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Los Angeles County Child Welfare-Involved Population Medi-Cal Analysis

Comparative Analysis of the Engagement in Care for Children in Medi-Cal Fee-for-Service vs. Managed Care and Learnings from Enhanced Care Management Early Implementation

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EXECUTIVE SUMMARY

In November 2023, the Los Angeles (LA) County Board of Supervisors passed a motion to address the implementation of new benefits for the child welfare-involved population launched through California's Medicaid waiver, California Advancing and Innovating Medi-Cal, known as CalAIM. The CalAIM waiver expanded services to managed care beneficiaries, including enhanced care management (ECM) for coordinated case management, referrals, and community resource navigation and community supports. Community supports (CS) provide 14 new concrete resources, such as housing assistance, medically tailored meals, housing modifications, respite care for caregivers, and asthma management. These benefits are designed to better address health and social needs for the most vulnerable and at risk Medi-Cal beneficiaries, including children and youth involved in the child welfare system. The Board directed the Office of Child Protection (OCP), in collaboration with key county departments, to engage Health Management Associates, Inc. (HMA), as the technical assistance provider with a focus on three priorities:

1. Identify the eligible child welfare-involved population for these new benefits and assess barriers and opportunities to access services
2. Work with multiple county departments and partners, including the Department of Children and Family Services (DCFS), managed care plans (MCPs), the Department of Mental Health (DMH), the Department of Health Services (DHS), the Department of Public Social Services (DPSS), and community partners to develop and pilot strategies to improve engagement in eligible services
3. Develop recommendations for LA County and, where appropriate, state consideration related to policies that will reduce barriers and support eligible children and youth

HMA's work was also informed by recent analysis led by L.A. Care and Children's Hospital Los Angeles (CHLA), as part of the Los Angeles County Children's Health Disparities Roundtable convened in November 2023. That meeting resulted in an Issue Brief that identified challenges and opportunities to improve quality, appropriateness, and ease of access to care supports to address the unique needs of children involved in the child welfare system.

Medi-Cal Enrollment Findings

Recognizing that approximately two-thirds of child welfare-involved children and youth in LA County are enrolled in fee-for-service (FFS) Medi-Cal and ineligible for new CalAIM supports, a primary focus of HMA's analysis was evaluating the benefits of enrollment in MCPs. HMA conducted a comparative analysis of the experience of children involved in the child welfare system in FFS versus managed care Medi-Cal through an analysis of federal T-MSIS data. The analysis examined the experience of the child welfare-involved population in primary and preventive healthcare services in Medi-Cal FFS versus managed care plans (MCPs) to inform decisions about existing practices for care management among the child welfare-involved population.

The comparative analysis of the child welfare population in Los Angeles County, San Diego County, and Riverside County revealed significant differences in healthcare engagement between children enrolled in FFS and those in MCPs, including:

- Across all counties, children in managed care consistently showed higher rates of engagement in primary and preventive healthcare services, including well child visits, behavioral health visits, dental exams, and social determinants of health (SDOH) screenings
- The data suggest that MCPs may provide more comprehensive and coordinated care, as illustrated by the data showing greater engagement in behavioral health services following a diagnosis for the child welfare-involved population
- Overall, the findings highlight the potential benefits of managed care in enhancing healthcare access and engagement for children in the child welfare system

HMA recognizes and appreciates the support and assistance of multiple county representatives from the Department of Public Health, DMH, DHS, and DCFS who provided feedback and validation of the methodology and results when reviewing the draft T-MSIS analysis.

Engagement in ECM Services Findings

The second major component of HMA's effort was to work with various county and community stakeholders to understand barriers to engagement in ECM and CS services. Input was solicited through stakeholder sessions, interviews, and feedback generated as part of a pilot ECM/CS referral process with the DCFS Glendora regional office. HMA identified the following four major barriers to engagement in ECM services for the child welfare-involved population:

Eligibility & Enrollment	Data Sharing	Provider Knowledge & Training	Insufficient Processes
• Two-thirds of LA County child welfare population are enrolled in FFS Medi-Cal and ineligible for services • DCFS social workers are unfamiliar with the benefit and how/why services would be beneficial	• No existing data-sharing protocols between DCFS and managed care plans to identify shared clients • ECM eligibility criteria do not match Medi-Cal aid codes (e.g., children in Family Maintenance)	• Lack of experience with child welfare-involved population; only one-third of providers are DCFS or DMH providers • Limited understanding of how to integrate ECM with other funded services	• Lack of established referral pathways/workflows • Confusion regarding multiple providers and designated roles • No established contact at local DCFS office(s)

- **Eligibility and enrollment:** DCFS's general practice is to disenroll children entering foster care from managed care and reenroll them in FFS Medi-Cal, ending their eligibility for CalAIM-related supports. Misperceptions among social workers and other county staff involved with the child welfare population about the managed care benefits, scope of services, and authorization requirements have inhibited enrollment in managed care.

- **Data sharing:** There are well-documented[1] challenges with providers and social workers that work with the child welfare-involved population having access to a comprehensive and integrated data source on children and youth, as well as barriers to data sharing across systems. In terms of access to ECM services, several challenges were identified, including lack of timely information about Medi-Cal enrollment status and associated managed care plans, lack of data sharing agreements between the county and MCPs, and insufficient Medi-Cal aid codes, which inhibits MCPs from identifying all eligible ECM Medi-Cal beneficiaries.
- **Provider Knowledge and Training:** As noted previously, sessions with DCFS social workers and community and county providers identified multiple misperceptions about the Medi-Cal system as well as limited understanding of how the new ECM benefit can integrate with existing child welfare services and supports. Medi-Cal MCPs that are responsible for building a network of service providers to provide ECM services are encouraged but not required to contract with existing DCFS service providers that may be less familiar with the unique complexities associated with supporting the child welfare-involved population.
- **Insufficient Processes:** The Glendora pilot demonstrated the need and value of creating tailored processes to support DCFS social workers in integrating ECM and CS services within existing referral processes. Though further work is needed on this pilot to determine how to increase opportunities for engagement in support, early results indicate that informing and working with social workers to design tailored processes would likely improve referrals and engagement in care.

Recommendations

The analysis and findings offer county departments that serve the child welfare population the opportunity to better understand these benefits and explore strategies to improve health care delivery and support for children and youth in foster care in Los Angeles County. Examples include reviewing and updating Medi-Cal enrollment practices and policies to align with the needs and interests of children and their families/caregivers.[2] Further work through the Glendora partner and ongoing engagement with stakeholders is needed to make further progress toward improving health outcomes for the child welfare-involved population. Lessons learned from this early work should inform and be incorporated into future efforts. Key findings include:

- Access to healthcare is not the primary role of child welfare social workers' and related providers' efforts (ECM provides a valuable resource to coordinate health and related services, particularly for individuals with complex health needs)
- The Medi-Cal system is complex and evolving, and most frontline social workers have had few, if any, resources to stay informed of new benefits and resources
- Social workers and supervisor education is critical to yield referrals and engagement in care

[1] Data challenges were identified and reviewed as part of the Children's Health Disparities Report as well Children and Youth in Foster Care: Background and Current Landscape, August 2020.

[2] According to Department of Health Care Services guidance, a child in foster care may be voluntarily enrolled in an MCP only when the county child welfare agency with responsibility for the care and placement of the child, in consultation with the child's foster caregiver, determines it is in the best interest of the child to do so and the department determines that enrollment is available to the child. See https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf.

- New benefits and data systems often are designed for the adult population without testing and adaptation to children and youth
- Data sharing is critical, and current limitations present a significant barrier to healthcare engagement
- Providers must have experience with the child welfare population to successfully engage eligible beneficiaries

Based on these findings, HMA recommends that LA County child welfare systems partners consider the following actions to address the unique healthcare and SDOH needs of the child welfare population.

1. **Establish a Clear Criterion and Process Related to Medi-Cal Enrollment and Disenrollment from Managed Care**

   All parties involved in addressing and supporting the child welfare population should be operating from a common set of criteria and framework to make determinations regarding care, with an emphasis on care continuity and full utilization of available benefits and supports. Recognizing that in almost all cases children enrolled in Medi-Cal who enter the child welfare system are likely enrolled in managed care, the current processes result in disenrollment from a plan and potential disruption to continuity of care. A specific criterion should be defined that identifies the exceptions under which children/youth would be disenrolled from their current plan and placed in FFS. Second, clearly defined roles and responsibilities among DCFS staff, DPH staff, caregivers/resource parents, and other partners like DPSS, are critical to success. Stakeholder input indicated the need to determine who is responsible for making the determination and on what basis. Accountability for decisions should be clarified with the appropriate deference to caregiver/resource parent choice and authority, as well as the youth's decisions, if age appropriate.

2. **Prioritize Training and Support for DCFS Children Social Workers Regarding Medi-Cal**

   Training and education for DCFS social workers and other providers working with the child welfare-involved population is critical when addressing misunderstandings regarding Medi-Cal benefits. This confusion is understandable given the significant changes in the system over the past 10 years and the evolving nature of available services and supports. Training and support should include FAQs and other tools, like the draft developed during the pilot to assist DCFS social workers and family members with navigating the Medi-Cal system. Parents, caregivers/resource parents, and transition-age youth should be informed of available Medi-Cal options.

