Date of Hearing: April 7, 2021

ASSEMBLY COMMITTEE ON HUMAN SERVICES
Lisa Calderon, Chair
AB 1051 (Bennett) – As Amended March 30, 2021

SUBJECT: Medi-Cal: specialty mental health services: foster youth

SUMMARY: Excludes foster youth or probation-supervised youth who are placed in a community treatment facility, group home, or Short-Term Residential Therapeutic Program (STRTP) outside their county of original jurisdiction, from the requirements of presumptive transfer of specialty mental health services (SMHS); permits an exception to this exclusion and describes the process by which an exception may be invoked and administered; enumerates contracting options and notification requirements for county mental health plans (MHPs) and SMHS providers; requires the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) to collect and make available certain data related to the presumptive transfer of foster youth; requires DHCS and CDSS, to create standardized forms for use during the presumptive transfer process; and, requires DHCS to work with stakeholders to create a standardized contract template for use during the presumptive transfer process, as specified. Specifically, **this bill**:

1) Excludes, upon the implementation of the provisions of this bill, foster youth or probation-involved youth who are placed in a community treatment facility, group home, or STRTP outside of their county of original jurisdiction from the requirements of presumptive transfer of SMHS, as specified.

2) States Legislative intent to ensure foster youth placed in congregate care settings outside their county of original jurisdiction are able to access SMHS in a timely manner, consistent with their individual strengths and needs and the requirements of federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

3) Makes Legislative findings that, because group home or STRTP placements are intended to be short-term, and community treatment facility placements are intended to be time-limited based on medical necessity, the responsibility for the provision of, or arrangement for, SMHS for a foster youth before placement and upon return from the temporary placement are vested with the county of original jurisdiction.

4) Makes Legislative findings that the placement of a youth in a group home, community treatment facility, or STRTP outside of the county of original jurisdiction should not disrupt continuity of care or adversely impact timely payment to the SMHS provider.

5) Prohibits foster youth placed in a community treatment facility, group home, or STRTP, from being presumptively transferred, unless an exception is invoked, as described by provisions of this bill.

6) Permits a request to invoke an exception in a manner established by DHCS and in consultation with stakeholders to be made by the foster youth, the person or agency that is responsible for making mental health care decisions on behalf of the foster youth, the county probation agency or the child welfare services agency with responsibility for the care and

placement of the foster youth, or any other interested party who owes a legal duty to the foster youth involving the youth's health or welfare, as defined by DHCS.

7) Deems the county probation agency or the child welfare services agency with responsibility for the care and placement of the foster youth, with input from the child and family team (CFT) if one exists, and in consultation with the foster youth and their parent, and other professionals who serve the youth as appropriate, as responsible for determining whether invoking an exception is appropriate pursuant to the conditions and exceptions established by certain provisions of this bill, as specified. Further, requires the person or entity that requested the exception, along with any other parties to the case, to receive notice of the county agency's determination.

8) Permits the individual or entity that requested the exception, or any other party to the case who disagrees with the determination made by the county agency, to request judicial review before the county's determination becomes final. Further, permits the court to set the matter for hearing and, further, permits the court to confirm or deny the transfer of jurisdiction or application of an exception based on the foster youth's best interest.

9) Permits an exception to be invoked, and presumptive transfer applied, for either of the following reasons:

    a) The foster youth's case plan includes a transition to a home-based setting in the county of residence or within the same geographic region; or,

    b) The MHP in the county of residence requests presumptive transfer to directly serve the youth and continued oversight and ensuring consistency of services can be provided through the members of the youth's treatment team.

10) Requires, in order to support service delivery, continuity of care, and timely payment, the placing agency to provide notification to the MHPs in the county of original jurisdiction and the county of residence before placing a foster youth out of county in a community treatment center, group home, or STRTP, and, further, permits the county to complete this notification through email.

11) Requires CDSS to maintain and update a contact list of county mental health plans on its internet website.

12) Requires, if notification prior to placement is not possible, the placing agency to notify the MHPs in the county of original jurisdiction and the county of residence no later than three business days after making the out-of-county placement.

13) Permits, to support service delivery, continuity of care, and timely payment, the community treatment facility, group home, or STRTP that accepts an out-of-county placement to also notify the county of original jurisdiction and county of residence about the out-of-county placement in their group home, facility, or program.

