Family First: *Responding to the Shifting Landscape of Child Welfare*

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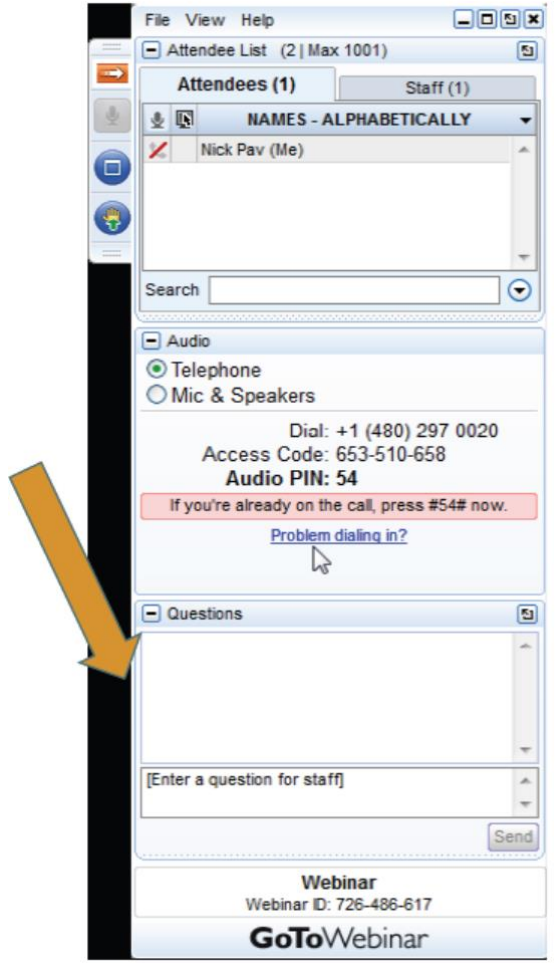


Today's Speakers

- **Angie Schwartz**
  Policy Director
  Alliance for Children's Rights

- **Brian Blalock**
  Cabinet Secretary, State of New Mexico
  Children, Youth, and Families Department

- **Cathy Senderling**
  Deputy Executive Director
  County Welfare Directors Association of California

- **Mark Mecum**
  Chief Executive Officer
  Ohio Children's Alliance

- **Sarah Helevy**
  Child Welfare Program Director
  Nebraska Appleseed

- **Sean Hughes**
  Managing Partner, Government Relations
  Social Change Partners

Family First Prevention Services Act

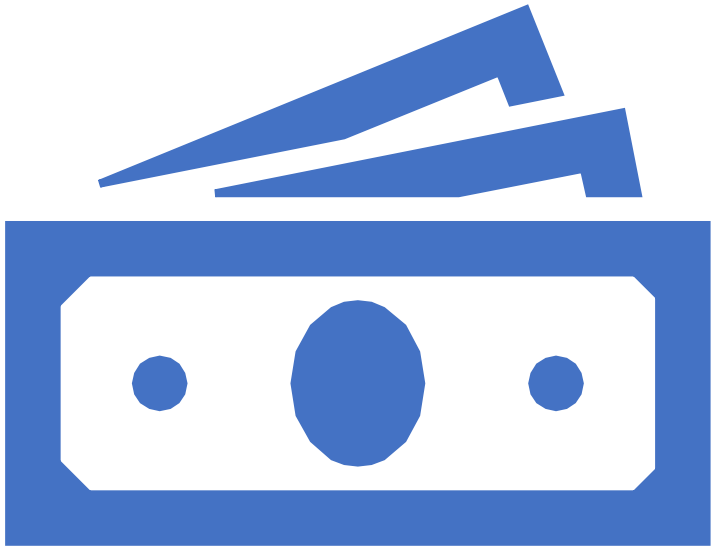
Overview

Three Prongs of Child Welfare Reform

Family First challenges states to explore ways to reform the entire continuum of our child welfare system:

- **Prevention:** Preventing children from ever coming to the attention of the child welfare system – preventing abuse and neglect
- **Intervention:** Allowing expanded interventions to stem a family crisis so that children can remain safely at home
- **Family Placements:** Restricting the number of children placed in congregate care/group homes to ensure that all children in foster care are raised in families

Family First Starts the Conversation, Budget Neutrality Limits the Scope



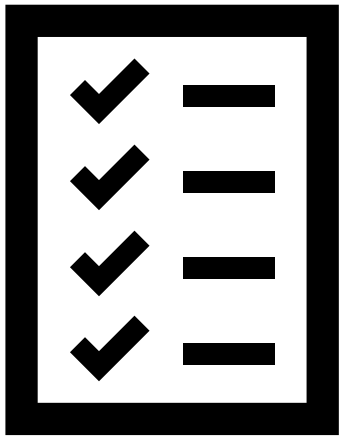
*Family First is **budget neutral**:*

- Family First redirects federal savings currently used to support children in congregate care ($641 million) and delays additional federal funds for the Adoption Assistance program for another six years ($505 million)

Congressional Budget Office findings:

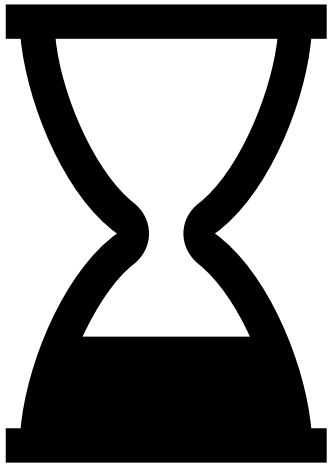
- Enacting this legislation would, on net, reduce direct spending by the federal government by $66 million over the 2017-2026 period.
- Beginning in 2020 about 30 percent of the spending on prevention services provided by states that exceed the MOE would be eligible for federal reimbursement. By 2026, that amount would increase to 95 percent as more evidence-based practices are identified and states become more adept at using those practices
- Estimates that about 70% of the children residing in group settings other than RTFs in 2020 would simply become ineligible for any reimbursement under title IV-E.

Effective Dates



- Most of FFPSA Chapter I took effect 10/1/19
- Some provisions took effect immediately:
  - Establishment of technical assistance office related to new optional prevention services
  - State review of licensing standards
  - Technical and conforming changes to name and contents of Part E of Title IV-E, adding “prevention”

Provision for States Needing Law Changes



- If a state needs law changes to implement any portions of FFPSA, state plan shall not be deemed out of compliance until first day of **first calendar quarter after close of next regular legislative session** following effective date

✓ ***Example: January 2020*** *is first date California could be deemed out of compliance if its state plan does not include required FFPSA items*

Two Year Delay

- States can delay the payment limitation and related requirements for up to two years.
  - Latest states can implement is October 1, 2021
- If a state chooses to delay, the state's ability to draw down Title IV-E for preventive services under Chapter I is delayed for the same period.

Prevention Under Family First

Optional Prevention Services

Opens Title IV-E for specified services to be provided at state option:

- **Mental health** and **substance abuse prevention** and treatment services provided by a qualified clinician
- **In-home parent skill-based programs** that include parenting skills training, parent education and individual and family counseling

- Prevention services can be given for **up to 12 months**

Who is eligible to receive prevention services?

(1) A child who is a “candidate” for foster care; - or -

(2) A parent or kin caregiver of the child who is a candidate for foster care is eligible regardless of whether they meet AFDC income eligibility requirements required for Title IV-E reimbursement – or –