3. **Continue to Collaborate with MCPs to Raise Awareness and Maximize Utilization of Medi-Cal Managed Care Benefits, Including CalAIM**

   The Glendora office pilot identified successful strategies and protocols to enable DCFS to quickly identify eligible children and youth and connect them to care. Ongoing partnership is needed between MCPs and DCFS, supported by the pending memorandum of understanding and continued collaboration. Policy recommendations were recently submitted to the Department of Health Care Services on necessary changes to reduce barriers to care. LA County and managed care plans are also exploring ways to leverage LANES, a health information exchange, to identify health plan status information and review engagement in care for the child welfare-involved population. These efforts should continue and be expanded to maximize utilization of available services.

About this Report

Health Management Associates, Inc. (HMA), conducted a comparative analysis of the experience of children involved in the child welfare system in fee-for-service (FFS) versus managed care Medi-Cal by analyzing federal T-MSIS data. The report builds on recent analysis led by L.A. Care and Children's Hospital Los Angeles (CHLA), with support from First 5 LA, HealthNet, and Molina, as part of the Los Angeles County Children's Health Disparities Roundtable, convened in November 2023. The Roundtable report focused on improving the quality, appropriateness, and ease of access to care supports to address the unique needs of children involved in the child welfare system.

The second component of this report is a synthesis of stakeholder feedback captured during focus groups and interviews, as well as input gathered during an initial pilot with the Department of Children and Family Services (DCFS) regional office in Glendora. Together, this quantitative and qualitative data analysis presents findings and recommendations to improve access to care for the child welfare-involved population.



BACKGROUND

Medi-Cal, California's Medicaid program, provides publicly funded health care coverage to eligible individuals based on income or other specified conditions. Approximately one-third of Californians, including 45 percent of children younger than 18 years old, are Medi-Cal members. At the point of enrollment and based on their location, beneficiaries are generally assigned to a managed care plan (MCP), which coordinates their care through contracts with the California Department of Health Care Services (DHCS). All children and youth in foster care who receive federal Social Security Act Title IV-E payments are categorically eligible for Medi-Cal, regardless of their household income level.[3] Under the federal Affordable Care Act, youth formerly in foster care and younger than 26 years old also qualify for Medi-Cal, regardless of their income.[4] In some counties, children in custodial care are required to enroll in managed care; however, in other counties, including Los Angeles (LA) County and San Diego County, children in child welfare custody may enroll in either managed care or fee-for-service (FFS) plans.

New Child Welfare Benefits in Managed Care

The California Advancing and Innovating Medi-Cal (CalAIM) initiative introduces expanded services to managed care, including enhanced care management (ECM) for coordinated case management, referrals, and community resource navigation. CalAIM also provides 14 new community supports, such as housing assistance, medically tailored meals, housing modifications, respite care for caregivers, and asthma management. These benefits are designed to address both health and social needs more fully, with particular emphasis on supporting children in foster care.

CHILD WELFARE ELIGIBLE POPULATIONS FOR ECM/CS

- Enrolled in managed care
- Are younger than age 21 and are currently receiving foster care in California
- 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 younger than age 21 and previously received foster care in California or another state within the last 12 months
- Are younger than age 18 and are eligible for and/or in California's Adoption Assistance Program
- Are younger than age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months

[3] In California, children and youth are enrolled in Medi-Cal via the foster care aid codes, at the time of the court's custody determination. Source: California Department of Health Care Services. Children and Youth in Foster Care: Background and Current Landscape. August 2020. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf.

[4] In California, children and youth are enrolled in Medi-Cal via the foster care aid codes at the time of the court's custody determination. Source: California Department of Health Care Services. Children and Youth in Foster Care: Background and Current Landscape. August 2020. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf.

COMPARATIVE ANALYSIS OF MEDI-CAL ENROLLMENT

Methodology

HMA conducted a comparative analysis of the experience of the child welfare-involved population based on a a review of available encounter and utilization data from the federal T-MSIS system. The Transformed Medicaid Statistical Information System (T-MSIS) dataset provides comprehensive Medicaid and Children's Health Insurance Program (CHIP) data from US states, territories, and the District of Columbia and is the largest national source of beneficiary information. The population for this comparative analysis includes Medi-Cal beneficiaries who were enrolled in Medicaid in December 2022 and residing in Los Angeles County. Beneficiaries were categorized as managed care members if they were enrolled in a comprehensive MCP in December 2022. All other beneficiaries were classified as FFS members.

The analysis included data on the following Medi-Cal populations identified by aid code:

- Child Welfare Population: Includes people classified with the following T-MSIS eligibility group codes:
    - 08 − Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
    - 09 − Former Foster Care Children
    - 28 − Reasonable Classifications of Individuals Under Age 21
    - 29 − Children with Non-IV-E Adoption Assistance
    - 30 − Independent Foster Care Adolescents
- Former Foster Care Youth: Includes beneficiaries with the T-MSIS eligibility group “09 – Former Foster Care Children”
- Broader comparison group of Medi-Cal beneficiaries ages 26 and younger

The T-MSIS eligibility codes correspond with the following California Medi-Cal aid codes: 03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U, 4A, 4C, 4E, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, and 5L. See Appendix 1 for a crosswalk of the T-MISIS eligibility group codes to Medi-Cal aid codes.

The following codes were used to identify the various services examined in this analysis:

- Well child visit: 99381−99385, 99391−99395
- Behavioral health visits: 90832−90834, 90836−90838, 90853, 96110, 96127, 96156−96161, 96164−96171, 97151−97158, 99406−99409, 99446−99452, 99484, 99492−99494, 99483, G2214
- Social determinants of health (SDOH) screening: G9919, G9920
- Dental exam: D0120

The analysis also included Medi-Cal beneficiaries who were enrolled in Medicaid as of December 2022 and residing in San Diego County and Riverside County. These counties were selected to assess the experience of children involved in the child welfare system in FFS versus MCPs residing in other counties.

Limitations of This Analysis

Federal T-MSIS data provided the basis for this comparative analysis, which has the following limitations:

- The most recent data are from 2022
- The comparative analysis only reflects a point in time (i.e., beneficiaries enrolled in Medi-Cal as of December 2022)
- Lack of disaggregated data within the T-MSIS eligibility group code
- The data exclusively focus on engagement in primary care and preventive services

The available data would support neither a comparative analysis of how engagement in care varies based on child welfare placement nor a comparative analysis for outcomes by placement (i.e., out-of-home placements versus in-home care versus kinship care). In addition, this comparative analysis focused solely on rates of engagement in primary and preventive care. Further analysis is necessary to determine long-term health or how Medi-Cal enrollment status may affect child welfare outcomes.

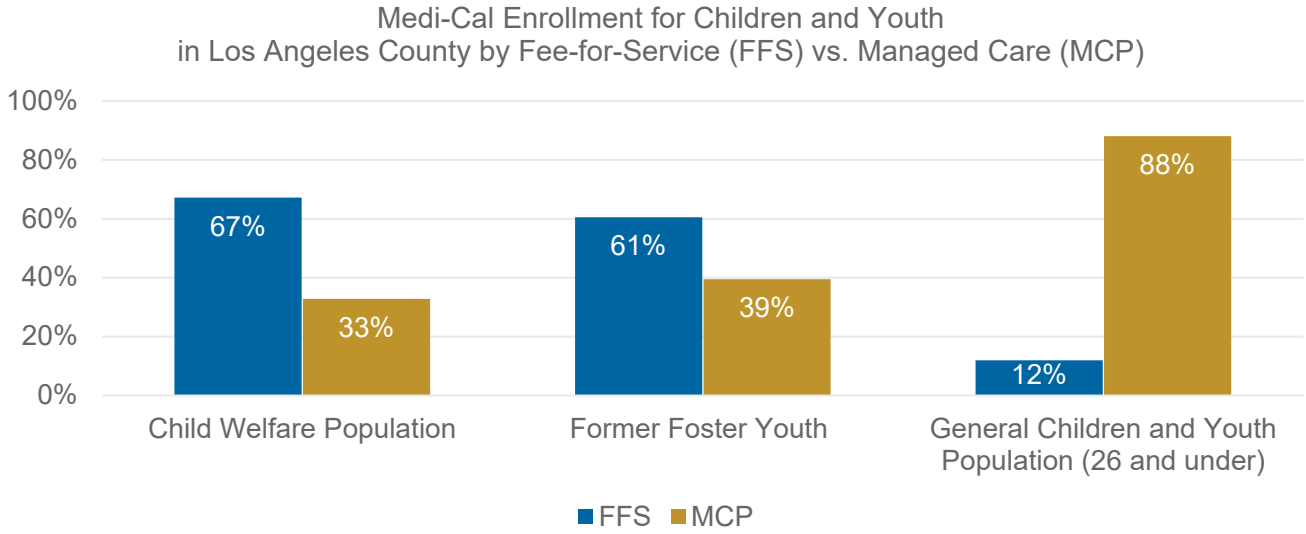
MCP versus FFS Enrollment Among Children and Youth

Children and youth in foster care who receive federal Social Security Act Title IV-E payments are categorically eligible for Medi-Cal.[5] Under the Affordable Care Act youth formerly in foster care and age of 26 or younger also are eligible for Medi-Cal, regardless of income.[6] In California, Medi-Cal managed care enrollment is mandatory for the general population, but those requirements vary by county for the child welfare population. In LA County, managed care enrollment is optional for children and youth in foster care. This difference is highlighted below. While 88 percent of the general children and youth population were enrolled in managed care in December 2022, only 33 percent of children and youth in foster care and 39 percent of former foster youth were enrolled in Medi-Cal managed care (see Figure 1).

