COMMITTEE ADDRESS
LEGISLATIVE OFFICE BUILDING
1020 N STREET, ROOM 521
SACRAMENTO, CA 95814
TEL (916) 651-1524
FAX (916) 266-9350

CHIEF CONSULTANT
MAREVA BROWN

PRINCIPAL CONSULTANT
TARYN A. SMITH

COMMITTEE ASSISTANT
MARK A. TEEMER, JR.

California Legislature

SENATE COMMITTEE ON HUMAN SERVICES

MIKE McGUIRE
CHAIR

Senate Human Services Committee &
Senate Budget and Fiscal Review, Subcommittee #3 on Health and Human Services

State Capitol, Room 3191
Sacramento, California
September 26, 2016, 1:00 p.m.

AGENDA

A Failure of Oversight: Misuse of Psychotropic Medications on California's Foster Children

I. Welcome

- Senator Mike McGuire, Chair, Senate Human Services Committee
- Senator Holly Mitchell, Chair, Budget and Fiscal Review, Subcommittee #3

II. Report: California's Foster Care System, the State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care

- Elaine M. Howle, California State Auditor

III. Oversight Mechanisms for Use Psychotropic Medication in Foster Care

- Will Lightbourne, Director, Department of Social Services
- Jennifer Kent, Director, Department of Health Care Services
- Frank Mecca, Executive Director, County Welfare Directors Association
- Barry Zimmerman, Director, Ventura County Human Services Agency
- Mary Adèr, Deputy Director, County Behavioral Health Directors Association of California
- Dr. William Arroyo, Medical Director, Children's System of Care, Los Angeles County Department of Mental Health

IV. Statewide Perspective

- Bill Grimm, Senior Attorney, National Center for Youth Law
- Carroll Schroeder, Executive Director, California Alliance of Children and Family Services
- Tisha Ortiz, former foster youth
- Mariah, former foster youth
- Dr. Lynn Thull, Mental Health Policy and Practice Improvement Consultant, California Alliance of Child and Family Services

V. State response

- Jennifer Kent, Department of Health Care Services
- Will Lightbourne, Department of Social Services

A Failure of Oversight: Misuse of Psychotropic Medications on California's Foster Children

A Joint Oversight Hearing of the Senate Human Services Committee and Senate Budget Subcommittee #3 on Health and Human Services

Senator Mike McGuire, Chair, Senate Human Services Committee
Senator Holly Mitchell, Chair, Senate Budget Subcommittee #3

September 26, 2016
1:00 p.m. - 4:00 p.m.
Room 3191

Ten years ago, the Legislature identified a growing concern within California's foster care system: increasingly, children in foster care were being prescribed psychotropic medications. Today, those concerns remain, although the numbers have grown significantly, from 1 percent of all foster youth in 2000 to 12 percent today. In August 2014, the San Jose Mercury News published a series of stories, "Drugging Our Kids," which found that youth in foster care were being prescribed psychotropic medications at heightened rates and in unsafe dosages as a means of controlling behavior. It cited data showing that one-quarter of all adolescents in California's foster care system were prescribed at least one psychotropic medication – more than three times the national rate for teens. The series led to Legislative hearings, bills and a request to the state Auditor to evaluate the state's tracking and oversight of psychotropic medication.

This hearing, which follows two Senate hearings in 2015 on psychotropic medication of foster children, is intended to look at the findings of the Bureau of State Audits, which recently released a report criticizing both the state and counties for allowing fragmented oversight to imperil foster children.

The auditor found that about 1 in 8 foster youth in California is prescribed psychotropic medication, or nearly 9,500 of the 79,000 foster youth in the study. In reviews of 80 individual case files in four counties, the auditor found nearly one-third of children prescribed psychotropic medications did not receive recommended follow-up visits and a significant number did not appear to have received appropriate mental health services. Nearly a quarter of the children whose files were reviewed were authorized to take medication in dosages that exceeded the state's recommended maximum and one in three did not have evidence of required court authorization for the medications, among other findings.