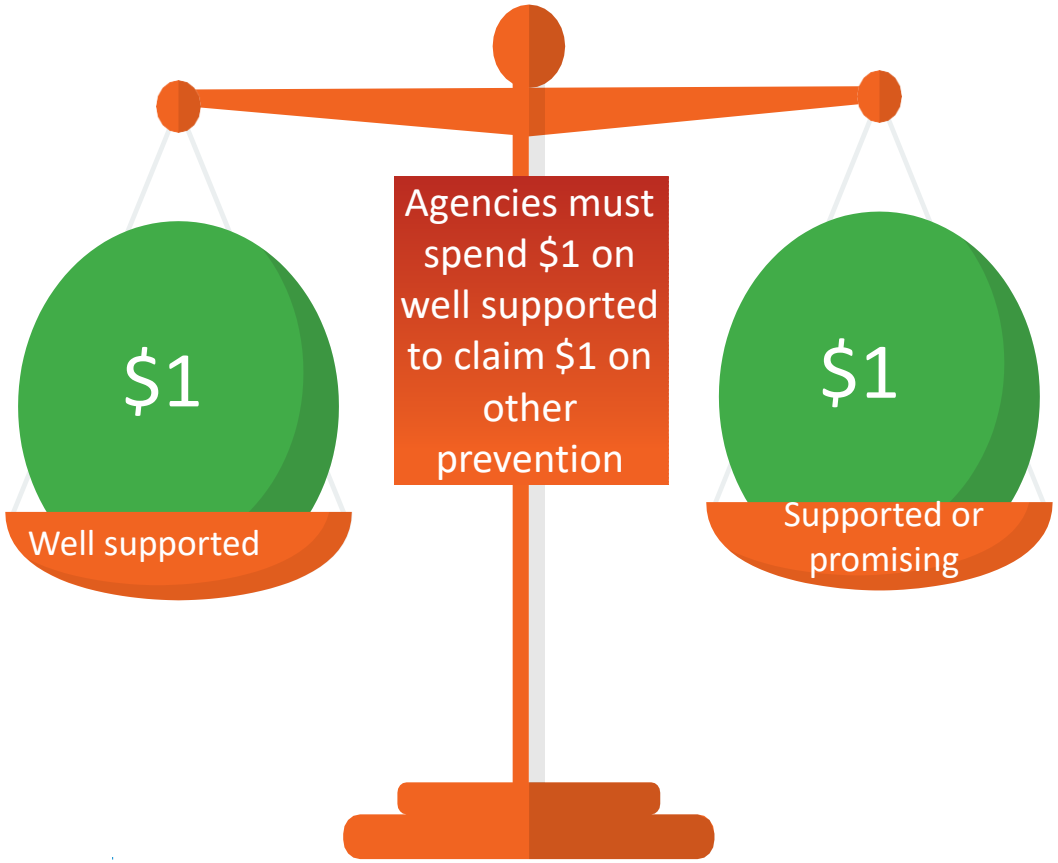
(3) Youth in foster care who are pregnant/parenting

Definition of "Candidate"

For purposes of this title, "candidate for foster care" means the following:

- A child who is identified in a prevention plan as being at **imminent risk** of entering foster care, but who can remain safely in the child's home or in a kinship placement as long as services available under the new title that are necessary to prevent the child's entry into foster care are provided
  - Includes a child whose adoption or guardianship arrangement is **at risk of a disruption or dissolution** that would result in a foster care placement

Evidence Based Programs



- Only prevention services that meet one of the three “evidence-based” (*promising, supported, and well-supported*) federal standards will be eligible for reimbursement.

- States are required to spend at least 50% of the total amount claimed for federal reimbursement for prevention services on “well- supported” programs.

- **10 programs** currently undergoing systemic review by HHS for inclusion in the Clearinghouse. These programs will be rated to indicate which evidence standard they meet.

Title IV-E Payer of Last Resort

If a public or private program providers (such as private health insurance or Medicaid) would pay for a service allowable under the Title IV-E prevention program, those providers have the responsibility to pay for these services before the Title IV-E agency would be required to pay .

For example, if a parent with Medicaid coverage is receiving mental health services that would be covered by Medicaid, and that are also allowable under the Title IV-E prevention program, Medicaid must pay for the service before the Title IV-E portion (if any) is paid.