[5] Children and youth living in California are enrolled in Medi-Cal via the foster care aid codes at the time of the court's custody determination. Source: California Department of Health Care Services. *Children and Youth in Foster Care: Background and Current Landscape*. August 2020. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf.

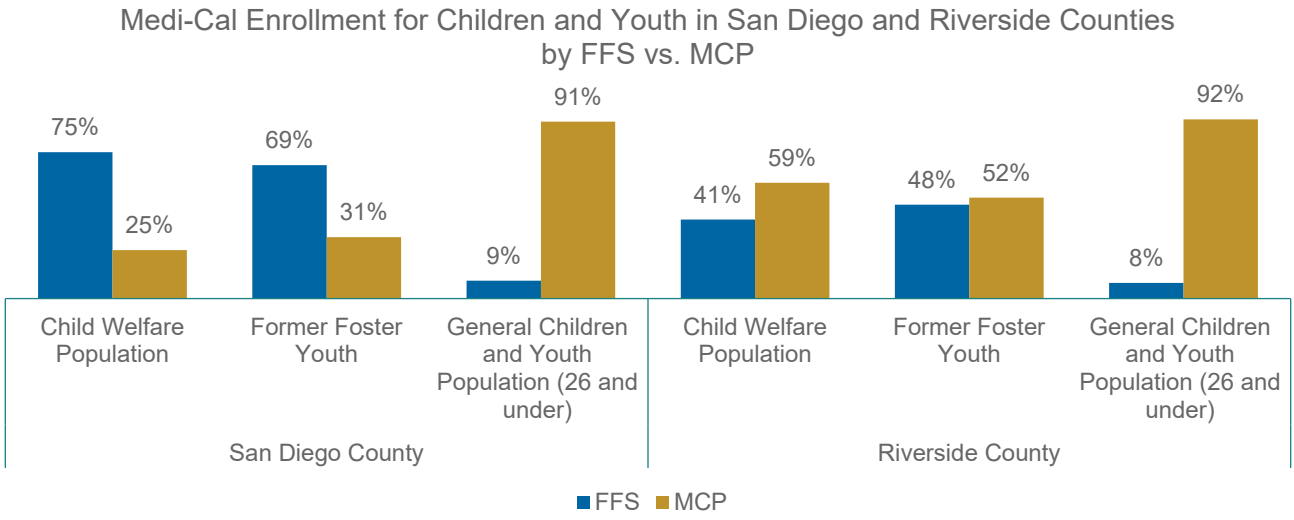
[6] California children and youth are enrolled in Medi-Cal via the foster care aid codes at the time of the court's custody determination. Source: California Department of Health Care Services. *Children and Youth in Foster Care: Background and Current Landscape*. August 2020. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf.

Figure 1. FFS and MCP Medi-Cal Enrollment for Children and Youth in Los Angeles County



HMA conducted comparable analyses for San Diego and Riverside Counties, both of which are multi-plan counties where Medi-Cal managed care enrollment is optional for the child welfare population. In Los Angeles County, more children and youth in foster care were enrolled in FFS Medi-Cal during the study period than people of the same age in general population. San Diego County and Riverside County, however, had slightly higher rates of enrollment in MCPs than FFS for the child welfare and former foster care populations (see Figure 2).

Figure 2. FFS and MCP Medi-Cal Enrollment for Children and Youth in San Diego and Riverside Counties





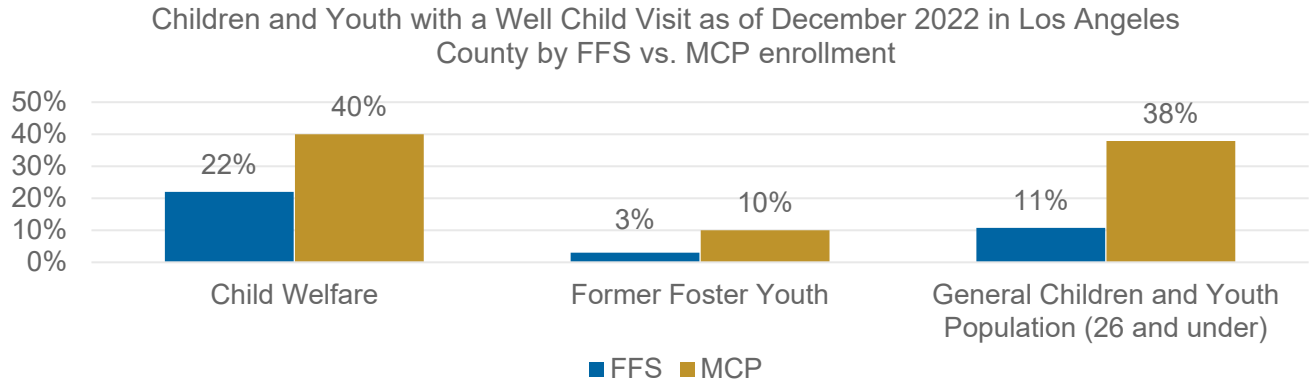
Child Welfare-Involved Children/Youth in Managed Care Are More Likely to Receive Well Child Visits

Routine well child visits, especially during the first five years of life, are essential for monitoring growth, development, and overall well-being. MCPs are contractually required to meet the minimum levels of a set of quality healthcare measures that DHCS identifies each year. One measure is well child visits (W30-6+ and W30-2+). In California, approximately 50 percent of children and youth enrolled in Medi-Cal managed care during the 2023 reporting year experienced a well child visit within the first 15 months of life.[1] In Los Angeles County, the percentage of children in the child welfare population who had a well child visit varies significantly between those in FFS versus MCPs. For children ages 0–5, 34 percent in FFS had a well child visit compared with 63 percent in managed care (see Table 1 and Figure 3). This trend continues across other age groups.

Table 1. Child Welfare Population with Well Child Visits by Age Group

Age Group	Fee-for-Service	Managed Care
0–5	34%	63%
6–11	25%	51%
12–18	23%	44%
19+	4%	11%

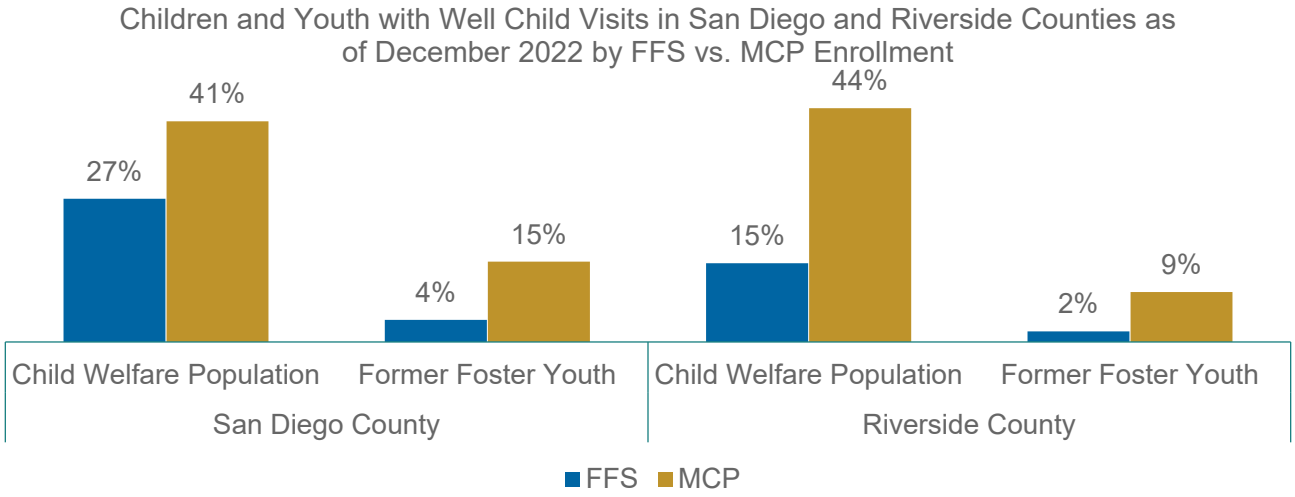
Figure 3. Children and Youth with a Well Child Visit in Los Angeles County by FFS vs. MCP Enrollment



Note: For all metrics, we used T-MSIS "other services" claims, including all claims other than those for inpatient services, long-term care, and prescription drugs. The claims were then filtered down to only those attributed to beneficiaries in the population defined in the methodology. For well child visits, claims with any of the following procedure codes were identified: 99381−99385, 99391−99395. Within that group of claims, the number of unique FFS and managed care beneficiaries was counted. For well child visit code definitions go to: https://www.cmadocs.org/newsroom/news/view/ArticleId/27840/Coding-Corner-CPT-reporting-for-preventive-medicine-services.

