



California
Children's
Trust


Wrapping Our Youth With the Supports They Need to Thrive

PART 2

CALIFORNIA'S BOLD COMMITMENTS PUT WRAPAROUND WITHIN REACH RIGHT NOW



MAY 2023



This issue brief is the second of a four-part series that builds the case for wraparound, and proposes a tiered structure and implementation approach by exploring the following:

- **Part 1:** How the legislative, legal, and reform history of wraparound has led to the current opportunity to codify the administrative and financing structures to realize its promise. [Read Part 1](#)
- **Part 2:** Detailed look at how the groundwork for increased access to community-based mental health services—and specifically wraparound—already exists through recent innovations and policy changes and how these services can be structured and delivered with a three-tiered approach.
- **Part 3:** The case for wraparound: good news, potential challenges, and how to get youth absolutely everything they need.
- **Part 4:** How implementation best practices for new and evolving youth mental health reforms have the opportunity to meaningfully expand access to wraparound.

Wraparound in California Has (Almost) Found Its Moment

California has recently made significant new commitments that put it on a path to be the first state in the country to ensure that all children in the foster care system have access to intensive community-based mental health services that integrate the primary principles of wraparound (defined in [Part 1](#) on page 3).

Current reforms and new benefits are intended to transform our state’s mental health system to be trauma-informed and provide services and supports well beyond the medical models of the past. Furthermore, the state is taking steps towards recognizing wraparound’s 30 years of evidence-based success by codifying it as a service available to our most vulnerable children and youth—those who have experienced system involvement.

To make these paper commitments real, California will need both to provide additional funding and advance an implementation strategy that ensures wraparound reaches all eligible children and youth, in all California counties. This will require blending and braiding multiple funding streams administered by several key actors, including managed care plans, county behavioral health systems, and local child welfare agencies—requiring overcoming historical silos and standoffs. Some of the current funding sources that make this a pivotal moment for wraparound are ongoing entitlement streams, while others are discretionary allocations. To make it all work, the state will need to provide clear guidance to counties, along with timely technical assistance.

The purpose of this paper is to elevate and celebrate the current commitments of California’s leaders while identifying the key questions and success factors that must shape implementation.

THE GOOD NEWS

+ Commitment: California has made a clear commitment to transform its mental health system to be trauma-informed and break the bonds of the traditional medical model that is misaligned with the needs of children and youth.

+ Reform: The Department of Health Care Services (DHCS) has made a first-of-its-kind decision to ensure all youth involved with child welfare, and those at risk of system involvement, have access to in-home, evidence-based mental health services.

+ New Benefits: New provider classes, Enhanced Care Management, Activity Stipends, and Short-Term Residential Therapeutic Program (STRTP) step-down provide intensive and coordinated supports for our youth with the highest needs.

+ Evidence: Practice over 30 years has confirmed the vital components of a successful wraparound model.

THE BIG QUESTIONS

? Unclear Path: The commitment has been made, but the administrative and fiscal path is unclear across numerous reform initiatives and enhanced benefits.

? Funding Diversion: Recently announced changes to the use of Mental Health Services Act (MHSA) funding could further divert resources from youth mental health services and supports.

? County Variation: Counties vary widely and dramatically in their mental health service models, administrative capacity, and financing strategies.

? Unprecedented Integrations: Solutions will require contracts that integrate funds administered by managed care plans, county mental health plans, and child welfare funding.



The Making of This Moment

In [How The History of Wraparound Sets the Stage for Success Now](#), our first paper in this four-part series, we detailed the two-decade journey of California’s evolution to be the first state in the country with a trauma-based children’s behavioral healthcare system.

LEGISLATIVE ORIGINS

1997 legislation launched wraparound and is now the foundation for Family First Prevention Services Act (FFPSA) step-down. The goal was always to maintain youth in the least restrictive environment, to track and evaluate outcomes, and to reinvest cost savings into child welfare programs. Subsequent changes to the program included expansion of wraparound for federally eligible foster care cases, children at imminent risk of removal and/or placed in foster care, and those children receiving Adoption Assistance Program (AAP) payments. These foundations are still in place, and California Department of Social Services (CDSS) recently updated its fiscal claiming instructions with CFL 20/21-94.¹

CONTINUUM OF CARE REFORM (CCR)

Strengthened the foundation for high fidelity wraparound, but fell short of mandating a clinical component to the wrap team. California created a statutory requirement for Child and Family Teams (CFTs) tasked with providing supports to system-involved youth through an integrated, cross-system framework using a team-based approach. However, a clinical component for CFTs was not mandated, and supports have fallen short for youth with intensive mental health needs.