Transitional Payments

- A state can receive “transitional payments” for prevention programs prior to the program’s inclusion in the Prevention Clearinghouse if the state:
  - **Completes and submits checklist**, with required documentation, to request transitional payments for a prevention program or service not yet rated by the Clearinghouse
  - **Submits checklist as part of the five-year plan**, or as an amendment to an approved five-year plan by October 1, 2021
  - **Documents** that, in determining the state’s designation(s) of **promising, supported, or well-supported**, for HHS consideration, the state: 1) conducted the independent systematic review; and 2) met the criteria outlined in statute re: requirements for an evidenced-based practice
  - Once a state’s program(s) or service(s) is approved as part of the five-year plan, any other state may submit a five-year plan for approval of a transitional payment for those same programs or services, but must submit the plan or amendment by October 1, 2021
- All other requirements for the Title IV-E prevention program outlined in ACYF-CB-PI-18-09 remain in effect for transitional payments
- Transitional payments in effect until end of the federal fiscal quarter following the Federal fiscal quarter in which the Clearinghouse rating is assigned

Implications for Child Welfare Systems

- In the initial years of implementation, Family First will only enable child welfare systems to draw down federal funds for a limited set of programs that have met rigorous evaluation criteria.
- States must work to identify additional programs for systemic review and inclusion in the Clearinghouse and engage partners in getting additional programs evaluated and reviewed.

Implications for Child Welfare Systems

- New federal funds are only available once the child meets the definition of candidate.
- Things to consider:
  - How does your state currently define candidates for Title IV-E admin claiming?
  - Can prevention services be voluntary if the child must meet the definition of candidate?
  - What happens if a child is determined a candidate and the child and/or parent are offered services but the child/parent is unsuccessful in meeting the parameters of the prevention plan?

Ohio Background

- Ohio's Governor Mike DeWine established FFPSA implementation as a key priority for his new Administration
- State Department Directors overseeing Child Welfare, Mental Health, Developmental Disabilities, and Medicaid are actively collaborating and coordinating their respective public policy formulation
- Our State Department overseeing Child Welfare is in the driver seat of managing Ohio's implementation, including our overarching vision
- ODJFS established a large and inclusive leadership committee of public and private officials that meet monthly to make key decisions and recommendations about FFPSA implementation

Ohio's Structure

Governor's Administration

- Leadership Committee
- Leadership Steering Committee → Key state officials, association leaders, Casey Family Programs
- Prevention Subcommittee
  - Workgroups: In-Home Parenting, Mental Health, SUD
- QRTP Subcommittee
  - Workgroups: Treatment Model, Accreditation, Agency Readiness, Assessment, Licensing, Courts
- Communications Subcommittee
- Model Licensing Standards Subcommittee

In total, about 100 different people regularly participate in committees and workgroups

Key Prevention Services Decisions Looming in Ohio

Service Array: Identify which evidence-based practices to *invest* Title IV-E Prevention dollars, and how to develop such a mechanism in a generally county-run child welfare structure; and also how to monitor and ensure >50% of Title IV-E dollars are spent on Well-Supported practices across all state and county payors.

Candidacy: Ohio proposed a definition of candidacy that is broad

Transitional Payments: Since Ohio isn't implementing FFPSA until 10/21, we may not need to act on the recent HHS transitional payment opportunity. By the time we go live, the services for which we want IV-E reimbursement may already be on the approved list. Any services approved by the feds are considered approved for any other state, so long as they are included on the state's IV-E Plan.

Nebraska Background

- Nebraska Department of Health and Human Services (NDHHS) announced early on that it would be an early adopter of the FFPSA prevention option
- This is consistent with a significant trend of foster care diversion in NE
  - A decade ago, NE had the highest rate of children in out-of-home care per capita of any state in the country
  - From Kids Count in Nebraska (2018):

5,765 kids

entered the child welfare system in 2017.

