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Medicaid Mental Health Waiver

Makes Life Difficult for Many of CA's Adopted and Foster Youth

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This article examines the challenges facing foster and adopted youth who are placed out-of-county and need mental health treatment. It begins with a brief review of the need for mental health services and explores California's system for providing them.

Then the authors describe the barriers to care and their causes, and finish with several principles for overcoming these barriers and providing the mental health care that foster and adopted youth are entitled to and desperately need.

James,¹ a foster youth from Ventura County, needed psychiatric care. Like most foster children, he is eligible for Medi-Cal, California's Medicaid program. Ventura County, where the youth was declared a dependent, is responsible for providing this coverage. Unfortunately, James was recently moved to a placement in Alameda County, more than 300 miles away.

California provides mental health services on a county-by-county basis. For that reason, James' social worker in Ventura County was unfamiliar with Alameda County's health care providers and with its billing and payment process.

Although the social worker contacted several local psychiatrists, he

couldn't find anyone who would accept James' Ventura County Medi-Cal. He even tried to set up an intercounty contract for James' services, a lengthy process. At this point, James had been without medication for so long that his social worker felt he had no choice but to request that the youth be uprooted from his placement and moved to a new home where he could receive treatment.

Situation Isn't Unique

James' situation is not unusual among California foster children who are placed outside of their "home" county. Also, although adopted youth are no longer dependents of the state, they face the same problems as youth who still are: their home county continues to provide Medi-Cal coverage, even if the families that permanently adopted them reside in other counties.

These children live in an administrative limbo caused by California's county-based, patchwork system of mental health care, frequently ending up in situations where, for weeks or months, they lack essential treatment. Like James, foster youth with unmet mental health needs often bounce from placement to placement, further undermining the likelihood they will succeed in a family setting and, in turn, increasing the possibility

they will end up in institutions, such as group homes, mental health facilities, or jail.

Thousands Denied Critical Services

Although federal Medicaid law and regulations provide a broad mandate for access to adequate mental health services for eligible foster and adopted children, many California youth are underserved.

The Little Hoover Commission reports that more than 50,000 youth in foster care in California who may need mental health services don't receive them.² In some counties, only half of youth in foster care receive the treatment they need.³ In Los Angeles County, there is a nine-month waiting list for some services.⁴

Access to publicly funded, specialty mental health services is of particular concern to youth in foster care and their advocates.⁵ Foster youth are more likely than other groups of Medi-Cal children to have a mental-health or substance-abuse problem.⁶ Nearly 70 percent of such youth will experience a mental health problem associated with their placement or with circumstances leading to their removal from the family home.⁷ The federal government has identified placement stability as one of three major areas of accountability

1 The name has been changed.

3 *Id.* at 77.

2 Little Hoover Commission, *Young Hearts and Minds: Making a Commitment to Children's Mental Health* (Oct. 2001), <http://www.lhc.ca.gov/lhcdir/report161.html>.

4 U.S. Department of Health & Human Services, Children's Bureau, *Final Report. California Child and Family Services Review* (2003) at 58, <http://www.acf.hhs.gov/programs/cb/cwrp/staterpt/ca/ca.pdf>.

5 See California Mental Health Directors Association, Termination Announcement, <http://www.cmhda.org/aso.html>.

6 Margo Rosenbach, *Children in Foster Care: Challenges in Meeting Their Health Care Needs Through Medicaid*, Mathematica Policy Research Inc. (March 2001) at 3, <http://www.mathematica-mpr.com/publications/PDFs/fostercarebrief.pdf>.