When comparing Los Angeles County with San Diego and Riverside Counties, the data indicated that managed care consistently results in higher engagement in well child visits across the child welfare and former foster care populations. Overall, the evidence suggests that **children in MCPs are more likely than FFS enrollees to receive regular preventive care** across Los Angeles, San Diego, and Riverside Counties (see Figure 4).

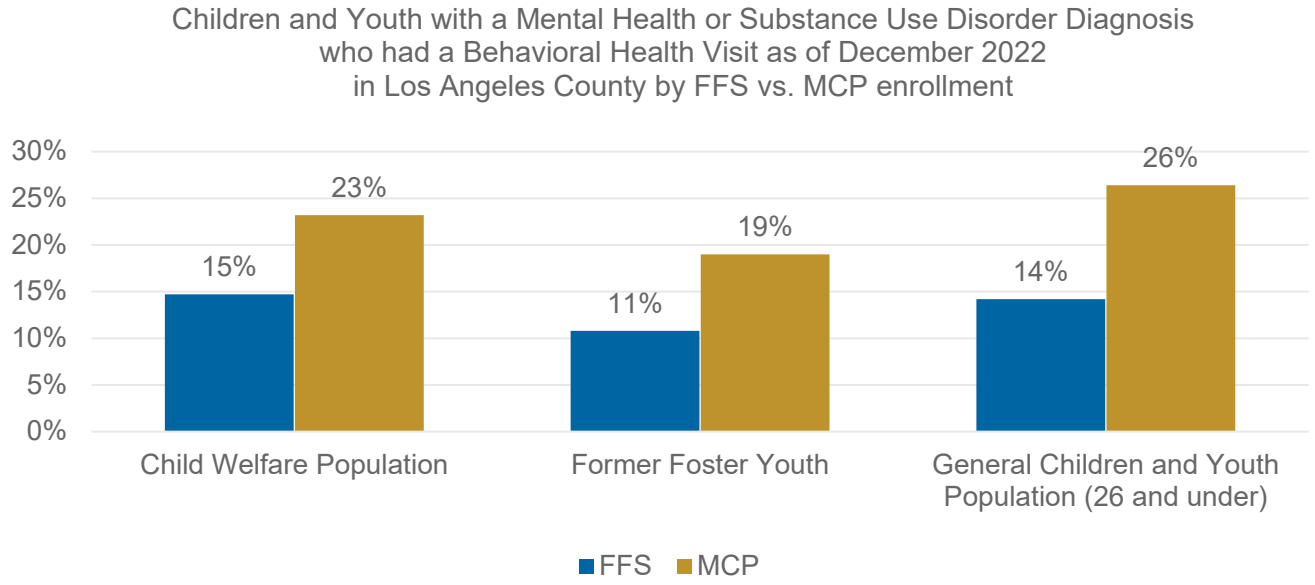
Figure 4. Children and Youth with a Well Child Visit in San Diego and Riverside Counties by FFS vs. MCP enrollment



Child Welfare-Involved Children/Youth in Managed Care with a Mental Health Diagnosis Are More Likely to Have a Behavioral Health Visit

Children enrolled in managed care have access to specialty mental health services regardless of whether they are enrolled in MCPs or FFS. The data indicated **that children in managed care were more likely to have behavioral health visits than those in FFS**. For example, 23 percent of children in managed care had a behavioral health visit versus only 15 percent in FFS (see Figure 5).

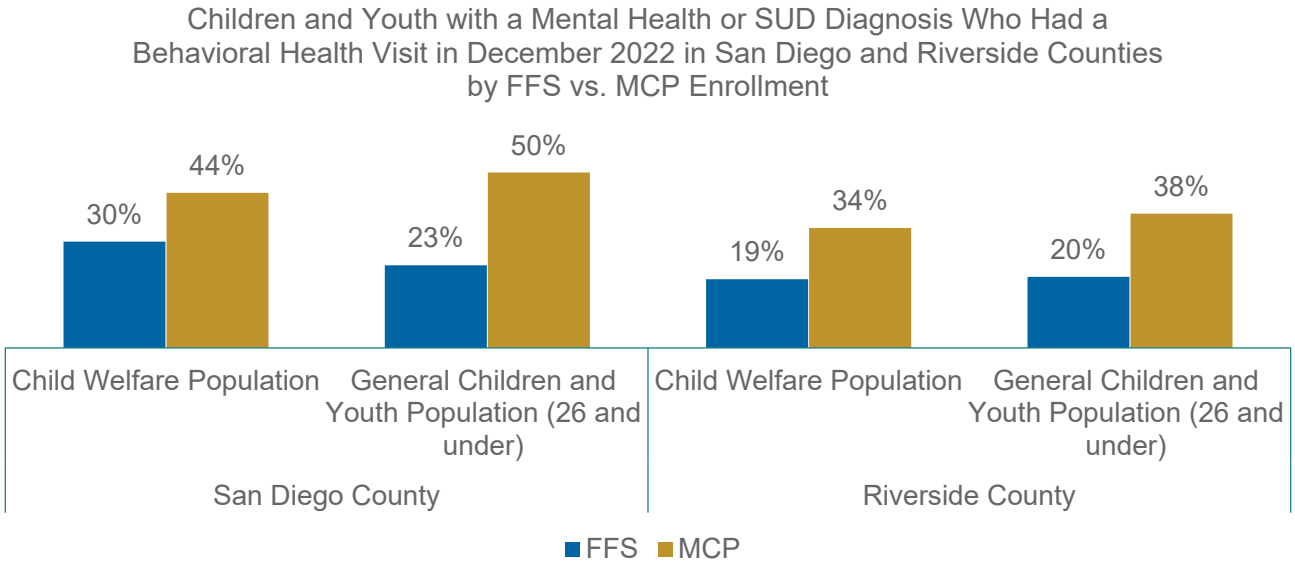
Figure 5. Children and Youth with Behavioral Health Visits in LA County by FFS vs. MCP Enrollment



Note: Beneficiaries who had at least one claim with a mental health diagnosis indicator or a substance use disorder (SUD) diagnosis indicator were included in the denominator for this metric. The T-MSIS mental health indicator is derived using ICD-9 codes 290−302, 306−319 and ICD-10 codes F01−F09, F20−F99. The T-MSIS SUD indicator is derived using ICD-9 codes 303−305 and ICD-10 codes F10−F19. For the numerator of this metric, claims with any of the following codes were identified: 90832−90834, 90836−90838, 90853, 96110, 96127, 96156−96161, 96164−96171, 97151−97158, 99406−99409, 99446−99452, 99484, 99492−99494, 99483, G2214. That group of claims those for FFS and managed care beneficiaries. Behavioral health code definitions are available at: https://www.ama-assn.org/delivering-care/public-health/behavioral-health-coding-guide.

When comparing these data with San Diego and Riverside Counties, similar patterns were observed. In San Diego County, children in managed care also were more likely to have behavioral health visits than those in fee-for-service. The same trend was apparent in Riverside County, where managed care enrollment is associated with higher rates of behavioral health visits. Overall, the data suggest that managed care may provide better access to behavioral health services for children involved in the child welfare system across Los Angeles, San Diego, and Riverside Counties (see Figure 6).

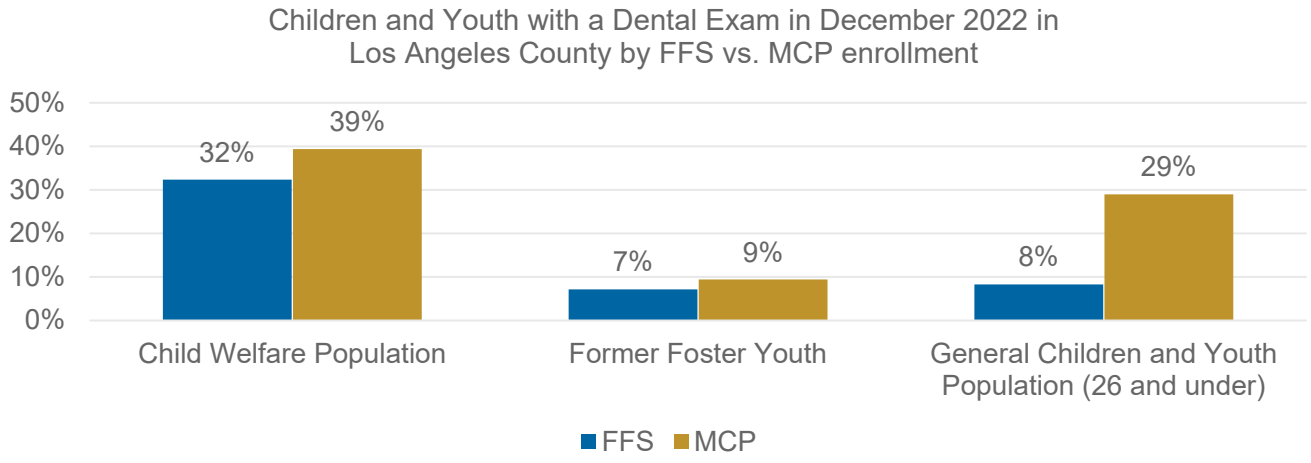
Figure 6. Children and Youth with a Behavioral Health Visit in San Diego and Riverside Counties by FFS vs. MCP Enrollment



