivers who may not have significant

[1] Policy manual page notes for ECM eligible populations will be: Children and youth who meet one or more of the following conditions:
(1) Are under age 21 and are currently receiving foster care in California;

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		youth who are under age 21 and are currently receiving foster care in California; are under age 21 and previously received foster care in California or another state within the past 12 months; have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state; are under age 18 and are eligible for and/or in California's Adoption Assistance Program; or are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the past 12 months. "	economic resources. Under this proposal, children in Guardianships will only have access for twelve months, rather than to age 21 (as per AAP). Additionally, there are also other children who are diverted from foster care altogether through Probate Guardianships. Often these are situations where the family has made arrangements for the care and custody of a child by a relative when a child's parent is unable or unavailable to provide this care.
17	Initial Child Welfare/Specialty Mental Health Assessment at Entry Point into Child Welfare.	DHCS proposes that a specialty mental health provider accompany the child welfare worker during the home visit, approximately 30 days following a hotline call, after a hearing substantiating an allegation of abuse or neglect, and upon the child's entry into the child welfare system.	CWDA is appreciative of the inclusion of this recommendation, per our joint proposal with CBHDA. We look forward to discussing how this will be implemented, including the following elements: • Whether the SMHS provider can continue to follow the foster child/family throughout the life of their case, as appropriate, for continuity of care. • How we can include referrals to Part 1 prevention services from CBOs to child welfare can be included. Note that those referrals may may not trigger an emergency response through the Hotline, but the

(2) Are under age 21 and previously received foster care in California or another state within the last 12 months;
(3) Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state;
(4) Are under age 18 and are eligible for and/or in California's Adoption Assistance Program;
(5) Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

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			family otherwise meets "candidacy" for Title IVE services. • Joint workforce training; • How other assessment tools (such as CANS or LA County's Multi-Agency Assessment Tool) will support this work.
19	Statewide Incentive Program	"Performance improvement measurements will also include rates specific to populations experiencing disparities in behavioral health care access and outcomes, specifically children and youth; individuals who are justice-involved; individuals experiencing or at risk of homelessness; the LGBTQ+ population; and American Indian individuals, Black individuals and other populations experiencing disparities as identified in DHCS' Health Equity Roadmap"	Please also add child welfare-involved youth specifically.
	Statewide Tools to Connect Beneficiaries Living with SMI/SED to Appropriate Care	"Along with building out the continuum of care, it also is important to help identify the appropriate level of care for Medi-Cal beneficiaries and to connect them to treatment."	There is a need for higher levels of proper facilities, such as psychiatric and residential facilities, and access to psychiatric care in lower-income communities. This is a need specifically noted by LA County, but impacts all counties. Please also reference the DHCS Assessment Report (January 2022).
20	Patient Assessment Tool	DHCS proposes to build on the current SMHS requirement for using the Child and Adolescent Needs and Strengths (CANS) tools for children and youth aged 6-20 for performance data reporting purposes to help guide level-of-care determination	CWDA urges this proposal commit to an alignment of the CANS tools and that DSS and DHCS work with counties to achieve this. We continue to have concerns that a CANS is not required for children ages 0-5 in SMHS (CWS completes this for our 0-5 population) to build consistency with the new Dyadic service billing. Aligning tools will allow for a more holistic approach to

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		and inform treatment planning for select intensive SMHS, including a stakeholder input process.	understanding and meeting the needs of families with young children across systems. Additionally, the CANS does not currently screen for possible exposure to substance uses in utero for youth over age 5 which would facilitate screening for FASD. Screening for FASD is critical at all stages given its potential impact on youth behaviors. Without such screening, therapy/treatments may be less effective, and this can significantly impact educational outcomes in school. CWDA is engaging with CDSS in discussions regarding potential modifications to CANS and encourages DHCS to be part of those discussions. We also highly encourage screening for other neurological disorders due to the known impact of trauma on the brain and the resulting brain injuries that lead to behavioral health disorders that can have life-long impacts if left undiagnosed.
20	Treatment Bed Availability Platform	"DHCS is exploring options to track the availability of inpatient and crisis stabilization beds on a statewide basis, making it easier to help people who require higher levels of care to find appropriate treatment options more quickly."	We appreciate inclusion of this and believe it is a significant need that should be addressed. We would also like to see a State commitment to addressing this gap statewide.
20	Promotion and Standardization of Quality of Care in Residential and Inpatient Settings	DHCS is committed to ensuring that individuals who are ready for discharge from inpatient and residential treatment are supported during the transition and connected to community-based services and supports, including housing.	This, in theory, is positive; however, there are large numbers of youth for whom this transition is not possible without a significant period of stabilization and without a great deal of planning, services, and coordination. Many youth require multiple lengthy inpatient stays or require long term treatment to be able to stabilize sufficiently to be placed in the community. We urge the Demonstration to address this gap or articulate a plan to begin to address this issue, working with county CWS agencies and County MHPs.