Additionally, the auditor criticized the state's fragmented oversight system for creating larger oversight deficiencies "leaving us unable to identify a comprehensive plan that coordinates the various mechanisms currently in place to ensure that the foster children's health care providers prescribe these medications appropriately." The report identified the California Department of Social Services (CDSS) as the state agency that should be providing oversight and faulted the Administration for exerting little system-effort to ensure that systems collaborate to ensure appropriate care for children. It found that combined data from CDSS and the Department of Health Care Services (DHCS) contains inaccurate and incomplete information and that neither department can identify which foster children are prescribed medication and in what dosages.

The auditor acknowledges that various recent efforts are in early stages of implementation to improve oversight of the use of psychotropic medications on foster youth, however, the report still finds significant gaps in oversight. Substantial criticism was levied at the counties' poor administration of the Health and Education Passports, which are supposed to be handed to each foster parent when the child is placed, and, if updated, should include information about current prescriptions. As the foster parent or group home staff are frequently the adults interacting with the doctor on the child's behalf, the lack of such information could lead to poor decision-making. The auditor identifies a lack of communication among departments– and specifically between county social services and mental health departments– as a significant gap in the system.

Background

Child welfare

Approximately 55,000 children and youth in California were in foster care as of April 1, 2016, or roughly 1 in 7 foster children nationwide.[1] About 85 percent of children in care were removed from their families due to neglect, 8 percent due to physical abuse, and 2 percent due to sexual abuse. The median length of time California children spent in foster care was about 15 months, as of 2012.

As of January 2015, 48 percent of youth placed in group homes in California through the child welfare services system had been there more than two years, and 23 percent had been there more than five years. The child welfare system is overseen by CDSS.

Mental health

Medi-Cal Mental Health. Three systems provide mental health services to Medi-Cal beneficiaries, and are overseen by DHCS:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal "specialty" mental health services under a waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, and psychologists, as well as psychiatric inpatient hospital services. County

[1] http://cssr.berkeley.edu/cwscmsreports/dashboard/

mental health plans are the responsible entity for ensuring specialty mental health services are provided. Medi-Cal enrollees must obtain their specialty mental health services through the county.

Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21. Generally, EPDST requires services be provided to correct or ameliorate physical and mental illnesses and conditions discovered through screening.

2. **Managed Care Plans (MCPs) -** Effective January 1, 2014, SB1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans excluding those benefits provided by county mental health plans under the state's specialty mental health waiver. Generally these are mental health services for those with mild to moderate levels of impairment. Mental health services provided by the MCPs include:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

3. **Fee-For-Service Provider System (FFS system) -** The mental health services listed below are also available through the Fee-For-Service/Medi-Cal provider system:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

In 2014, mild to moderate mental health benefits were added to coverage requirements for managed care plans and fee for service providers. The law made no change to specialty mental health services provided by county mental health plans. For children, the addition of these benefits to managed care provided an alternative channel to access "basic" mental health services, which they already were entitled to receive. (These benefits were not provided to adults prior to 2014.) Consequently, if a child meets the medical necessity criteria for any specialty mental health services, they are entitled to these services through the county mental health plan, regardless of impairment level (mild, moderate, or severe).

According to data provided by DHCS, in 2014-15, 42,260 foster children – or 47.8 percent of children in foster care – were receiving specialty mental health or psychosocial services. Of these, 44.2 percent of foster children, or 39,109 children were receiving specialty mental health services through county mental health plans. (See Attachment A)

Approximately 34 percent of foster children are enrolled in Medi-Cal managed care for their health care coverage. Most of the remaining foster children receive health services through the Medi-Cal fee-for-service system.

Mental Health Services Act. The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are used to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources. Most of the act's funding is to be expended by county mental health departments for mental health services consistent with their approved local plans.

According to a 2016 report by the National Alliance on Mental Illness of California, various counties use MHSA funds to provide mental health services to children in foster care.

Prior hearings

In August 2015, the Senate Human Services and Senate Health committees held a joint oversight hearing entitled, "Psychotropic Medication and Mental Health Services for Foster Youth: Seeking Solutions for a Broken System." The hearing focused on system-wide standards and oversight tools used by state and local agencies in evaluating the effectiveness of county mental health plans, county child welfare agencies, contracted providers, and individual prescribers in providing access to a broad spectrum of timely, effective, trauma-informed psychosocial services that minimize the need for psychotropic medication.