Child Welfare-Involved Children/Youth in Managed Care More Likely to Receive Dental Exams

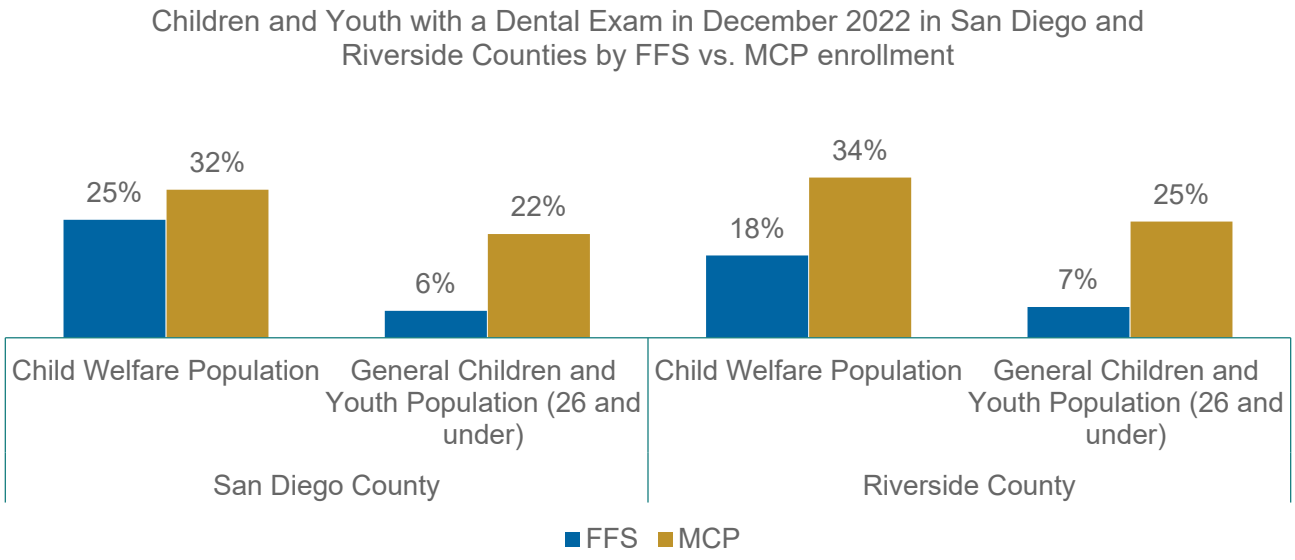
Routine dental exams are important for preventing tooth decay and other oral health problems among children and youth. The data indicate that children in MCPs more likely to have dental exams than those in FFS. For example, in LA County, 39 percent of the child welfare population in managed care had a dental exam, compared with only 32 percent in FFS. For the general children and youth population, a 21 percent difference was evident between children in MCPs versus FFS receiving a dental exam (see Figure 7).

Figure 7. Children and Youth with a Dental Exam in Los Angeles County by FFS vs. MCP Enrollment



When benchmarking these data against San Diego and Riverside Counties, similar patterns were observed. In San Diego County, children in managed care also were more likely to have dental exams than those in fee-for-service. The same trend was seen in Riverside County, where MCP enrollment is associated with higher rates of dental exams. Overall, the data suggest that **managed care may provide better access to dental services for children involved in the child welfare** system across Los Angeles, San Diego, and Riverside Counties (see Figure 8).

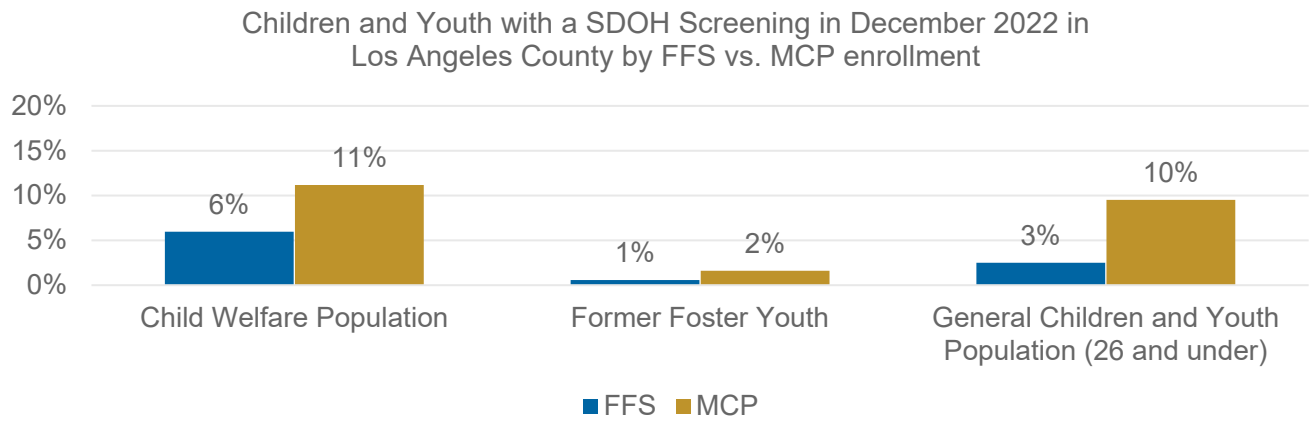
Figure 8. Children and Youth with a Dental Exam in San Diego and Riverside Counties by FFS vs. MCP Enrollment



Child Welfare-Involved Children/Youth in Managed Care Are More Likely to Receive a SDOH Screening

Addressing the social needs of children and their families supports the health and well-being of a child, and screenings for SDOH are useful in identifying non-clinical factors that may affect a child's health and well-being. The data indicate that children in managed care were more likely to receive SDOH screenings than those in FFS. This trend is consistent across all populations. For example, approximately 11 percent of the child welfare population enrolled in managed care received this screening compared to 6 percent of FFS enrollees (see Figure 9).

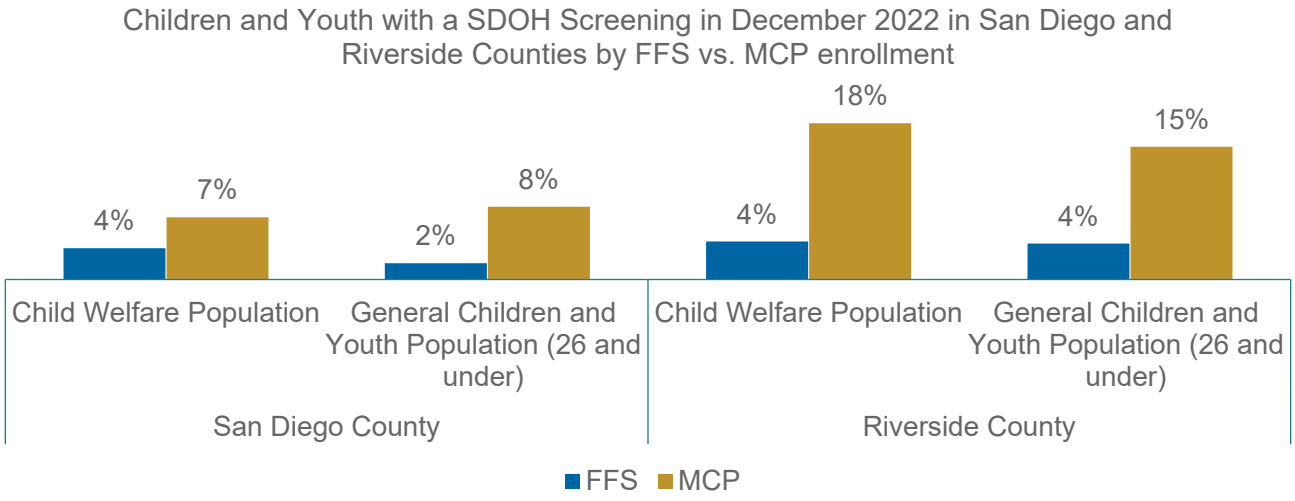
Figure 9. Children and Youth with a SDOH Screening in LA County by FFS vs. MCP Enrollment



Note: For this metric, claims with any of the following procedure codes were identified: G9919, G9920. Within that group of claims, the number of unique FFS and managed care beneficiaries was counted. Code definitions available at: https://www.caresource.com/documents/ga-med-p-2116853-2023-incentive-limits-for-sdoh-network-notification.pdf.