7 Little Hoover Commission, *supra* note 3 at 22.

for state child-welfare programs in achieving positive outcomes for youth who are in out-of-home care.⁸

Stuck in Administrative Limbo

Medi-Cal, like all state Medicaid programs, is a jointly administered federal and state program that provides medical assistance to low-income people under Title XIX of the Social Security Act.⁹ Children in foster care are automatically eligible for Medi-Cal coverage if they receive Title IV-E foster-care assistance.¹⁰

Those who are not eligible for IV-E assistance can still qualify for Medi-Cal through one of the other mandatory eligibility categories (for example, if they receive Supplemental Security Income benefits¹¹) or one of the optional categories (for example, if they are deemed “medically needy”¹²). A state’s participation in the Medicaid program is completely voluntary.¹³ By choosing to participate and accept federal funds, however, California is obligated to comply with the requirements of the Medicaid Act.¹⁴

In California, Medi-Cal mental health services are provided under authority of a 1915(b) “freedom of choice” Medicaid waiver,¹⁵ known as the Specialty Mental Health Services Consolidation Waiver.¹⁶ The waiver provision, which provides exemption from some Medicaid regulations, seeks to promote cost effectiveness and efficiency in state Medicaid plans.¹⁷

The Centers for Medicare and Medicaid Services, the federal agency that oversees state Medicaid plans, approved California’s most recent waiver renewal request on April 1, 2005. The current waiver renewal expires March 31, 2007.¹⁸

The Role of Mental Health Plans

Under the waiver, mental health services that Medi-Cal covers are delivered through managed care organizations run by individual counties rather than the state.¹⁹ These organizations, called mental health plans (MHPs), have responsibility for providing mental health care to all Medi-Cal recipients.

Each MHP oversees a provider network for psychiatric inpatient hospital services and professional specialty mental health services.²⁰ California’s managed care plan restricts an enrollee’s choice of plan to the county MHP, and the enrollee’s choice of provider to those within the MHP’s provider network. The restrictions are authorized under the state’s 1915(b) waiver.

Problems for foster and adopted youth arise when they move from one county to another. For the general Medi-Cal population, a move between counties requires enrollment in the new county’s MHP and switching health care providers.

Caught Between Counties

For youth who are adopted or in foster care, the transition is much more challenging because they remain under the jurisdiction of the county in which they first entered the foster care system (the “home” county). When a foster child moves to a new county (the “host” county), the home county continues to be responsible for providing and paying for mental health services,²¹ and the home county social worker retains control over the case.

Because mental health services are provided within the context of county-based MHPs, the home county’s preapproved provider network

isn’t available to treat youth in the host county. This situation is further complicated by the fact that California allows each county to design and implement its own provider network and delivery system.

Consequently, no two systems use the same contracting process and often don’t even supply the same range of mental health services.²² Neither does California mandate a statewide system for intercounty contracting.²³

Accessing Services is Problematic

The enormous practical challenges created by this system make it difficult to access services: treatment is frequently delayed or foregone, and children and families are left to manage without appropriate care.

For example, it took more than 40 calls over a two-month period to secure a psychiatrist for Stan, a Northern California foster youth.²⁴ The social worker on the case found that the home and host counties had such different processes for enrolling youth that they may as well have been speaking different languages.

Although the social worker was eventually able to secure a psychiatrist, the host county subsequently refused to pay for or provide other high-end services Stan needed, and now wants to move him out of its jurisdiction. Amid this back-and-forth, the social worker has seen the benefits of Stan’s previous therapy slowly recede and his behavior deteriorate.

Simply locating service providers for youth living outside their home counties is a great challenge, but it is only the first obstacle to overcome. In addition:

8 U.S. Department of Health & Human Services, HHS Issues *Final Child Welfare Regulations to Improve Services and Outcomes for Children* (Jan. 25, 2000), <http://www.hhs.gov/news/press/2000pres/20000125.html>.

9 42 U.S.C. § 1396 et. seq. (2005).

10 42 U.S.C. § 1396a(a)(10)(A)(i)(I) (2005).

11 42 U.S.C. § 1396a(A)(10)(A)(i)(II) (2005).

12 42 U.S.C. § 1396a(A)(10)(A)(ii) (2005).

13 *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 502 (1990).