KATIE A. AND INTENSIVE CARE COORDINATION

Further expanded access to the clinical components of wraparound but only for a subset of eligible children and youth. The settlement created a broad array of wraparound, community based, and clinical care supports for youth in California, including Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC). However, the reach of these services has been limited by the strict interpretation of medical necessity, as well as financing challenges at the county level.

CALAIM

Added the clinical component missing in CCR—for all system-involved youth, not just Katie A. eligible youth. With CalAIM, California has made a bold commitment to creating a system that recognizes the prevalence of trauma among children who are involved in various systems, creating automatic eligibility for specialty mental health services (SMHS) among all systems-involved youth.



¹ State of California, Health and Human Services Agency. Updated Comprehensive Claiming Instructions for the Wraparound Program, [County Fiscal Letter No. 20/21-94. April 30, 2021.](#)

California's Bold "Moment-Making" Moves

Though systems change often takes longer than we'd wish, several recent essential steps are *making the moment* for the expansion of wraparound:

The Department of Health Care Services (DHCS) proposed a set of [Medi-Cal Foster Care Strategies](#), many in partnership with the California Department of Social Services (CDSS). The goal is to ensure that children and youth involved with the child welfare system have streamlined access to reliable, high-quality, integrated, trauma-informed, strength-based, patient-centered, and family-centered care.

→ MOMENT-MAKING MOVE

DHCS states that they are committed to providing "Evidence-based in-home and family therapies for all children involved with child welfare." This is the definition of wraparound for all of the nearly 55,000 children and youth in out-of-home care in California—a bold move when considering the current 48% penetration rate for SMHS for youth in foster care.

DHCS has set Enhanced Care Management (ECM) rates for when the benefit goes live in July 2023 for youth 21 years of age and younger. ECM is a managed care benefit that addresses through the coordination of services and comprehensive care management the clinical and non-clinical needs of high-need individuals—those experiencing homelessness, serious behavioral health or substance use disorder needs, enrolled in California Children's Services (CCS) with additional needs beyond their CCS condition, involved in child welfare, or involved in the justice system.

→ MOMENT-MAKING MOVE

DHCS set an advantageous rate that can support the expansion of intensive community health services for wraparound supporting children and youth in foster care because child welfare is a population focus. This is an important component that is creating momentum and bringing the pieces together to support wraparound.

1915(b) waiver: In 2021, the state secured federal approval of key revisions to its 1915(b) Medicaid waiver. It's time to make the paper promise of the waiver real by making access

available to every child in out-of-home placement, with the July 1, 2023, payment reform as the mechanism of the change.

→ MOMENT-MAKING MOVE

DHCS has the opportunity for a "moment-making move," but has not yet made that commitment. Children and youth in foster care are not immune to the forces driving the larger mental health crisis for young people, and in fact, many have significant and unmet mental health needs as a result of failures by the systems that are supposed to support them. Those supports have not been timely or appropriate—and too often, access has been limited. For these children and youth we should ensure access to, and delivery of, every available service—and yet, the data shows that only approximately 47% of this population is receiving any type of specialty mental health service.

California Department of Social Services (CDSS) phased out out-of-state residential facility placements for children in foster care ([AB 153](#)), removing foster children from out-of-state facilities by July 1, 2023. Bringing them home creates an undeniable need and opportunity to leverage community-based wraparound mental health services as a primary strategy to support youth in our communities.

→ MOMENT-MAKING MOVE

In 2020, CDSS reviewed the operations of all certified out-of-state facilities and found significant licensing violations. In December 2020, CDSS decertified all of the out-of-state facilities for failure to meet licensing standards, and all youth placed in those facilities returned to California. The move recognized that the pre-existing certification process had failed to ensure the health, safety, and well-being of children, and that children are better served when they can develop and maintain local support closer to their families and communities. The state should specifically articulate and finance wraparound as a key strategy for providing the in-community support young people need to thrive.