In February 2015, the Senate Human Services Committee and the Select Committee on Mental Health held an informational hearing entitled, "Misuse of Psychotropic Medication in Foster Care: Improving Child Welfare Oversight and Outcomes within the Continuum of Care" that highlighted concerns about a statewide trend toward increased prescribing of psychotropic medications. The hearing included testimony indicating that California's child welfare and children's mental health systems are over-reliant on psychotropic medication among foster youth and do not effectively manage the provision of such medication leading to unnecessary prescribing, inappropriately high dosages of medication for children, and inappropriate use of multiple medications, and usage occurring at longer durations than appropriate. In response to these concerns, the hearing focused on oversight of individual cases, including court authorization procedures which informed the development of several bills.

Additionally, both hearings highlighted concerns that breakdowns in the provision of effective trauma-informed psychosocial services has led to system-wide failures in treating children and youth who later suffer from trauma-related behavioral health challenges, for which medication is seen as the only available treatment option.

Recent reforms

A series of bills and other reforms followed last year's Legislative hearings and related media reports about the overuse of psychotropic medications on foster youth.

SB 238 (Mitchell, Chapter 534, Statutes of 2015) requires data sharing agreements between DHCS and the CDSS as well as between the state and county placing agencies to provide information about children and foster youth taking psychotropic medication. It requires CDSS, in consultation with DHCS and stakeholders, to develop and distribute a monthly report to each county placing agency, which must include information on what psychotropic medication have been authorized for a child and pharmacy data based on paid claims and managed care encounters, including the name of the psychotropic medication, quantity, and dose prescribed for the child. Additionally, the monthly reports must include information about psychosocial interventions and incidents of polypharmacy.

Additionally, SB 238 required a system to flag social workers about situations that may warrant additional follow-up. The indicators may include, but need not be limited to, an indicator that identifies each child under five years of age for whom one or more psychotropic medications is prescribed and an indicator that identifies each child of any age for whom three or more psychotropic medications are prescribed.

SB 238 requires robust data sharing agreements between DHCS and CDSS and county placing agencies in a three-way arrangement known as the Global Interagency Agreement (GIA). Under the GIA, DHCS will provide DSS with both medical and pharmacy claims level detail, with which DSS will match with their foster care specific data. This combined, matched data will then be provided to each county's foster care placing agency. As of September 2016, 22 of the 59 counties had data sharing agreements, and two others had separate data use agreements:

Alameda	**Butte**	**Contra Costa**	**El Dorado**	**Humboldt**	**Kern**	**Lake**
Madera	**Mendocino**	**Modoc**	**Placer**	**Sacramento**	**San Diego**	**San Francisco**
San Luis Obispo	**San Mateo**	**Santa Clara**	**Santa Cruz**	**Sonoma**	**Ventura**	**Yolo**
Yuba						

*Los Angeles and Riverside counties have separate data use agreements

SB 484 (Beall, Chapter 540, Statutes of 2015) mandates additional review and increased standards of psychotropic medication usage in group homes, and creates new

data collection and notification requirements for the Community Care Licensing Division (CCLD) within CDSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

SB 319 (Beall, Chapter 535, Statutes of 2015) authorizes a foster care public health nurse to monitor and oversee the child's use of psychotropic medications, and authorizes the release of health information, as specified. It also requires a foster care public health nurse to assist a nonminor dependent to make informed decisions about health care.

2016 Budget includes $1.65 million General Fund (with an assumed federal match of $4.95 million) to fund the hiring of additional public health nurses to improve the monitoring of psychotropic drug use in foster care. The 2016 Budget also includes the addition of one full-time permanent research position at DHCS and $134,000 ($67,000 General Fund) in 2016-17 and $125,000 ($63,000 GF) ongoing, to implement the requirements of SB 238; and for CDSS includes $149,000 ($100,000 General Fund) in contract funding to develop monthly, county-specific reports for children in foster care who are prescribed psychotropic medications through Medi-Cal, and two-year limited-term funding of $833,000 ($684,000 General Fund) to support approximately five positions (three licensing program analysts (LPA), 0.5 licensing program manager I, 0.5 office assistant, and one associate governmental program analyst), both to implement the requirements of SB 238 and SB 484.