14 *Id.*

15 See 42 U.S.C. § 1396(n) (2005).

16 See California Department of Mental Health, *Section 1915(B) Waiver Proposal for California’s Medi-Cal Specialty Mental Health Services Consolidation Waiver Program* (Jan. 2005).

17 Jane Perkins, et al., *National Health Law Program, an Advocate’s Guide to the Medicaid Program*, 2.6 (2001); see also 42 U.S.C. § 1396(n) (2005).

18 Letter from Teresa Pratt, director of the Centers for Medicare & Medicaid Services, to Stan Rosenstein, deputy director of Medical Care Services, California Department of Health Services (April 26, 2005) (on file with the authors). California’s initial waiver period began on March 17, 1995, as the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation. When it was first renewed, effective September 5, 1997, it was renamed the Medi-Cal Specialty Mental Health Services Consolidation waiver program, *supra*, note 16.

19 *Id.*

20 California Department of Mental Health, *supra*, note 17.

21 Cal. Welf. & Inst. Code § 5777(a)(3) (West 2005).

22 Cal. Code Regs. tit. 9, § 1810.345 (West 2005).

23 Cal. Welf. & Inst. Code § 5777.6 (West 2005).

24 E-mail interview with social worker (Dec. 11, 2003).

- Providers often are reluctant to enter into contracts with MHPs outside their own county. Typically, these government contracts are administratively complex and time-consuming, and they likely will cover only a very small group of prospective clients, sometimes no more than one child.²⁵
- When a home county offers a particular treatment but the host county doesn't, ²⁶ the home county must search for a provider to enter into a one-time contract for the needed service.
- Home counties end up paying much higher fees for individualized contracts than they pay for similar, in-county contracts. Medi-Cal reimburses counties for these higher fees up to a certain point, but beyond that point the home county bears the costs.²⁷
- When a provider is credentialed by the host county, California law requires the home county to accept the credential.²⁸ But if a provider is not in the host county's network, the home county must go through the process of approving the provider according to Medi-Cal standards before it completes a contract, which requires additional time and expense.²⁹
- Payments between counties can be long delayed and difficult to collect. Host counties may not receive reimbursement for months or years for out-of-county youth.
- Many counties have limited treatment resources, especially for high-intensity services. In an environment of severely limited capacity, MHPs may prefer to serve children from their own county.

Taken together—the difficulty finding doctors, therapists, and counselors; limited resources; high administrative

costs; no guarantee of payment—these primarily administrative obstacles combine to systematically deny out-of-county foster and adopted youth access to appropriate care.

Reform Proposals Fall Short

The challenges posed by California's 1915(b) waiver on children who cross local political boundaries were acknowledged almost from the outset. In 1998, the MHPs selected the California Mental Health Directors Association (CMHDA) to oversee inter-county administration of mental health services statewide.³⁰

In turn, CMHDA contracted with Value Options to handle this task.³¹ Value Options is a private administrative-services organization (ASO) whose primary business is managing public-sector, Medicaid-funded programs. Value Options has worked with many children's managed care programs in the nation.³²

Under the CMHDA contract, Value Options had authority to credential mental health providers, authorize outpatient services, and provide streamlined billing and payment.³³ By 2002, it had served about 10,000 children, with about 5,000 children active at any given time.³⁴

However, the ASO strategy was not a complete response to the challenge of providing care to out-of-county youth. Several counties declined to participate, and counties that did contract with Value Options had to shoulder some administrative burdens. In addition, Value Options was set up to authorize and pay only for basic mental health services, including assessment, therapy, and medication management.

Value Options didn't necessarily reduce the delay that children seeking services outside their home county experienced. When a provider wasn't

available through the MHP in the child's county of residence, Value Options searched for other local providers, seeking an individual contract for that child, which could take two to four weeks.³⁵

If that search was unsuccessful, Value Options referred the child back to his or her home county for service. This essentially made the home county ultimately responsible for providing services, causing further delay.³⁶

Law Requires Access to Services

In 2000, the state legislature passed SB745 to "require the establishment of a procedure to ensure access to outpatient mental health services..." for out-of-county foster youth. The bill acknowledged that "foster children who are placed outside their county of [adjudication] and who need specialty mental health services provided by county mental health plans encounter delays and difficulties in accessing these specialty mental health services."

