

Foster Youth and Medi-Cal: **Delineating the Problems, Proposing Solutions**

RANDY MORRIS

EXECUTIVE SUMMARY

County foster care eligibility operations are responsible for establishing and maintaining health coverage for foster youth through the state Medi-Cal program. Too often, unfortunately, Medi-Cal coverage is not quickly established upon children's entry into foster care, disruptions in coverage are common, and a multitude of technical problems lead to barriers in receiving needed primary and behavioral health services.

This case study explores some of the reasons why so many problems exist related to Medi-Cal for foster youth. Each county that was interviewed identi-

fied the same list of problems, was unable to identify local solutions, and expressed frustration with the larger system's failure to remedy the problems. Political problems are identified as the primary barrier to moving toward solutions. The recommendation put forth at the conclusion of this paper is one that is already being implemented. Alameda County offers its experience of addressing these problems by bringing together stakeholders who can delineate the problems, as well as state and legal advocacy partners who have the capacity to move solutions forward.

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Introduction

While foster care services are primarily delivered by child welfare services social workers, a critical component of the system is delivered by another professional group known as eligibility workers. Eligibility workers are responsible for administering foster care cash payments, as well as establishing and maintaining health coverage for foster children through the state Medi-Cal program. Arguably, no other corner of the system causes as much distress as when foster care payments are delayed or perceived to be below an expected amount, or when Medi-Cal coverage is delayed or otherwise disrupted. This paper will focus on the Foster Care Medi-Cal program as problems with this program seem to be a primary frustration in many California counties.

In Alameda County, frustrations with the Foster Care Medi-Cal program have been expressed in different ways and by different stakeholders. Child welfare staff, caregivers, the courts, and service providers have expressed frustration related to Medi-Cal for years, and have often pointed to the county foster care eligibility operation as the source of the problems. More recently, in response to growing demands for foster care systems to improve “well-being” outcomes, many jurisdictions, including Alameda County, have expanded their Medi-Cal-funded primary and behavioral health services. With increased services comes a greater need for Medi-Cal to be financially capable of paying for them. In the Alameda County foster care system, efforts have been made to coordinate with public partners in health care and behavioral health care services for the growth and oversight of many of these services. Provider networks were formed with

public partners; however, meetings with these groups tended to be dominated by discussions related to complications with Medi-Cal. My motivation for selecting this issue for the BASSC case study was influenced by the barriers that arose in seeking to resolve the Medi-Cal related concerns, and was chosen with the hope that other counties might provide guidance.

Can a County ‘Fix’ This Problem?

Some efforts have been made in Alameda County to address the many problems identified with the Medi-Cal program for foster youth. Some modest changes in Medi-Cal procedures were vetted through the Labor-Management process, leading to some gains. Additionally, communication with local stakeholders was initiated to discuss the complexity of the unresolved issues in an effort to pre-emptively address frustrations and assumptions that the issue wasn’t known or being taken seriously. However, in large part, solutions seemed out of reach and frustrations seemed to be increasing.

Because this topic was not offered through the BASSC program, the BASSC Coordinator offered to solicit a host county through the agency directors. Unfortunately, no county responded to the request to host, indicating they all struggled with the same issues. This reality forced a shift in case study focus from looking to other counties for solutions to, instead, exploring the depth and breadth of the problem shared by other counties to help inform a recommendation for solution. Using relationships developed as a participant in the BASSC program, contacts were made in Santa Cruz, San Francisco, and Contra Costa Counties.

Defining the Problem

Through conversations with the three counties mentioned, it became clear that the “problem(s)” with Medi-Cal and foster youth fell into two categories: the technical and the political. Technical problems refer to issues related to the Medi-Cal program, the computer systems used within the program, and the regulations and procedures used to administer it. Political problems refer to the ‘culture’, including perceptions within county operations, state operations, and between county and state. Due to space limitations for this paper, the remainder of the paper will focus on the political problems, with a list of technical problems outlined in the appendix for reference.

There are several problems associated with Medi-Cal for foster youth that can be classified as political. These political problems are being identified because the common experience of Alameda and the other counties interviewed is that the local foster care eligibility operation is the most commonly pointed to source of these problems and barrier to solutions. This dynamic seems to contribute to an impasse and to a lack of movement toward solutions for the technical problems that ultimately are required to resolve these issues.