When comparing these data with those for San Diego and Riverside Counties, similar patterns emerged. In San Diego County, children in MCPs were also more likely to receive SDOH screenings than those in FFS. The same trend was observed in Riverside County, where managed care enrollment was associated with higher rates of SDOH screenings. Overall, the data suggests that **managed care may provide better access to SDOH screenings for children involved in the child welfare system** across Los Angeles, San Diego, and Riverside Counties (see Figure 10).

Figure 10. Children and Youth with a SDOH Screening in San Diego and Riverside Counties by FFS vs. MCP Enrollment





SUMMARY

All California children and youth in foster care who receive federal Social Security Act Title IV-E payments are eligible for Medi-Cal, regardless of their household's income level.[7] Children in foster care are not required to enroll in a managed care plan, unless they reside in a county that has a County Organized Health System that mandates managed care enrollment.[8] Hence, many foster children in California are in Medi-Cal FFS compared with the general children and youth population.[1] Reflective of this trend is Los Angeles County, where 88 percent of children and youth younger than age 26 enrolled in Medi-Cal were in managed care as of December 2022 versus one-third (33%) of the child welfare population in Los Angeles County.

Given the expanded benefits for the child welfare population under CalAIM, further analyses and measurements of quality are needed to determine whether children and youth experience better overall health outcomes and well-being when enrolled in managed care versus FFS Medi-Cal. HMA conducted a comparative analysis of the experience of children involved in the child welfare system in fee-for-service versus managed care by analyzing federal T-MSIS data. The analysis examined the experience of the child welfare-involved population in primary and preventive healthcare services.

[7] In California, children and youth are enrolled in Medi-Cal via the foster care aid codes at the time of the court's custody determination. Source: California Department of Health Care Services. *Children and Youth in Foster Care: Background and Current Landscape*. August 2020. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf.

[8] In California, children and youth are enrolled in Medi-Cal via the foster care aid codes at the time of the court's custody determination. Source: California Department of Health Care Services. *Children and Youth in Foster Care: Background and Current Landscape*. August 2020. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf.

KEY TAKEAWAYS

The comparative analysis of the child welfare population in Los Angeles, San Diego, and Riverside Counties revealed significant differences in healthcare engagement between children enrolled in FFS and managed care:

- Across all counties, children in managed care consistently show higher rates of engagement in primary and preventive healthcare services, including well child visits, behavioral health visits, dental exams, and SDOH screenings.
- The data suggest that managed care may provide more comprehensive and coordinated care, leading to improved health outcomes for this vulnerable population.
- Overall, the findings highlight the potential benefits of managed care in enhancing healthcare access and engagement for children in the child welfare system.



Managed Care vs. Fee-for-Service
In Los Angeles County, the majority of children and youth in foster care are enrolled in fee-for-service compared to the general population. However, in San Diego and Riverside counties, there are slightly higher rates of enrollment in managed care versus fee-for-service for the child welfare and former foster care populations.



Access to Primary and Preventative Healthcare Services
Children enrolled in managed care are more likely to have well-child visits, behavioral health visits, dental exams, and social determinants of health (SDOH) screenings compared to those in fee-for-service. This trend is consistent across all age groups and counties.



Improved Health Outcomes
The data suggests that managed care may provide more comprehensive and coordinated care, leading to improved health outcomes for children involved in the child welfare system.

The analysis and findings help county departments that serve the child welfare population better understand these benefits and explore strategies to improve healthcare delivery and support for children and youth in foster care in LA County. Opportunities include reviewing and updating current Medi-Cal enrollment practices and policies to align with the needs and interests of the child and their family/caregiver.[9]

[9] According to DHCS guidance, a child in foster care may be voluntarily enrolled in an MCP only when the county child welfare agency with responsibility for the care and placement of the child, in consultation with the child's foster caregiver, determines it is in the best interest of the child to do so and the department determines that enrollment is available to the child. For details, go to: https://www.dhcs.ca.gov/provgovpart/Documents/Children-and-Youth-in-Foster-Care-Landscape-Overview.pdf.

GLENDORA OFFICE PILOT

Background on Pilot and Participants

In November 2024, DCFS, OCP, Los Angeles County managed care plans, and two ECM providers (Five Acres and Sycamores) partnered in a pilot that tested and identified best practices to increase connections with ECM services. The objectives of the pilot included:

- Engage DCFS social workers to build their awareness of ECM
- Enroll eligible children/youth from the Glendora DCFS office in ECM by testing out referral pathways between the local office and ECM providers
- Capture learnings from the pilot to inform MCP and DCFS engagement moving forward
- Increase awareness among DCFS social workers of managed care services and benefits

Though social workers are encouraged to share information about ECM services with any eligible child/youth involved in the child welfare system, populations of interest include those in the Family Maintenance Program, those in the Adoption Assistance Program, and transition age youth. The pilot will continue until at least 50 eligible children/youth are successfully enrolled in ECM.

Learnings

Before any referrals were made, a series of sessions were conducted with the Glendora office staff to understand the process for connecting social workers with other community-based support programs. Using this information, a standardized workflow for ECM referrals was co-designed with partners in the pilot. An ECM Interest Form was also created. In December 2024, the workflow was circulated to the partners in the pilot and ECM providers were provided with training and a desk reference guide for each MCP's plan-specific ECM referral process (e.g., contact information, online links).

At the start of the pilot, 135 children/youth were identified as potential referrals for ECM because of their enrollment in managed care plans. Although this list was a helpful starting place for participating social workers, we found that some children/youth on the original list were no longer enrolled in managed care and were now FFS participants. Part of the pilot focuses on identifying ways to have real-time access to an individual's Medi-Cal managed care status.

HMA facilitated five in-person informational sessions for the Glendora office to increase awareness and understanding of ECM and its value for social workers. FAQs based on questions raised during the sessions were developed and shared with the Glendora teams. Additionally, a resource document was developed and shared that explained the benefits and differences between managed care and FFS to serve as a learning vehicle for DCFS staff.

As of April 30, 2025, a total of 19 referrals had been made, 11 of which resulted in successful enrollment in ECM. Of the remaining eight referrals, three were in process, two children were found to be Medi-Cal FFS enrollees, and three did not participate because they were already engaged with another ECM provider. When ECM enrollment did not occur, the pilot partners reviewed the cases to discuss possible barriers and to identify potential improvements and adjustments in the process for future referrals.

Value of ECM

Seven-year-old Jack (not client's real name) was referred to our ECM program due to serious mental health needs and being a high utilizer of emergency department (ED) services.

Jack has epilepsy, diabetes, and behavioral issues that were affecting his functioning at school and in his afterschool program.

Jack's mom is a single working mom with limited English proficiency who felt overwhelmed trying to navigate the various systems of care to get Jack the care he needs.

Our Lead Care Manager assisted with the following:

- Coordinating appointments with Jack's pediatrician and specialists so that Jack could receive consistent medical care instead of emergency services in the ED
- Arranging for interpreter services during appointments so that his mom will better understand Jack's needs
- Securing an evaluation for autism through the regional center
- Updating Jack's Individualized Education Program (IEP) to include one-on-one behavioral support at school and in his afterschool program to help him manage his aggressive behaviors

Eventually, Jack was ready to successfully discharge from our ECM program. At the discharge planning meeting, his mom expressed gratitude for ECM services in helping Jack get the support and services he needs and helping her feel more empowered to access the services she and Jack need in the future.



Barriers and Challenges

The pilot identified multiple issues that affect the successful enrollment of eligible children and youth in ECM and CS services. Ongoing meetings with providers, managed care plans, and county departments that engage with the child welfare-involved population were used to deepen understanding of the underlying barriers and propose solutions. Obstacles included:

- **Eligibility and enrollment**: DCFS general practice is to disenroll children from managed care and reenroll them in FFS Medi-Cal, making them no longer eligible for CalAIM supports. Misperceptions about the managed care benefits, scope of services, and authorization requirements among social workers and other staff involved with the child welfare population have inhibited enrollment in managed care.
- **Data sharing**: There are well-documented[10] challenges with providers and social workers who work with the child welfare-involved population having limited access to a comprehensive and integrated data source on children and youth, as well as barriers to sharing data across systems. In terms of access to ECM services, several challenges were identified:
    - Limited timely information about Medi-Cal enrollment status and associated managed care plans
    - Lack of data sharing agreements between the county and managed care plans
    - Insufficient Medi-Cal aid codes, which inhibits managed care plans from identifying all eligible ECM Medi-Cal beneficiaries
- **Provider Knowledge and Training:** As noted earlier, sessions with DCFS social workers, community providers, and county providers helped identify multiple misperceptions about the Medi-Cal system as well as highlight the limited understanding of how the new benefits can integrate with existing child welfare services and supports. Medi-Cal MCPs are responsible for building a network of service providers to provide ECM services and because they are not required but are encouraged to contract with existing DCFS services providers, some ECM providers may be less familiar with the unique complexities associated with supporting the child welfare-involved population.
- **Insufficient Processes:** The Glendora pilot demonstrated the need and value of creating tailored processes to support DCFS social workers in integrating ECM and CS services into existing referral processes. Although further work is needed to determine how to increase opportunities for engagement, early results indicate that informing and collaborating with social workers to design tailored processes will likely improve referrals and engagement in care.