3,241 (56%) were non-court involved

2,524 (44%) were court involved

Nebraska's Structure

Appleseed convened a kick-off event with nearly 100 stakeholders on May 1, 2018

NDHHS formed workgroups of interested stakeholders, starting in the summer of 2018

Workgroups include:

- Prevention Services & Program Plan, Criminal Record & Registry Checks for Adults, FC Maintenance Payments, Kinship Navigator, Prevention of Inappropriate Diagnoses, Child Maltreatment Deaths, Foster Family Recruitment & Retention, Model Licensing Standards

Prevention workgroup conducted a statewide scan of services and developed a chart of EBPs

NDHHS issued RFQs for: kinship navigator (2 contracts awarded), in-home parenting skills services, and SA/MH services (not yet awarded)

NDHHS circulated a draft 5-year SPA for stakeholder feedback

Key Decisions in Nebraska:

Definition of Candidate for Foster Care

In the proposed State Plan Amendment Nebraska has defined "candidate" consistent with federal language:

Children and youth identified as being a candidate for foster care are those at imminent risk of entering foster care, as defined by Nebraska Revised Statute 71-1901, but can remain safely in the child's home or kinship/relative home as long as Title IV-E prevention services are necessary to prevent entry into the foster care system are provided. This includes those children and youth who are:

1. *residing in a family home accepted for investigation, or with an active, ongoing case based on a Structured Decision Making (SDM®) intake assessment, including non-court and court involved cases where child may be a state ward;*
2. *the subject of a case filed in juvenile court as being mentally ill and dangerous as defined by Nebraska Revised Statute 43-247 (3)(c);*
3. *pre- or post-natal infants and/or children of an otherwise eligible pregnant/parenting foster youth in foster care;*
4. *at risk of an adoption or guardianship disruption or dissolution that would result in a foster care placement.*

Nebraska Prevention Services (draft)

Nebraska Title IV-E Prevention Services							
	EBP	**Target Population in Years**	**Average Length of Service[3]**	**Outcomes (CEBC?)[4]**	**Estimated Title IV-E Clearinghouse Rating[5]**	**CEBC Rating**	**Being Reviewed by Title IV-E Clearinghouse[6]**
In-Home Parenting	Healthy Families America (including Healthy Families America: Child Welfare Adaptation)	Parents of children 0-5 (must be under 2 at time of referral)	Until child is 3, can be offered until age 5	Increased nurturing parent-child relationships, health child development, enhanced family functioning, increased protective factors, reduced risk	Well-supported	Well-supported	**Yes**
	Parents as Teachers	Parents of children 0-5	At least 2 years	Increased knowledge of child development, improved parenting practices, detection of developmental delays, school readiness	Promising	Promising	**Yes**
Mental Health	Trauma-Focused Cognitive Behavioral Therapy	Children 3-18 and their caregivers	3-5 months	Improved PTSD, depression, anxiety symptoms, reduced behavior problems, improved adaptive functioning improved parent skills, reduced parent distress.	Well-supported	Well-supported	**Yes**
	Multisystemic Therapy	Children 12-17 and their caregivers	3-5 months	Youth: Reduce behavior problems. Caregiver: increased ability to address parenting difficulties and empower youth.	Supported	Well-supported	**Yes**
	Parent and Child Interaction Therapy	Children 2-7 and their caregivers	4-5 months	Child: Increased parent-child closeness, decreased anger and frustration, increased self-esteem. Parent: Increased ability to comfort child, improved behavior management and communication with child.	Well-supported	Well-supported	**Yes**
	Family Centered Treatment	Children 0-17 and their caregivers	6 months	Family stability, increase family functioning in the critical areas contributing to increased risk of family dissolution, increase effective coping, reduce harmful or hurtful behaviors, build upon strengths to sustain changes made	Promising	Promising	**No, DCFS currently has a contract**
MH/SA	Motivational Interviewing	Caregivers or adolescents	1-3 sessions	Enhance internal motivation to change, reinforce that motivation, and develop a plan to achieve change.	Well-supported	Well-supported	**Yes**

New Mexico Background

- Prior administration indicated that it planned on opting in based on its understanding that FFSPA would allow for upstream prevention and additional funding to help revamp the foster care system and, specifically, assist with congregate care reform.
- Current administration is committed to many of the principles that have been associated with FFSPA – even if the federal law does not help states achieve them.
    - Including congregate care reform, building services to increase supports for youth to remain in less restrictive settings, and re-imagining prevention.