14) Prohibits timely placement timeframes, as specified by provisions of this bill, from beginning until MHPs are notified of the placement by the placing agency or the placement provider.

15) Requires CDSS to verify that notification to the MHPs in the counties of original jurisdiction and residence has been made, as specified.

16) Permits an exception to be applied at any point during the foster youth's placement out of county, and, further, requires the placing agency to provide notification to the MHPs in the counties of residence and original jurisdiction within five business days of the exception's approval or denial, as specified.

17) Requires, when an exception occurs, the MHP in the county of residence to notify the provider, thereby initiating the timely payment timeframes described by the provisions of this bill, as specified.

18) Requires the MHP in the county of residence, upon the presumptive transfer, to assume responsibility for the authorization and provision of mental health services consistent with federal EPSDT requirements, as defined in current law, and the payment for services.

19) Requires a request to invoke an exception, the reasons claimed as the basis for the request, a determination whether an exception is deemed to be appropriate, and any objections to the determination be documented in the foster youth's case plan, as specified by current law.

20) Requires, no later than July 1, 2022, DHCS and CDSS to adopt regulations to implement the provisions of this bill, and, further, permits DHCS and CDSS to implement and administer certain provisions of this bill through all-county letters, information notices, or similar written instructions until regulations are adopted, as specified.

21) Requires DHCS, if it deems it necessary, to seek approval from the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services before implementing certain provisions of this bill, as specified.

22) Requires DHCS, no later than January 1, 2022, and if it makes the determination that it is necessary to seek federal approval, to make an official request for approval from the federal government, as specified.

23) Requires certain provisions of this bill be implemented only if, and to the extent that, federal financial participation is available and all necessary federal approvals have been obtained, as specified.

24) States Legislative intent to support timely payment to the provider for services to help ensure foster or probation involved youth placed out of county receive the care and treatment they need.

25) Makes the following changes relating to timely provider payments in instances when a foster or probation involved youth is placed out of county in a group home, community treatment facility, or STRTP, and the youth is not presumptively transferred:

    a) Requires the MHP in the county of original jurisdiction and the provider of services to choose one of the following options in order to ensure timely payment:

        i.) Utilize an existing contract between the MHP in the county of original jurisdiction and the out-of-state SMHS provider; or,

ii.) Establish, if no contract exists, but both the MHP and the provider agree to establish a comprehensive contract for payment of SMHS for a youth or multiple youths, a comprehensive contract for payment of services within a mutually agreed upon timeframe.

b) Requires, if neither of these options are available, payment for the SMHS be made through an agreement between the MHP in the county of residence and the MHP in the county of original jurisdiction. Further, requires the agreement between these two parties to require the MHP in the county of residence to pay the SMHS provider under an existing contract, single case agreement, or other payment mechanism with the SMHS, and, further, declares that, in this instance, financial responsibility for the youth remains with the county of original jurisdiction as the youth has not been presumptively transferred.

c) Requires, if no contract exists between the MHP in the county of residence and the SMHS provider, and if the MHP in the county of residence does not intend to enter a payment agreement with the SMHS provider, the [MHP in the] county of original jurisdiction be responsible for payment, and, further, requires the county of original jurisdiction to establish a contract, single case agreement, or other payment agreement for payment of SMHS.

d) Requires, in instances when the county of original jurisdiction and SMHS provider enter into a contract, single case agreement, or other payment mechanism, the establishment of the agreement be made within 30 days, and, further, prohibits this timeframe from beginning until the MHPs in the counties of original jurisdiction and residence have been notified of the out-of-state placement by either the placing agency or the placement provider.

26) Requires, for STRTPs, starting from the date of placement, the provider be paid for the services, as specified, based on medical necessity and verified, as determined by the mental health assessment, and the terms of the contract or agreement with the county or original jurisdiction or the county of residence, whichever applies, and further, permits the contract or agreement to expand the scope of reimbursable services.

27) Requires DHCS, in collaboration with CDSS, to collect data on the receipt of EPSDT SMHS by foster youth who are placed outside of their county of original jurisdiction, and further, requires these data to be included in DHCS' Medi-Cal SMHS performance dashboard. Further, requires these data contain, on the state level and for each county, by placement type, all of the following:

a) The number of foster youth placed out of county;

b) The number of foster youth placed out of county who receive SMHS; and,

c) For foster youth placed out of county who receive SMHS, the number of foster youth for whom the county of original jurisdiction is responsible for providing or arranging for those services, and the number of foster youth for whom the county of residence is responsible for that provision or arrangement.

28) Requires, if a foster youth is placed in a congregate care setting outside of their county of jurisdiction and the county of jurisdiction retains responsibility for SMHS, the placing agency to inform, if possible at the time of placement, but no later than three business days from placement, the MHPs in the county of residence and the county of original jurisdiction.

29) Requires, for foster youth placed in an STRTP or other congregate care facility outside the county of jurisdiction pursuant to the MHP approval, a mental health assessment be completed or received by a licensed mental health professional within ten calendar days of a youth's admission.

30) Requires, if relying upon a previous completed mental health assessment, the previously completed assessment be completed within 60 calendar days before admission and performed by a licensed mental health professional or an otherwise recognized provider of mental health services acting within their scope of practice. Further, authorizes an exception in instances in which a licensed mental health professional determines it is more clinically appropriate to complete a more current mental health assessment.

31) Requires the mental health assessment to include a mental health status examination.

32) Entitles, pursuant to federal law and regardless if the presumptive transfer is made, foster youth placed out of county to continue their therapeutic relationships with prior treatment providers if chosen by the youth, and, further, requires any changes to treatment providers be made in consultation with the youth in the context of the CFT, as specified.

33) Requires the MHP in the county of jurisdiction to notify the MHP in the county of residence of any third-party service provider if additional information must be obtained directly from the third-party service provider.

34) Requires the MHP in the county of jurisdiction to provide to the MHP in the county of residence both of the following:

    a) Contact information for the third-party service provider, if applicable; and,

    b) Any completed assessment or client plans.

35) States Legislative intent that all eligible youth, including youth in the state's child welfare system, have timely access to mental health care through the federal EPSDT program, and that, in order to fulfill this responsibility, all MHPs operating in the state use standardized forms to facilitate efficient and effective provision of mental health services by SMHS providers to all foster youth, regardless of the county in which the youth live.

36) Requires, no later than March 1, 2022, DHCS, in consultation with CDSS and stakeholders, to create standardized forms that are to be used by counties for the purpose of simplifying the notification of out-of-county placements, and presumptive transfers or waivers thereof, including in the case of foster youth placed in home-based care and congregate care, as specified.

37) Requires, no later than June 1, 2022, DHCS to work with CDSS to determine the feasibility of automating forms through the child welfare automation data system for use by county child welfare agencies and county MHPs.

38) Requires, no later than June 1, 2022, DHCS to work in consultation with stakeholders, as specified, to create a standardized contract template for use by a county of original jurisdiction for services provided by an out-of-county community treatment facility, group home, or STRTP, as specified.

39) Makes technical and conforming changes.

EXISTING LAW:

1) Establishes a state and local system of child welfare services, including foster care, for children who have been adjudged by the court to be at risk or have been abused or neglected, as specified. (Welfare and Institutions Code Section [WIC] 202)

2) States that the purpose of foster care law is to provide maximum safety and protection for children who are currently being physically, sexually, or emotionally abused, neglected, or exploited, and to ensure the safety, protection, and physical and emotional well-being of children who are at risk of harm. (WIC 300.2)

3) Defines "Early Periodic and Screening Diagnostic, and Treatment Services" as screening services, vision services, dental services, hearing services, and other necessary health care, diagnostic services, treatment and other measure to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, including SMHS, for certain eligible individuals who are under the age of 21. (42 United States Code 1396d(a)(4)(B))

4) Defines "medical necessity criteria" for purposes of determining Medi-Cal reimbursement for SMHS as including certain diagnoses, including: mood disorders, anxiety disorders, eating disorders, and adjustment disorders, among others. (9 California Code of Regulations 1830.205(a) and 1830.210)

5) States Legislative intent to ensure that foster children who are placed outside of their county of original jurisdiction are able to access SMHS in a timely manner, consistent with their individual strengths and needs and the requirements of the federal EPSDT services. (WIC 14717.1(a)(1))

6) States Legislative intent to overcome any barriers to care that may result when responsibility for providing or arranging for specialty mental health services to foster children who are placed outside of their county of original jurisdiction is retained by the county of original jurisdiction. (WIC 14717.1(a)(2))

7) Requires the California Health and Human Services Agency (CHHSA) to coordinate with DHCS and CDSS to issue policy guidance concerning the conditions for and exceptions to presumptive transfer, in consultation with CDSS, and with the input of stakeholders, as specified. (WIC 14717.1(b)(1))

8) Defines "presumptive transfer" as the requirement that, absent any exceptions as established by current law, responsibility for providing or arranging for specialty mental health services promptly transfer from the county of original jurisdiction to the county in which the foster child resides, under certain conditions, as specified. (WIC 14717.1(c))

9) Allows, on a case-by-case basis, and when consistent with the medical rights of children in foster care, presumptive transfer to be waived and requires the responsibility for the provision of SMHS to remain with the county of jurisdiction if certain exceptions exist, as specified. (WIC 14717.1(d)(1))

10) Defines "community treatment facility" as any residential facility that provides mental health treatment services to children in a group setting and that has the capacity to provide secure containment. (Health and Safety Code Section [HSC] 1502(a)(8))

11) Defines a "short-term residential therapeutic program" as a residential facility operated by a public agency or private organization and licensed by CDSS that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term, 24-hour care and supervision to children. Further, requires the care and supervision provided by an STRTP be nonmedical, except as otherwise permitted, as specified. (HSC 1502(a)(18))

12) Allows a STRTP to accept for placement a child who has been assessed as meeting the medical necessity criteria for Medi-Cal SMHS, and the child has been assessed as seriously emotionally disturbed or if the child has been assessed as requiring the level of services provided by the STRTP in order to meet their behavioral or therapeutic needs, as specified. (WIC 11462.01(b)(3)(A),(B), and (D))

13) Enumerates the roles and responsibilities of interagency placement committees as it relates to the placement of dependents and wards into STRTPs, group homes operating at a rate classification level 13 or 14, as specified, and out-of-state residential programs, as specified. (WIC 4096(a))

14) Requires an interagency placement committee to, as appropriate, make certain requirements, with recommendations from the CFT, within 30 days of placement, and further requires the interagency placement committee, if, with recommendations from the CFT, it determines the placement is appropriate, to transmit the approval, in writing, to the county placing agency and the STRTP. (WIC 11462.01(h)(3)(A)(i) and (ii))

15) Specifies that certain conditions enumerated in current law may not prevent the emergency placement of a youth into a certified STRTP prior to the determination by the interagency placement committee, but only if a licensed mental health professional has made a written determination within 72 hours of the youth's placement, that the youth requires the level of services and supervision provided by the STRTP in order to meet the youth's behavioral or therapeutic needs, as specified. (WIC 11462.01(h)(3))

16) Defines a "child and family team" as a group of individuals who are convened by the placing agency and who are engaged through a variety of team-based processes to identify the strengths and needs of the child or youth and their family, and to help achieve positive outcomes for safety, permanency, and well-being. (WIC 16501(a)(4))

17) Requires moneys in the Behavioral Health Subaccount and the Behavioral Health Services Growth Special Account be used exclusively to fund certain activities, including Medi-Cal SMHS, including the EPSDT Program, as specified. (Government Code Section 30025 (f)(16)(B))

FISCAL EFFECT: Unknown

COMMENTS:

Child welfare services (CWS): California's CWS system exists to protect children from abuse and neglect, and in doing so, to provide for their health, safety, and overall well-being. When suspicions of abuse or neglect arise, often as a result of a report by a mandated reporter like a doctor or teacher, Child Protective Services is tasked with investigating the report. If the allegation of abuse or neglect is substantiated, it is then determined whether it is in the best interest of the child to remain in their parent's custody or be placed within the CWS system. If a child is suspected to be at risk of neglect, abuse, or abandonment, the juvenile court holds legal jurisdiction, and the CWS system appoints a social worker to ensure that the needs of a youth are met. As of October 1, 2020, there were 60,045 youth placed in California's CWS system.

Continuum of Care Reform (CCR): In recent years, California has enacted legislation, known as CCR, to improve placement and treatment options for youth in foster care. AB 403 (Stone), Chapter 773, Statutes of 2015, sponsored by CDSS, sought to improve outcomes for children and youth served by the CWS system by working to ensure that foster youth have their day-to-day physical, mental, and emotional needs met, that they have the opportunity to grow up in permanent and supportive homes, and have the opportunities necessary to become self-sufficient and successful adults. CCR also sought to reduce the use of congregate care as a frequently used placement option for youth, as data have demonstrated that youth placed in congregate care settings experience poorer outcomes than youth placed in family settings. Subsequent legislation to further facilitate implementation of CCR efforts include AB 1997 (Stone), Chapter 612, Statutes of 2016, AB 404 (Stone), Chapter 732, Statutes of 2017, AB 1930 (Stone), Chapter 910, Statutes of 2018, AB 819 (Stone), Chapter 777, Statutes of 2019, and AB 2944 (Stone), Chapter 104, Statutes of 2020.

Mental health needs of foster youth: Children placed in the CWS system are removed from their parents' custody because they have suffered abuse or neglect, often at a young age. Research on brain development demonstrates that infancy and early childhood are critical periods in a child's development when it comes to forming attachments, and laying the foundation for future skills such as empathy, trust, and problem solving. In 2012, a publication in the American Psychological Association found that nearly half of foster youth were determined to have clinically significant emotional or behavioral health problems, and children under age seven who enter foster care show increased rates of developmental problems. Additionally, foster youth are at a greater risk to struggle in school, face difficulties finding employment, and experience substance use issues.

In recognition of the mental health needs of foster youth, and pursuant to federal and state laws and regulations, California provides a number of services and supports to meet the mental health needs of children in the CWS system. These supports include, but are not limited to:

- *Child and Family Teams:* CFTs were formally adopted by CCR, and include a group of caring adults who are convened by the placing agency and use team-based processes to identify the strengths and needs of a youth in order to help achieve positive outcomes for their safety, permanency, and well-being. CFTs, depending on the needs of the youth, meet at least once every 90 days, or on an as-needed basis, and ensure decisions around placement and services are youth-centered.

- *Functional assessment of needs:* The Child and Adolescent Needs and Strengths (CANS) functional assessment was chosen in order to emphasize the need for one comprehensive assessment to inform placement decision and service provision for foster youth, and to support case planning and coordination of services during the CFT process.

- *Short-term residential therapeutic programs (STRTPs):* In keeping with CCR's goal to reduce reliance on congregate care settings, California adopted a new licensing category, known as STRTPs, which provide short-term, 24-hour care and supervision to youth. STRTPs are intended to provide mental health interventions to stabilize, support, and transition youth with high level mental health needs to lower levels of care using trauma-informed, culturally relevant services, including SMHS.

Medi-Cal, which is California's Medicaid program, provides free or low-cost health coverage to foster youth, among other eligible populations, and is administered by DHCS. Medi-Cal contains a child health component, known as the EPSDT, which provides comprehensive health care services to children under the age of 21 who have full-scope Medicaid eligibility; this includes foster youth, who are categorically eligible for Medi-Cal and, therefore, EPSDT. Specifically, EPSDT includes screening, diagnostic, and treatment services that seek to ensure youth receive adequate health care. EPSDT also includes SMHS, which are available to children and certain adults who meet specific medical necessity criteria, as defined in current law.

What constitutes medical necessity criteria is different for children and youth under the age of 21 than that of adults. In order to be eligible under EPSDT, children must have a covered diagnosis and meet certain criteria, including: have a condition that would not be responsive to physical health care-based treatment; and, the services are determined to be necessary in order to correct or address a mental illness and condition discovered by screening conducted by a qualified provider. Specialty mental health services include: assessment, collateral, therapy, rehabilitation, crisis intervention and stabilization, and medication support, among other services.

Presumptive transfer of specialty mental health services: A primary goal of the CWS system is to preserve familial ties whenever possible, while still providing for the best placement possible that meets the needs of the youth. At times, the best placement for a youth, be it with relatives, approved caregivers, or in a congregate care setting, is located outside of the county in which a youth entered the CWS system (the county in which a youth entered the CWS system is known as the "county of original jurisdiction," while the county in which a youth is placed is known as the "county of residence").

On July 1, 2018, of the 59,223 youth in the CWS system, 13,206 were placed out of their county of original jurisdiction. These youth, sometimes referred to as "out of county youth," have a higher chance of poorer outcomes. In 2011, a Child Welfare Council report determined that out-of-county placements tended to be for youth who were older and in care longer, more likely to have been diagnosed with a serious mental health disorder, more likely to be placed in a group home, and less likely to receive mental health services compared to their in-county placed peers.

To combat the potential for poorer outcomes, several legislative solutions have been adopted, including:

- SB 745 (Escutia), Chapter 811, Statutes of 2000, adopted, among other things, the requirement that each local MHP establish a procedure for ensuring access to EPSDT-

required outpatient SMHS for any youth in foster care who has been placed outside of their county of original jurisdiction; and,

- SB 785 (Steinberg), Chapter 469, Statutes of 2007, sought to facilitate the receipt of medically necessary SMHS by a foster child who is placed outside of their county of original jurisdiction. SB 785 also required the Department of Mental Health (now, DHCS) to standardize certain contracts, authorization procedures, and documentation standards and forms.

AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016: Following the efforts of SB 745 and SB 785, AB 1299 provided for the presumptive transfer of SMHS for foster youth placed out of county in California. The stated goal of the bill was to ensure that youth who are placed outside of their county of original jurisdiction are able to gain access to SMHS in a timely manner and in a way that is consistent with their individual strengths and needs, as well as the requirements of federal EPSDT services. AB 1299 required CHHSA to coordinate with DHCS and CDSS to facilitate the prompt receipt of SMHS for youth placed out of their county of original jurisdiction, and established the presumptive transfer of SMHS when a youth is placed out of county. Specifically, pursuant to the requirements of AB 1299, when a youth is placed in a county other than their county of original jurisdiction, the responsibility for the authorization for or provision of SMHS is presumptively transferred to the county in which the youth resides (the county of residence).

AB 1299 provided for presumptive transfer to be waived (meaning the responsibility for the authorization and provision of SMHS remains with the county of original jurisdiction) on a case-by-case basis, and as requested, when consistent with the medical rights of the youth and when certain reasons for exemption exist, including when: presumptive transfer would disrupt continuity of care or delay access to services; would interfere with family reunification efforts; it is anticipated that a youth's placement out of county will last less than six months; or, the youth's residence is located within 30 minutes of travel time from their specialty mental health care provider in their county of jurisdiction.

Legislative hearings: foster youth mental health: In October 2018, the Assembly Human Services Committee and the Assembly Select Committee on Foster Care held a joint informational hearing examining the mental health needs of foster youth, what services and supports are provided to address those needs, whether those services and supports are adequate, and what, if any, gaps exist in ensuring foster youth receive the services to which they are statutorily entitled. During the hearing, some participants raised questions as to whether the goals of AB 1299 were being achieved, and specifically, whether youth placed out of county in STRTPs were receiving adequate and timely access to SMHS, among other findings. In February 2019, a subsequent informational hearing was held by this Committee to discuss how presumptive transfer has impacted the provision of mental health services to foster youth. The background paper prepared for the February 2019 hearing states:

> "A number of factors contribute to the complicated landscape in which presumptive transfer operates, including, among others: realigned funding streams; split responsibilities across state departments; varying and multiple contract requirements and processes for providers; payment and reimbursement requirements and timelines related to the provision of mental health services that can be confusing and significantly burdensome for counties and providers; the involvement of different county-level

> agencies responsible for child welfare services and mental health services; and changes resulting from the much-needed reform driven by CCR, including the conversion of group homes to STRTPs. Not all of these factors are negative, but they can complicate the intent and implementation of presumptive transfer."

The hearing also found that it is difficult to ascertain how many youth across California are subject to presumptive transfer and waiver of presumptive transfer, as DHCS reported that it does not currently collect data on the number of out-of-county foster youth whose SMHS were subject to presumptive transfer or waiver thereof.

As a result of these legislative hearings, AB 826 (Reyes) of 2019, was introduced to address the issues related to presumptive transfer and the lack of data detailing the number of youth subjected to presumptive transfer. Specifically, AB 826 was substantially similar to this bill in that it would have excluded foster youth placed in an STRTP outside of their county of original jurisdiction from being subject to presumptive transfer, unless a specified exception is invoked. AB 826 also: would have delineated circumstances and protocols related to presumptive transfer for youth placed in an out-of-county STRTP; would have required data be made available on the Medi-Cal SMHS dashboard; and, would have required DHCS and CDSS to determine the feasibility of automating certain forms for use by county child welfare agencies and county mental health plans in instances where presumptive transfer is invoked. AB 826 was held in the Senate Human Services Committee and was later amended to pertain to emergency food assistance amidst the COVID-19 pandemic.

Need for this bill: The provisions of this bill seek to address issues that emerged during this committee's informational hearings in 2018 and 2019, and subsequent conversations with stakeholders, as they pertain to ensuring that foster youth have timely and adequate access to the SMHS to which they are entitled. Specifically, this bill pertains to foster youth who are placed out of county in a community treatment facility, group home, or STRTP. By their very nature, and in keeping with the tenets of CCR, these facilities are intended to be short-term placement options for youth who require specialized, intensive services prior to transitioning to lower levels of care. This bill would remove the application of presumptive transfer requirements to youth placed out-of-county in community treatment facilities, group homes, or STRTPs, and instead, establishes a separate process through which an exception to this exemption can occur. This bill also enumerates options for county MHPs and SMHS providers when establishing a contract for payment, in addition to specific notification requirements and responsibilities, in order to support timely payments to providers. Additionally, this bill would require DHCS, in collaboration with CDSS, to collect and make available certain data related to presumptive transfer. Finally, the provisions of this bill seek to streamline the presumptive transfer process by requiring DHCS, in consultation with CDSS, to create standardized forms for use by counties no later than March 1, 2022, and by requiring DHCS, in consultation with stakeholders, to create a standardized contract template for use by counties no later than June 1, 2022.

According to the author, "Foster youth have a higher risk of developing a mental health issue and they need to be guaranteed that they can receive their mental health care in a timely manner. This bill will help do that by clarifying that presumptive transfer cannot be applied to foster youth that are transferred out of county temporarily into an STRTP, unless care would be improved with a transfer for the youth is expected to reside in the new county permanently. [This bill] will also support timely payment by providing payment contract options between providers and counties. Providing counties and providers with these options helps guarantee timely care by guaranteeing

timely payment. The goal is to make temporary out-of-county transfers as seamless as possible for foster youth and make sure they have access to the mental health care that they need."

Double referral: This bill will be referred to the Assembly Health Committee should it pass out of this committee.

PRIOR AND RELATED LEGISLATION:

AB 826 (Reyes) of 2019, as introduced, was substantially similar to this bill and would have excluded foster youth placed in STRTPs outside of their county of original jurisdiction from being subject to presumptive transfer unless a specific exception is invoked, among other requirements. AB 826 was amended on July 2, 2020, to pertain to emergency food assistance.

AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, provided for presumptive transfer of specialty mental health services for foster youth placed out of county, and required the CHHS to coordinate with DHCS and CDSS to facilitate the prompt receipt of specialty mental health services, among other things.

AB 785 (Steinberg), Chapter 469, Statutes of 2007, required the Department of Mental Health (now, DHCS) to standardize certain contracts, authorization procedures, and documentation standards and forms, and required the provision of specialty mental health services for certain foster youth to transfer from the county of jurisdiction to the county of residence of their legal guardians or adoptive parents.

SB 745 (Escutia), Chapter 811, Statutes of 2000, adopted, among other things, the requirement that each local mental health plan establish a procedure for ensuring access to EPSDT-required outpatient specialty mental health services for any youth in foster care who has been placed outside of their county of jurisdiction.

REGISTERED SUPPORT / OPPOSITION:

Support

County behavioral Health Directors Association (Sponsor)
California Access Coalition
California State Association of Counties (CSAC)
Cardenas Consulting Group
CASA Pacifica Centers for Children and Families
Steinberg Institute

Opposition

None on file

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