The first political problem identified by all counties interviewed is the sense that foster care eligibility is the “foster child” of the system. According to those who use and manage it, the CalWIN system used to administer Medi-Cal proves to be a part of this dynamic, as foster care eligibility technical issues end up “in the back of the line” when it comes to having its needs met by the CalWIN system. Further, each county had a different history of where the program had been housed, either within the broader eligibility department or within the foster care department or, as was the case in one county, going back and forth a few times. Each county expressed the same feeling that, regardless of where the operation was housed, resources and support seemed to focus on the other eligibility operations to the neglect of foster care eligibility. In each county, at some point in time, foster care eligibility was not provided the same level of training and procedure resources as the other opera-

tions. At the same time, a culture existed where other eligibility operations ‘looked down’ on foster care eligibility as being ‘less than’, with seemingly little insight or acknowledgement that the likely source of this ‘lesser than’ culture was created by a failure of the system to treat the operation as equal. Finally, each county agreed that when housed in the larger eligibility department, foster care eligibility was “lost” amidst the larger eligibility programs. When housed in the foster care department, children’s department staff had not been promoted from eligibility operations and therefore lacked an understanding of the needs of eligibility. In essence, foster care eligibility always seems to land as a ‘square peg in a round hole’, regardless of where it sits in the agency.

Another political problem is the tension that seems to exist between child welfare workers and eligibility workers. Each county somewhat passionately testified to the same dynamic of polarization between the two groups: eligibility workers are lower paid, less professional, and in “support” positions, juxtaposed with higher paid, Master’s level professional positions, who receive empathy for the demands of their position more often. Eligibility workers feel disrespected by the social workers, and social workers don’t feel supported by the eligibility workers, nor do they understand the more rigid and rule-bound requirements of eligibility.

Because of the complexity and breadth of these problems, a third political problem arises as to who is responsible to resolve them. County foster care eligibility operations look toward the state to fix the technical problems. Because the technical problems vary, solutions may be quite different for each one, and don’t appear to be well understood by those outside of the operation. Each county interviewed described that it appears the state and other stakeholders keep looking toward the county foster care eligibility operation as the operation responsible to solve technical problems. If those who are operating county foster care operations are correct that solutions are beyond their control, an impasse remains.

Recently, one of these technical problems received attention from the state, after more than a de-

cade of having been being identified. A fourth political problem has been exposed during this dialogue: state agencies of health care, mental health, and social services don't seem to agree if the problem is as real as has been described and they have differing, and even contradictory, perceptions of the problem. In response to a growing number of complaints over the years that these state agencies are not collaborating as well as they could to support improving outcomes for foster youth, legislation was passed to create a state Child Welfare Counsel. Co-facilitated by the state's Secretary of Health & Human Services who oversees the departments, this counsel has been looking at the challenges surrounding Medi-Cal for foster youth placed out of county, as referenced in the appendix as one of the many technical challenges. Diagnostic of this tension, the Director of the State Department of Mental Health announced during a public counsel meeting that State SB 785 had resolved the issue, even though it was well-known to be a band-aid-fix that was not solving the problem in practice at the county level. This discourse led to a fury of emails to the State, substantiating how unresolved the issue remains; the differing understandings of the status of the solution within state leadership points out the complexity of this multi-layered problem.

Moving Toward Solution

With permission from Alameda County's Children's Department director and the agency director, conversations with CDSS were held in order to begin movement toward some solutions. In summary, CDSS representatives acknowledged that the state is not as familiar with the technical aspects of Medi-Cal problems for foster youth as the counties are. They did express interest in working directly with a county that would be willing to offer itself as a laboratory to help inform the discussion. Alameda County offered to serve in this capacity and the State agreed, in part because of the many Medi-Cal funded services in Alameda County. Further, the role of the National Center for Youth Law (NCYL), which is based in Alameda County, was discussed. As a result

of NCYL's lawsuit against CDSS related to Medi-Cal and foster youth (Katie A), NCYL has been working with CDSS leadership closely in closed mediation over the Katie A matter and has reportedly moved toward a more collaborative partnership. Based on this, a decision was made to approach NCYL to solicit their participation, and they agreed.

To help move the process forward, Alameda County was able to hire a consultant as well. As a participating county in the Title IVE waiver, Alameda has the opportunity to reinvest savings in improving its outcomes. Part of the county's waiver strategy includes linkage to Medi-Cal funded services; therefore, hiring a consultant to help resolve these issues lined up well with this objective. A highly respected and recently retired Public Health Nurse who has worked with many state and Alameda County staff, as well as NCYL, on these issues, was hired for the position.

At the time of this writing, these issues are being further researched by the recently-hired consultant, and an initial meeting is being established with the following parties: NCYL, CDSS, Alameda FC Eligibility management, and other Alameda Stakeholders (BHCS, HCSA, Juvenile Probation, & a provider representative). The meeting will be the first in a series of meetings to be held between now and the end of the current Secretary of Health & Human services appointment, which ends when a new governor is elected. The current secretary has been identified as someone committed to addressing barriers to improved outcomes for foster youth and has been gaining a growing understanding of the problems with Medi-Cal as a result of her role on the Child Welfare Counsel.