[10] Data challenges were identified and reviewed as part of the Children's Health Disparities Report as well Children and Youth in Foster Care: Background and Current Landscape.

Next Steps

As the pilot progresses, partners will continue to identify opportunities to establish understanding and increase awareness of ECM services through relationship building and making local level connections.

Modifications to the standardized workflow will create a proof of concept that can be replicated and scaled at other DCFS sites. The pilot partners anticipate that this standardized workflow will become embedded in DCFS social workers' day-to-day activities with minimal burden and still create opportunities to connect eligible children/youth with ECM services.



APPENDICES

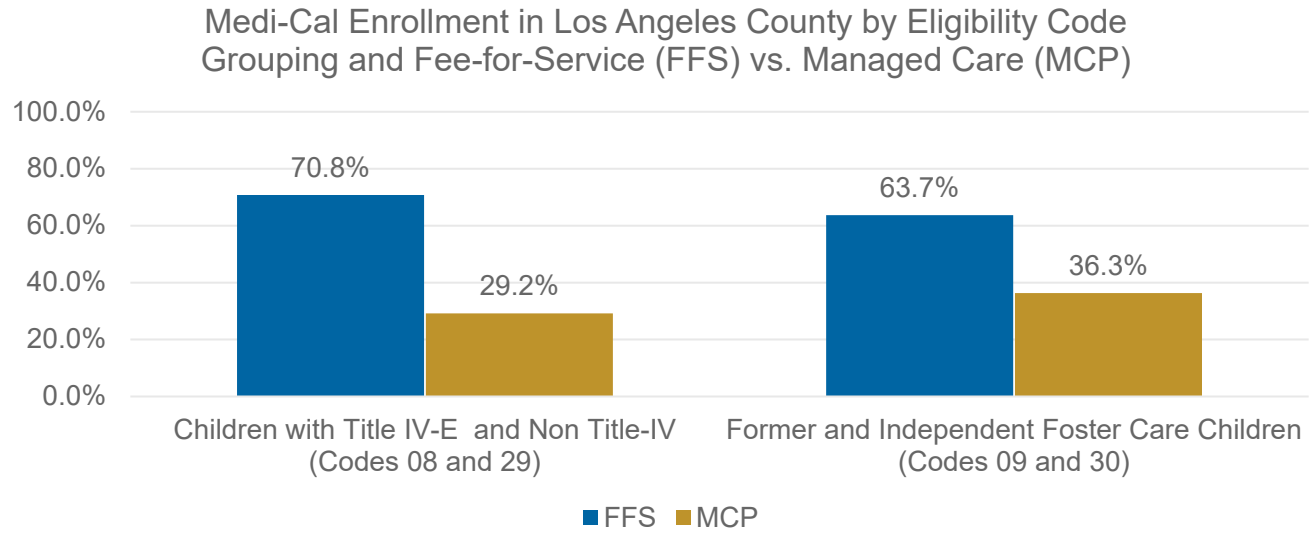
Appendix 1. Crosswalk of Medi-Cal Aid Codes to T-MSIS Eligibility Group Codes

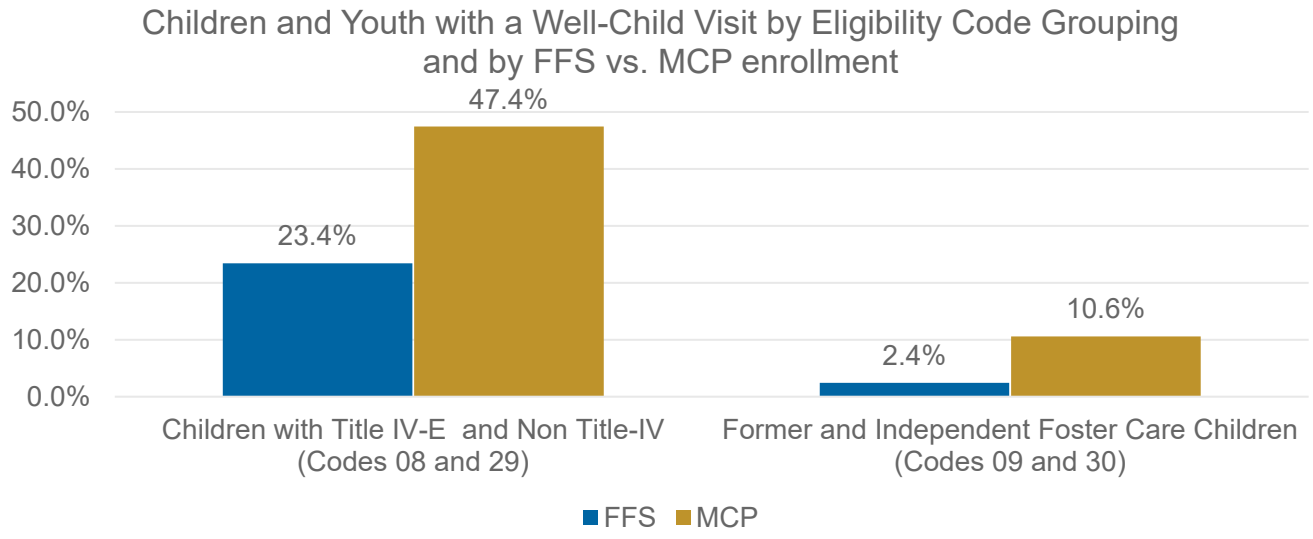
AID CODE	AID CODE NAME	T-MSIS ELIGIBILITY GROUP CODE	ELIGIBILITY GROUP
40	Aid to Families with Dependent Children (AFDC) - State Foster Care	28	Reasonable Classifications of Individuals Under Age 21
42	Aid to Families with Dependent Children (AFDC) - Federal Foster Care	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
43	Aid to Families with Dependent Children (AFDC) - State Extended Foster Care	28	Reasonable Classifications of Individuals Under Age 21
45	Non-Aid to Families with Dependent Children (AFDC) Foster Care	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
46	Foster Care California Placement - Interstate Compact on the Placement of Children (ICPC)	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
49	Title IV-E Extended Foster Care - Aid to Families with Dependent Children (AFDC) Non-Minor Dependent (NMD)	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
03	Adoption Assistance Program (AAP)	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
04	Adoption Assistance Program (AAP)/Aid for Adoption of Children (AAC)	29	Children with Non-IV-E Adoption Assistance
06	Adoption Assistance Program (AAP) - Child	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
07	Adoption Assistance Program (AAP) - Title IV-E Extended	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
2P	Foster Children/Youth - Approved Relative Caregiver (ARC) - Medi-Cal for Non-State CalWORKS	28	Reasonable Classifications of Individuals Under Age 21
2R	Foster Care Non-Minor Dependents (NMD) - Approved Relative Caregiver (ARC) - Medi-Cal for Non-State CalWORKS	28	Reasonable Classifications of Individuals Under Age 21
2S	Foster Children/Youth - Approved Relative Caregiver (ARC) - Medi-Cal for CalWORKS	28	Reasonable Classifications of Individuals Under Age 21
2T	Foster Children/Youth - Approved Relative Caregiver (ARC) - Medi-Cal for State CalWORKS	28	Reasonable Classifications of Individuals Under Age 21