Protective Services

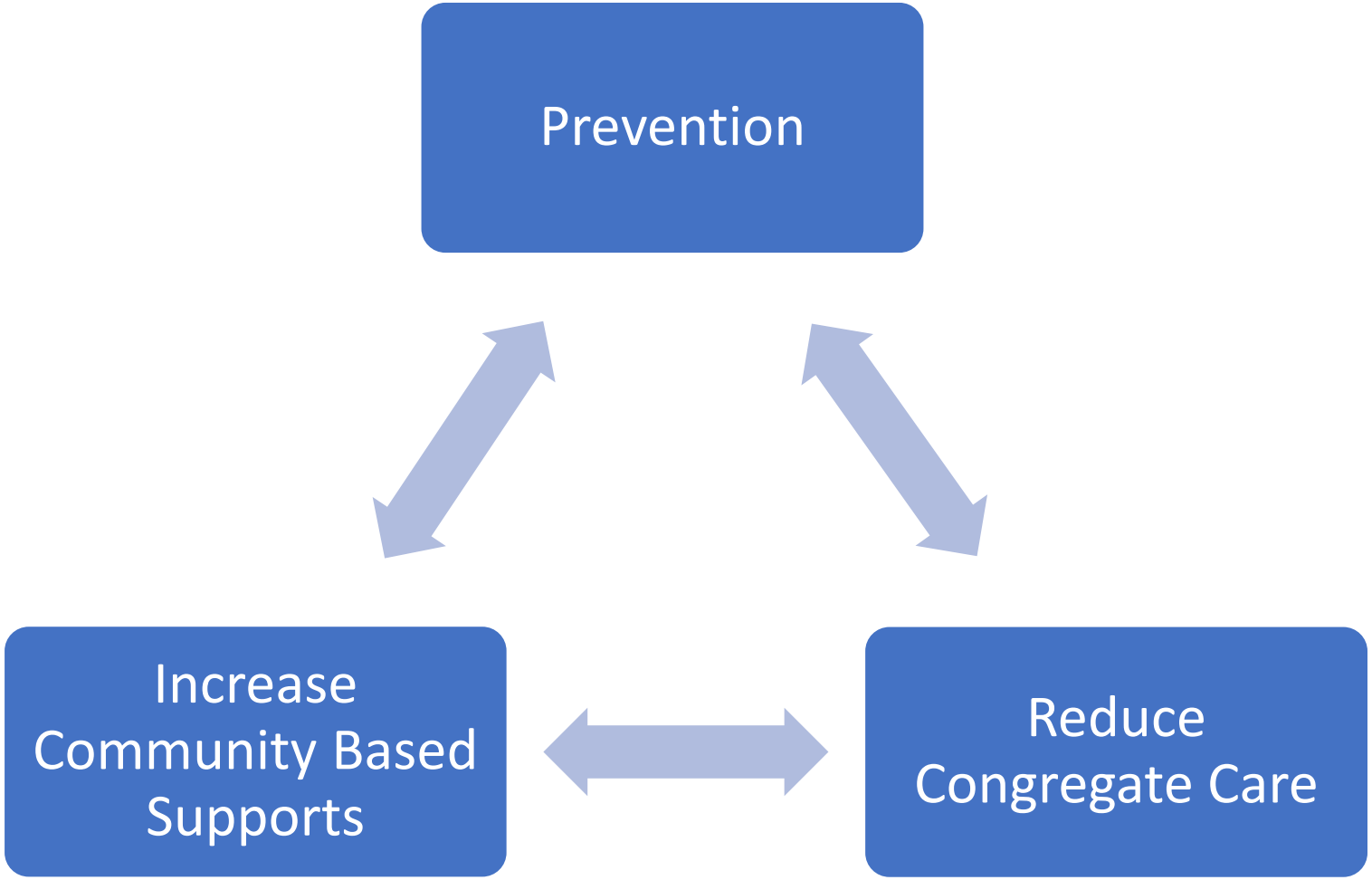
Behavioral Healthcare

New Mexico Children, Youth, & Families

Juvenile Justice

Early Childhood

New Mexico Key Considerations:
How to Build More Appropriate Placements



New Mexico:
FFSPA Implementation Work Streams

Congregate Care Reform

- QRTP Licensing
- Building out exceptions for special populations

Community Based Supports

- Kinship Care
- Community Based Mental Health Services

Prevention

- **Restructuring Front Door Access (SCI, Homelessness Partnerships)**
- **Behavioral Healthcare Supports for Parents (HB 230, residential stays, MST <u>with blended funding</u>)**

California Background

- State agency oversight, County-administered system
- Seven counties with Title IV-E waivers, mostly large counties
- State opted into ACA coverage expansion: 13 million on Medicaid

California Continuum of Care Reform

2016 legislation created CCR effort: pre-FFPSA

- Lower group home placement rates and lengths of stay
- Change group homes into short-term therapeutic programs with an emphasis on treatment
- Increase efforts to recruit, retain and support foster caregivers, including relatives and non-relatives
- Institute team-based case planning including child and family and others important in their lives

Related efforts

- Financial support for relatives starting at time of placement
- In-home, on-demand support for caregivers and youth
- Efforts to coordinate services to high-needs youth

California FFPSA Implementation

- **Assumptions**
  - California will delay implementation until 2021
  - Much of CCR comports with requirements in FFPSA for QRTP services and placements
  - California will need law changes for anything inconsistent between FFPSA and current California law – likely to start working on this in 2020, with additional changes in 2021 session.
- **Broad-based stakeholder group led by CDSS**
  - Has been meeting for about four months
  - Subgroups related to key issues in each part of the new law (prevention, placement, etc.)

California Key Decision Points: Prevention Services

How to identify those eligible for services?

Exploring use of an assessment tool

Whether we can have an alternate interpretation of the definition of candidacy ?

Tier 1 Definition

Tier 2 Definition

How do we ensure the capacity to offer the approved services?

Exploring how to leverage community-based organizations such as service providers