Additionally, the following bills are currently enrolled, and awaiting the Governor's signature to be enacted:

SB 253 (Monning, 2016) requires that an order for administration of a psychotropic medication to a foster child be granted only upon a court's finding that it is in the best interest of the child. Mandates that a court determine lab screenings and other requirements have been met and imposes other court oversight mechanisms. Requires a pre-authorization review under certain circumstances

SB 1291 (Beall, 2016) requires annual mental health plan reviews to be conducted by an external quality review organization (EQRO) and, commencing July 1, 2018, and would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the DHCS to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. It requires any corrective action plan to be posted on the county's website.

SB 1466 (Mitchell, 2016) requires**,** consistent with federal law, that screening services under the EPSDT program include screening for trauma, as specified. It requires DHCS, in consultation with CDSS and others, to adopt, employ, and develop, as appropriate, tools and protocols for screening children for trauma.

SB 1174 (McGuire, 2016) requires DHCS and CDSS under a specified data-sharing agreement, to provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for specified children and minors placed in foster care using data provided by the two state agencies.

AB 741 (Williams, 2016) expands the definition of a short-term residential treatment center to include a children's crisis residential center to be used as a diversion from psychiatric hospitalization, and limits the stay to 10 consecutive days and no more than 20 total days within a six-month period.

Continuum of Care Reform (CCR) effort

In 2012, CDSS convened a working group to recommend changes to the current rate-setting system, services, and programs serving children and families in the continuum of foster care settings. The three- year effort came in response to statutory requirements in budget trailer bill *(SB 1013, Senate Budget Committee, Chapter 25, Statutes of 2012)*, which mandated the workgroup consider, at a minimum, reforms to programs provided by Foster Family Agencies and group homes, and how to ensure the provision of services in family-like settings, including after care services, when appropriate. In January 2015, the CDSS published the "California's Child Welfare Continuum of Care Reform" report. It outlined an interdependent approach to improving California's child welfare system by improving assessments of children and families, and centering support services for children in home-based family care settings rather than in group care.

Two subsequent CDSS-sponsored bills, *AB 403 (Stone, Chapter 773, Statutes of 2015*) and *AB 1997 (Stone, 2016*), which is awaiting the Governor's signature, enacted the reforms. These bills focus delivery of appropriate treatment and services on the child regardless of living arrangement, rather than using the placement setting to drive decisions about services which historically has caused a child to "fail upwards" into higher levels of care. Overall, CCR emphasized the creation of supports for resource families to decrease group care. Short term treatment facilities are required to have mental health approval and oversight from the county mental health plan. CCR has required increased coordination between child welfare and mental health services.

State Guidelines for Use of Psychotropic Medication

In April 2015, CDSS and DHCS jointly released "Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care," which outlines parameters for safe prescribing, identifies situations which should flag further review and underscores the concept that psychotropic medications should be used in conjunction with other strategies to help a foster child. The guidelines were an outcome of the state's Quality Improvement Project, convened jointly by DHCS and CDSS in October 2012 to identify effective strategies to oversee and monitor the use of psychotropic medications of children and youth in the foster care system.

EPSDT Performance Outcome System (POS)

SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013 required DHCS to establish a Performance Outcome System to better understand the statewide outcomes of specialty mental health services provided, and to ensure compliance with federal EPSDT requirements. The EPSDT Performance Outcomes System is intended to establish outcome measurements for clients receiving specialty mental health services. It also required the development of measures for screening and referring Medi-Cal beneficiaries to mental health services. DHCS released the first EPSDT POS reports in February 2015.

In August 2016, DHCS released four population-based reports (large, medium, small and rural county) and the first ever county specific POS reports. Among the key findings of these population-based reports is that for all four-population categories, the number of children being served through the specialty mental health system (county mental health plans) has increased from 2010-11 through 2013-14; however, the penetration rate for these services has declined.