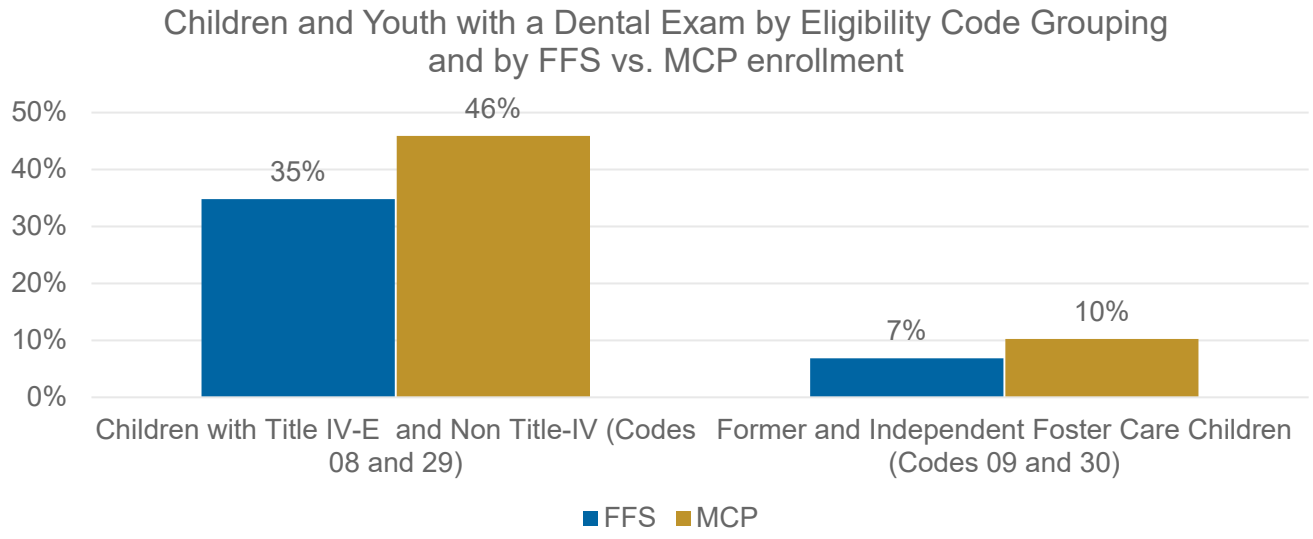
AID CODE	AID CODE NAME	T-MSIS ELIGIBILITY GROUP CODE	ELIGIBILITY GROUP
2U	Foster Care Non-Minor Dependents (NMD) - Approved Relative Caregiver (ARC) - Medi-Cal for State CalWORKS	28	Reasonable Classifications of Individuals Under Age 21
4A	Adoption Assistance Program (AAP) - Adoption Out-of-State	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
4C	Foster Care Supportive Transitional Emancipation Program (STEP)	30	Independent Foster Care Adolescents
4E	Hospital Presumptive Eligibility (HPE) - Former Foster Youth	09	Former Foster Care Children
4F	Foster Children/Youth - Kinship Guardianship Assistance Payment (Kin-GAP)	28	Reasonable Classifications of Individuals Under Age 21
4G	Foster Children/Youth - Kinship Guardianship Assistance Payment (Kin-GAP) State Program	28	Reasonable Classifications of Individuals Under Age 21
4H	Foster Children/Youth - in CalWORKS	28	Reasonable Classifications of Individuals Under Age 21
4K	Foster Children/Youth - Emergency Assistance (EA)	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
4L	Foster Children/Youth - in 1931(b)	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
4M	Former Foster Youth (FFY)	09	Former Foster Care Children
4N	Foster Care Non-Minor Dependent (NMD) - CalWORKS	28	Reasonable Classifications of Individuals Under Age 21
4S	Foster Care Non-Minor Dependent (NMD) - Title IV-E Extended - Kinship Guardianship Assistance Payment (Kin-GAP)	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
4T	Foster Children/Youth - Title IV-E Kinship Guardianship Assistance Program (Kin-GAP)	08	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
4W	Foster Care Non-Minor Dependent (NMD) - Kinship Guardianship Assistance Program (Kin-GAP) - State Cash	28	Reasonable Classifications of Individuals Under Age 21
5K	Emergency Assistance (EA) Foster Care	29	Children with Non-IV-E Adoption Assistance
5L	Emergency Assistance (EA) Foster Care	29	Children with Non-IV-E Adoption Assistance

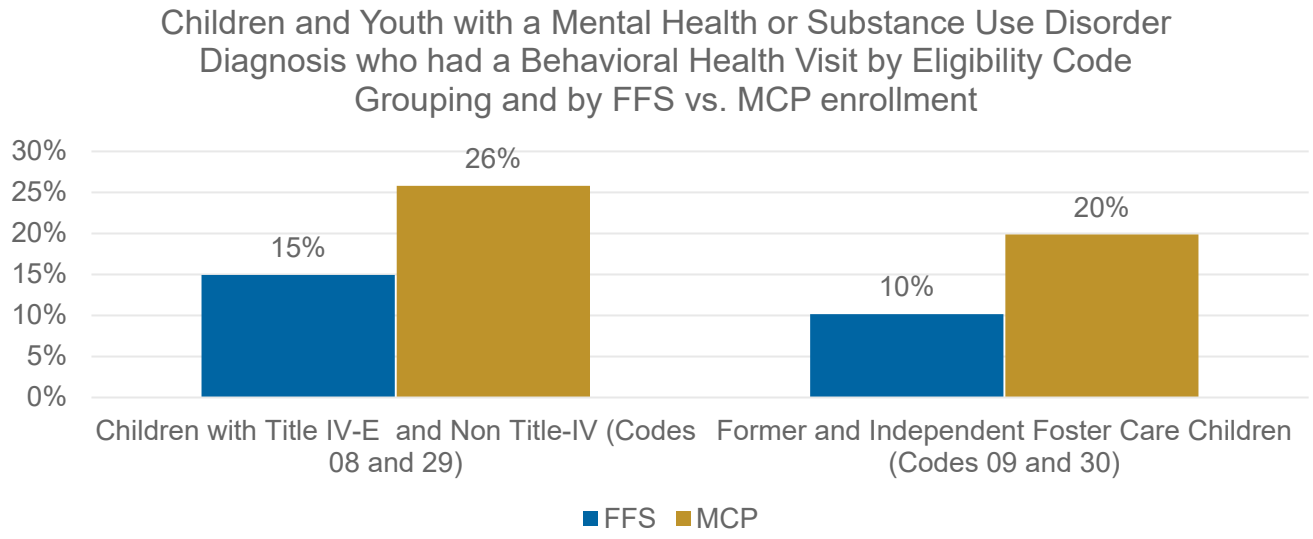
Appendix 2. Requested Data Analysis

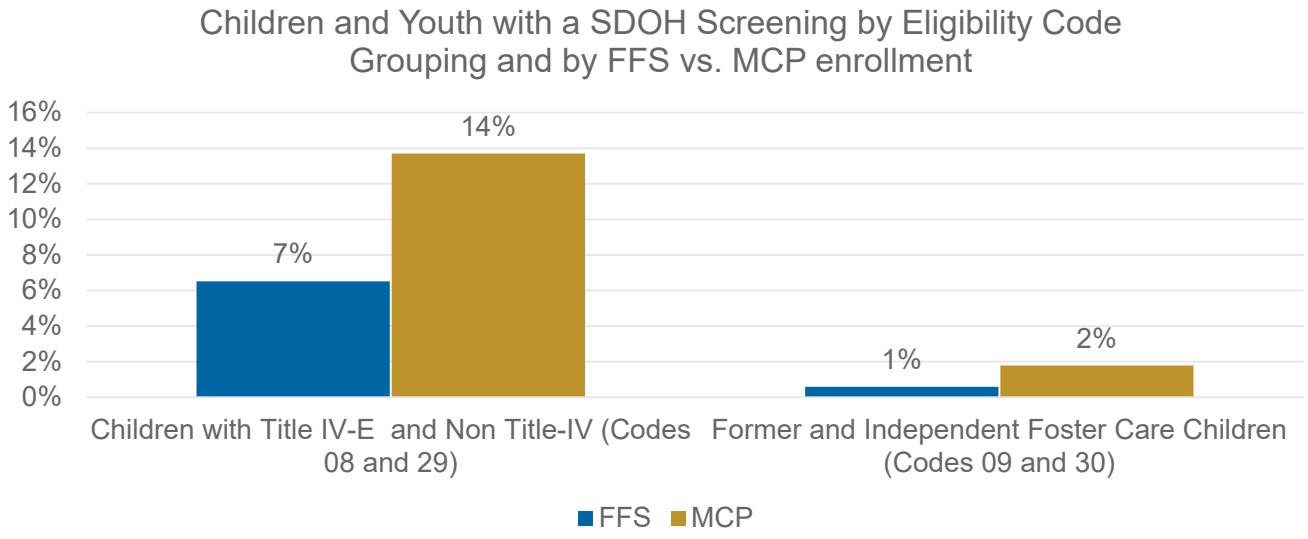
County stakeholders requested a comparative analysis between T-MSIS eligibility group codes 08 (Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care) and 29 (Children with Non-IV-E Adoption Assistance) versus group codes 09 (Former Foster Care Children) and 30 (Independent Foster Care Adolescents) in Los Angeles County. The following are the additional requested analyses for this eligibility grouping. The data indicate that managed care consistently results in higher engagement in primary and preventive healthcare services with no significant trends attributed to subpopulations.






Children and Youth with a Dental Exam by Eligibility Code Grouping and by FFS vs. MCP enrollment
50%
40%
30%
20%
10%
0%
35%
46%
7%
10%
Children with Title IV-E and Non Title-IV (Codes 08 and 29)
Former and Independent Foster Care Children (Codes 09 and 30)
FFS
MCP


Children and Youth with a Mental Health or Substance Use Disorder Diagnosis who had a Behavioral Health Visit by Eligibility Code Grouping and by FFS vs. MCP enrollment
30%
25%
20%
15%
10%
5%
0%
15%
26%
10%
20%
Children with Title IV-E and Non Title-IV (Codes 08 and 29)
Former and Independent Foster Care Children (Codes 09 and 30)
FFS
MCP


Children and Youth with a SDOH Screening by Eligibility Code Grouping and by FFS vs. MCP enrollment
16%
14%
12%
10%
8%
6%
4%
2%
0%
7%
14%
1%
2%
Children with Title IV-E and Non Title-IV (Codes 08 and 29)
Former and Independent Foster Care Children (Codes 09 and 30)
FFS
MCP