With this timeframe in mind, and given that the recommendations of this writer have already been authorized and set in motion, it is anticipated that two to three meetings of this group will take place in the next several months, delineating the issues identified in this paper. Alameda County may come to realize there are solutions that can be implemented locally that have not yet been identified. It is equally likely that, as a result of Alameda County sharing its

experience of the day-to-day barriers to fixing these issues, those in positions of influence will be assisted in discovering remedies.

Too often it seems that problems this complex are “fixed” with solutions generated by people who are removed from the day-to-day technical issues. Often these solutions cannot reasonably be implemented at a county level, or simply don’t fix the problem (such as SB 785, which was created with the best of intent, but fell short). It is the hope of this writer that the process that has been initiated of allowing one county to share its experience in detail with a broad group of stakeholders, some of whom have authority to move realistic solutions forward, will result in a more effective outcome.

Acknowledgements

In closing, I would first like to thank my department director and supervisor, Carol Collins, for challenging me to put as much of my skill and talent toward identifying solutions to the problem as toward articulating the depth of the challenge. In addition, I thank my agency director, Yolanda Baldovinos, for supporting my participation in BASSC and for allowing me to change my case study topic given the outstanding challenges of the program and the opportunities BASSC would create by thinking more broadly about the problem and solutions. A special thanks to CDSS leadership for speaking candidly with me about the complexity of the politics at the state level, and for partnering with me in thinking toward a solution. Finally, I must acknowledge those in my partner counties who took time out of their busy days to speak to me about this topic: Mark Holguin, Child Welfare Manager (Santa Cruz County); LaRaye Davis, Eligibility Analyst (Santa Cruz County); Lucy Rodriguez, Supervising Eligibility Worker (Santa Cruz County)); Martha Singleton, Foster Care Eligibility Program Manager (San Francisco County); Julie Stuscavage, Eligibility Analyst (Contra Costa County); and Dana Fabella, former Children’s Director (Contra Costa County).

APPENDIX

Technical Problems

Out of County Placements

This issue is already receiving significant attention at the state level. The National Center for Youth Law and others have taken up this cause, which has led to a subcommittee of the state Child Welfare Counsel being formed to address the problem. In short, because foster youth retain their 'county of origin' Medi-Cal code despite residing in another county and inheriting the host county 'residence code', access and funding to mental health services becomes extremely problematic.

Other Health Coverage

At times, foster care Medi-Cal cases include "other health coverage (OHC)" codes, such as Kaiser. Serious barriers to health and behavioral health services are created when Medi-Cal includes these other coverage codes, as Medi-Cal and the "other" health carrier often look to each other as the primary responsible health insurance. State fixes to "hide" the OHC require state employee action and, until recently, often took months. Even with a "quick" response by the state, emergency situations often cannot be resolved until the state "fix" is completed, which minimally takes a few days.

County Organized Health Systems (Plans)

These "COHS/P" systems are increasingly becoming the way of doing business within county health care systems, but unintentionally are creating confusion with Medi-Cal status for foster youth. Resulting problems have included how and when to disenroll foster youth from these plans, whether providers will get paid when these codes are in the MEDS system, and barriers to accessing immediate primary health services as these plans are tied to an identified primary care provider who is often nowhere near a foster youth's new placement.

SSI Medi-Cal

State legislation now mandates that older foster youth are referred to SSI when they are eligible to ensure that this safety net of public support is in place for them upon emancipation. An unintended consequence of this state mandate is a host of complications with SSI Medi-Cal for foster youth. When the Federal Social Security Administration (SSA) establishes SSI for an eligible foster youth, this office takes over 'jurisdiction' of the Medi-Cal case. SSA practice is to establish Medi-Cal in the place of residence of the client, not the county of origin of the foster youth. Therefore, unless other system fixes are in place, any foster youth residing outside their county of origin when SSI is established will have their Medi-Cal switched to the county in which they reside. This will often disrupt payment of existing services tied to a contract in the county of origin.

Transitioning from Foster Care Cash Case—CEC/FFCC Medi-Cal

In theory, foster youth should be able to maintain Medi-Cal coverage under either CEC or FFCC (when aging out of care), but due to a host of technical reasons, these transitions are often fraught with complications. For example, under the CEC program, a birth certificate is required and when no birth certificate exists, Medi-Cal is dropped.

CalWIN

The computer system CalWIN that is used by many counties was and continues to be focused on supporting the larger social service benefit programs: Food Stamps, CalWORKS, IHSS, & General Assistance. Because foster youth do not apply for benefits themselves, often change placements, live in counties outside their county of origin, and go through many transitions (e.g., on and off foster care cash grants), CalWIN is not set up well to interface with these realities. Some of the individuals interviewed for this paper sat on CalWIN implementation committees and reported that the unique needs of foster youth received little attention during implementation discussions. Alameda and the other counties interviewed described spending significant time and resources looking for ways to "trick" the CalWIN system in an effort to have it work for foster youth. These band-aid solutions will always lead to continued problems.