Additionally, earlier this month, the state released its first Foster Care EPSDT POS report, which similarly indicates that the number of Foster Care children being served through the specialty mental health system (county mental health plans) has increased from 2011-12 through 2013-14 from 38,961 to 41,005; however, the penetration rates for these services has declined by nearly 2 percent.

This report also shows that in 2014-15, 25.3 percent of the Foster Care children receiving specialty mental health services were age 0-5, 31.1 percent were age 6-11, 35.7 percent were age 12-17, and 7.9 percent were age 18-20. In contrast, for all children, in 2014-15, 12.4 percent of children receiving specialty mental health services were age 0-5, 33.7 percent were age 6-11, 41.7 percent were age 12-17, and 12.2 percent were age 18-20.

Katie A. implementation

In July 2002, plaintiffs filed a class action suit alleging violations of federal Medicaid laws, the American with Disabilities Act, and other state and federal statutes because the state failed to provide mental health services for foster youth. Nine years later a federal district judge approved a settlement agreement that would provide intensive home- and community-based mental health services for children in foster care or at risk of removal from their families.

As part of the agreement, the state agreed to pay for therapeutic foster care and to seek federal matching dollars for that treatment. The settlement was followed by monitoring by a Special Master appointed by the judge to ensure DHCS and CDSS could come to agreement about provision of mental health services to foster youth. Other elements of the core practice model adopted by DHCS and CDSS included a promise to continue working collaboratively to provide foster children with mental health services, data

collection and mental health screening and assessment for foster youth. In 2013, the court discontinued monitoring, and the state continues to host implementation updates.

Child Welfare Services – New System (CWS-NS) Project

The Child Welfare Services – New System (CWS-NS) Project will replace the aging Child Welfare Services/Case Management System (CWS/CMS). The CWS-NS Project is intended to make the system easier to use for CWS workers, result in enhanced data reliability and availability, allow user mobility, and automate system interfaces with other state partners to enable data sharing. This represents an opportunity to better update and share information contained in a foster youth's Health and Education Passport.

The CWS-NS Project is not expected to implement fully until later in 2020. Various system releases will begin to roll out beginning in July of 2017, starting with intake components. Currently, other pending releases include licensing, case management, resource management/court processing, and eligibility/financial management.

Ongoing concerns

California's county-based child welfare system serves as the de-facto parent for approximately 55,000 children at any given time who have been removed from home based on allegations of abuse or neglect. Various studies have indicated that the type of abuse or neglect that warrants a child's removal, compounded by the child's removal from their home of origin, creates a level of trauma that merits a mental health evaluation and treatment. However, competing local priorities between child welfare, mental health and education create obstacles to effectively serving children. As the Auditor highlighted, significant gaps in record keeping at the county level mean the state is unable to identify whether many foster youth are receiving mental health treatment, what medications they are taking and whether those medications are taken at dangerous levels or for off-label purposes. Data and access problems are compounded by a severe shortage of child and adolescent psychiatrists to treat children in foster care

While recent legislation intended to close some of those gaps, the Auditor's report highlights a fragmented oversight system in which the state, as foster childrens' de-facto parent, has been ineffective. In addition, the following are key issues that should be considered when evaluating next steps to improve the provision of services and quality of life of foster children.

State's inadequate oversight of county mental health plans and absence of timely access standards for specialty mental health services

Concerns have been raised not only by stakeholders, but also by the federal Centers for Medicare and Medicaid Services (CMS), about DHCS's oversight of county mental health plans and in particular violations by county mental health plans that significantly impede a beneficiaries' access to care, such as not maintaining a 24-hour hotline with appropriate language access, not maintaining a beneficiary grievance and appeal log and

not monitoring timeliness of care. Thirteen new positions at DHCS were added in the 2016 budget to improve the state's oversight of county mental health plans and meet the terms and conditions of the specialty mental health waiver extension. Seven positions were added in the 2014 budget to address similar concerns by CMS. One of the key functions of these positions will be to improve tracking, monitoring and improvement of timeliness of care, access to care, and MHP and subcontractor grievances and appeals.