WHY THE MOMENT MUST BE NOW

As spotlighted in recent conversations about the current mental health crisis, system-involved youth urgently need access to high quality community-based mental health supports. As many as 80% of children in foster care have significant mental health needs, and ALL have faced and overcome adversity and trauma. California has demonstrated a significant commitment to fundamentally reforming its mental health system to be trauma-informed and ACEs-aware, and now is the moment to act at scale for some of California’s most vulnerable children.

Evidence shows that wraparound works, and we cannot safely enable children and youth to move to least restrictive community placements without the comprehensive support of wraparound.

Wraparound services, when delivered with high fidelity to the values and approaches previously noted, have been increasingly shown to be effective in supporting youth and families to thrive in their communities. For system-involved youth, wraparound has been shown to reduce placement changes; prevent unnecessary institutionalization; support least restrictive, most family-like settings; and reduce the need for foster care.

Recommendations: Realizing the Moment

✓ ALIGN CDSS AND DHCS REFORM ACTIONS

Although DHCS and CDSS partnered on some of the [Medi-Cal Foster Care Strategies](#) proposed in late 2022, there is still no shared implementation strategy for the budgeting and contracting processes that must be in place at the county level to realize the vision—this despite numerous and often overlapping planning tables and reform initiatives. At minimum, counties should be tasked with leveraging Medi-Cal for specialty mental health and wraparound services that are currently being funded by CDSS through realignment dollars. This strategy will be discussed in more detail in our next paper.

Developing an affirmative and positive vision and execution strategy for meeting the social, emotional, and developmental needs of children involved with the child welfare system is essential to bridging the multiple reform initiatives currently in planning and implementation across CDSS and DHCS—Family First Prevention Services (FFPS), ECM, California Wraparound, Continuum of Care Reform (CCR), and the DHCS Foster Care Model of Care.

Additionally, existing legislative and regulatory guidance is simply not showing up in the lives of children in foster care. New access criteria have not led to increased access (penetration) rates. CCR reforms have gone unrealized. Under the most recent implementation strategy, ECM excludes 46% of the target population because of their status as fee-for-service beneficiaries instead of MCP enrollees. Community partners that currently serve child welfare are not paneled and credentialed with managed care plans (MCPs), and MCPs have little or no history working in child welfare.

✓ CAPTURE THE PROMISE OF NEW ACCESS CRITERIA

California is leading the nation in the design and development of trauma-informed and ACEs-aware access criteria. Breaking new ground, the state’s recently approved 1915(b) waiver deems all children involved with child welfare eligible for SMHS (BHIN 21-073). Concurrently, new benefit designs in managed care plans

(Family Therapy Benefit and Enhanced Care Management) have removed diagnosis as a prerequisite for care and named child welfare as a population of focus. This dramatic expansion of eligibility and focus on child welfare should lead to significant expansion in access to care and support but it hasn't. Simply changing eligibility criteria and naming priority populations falls far short of clarifying a shared vision and strategy for the social and emotional health of children involved with child welfare.

Counties need technical assistance and support in designing their system and building the capacity of available providers. Contracting processes, screening, braiding funding—including integrating managed care plans—are examples of areas in which counties will need to redesign the interaction between child welfare and children's behavioral health. Some counties have already moved ahead but others need more technical assistance to make this promise a reality.

✓ **STANDARDIZE THE BENEFICIARY EXPERIENCE AT THE COUNTY LEVEL**

Access to SMHS varies by 400% across counties in California. Availability of wraparound models also varies dramatically depending on the mental health plan and child welfare collaboration at the local level, the availability of providers, and the availability of local resources to pledge to the design and development of dedicated supports for children in foster care. Additionally, there is often wide variability in how well the Child and Family Teams (CFT) practices meet the fidelity of the wraparound model as prescribed by CDSS, offering an opportunity for the state to better support and ensure compliance with this key component of wraparound.

Even among counties with some access to wraparound supports, contracting models and reimbursement practices vary widely. Quality and fidelity are difficult to measure and there is little collaboration between child welfare and behavioral health in setting standards, measuring outcomes, or improving access. Establishing, monitoring, and enforcing implementation standards at the county level is essential to making the promise of wraparound a reality in the experience of children, youth, and families.