The statute required that "[e]ach local mental health plan shall establish a procedure to ensure access to outpatient mental health services, as required by Early Periodic Screening and Diagnostic Treatment [EPSDT] program standards, for any child in foster care who has been placed outside his or her county of adjudication."³⁷

Notwithstanding these efforts, access problems continued. The Department of Mental Health acknowledged the continuing problems in a notice that addressed therapeutic behavioral services: "DMH recognizes the challenges inherent in developing and implementing procedures for providing EPSDT mental health services to children/youth placed out-of-county and is aware that some MHPs may need technical assistance in overcoming these challenges."³⁸

25 California Mental Health Directors Association, Children's System of Care Foster Care Subcommittee, *Challenges to Providing Mental Health Services to Foster Youth Placed Out-of-County* (Jan. 2005) at 2, http://emq.org/press/docs/challenges_outofcounty.pdf.

26 Although the definition of "medical necessity" (a guide for determining which conditions are to be covered under state Medicaid programs) must be uniform statewide, counties have the discretion to

choose the treatment options they will provide in response to those conditions. Cal. Code Regs. tit. 9, § 1810.345(a) (West 2005).

27 See Cal. Welf. & Inst. Code § 5777(a)(1) (West 2005). "The mental health plan shall bear the financial risk for the cost of providing medically necessary mental health services...irrespective of whether the cost of those services exceeds the payment set forth in the contract."

28 Cal. Welf. & Inst. Code § 5777.6(2)(3) (West 2005).

29 Perkins, *supra* note 18.

30 Protection and Advocacy Inc., *Managing Mental Health Care: A Report on California's Medi-Cal Managed Care System, 1997–1999* (Jan. 2000), <http://www.paica.org/pubs/507101.htm>.

31 California Mental Health Directors Association, *About the ASO*, <http://www.cmhda.org/aboutaso.html>.

32 *Id.*; Value Options, <http://www.cmhda.org/documents/VOMark.doc>.

33 *Id.*, California Mental Health Directors Association, *supra* note 32.

34 California Department of Mental Health, *Medi-Cal Specialty Mental Health Services Consolidation Request for Waiver Renewal* (2002) at 40.

35 Compilation of California Mental Health Directors Association survey responses (July 14, 2006) (surveys on file with the authors).

36 *Id.*

37 Cal. Welf. & Inst. Code § 5777.6 (a).

38 California Department of Mental Health, *Information Notice 05-08* (July 15, 2005).

The state's admission may have been partly a result of the breakdown of the ASO arrangement. In June 2004, due to increasing administrative costs and other circumstances, CMHDA stopped managing the ASO program and terminated its contract with Value Options.³⁹

Since then, although many California counties have continued to contract with Value Options independently, nearly a third of the counties have opted to administer intercounty services themselves.⁴⁰

Working Group Recommends Changes

The California Institute for Mental Health and the Child and Family Policy Institute of California, with the support of a grant from the Zellerbach Family Foundation, launched the most recent effort to resolve access problems. A working group convened to review access barriers and recommend solutions.

In April 2006, the working group released its initial recommendations.⁴¹ First and foremost, they address the needs of youth who have been permanently placed and are no longer dependents of the state (but who still face these administrative hurdles)—what the committee calls “Strategy A.”⁴²

Strategy A proposes a straightforward solution: transferring Medi-Cal responsibility to the county of residence for youth in permanent placements, as is the case for the general population of Medi-Cal beneficiaries who change counties of residence.