In response to concerns raised by CMS, an effort was launched to establish statewide timely access standards for specialty mental health services provided by county mental health plans. The effort has been put on hold given new federal managed care regulations, which will require county mental health plans to move toward a managed care model. Without such standards, there is no system in place to track and enforce timely access to services.

Mental health services penetration rates going down

As noted above, while the number of Foster Care children being served by county mental health plans has increased over the last few years, the penetration rate has decreased. DHCS is not able to provide information as to why the penetration rate has decreased and indicates that since these reports are still relatively new, it plans to work with stakeholders on determining a framework to assess the findings of the data. Even though these Foster Care specific-reports are new, the statewide aggregated EPSDT POS reports, first published in February 2015 show the same trend. Consequently, DHCS has had over 18 months to look at these trends and draw conclusions and make recommendations, but nothing has been done.

"Mild to Moderate" impairment level distinction has created confusion

As discussed earlier, in 2014, mild to moderate mental health benefits were added to Medi-Cal managed care and fee-for-services. For children, that distinction does not apply: All children in Medi-Cal are entitled to specialty mental health services, provided by county mental health plans, under EPSDT services regardless of impairment level, as long at the child meets medical necessity criteria.

However, the distinction on the adult side has created significant confusion about whether children should be referred to managed care or fee-for-service if a mental health assessment determines they have "mild or moderate" mental health needs. At recent CCR workgroup meetings and the Medi-Cal Managed Care Advisory Committee, DHCS has not been direct in its communication on this issue. This has intensified the confusion and creates opportunities for children to be shuffled back and forth between systems.

Successful implementation of CCR will require collaboration between child welfare and mental health

The Auditor identified a system of oversight so fragmented that neither CDSS nor DHCS can identify which children are taking psychotropic medications or in what quantity.

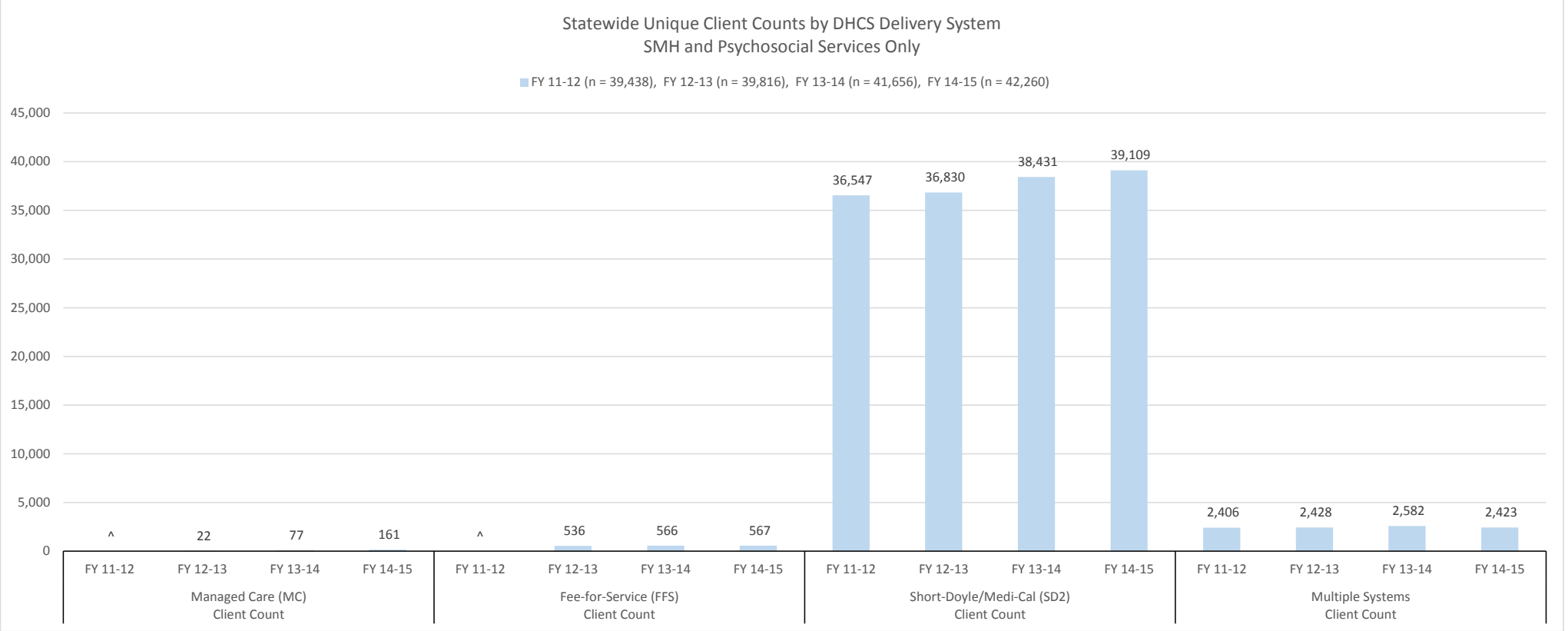
Collaboration between these state agencies is essential not only in overseeing the care of foster youth taking these medications, but in the state's CCR efforts, which are intended to roll out beginning January 1, 2017. Leadership by CDSS and cooperation from its state and county partners are essential for the successful implementation of the reform efforts. The concurrent effort to properly oversee the use of psychotropic medications on foster youth provides an opportunity to integrate both efforts. However, it also creates a challenge for CDSS to remain focused on key reforms in each effort while implementing major statewide change.

Technology

A key finding of the Auditor was that the Health and Education Passports used by count child welfare agencies to inform caregivers about a child's health is woefully inadequate. Data is missing or incorrect in a significant number of cases, including the type and dosage of psychotropic medications. Inputting information into the passport relies on a foster parent or group home provider carrying a paper copy of the document into a psychiatrist's office, having the doctor record visit information, and then having the foster parent or group home provider hand that document to the social worker for entry into the county's system. CDSS's plans for its CWS/New System project may provide an opportunity for third parties to access health, education and child welfare records in a single place, when it rolls out the case management component in several years, if the state and counties can agree how to address privacy concerns in the various systems. However, ongoing disputes over privacy issues continue to prevent most of the counties from sharing this information.

CDSS Foster Care Clients by DHCS Delivery System
Specialty Mental Health (SMH) or Psychosocial Services Only

	FY 11-12			FY 12-13			FY 13-14			FY 14-15		
	Foster Care Youth with SMH or Psychosocial Services	Certified Eligible Foster Care Youth	Percentage of Eligibles Receiving SMH or Psychosocial Services	Foster Care Youth with SMH or Psychosocial Services	Certified Eligible Foster Care Youth	Percentage of Eligibles Receiving SMH or Psychosocial Services	Foster Care Youth with SMH or Psychosocial Services	Certified Eligible Foster Care Youth	Percentage of Eligibles Receiving SMH or Psychosocial Services	Foster Care Youth with SMH or Psychosocial Services	Certified Eligible Foster Care Youth	Percentage of Eligibles Receiving SMH or Psychosocial Services
MC	^	79,145	^	22	81,109	0.0%	77	86,084	0.1%	161	88,477	0.2%
FFS	^	79,145	^	536	81,109	0.7%	566	86,084	0.7%	567	88,477	0.6%
SD2	36,547	79,145	46.2%	36,830	81,109	45.4%	38,431	86,084	44.6%	39,109	88,477	44.2%
Multiple	2,406	79,145	3.0%	2,428	81,109	3.0%	2,582	86,084	3.0%	2,423	88,477	2.7%
Total	**39,438**	**79,145**	**49.8%**	**39,816**	**81,109**	**49.1%**	**41,656**	**86,084**	**48.4%**	**42,260**	**88,477**	**47.8%**



Please note -

- Foster Care clients presented in this report are identified by having an Out-of-Home Foster Care Placement from a matched data set provided by the California Department of Social Services, Child Welfare Services/Case Management System (CWS/CMS) as of September 13, 2016.
- Mental Health Services were expanded in Managed Care through the ACA Optional Benefits Expansion effective January 1, 2014.

^Data suppressed to protect patient privacy.