✓ **INCREASE FEDERAL FINANCIAL PARTICIPATION (FFP)**

By changing the basis of claims from Certified Public Expenditure (CPE) to Intergovernmental Transfer (IGT), behavioral health payment reform offers an unprecedented opportunity to blend sources of non-federal share to increase federal financial participation. It also represents a new opportunity to move away from diagnosis-based per minute reimbursement and into case rate models that will more effectively capture federal matching funds, encourage collaboration among county child-serving systems (child welfare/behavioral health/probation), and expand the use of culturally concordant providers while promoting value-based contracting models.

✓ **INTEGRATE AND EXPAND WORKFORCE WITH RELEVANT LIVED EXPERIENCE**

Wraparound programs rely on team-based models of care. Most wrap programs include only one licensed clinician working on a team with a case manager, peer partner, or family engagement specialist. This model represents an evidence-based practice for centering staff with lived experience and integrating social model supports with traditional clinical services. While this change requires time, [new Medi-Cal reimbursable career pathways](#) are becoming available to accelerate expansion.

✓ **CONSIDER IMPLEMENTING THIS RECOMMENDED THREE-TIER APPROACH**

CCT has analyzed wraparound contracts from a variety of providers across multiple safety net systems. We think there is an opportunity to align existing regulatory and legislative mandates with a simple three-tiered approach (described below) to ensure all children in foster care get access to high fidelity wraparound supports. Our next paper will also discuss the creation of a services rate to supplement the current Aid to Families with Dependent Children - Foster Care (AFDC-FC) care and supervision rate that would follow these tiers and be Medicaid leverageable. This would ensure that every child in care would receive funding for both care and supervision and community-based services to help provide the practical implementation funding on the ground to realize the promise of CalAIM.

PROPOSED WRAPAROUND LEVELS OF CARE

In partnership with many of California’s leading wraparound providers, we reviewed sample contracts and asked the providers how they might stratify and organize levels of care in the wraparound programs they administer. This proposed three-tier model is the result of those conversations, and is a foundational point in our proposal to expand high fidelity wraparound in California. Subsequent papers in this series will go deeper into the costs of each tier of service and supports, and will examine the various ways counties fund wraparound, including 2011R, 1991R, MHSA, county general fund or other local tax or assessment revenue. All of these ideas require our collective thinking, revision, and action to deliver the best supports for our most vulnerable young people.

Tier	Summary of Services	Staff/Roles Available	Direct Service Hours (Average per Month)
Wrap Tier 1	<ul style="list-style-type: none"> • Case Management • Linkages • Behavioral Coaching 	BA/Mental Health Rehabilitation Specialist (MHRS) Counselor BA Coach/Peer Support	12 to 23
Wrap Tier 2	Everything listed in Tier 1 plus the following: <ul style="list-style-type: none"> • CFT Facilitation • Behavioral Coaching • Parent Support/Advocacy • Family Finding and Engagement • Flex Funds • 24/7 Support 	MA Facilitator/Clinician, Parent Partner BA/MHRS Counselor, Permanency Specialist	24 to 36
Wrap Tier 3	Everything listed in Tiers 1 and 2 plus the following: <ul style="list-style-type: none"> • Intensive In-Home Stabilization • Therapy 	MA Facilitator/Clinician, Parent Partner BA/MHRS Counselor, Permanency Specialist	45 to 75

Conclusion

Over the past decade, behavioral and mental health needs and acuity have increased for all children and youth. But profound need has always existed in the child welfare population. California’s recent reforms and commitments give us a chance to address this need at scale—right now.

For more than 30 years, the best practice for intensive community mental health services for the foster care population has been the principles and practice of wraparound. In California, the foundation for wraparound has already been established by a well-documented set of legislation, litigation, reform, and Medicaid mandated approaches.

To fully achieve the vision of wraparound we must address a set of essential challenges. DHCS and CDSS must more effectively work together to pool their non-federal resources, expand access to federal financial participation, move to a case rate, and simplify contracting.

The state has made a significant new commitment to children and youth in out of home care. To make it real, we need to solve for a set of known implementation challenges and guarantee consistent execution across counties. California’s young people in care deserve everything we can give them, and we are closer now than ever before.



**California
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The California Children's Trust (CCT) is a statewide initiative to reimagine our state's approach to children's social, emotional, and developmental health. We work to transform the administration, delivery, and financing of child-serving systems to ensure that they are equity driven and accountable for improved outcomes. CCT regularly presents its Framework for Solutions and policy recommendations in statewide and national forums.

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CCT FRAMEWORK FOR SOLUTIONS