“Strategy B” attempts to streamline the process for youths in out-of-county foster placements. First, it stresses the importance of intercounty and interdepartmental collaboration: the host county and home county MHPs should coordinate services and work together with the agency that arranges for a youth's placement.

Second, it stresses the importance of mandatory timelines for contracting with and certifying providers. The home county must contract or certify using its own process within 30 days or default to the host county's contracting and certification process.

Third, the proposed strategy recommends standard form contracts for in-network providers, and emphasizes proactive steps by the state to ensure that providers have easy access to the information they need to work with other counties, including complete information about each MHP and available providers.

The working group's recommendations emphasize reducing administrative burdens and MHP risk. Standardizing contracts and procedures will likely help in this regard. In addition, eliminating cross-county responsibilities for permanently placed children will improve access to appropriate mental health care for children who are no longer court-supervised.

The recommendations fall well short of solving access problems for foster youth because they don't address the critical questions of resource capacity, financing, or accountability.

Federal Law Mandates Adequate Care

Federal Medicaid law and regulations require participating states to provide access to adequate mental health services for eligible youth, including foster and adopted children. Under Medicaid's EPSDT provisions, states must provide screening services to identify defects, conditions, and illnesses.

States must then provide the necessary diagnostic and treatment services to correct or ameliorate these conditions.⁴³ The Medicaid Act further requires that one state agency oversee a state's Medicaid program (California hasn't been exempted from this requirement through its waiver program).⁴⁴

The single state agency must ensure the “proper and effective operation of the state Medicaid plan” by monitoring local agency operations and taking corrective action when necessary.⁴⁵

In California, the Department of Health Services fills that role, supervising the administration and operation of Medi-Cal in all 58 counties.⁴⁶ The department has assigned oversight responsibility for mental health services to the state Department of Mental Health (DMH).⁴⁷

To meet federal guidelines for statewide oversight of access to care, California law mandates that each county MHP have a plan that ensures access to outpatient mental health services, as required by the federal EPSDT program, for any dependent child who is placed out of county.⁴⁸ Although DMH contracts with county MHPs to deliver medically necessary care to Medi-Cal beneficiaries, ultimately it is DMH's responsibility to provide appropriate mental health care to foster and adopted youth.

“Reasonable Promptness”

Federal law also requires prompt access to care without delay caused by agency administrative procedures.⁴⁹ California hasn't waived this provision as part of its 1915(b) waiver program⁵⁰ and courts have interpreted the “reasonable promptness” clause to be enforceable by private citizens under § 1983.⁵¹

Particular administrative procedures have explicit time limits; for example, a Medicaid application must be processed within 45 days.⁵² Although there is no explicit time limit for “reasonable promptness” in delivering services, courts have interpreted this to mean that there cannot be waiting lists for services because of administrative problems.⁵³

The 1915(b) waiver doesn't exempt California from providing the full array of services required under EPSDT, nor does it allow the state to

39 California Mental Health Directors Association, *supra* note 32.

40 *Id.*; ASO Termination Announcement, http://www.cmhda.org/documents/ASO_Term_Notice_6-2-04.doc.

41 Zellerbach Family Foundation, *Mental Health Services for Foster Children Placed Outside Their County of Jurisdiction: Recommendations* (Jan. 2006).

42 *Id.* at 2.

43 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), and 1396d(r) (2006).

44 42 U.S.C. § 1396a(a)(5) (2005).

45 Perkins, *supra* note 18.; See also 42 U.S.C. § 1396a(a)(4) (2005).

46 Cal. Welf. & Inst. Code § 14100.1 (2005).

47 Cal. Welf. & Inst. Code § 14682 (2005).

48 Cal. Welf. & Inst. Code § 5777.6 (2005).

49 Blanco v. Anderson, 39 F.3d 969, 971 (9th Cir. 1994). See also 42 U.S.C. § 1396a(a)(8) (2005), 42 C.F.R. 435.930(a) (2005).