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			For foster youth who are discharged from a hospital setting or who are never formally admitted (i.e. Emergency Room stay due to 5051 crisis), hospitals should be required to provide a discharge plan that is coordinated with the County MHP and, if applicable, the managed care plan. Many foster youth are in need of services from a Partial Hospitalization Program after discharge yet they often do not receive such services.
21	Promotion and Standardization of Quality of Care in Residential and Inpatient Settings	DHCS is committed to ensuring that individuals who are ready for discharge from inpatient and residential treatment are supported during the transition and connected to community-based services and supports, including housing.	We appreciate this commitment and would like to continue to work with DHCS to achieve this goal. Would "residential treatment settings" include STRTPs which are also considered residential treatment? If so is this requirement met solely through Wraparound pursuant to federal and state law requirements for 6 months of after care services or can we consider additional innovative options (such as patient-centered models of care as recommended by CMS)? This is an area which needs significant improvement in our system, as youth in CWS are commonly discharged from acute inpatient/residential settings without much coordination/discharge planning. We believe a lot of work will be needed on this one, many kids leave the hospital when they are truly not ready and then are back in the hospital that same day or the next.
21		"….proposes to require all mental health and residential facilities and counties to meet CMS requirements related to employing a utilization review process to ensure access to appropriate levels of care and appropriate inpatient/residential admissions and length of stay, conducting	This would be a great time to collect data on outcomes to learn more about whether the discharge plan was successful or whether the client experienced a subsequent acute incident.

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		intensive predischarge care coordination, incorporating housing needs during discharge planning and making referrals to community services before discharge, and following up with beneficiaries within 72 hours of discharge."	
21	Improving Statewide County Accountability	DHCS proposes to amend MHP contracts to support accountability and improved outcomes. DHCS also proposes enhanced training, technical assistance, and the potential use of sanctions.	We support this proposal and appreciate inclusion of potential items related to improving outcomes for child-welfare involved youth and families. We welcome opportunities to be part of implementation discussions with other stakeholders. Given recent changes to access criteria to SMHS for foster children and candidates of foster care, we would expect some accountability measures to track increased access to services across both MCPs and MHPs as a result of the change. We are, however, concerned with the proposal to institute fiscal sanctions, as this may only serve to undermine access to services for children, youth and families. We prefer to see targeted investments to counties to fill gaps in access to care.
25	Rent/Temporary Housing	DHCS proposes to allow counties to cover rent/temporary housing for up to six months for certain high-need beneficiaries.	We appreciate this proposal and view this as an opportunity to support transitioning foster youth. We also urge inclusion of CWS (and other stakeholders) to provide guidance to MCPs of target populations at risk of homelessness and discussion of how this proposal can be part of a comprehensive approach to support youth exiting the foster care program.
42	Improving Care Coordination and Transitions to Community-Based Care	Various strategies listed	We support the intent of this proposal. Note there is a need for better care coordination across counties when children are placed out-of-county. We would also like to see more discussion on care coordination with Local Education Agencies. It's important that home-based services and school-based services complement each other.

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43	Increasing Access to Continuum of Care, Including Crisis Stabilization Services	Various strategies listed	How will the demonstration expand access to crisis stabilization services for younger children under 13 years old?
No page #	Children with Developmental Disabilities	No proposal	No proposal nor mention. This is the population of greatest struggle for child welfare agencies when the youth have co-occurring I/DD and MH needs. There is a need for improved cross-agency coordination of care and services (to include MCPs) and ensuring youth have access to trauma-informed therapies. Please refer to memo for additional comments.
No page #	Parental access to SMHS	No Proposal. CalAIIM did update the medical necessity criteria; however, this continues to exclude parents of foster children if they have their own mental health or substance use needs.	Consider proposing to allow for automatic eligibility to parents to access SMHS if their child is eligible and their own needs are interfering with their ability to attend to their children's healthy development or impedes their ability to address other issues listed in the "Z" codes (i.e food insecurity, homelessness, etc.). Either clarify, or create, automatic access under the "other life functioning" provision of eligibility for SMHS.[2] Please refer to our memo for additional comments.
No page #	Access to dental, vision care	No proposal	No mention of this; dental benefits in particular were raised as a concern by foster youth in the BH Model of Foster Care workgroup. Issues raised by our PHNs to access dental services also. Please refer to memo for additional comments.
No page #	Foster Youth in Fee for Service	No proposal	An unknown number of foster youth will likely remain in fee-for-service. It is unclear from the proposal what services they will have access to, but this should be acknowledged if not addressed in the concept paper. Please refer to memo for additional comments.

[2] SMHS access criteria for 21+ requires (1) The person has significant impairment in social, occupational, or other important life activities and/or there is reasonable probability of significant deterioration in
Current definition: …"Important area of life functioning and (2) the significant impairments listed above are due to a mental health disorder, Diagnostic Statistical Manual, Fifth Edition (DSM-5), either diagnosed or suspected, but not yet diagnosed.

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No page #	Opt-in provisions, including IMD Waiver and community supports under CalAIM		How will we know what counties are opting in to the IMD waiver, and what community supports the MCPs decide to offer? This would be helpful when foster children are placed in other counties.

Reference: Federal CMS letter August 2022 https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf