Date of Hearing: April 9, 2019

ASSEMBLY COMMITTEE ON HUMAN SERVICES
Eloise Gómez Reyes, Chair
AB 826 (Reyes) – As Amended March 21, 2019

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

SUMMARY: Requires the California Health and Human Services Agency (CHHSA) to coordinate with the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) to issue policy guidance related to determining the county of responsibility for arranging and providing specialty mental health services (SMHS) to a foster youth who is placed out of county in a short-term residential therapeutic program (STRTP), and requires DHCS, in consultation with county and state agency partners, to develop standardized forms and uniform contracting processes for county mental health plans (MHPs) that contract with SMHS providers, and to collect and report data to the Legislature regarding out-of-county foster youth and their access to specialty mental health services. Specifically, **this bill**:

1) State Legislative intent related to timely access to mental health care for foster youth and facilitation of efficient and effective provision of mental health services by providers of SMHS through the employment of uniform contracting processes.

2) Requires DHCS in consultation with the County Behavioral Health Directors Association of California (CBHDA), to develop standardized forms and uniform contracting processes to be used by MHPs when contracting with providers of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) SMHS, and, further, requires DHCS to seek any necessary federal waivers or state plan amendments necessary to carry out certain provisions of this bill, as specified.

3) Excludes, upon the implementation of the provisions of this bill, foster youth who are placed in an STRTP outside of their county of original jurisdiction from the requirements of presumptive transfer of SMHS, as specified.

4) States Legislative intent related to the placement of foster youth in congregate care settings outside of their county of origin and their timely access to specialty mental health services, and related to determining, on a case-by-case basis, the responsibility for the provision of, or arrangement for, SMFS to these foster youth.

5) Defines "county of responsibility" as the county determined through the process described by the provisions of this bill to be responsible for providing or arranging for SMHS for foster youth placed in an STRTP.

6) Requires, no later than July 1, 2020, CHHSA to coordinate with DHCS and CDSS, and in consultation with various stakeholders, as specified, to issue policy guidance related to the determination of county of responsibility for purposes of facilitating the receipt of SMHS for foster youth placed in STRTPs out of county, and, further, requires the policy guidance to ensure all of the following:

    a) The determination of the county of responsibility improves access to SMHS consistent with the mental health needs of the foster youth;

b) The determination of the county of responsibility does not disrupt the continuity of care for the foster youth;

c) Consistent application across the state of factors used to determine the county of responsibility;

d) Determination of the county of responsibility by the county placing agency is applied on a case-by-case basis for each foster youth, based on a recommendation from the interagency placement committee, that considers input from the child and family team (CFT); and,

e) Availability of a procedure for expedited transfer within 48 hours of placing the youth outside the county of original jurisdiction.

7) Requires the county placing agency to determine the county of responsibility in conjunction with certain assessments, as specified in current law, and, further requires the determination to, whenever possible, consider recommendations from the CFT, and take into account certain factors, including, but not limited to:

a) Continuity of care and timely access to services provided to the foster youth;

b) Impact on family reunification efforts;

c) Expected duration of out-of-county placement of the foster youth; and,

d) Distance between a foster youth's residence and their established specialty mental health care provider in the county of original jurisdiction.

8) Requires, if a foster youth is placed in an STRTP on an emergency basis, the determination of the county of responsibility by the county placing agency take place during, and subject to, certain processes of the interagency placement committee, as specified in current law.

9) Requires, if an MHP in the county of original jurisdiction has completed an assessment of needed services, and the county of residence is determined to be the county of responsibility, the MHP in the county of residence to accept the assessment, and, further, allows in those instances the MHP in the county of residence to conduct additional assessments, as specified.

10) Requires the county of residence, if the county of residence is determined to be the county of responsibility, to assume responsibility for the authorization and provision of SMHS and payment for services, and, further requires youth transferred to the MHP in the county of residence to be considered part of the county of residence caseload for claiming purposes from the Behavioral Health Subaccount and the Behavioral Health Services Growth Special Account, as specified.

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

12) Requires, if DHCS determines that it is necessary, DHCS to seek federal approval from the Centers for Medicare and Medicaid Services (CMS) no later than January 1, 2021.

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

14) 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.

15) Requires this data be reported to the Legislature without any personal identifying information, on the state level and for each county, and, further, requires, 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 who are 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.

16) Requires DHCS, in conjunction with CDSS, to report the deidentified data to the Legislature no later than December 31, 2020, and annually thereafter no later than December 31 of each year.

17) Make technical 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 [WIC] Section 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 specialty mental health services 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) 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))

8) Requires 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))

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 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. (Health and Safety Code Section 1502 (a)(18))

11) 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))

12) 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))

13) 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))

14) 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))

15) 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))

16) 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 2018, there were 59,487 youth between the ages of 0 and 21 placed in California's CWS system.

Continuum of Care Reform: Over the past four 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, and AB 1930 (Stone), Chapter 910, Statutes of 2018.

Mental health needs of foster youth: Children who are removed from their parents' custody and placed in the CWS system have often suffered abuse and neglect at a young age, and 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. A 2012 publication in the American Psychological Association found that nearly half of youth in foster care 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. Foster youth are also at a greater

risk to struggle in school, face difficulty finding employment, and experience substance use issues.

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

- *Child and Family Teams (CFTs):* CFTs were formally adopted by CCR, and include a group of caregivers 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 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 placement and services decisions are youth-focused.

- *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, CCR 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 specialty mental health services.

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 Early Periodic Screening, Diagnostic, and Treatment benefit (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 "specialty mental health services" 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 youth in care. 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 youth diagnosed with a serious mental health disorder, more likely to be 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, which 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 jurisdiction; and,

- SB 785 (Steinberg), Chapter 469, Statutes of 2007, which 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: Following the efforts of SB 745 and SB 785, AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, 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; presumptive transfer 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.

Need for this bill: The provisions of this bill seek to address the issues that emerged during the informational hearings held during the fall and winter by this committee as they pertain to ensuring that foster youth have timely and adequate access to the SMHS to which they are entitled. Specifically, the bill speaks to presumptive transfer as it applies to youth who are placed out of county in an STRTP. By its very nature, an STRTP is intended to be a short-term placement option 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 out-of-county placements in STRTPs, and instead, establishes a separate process through which an interagency placement committee, on a case-by-case basis, can make a recommendation when determining whether the county of original jurisdiction or the county of residence should retain or assume responsibility for the arrangement and provision of SMHS. The bill also seeks to facilitate more efficient and effective provision of SMHS by requiring DHCS, in consultation with CHBDA, to develop uniform contracting processes and standardized forms for when an MHP contracts with a SMHS provider. Finally, the bill requires DHCS, in collaboration with CDSS, to collect and report to the Legislature, on an annual basis, certain data related to the receipt of SMHS by foster youth who are placed out of county.

According to the author, "Approximately 1 in 5 foster youth are placed in homes and facilities in a county in which they entered the foster care system. This 'out of county' placement can occur for a variety of reasons, such as being placed with a family member who lives elsewhere or in a group home setting thought to be best equipped to meet a youth's particular needs. The state's adoption of 'presumptive transfer' sought to ensure that foster youth who were placed out of county were able to access timely and adequate mental health services. For youth placed out of county in resource family homes, such as when a youth relocates in order to live with relatives, presumptive transfer is reportedly working. However, when youth are placed in short-term residential therapeutic programs (STRTPs), or in group homes in transition, some providers and counties report problems with reimbursements and multiple, complicated contracting

processes. These complications may ultimately hinder out-of-county foster youth's access to the most appropriate mental health services, going counter to the very goals of presumptive transfer. This bill addresses this problem by removing the application of presumptive transfer requirements to out-of-county STRTP placements, and instead establishes a separate process to determine where responsibility for provision of or arrangement for mental health services should rest. Additionally, this bill streamline**s** certain processes between county mental health plans and services provider as they relate to the provision of mental health services for foster youth placed out of county. Lastly, this bill calls upon the Department of Health Care Services and the Department of Social Services to collect and annually report to the Legislature data on out-of-county foster youth and their access to specialty mental health services. This bill ensure**s** that every foster youth, regardless of their county of jurisdiction or placement, has timely access to the mental health services that can help set them up for healthy, successful lives in the near- and long-term."

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

RELATED AND PRIOR LEGISLATION:

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 California Health and Human Services Agency 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

None on file

Opposition

None on file

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