50 California Department of Mental Health, *supra* note 17 at 13–14.

51 Bryson v. Shumway, 308 F.3d 79, 88 (1st Cir. 2002).

52 42 C.F.R. § 435.991 (2005).

53 Sobky v. Smoley, 855 F.Supp. 1123, 1147–1148 (E.D. Cal. 1994).

unreasonably delay access to services. On the contrary, under federal Medicaid regulations, a waiver program cannot substantially impair access to services of adequate quality when the services are medically necessary.⁵⁴

Furthermore, the legislative history of the Medicaid Act's waiver provisions indicates that the statute sought more than simply to forbid "impairing" access; it also sought to ensure that a waiver program maintain or improve access to services.⁵⁵ For foster youth placed out of county, it appears that California's waiver program doesn't meet this legislative mandate.

The administrative barriers to care posed by California's 1915(b) mental health waiver delay and deny services to foster and adopted youth in violation of federal law. Barriers the waiver created aren't just minor inconveniences or technical violations. Rather, they visit real harm on foster and adopted youth when medications are denied, therapy is delayed or foregone, and needed intensive services are unavailable.

Unmet mental health needs cause an escalation in disruptive behavior, failure in school, placement disruptions, and entanglement with juvenile justice. Moreover, the cross-county barriers impact many children and a substantial part of the mental health system. Youth in foster care make up only 1–3 percent of the total Medi-Cal population, yet 41 percent of funding for children's mental health goes to foster-child care⁵⁶ and more than 20 percent of California foster youth reside in placements outside their counties of origin.⁵⁷

Principles for Reform: State Leadership, Accountability, And Teamwork

For almost a decade, the problem of providing timely and appropriate mental health care to out-of-county youth has gone unresolved. Two

primary barriers have confounded efforts to provide adequate care: "political geography" and "silos."

The political geography problem arises because the MHP provider networks created within county lines under California's waiver system can't care for children who cross county lines. As a result, 58 counties must coordinate screening, assessments, treatment planning, authorization, credentialing and contracting with providers, case management, treatment, payment, reimbursement, and oversight—often on an individualized basis—for more than 5,000 children every year. This problem is directly attributable to California's 1915(b) mental health waiver.

The silos problem refers to the challenge of getting adequate care for multi-needs youth from compartmentalized child-serving bureaucracies. All cross-county children who need mental health services are clients of two or more child-serving agencies—typically, child welfare and mental health, although probation and special education may be involved. Each of these agencies has its own culture of purposes, protocols, regulations, and financing. When multiple agencies are involved in providing care, their bureaucratic cultures can clash and coordination may be diminished or fail altogether. Ineffective care coordination—e.g., between child welfare's placement and mental health's treatment decisions—can spell disaster for an abused or neglected child.

The silos problem isn't a direct result of the waiver, but the waiver's county-based structure makes coordination between social-services and mental-health agencies much more difficult.

When political geography and silo problems converge, as they do for foster and adopted youth placed out-of-county, the results—improper service delays and denials—aren't surprising. What is surprising is that after a decade or

longer, the state and counties haven't resolved these problems.

Guiding Principles Could Lead to a Solution

The barriers aren't insurmountable. Although the challenge is significant, adherence to a few key principles could guide policy-makers to a solution.

PRINCIPLE ONE: Leadership is necessary to end unlawful delays and denials of services.

The law entitles out-of-county foster and adopted children to adequate care. They often are treated as though their entitlement depends on available resources or administrative convenience. Such presumptions are wrong.

The status quo is both unacceptable and illegal. DMH is the Medicaid agency delegated with the federal and state responsibility of providing adequate care to eligible youth. Counties also could provide leadership and, together with DMH, craft a solution to the out-of-county problem. As well, a federal judge could be the catalyst for ending this long-standing harm.

PRINCIPLE TWO: Access must take precedence over control.

Proposed solutions up to now have put financial risk for home MHPs ahead of health care access for out-of-county foster and adopted youth. Virtually all of the organizational challenges to providing out-of-county care are based on MHPs' desire to retain control of the delivery of services to "their" youth living in other counties. This approach is a hallmark of the political geography problem.

There is a far better approach: simply transfer treatment responsibility for out-of-county youth to

54 Perkins, *supra* note 18; see also 42 U.S.C. § 1396(n)(b)(1) (2005). The statewide definition of medical necessity is enumerated in Cal. Code Regs. tit. 9, §§ 1820.205, 1830.205, and 1830.210 (2005).

55 See Perkins, *supra* note 18 at 2.23 n.68.

56 Children's Advocacy Institute, *California Children's Budget 2002–03* at 5-27, http://www.caichildlaw.org/Advocacy.htm#Budget_Advocacy.

57 Children's System of Care Foster Care Subcommittee, *supra* note 26 at 2.

their host counties. They would then be treated no differently than other youth in their county of residence. Under this straightforward “host access” solution, the home county would have payment responsibility and the host county treatment responsibility. The state would have to set up an accounting system to manage funds transfers among counties.

Opponents of host access contend that it would place unacceptable financial risk on home counties because they wouldn’t have any control over expenditures for out-of-county youth. Moreover, they argue, the home county would lose control over the array and quality of services provided. These are really arguments of principle, much like the principled notion of “no taxation without representation.” As a practical matter, however, they have little merit.

First, home counties would retain considerable direct control over expenditures because they have authority over placement decisions.

Second, there is no reason to believe that host counties would systematically provide care of lower quality or higher cost than home counties do. Indeed, evidence indicates that it’s more expensive for home counties to provide care to out-of-county youth than it is for host counties. Under the host access approach, home counties might pay somewhat more or less for services to individual out-of-county youth compared to in-county youth, but this wouldn’t significantly affect their financial risk.

Third, home and host counties likely would take different approaches to providing care in particular cases. As a result, host counties might charge home counties for providing services that wouldn’t be offered or available in the home counties. This is to be expected in a county-based system that champions flexibility and county autonomy.

It’s difficult to accept the argument that host counties can’t be trusted to provide appropriate care. Under state policy, which counties ardently

support, all county MHPs are entrusted to provide adequate and appropriate care.

Moreover, most host counties are also home counties. How could it be that counties are capable home county providers, but incapable host county providers? As long as the services provided are medically necessary and clinically appropriate, as they must be for state and federal cost-sharing, it strains credibility to believe that home counties will be disadvantaged by relinquishing control over service decisions for out-of-county youth.

Thus, arguments for maintaining home-county control fail as a practical matter. As an argument of principle, retaining home county control fails as well because it runs afoul of two powerful, competing principles: compliance with state and federal law, and providing appropriate health care to children in need. Yes, counties may be required to pay for services they don’t directly control. But if, by refusing to cede control, they unlawfully deny neglected and abused children access to necessary mental health care, the balance of competing principles weighs heavily in favor of access to care.

After 10 years of “principled” resistance, the time for practical solutions is at hand.

PRINCIPLE THREE:

You can’t do it alone.

A team approach is necessary to meet the challenge of providing adequate access to mental health care for all multiagency youth—especially for out-of-county youth.

Neither individual counties, nor individual agencies, can do it alone.

At a minimum, the team should include the social worker from the home county, his or her counterpart from the host county, and an MHP case manager from the host county. Better yet, it should encompass the child, his or her parents or caretakers, and providers and informal supports from the host county who will help care for the child.

The team approach could reduce barriers to care that arise when agencies act within separate silos. It also can

ensure that the home and host counties share ownership of planning for and implementation of an individualized treatment plan, and that both child-welfare and mental-health resources are available to meet the needs of out-of-county foster or adopted youth.

Enacting these three principles—DMH leadership, a shift of treatment responsibility to host counties, and teamwork in planning and implementation—would overcome the political-geography and silos problems that have curtailed adequate access to mental health care for out-of-county youth for many years.

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