Special Populations

Pregnant & Parenting Youth: Opportunity for Primary Prevention

- Can serve **any** youth in care who is pregnant (expectant) or parenting (no candidacy requirement)
- Must be included in youth's case plan
- Must list services or programs to be provided to or on behalf of child to ensure youth is prepared (in the case of a pregnant youth) or able (in the case of a parenting youth) to be a parent
- Must describe foster care prevention strategy for any child born to the youth
- Must comply with other requirements that HHS Secretary may establish

Licensed Residential Treatment Facility

- States can pay for children **to be placed with a parent** in a licensed residential treatment facility for substance abuse if:
  - Recommendation for placement is specified in child's case plan before placement
  - Treatment facility provides, as part of treatment for substance abuse, parenting skills training, parent education, and individual and family counseling
  - Substance abuse treatment, parenting skills training, parent education and individual and family counseling is provided under an organizational structure and treatment framework that is trauma-informed
- Can implement this provision separate from the other prevention services and prior to implementing the new restrictions on group homes/congregate care
- NO requirement that 50% of funds be spent on a well-supported program

Homeless Youth

Many homeless youth – including those who have suffered abuse and/or neglect – are classified as “runaways” and fail to receive appropriate interventions

FFPSA may also provide any opportunity to leverage federal dollars to provide prevention services to unaccompanied homeless youth suffering from mental health and/or substance abuse challenges

States will need to incorporate this population into their definition of “candidates for foster care”

It will also be important for states to create pathways to foster care for this population if that is in youth’s best interests

Implications for Child Welfare Systems

- States should think innovatively about the special populations that can potentially benefit from prevention services funded through FFPSA and build them into their revised IV-E plans
- It will also be important to build the capacity of providers to deliver services to these unique populations

Ohio: Key Decisions Regarding Special Populations

Ohio decided to not specifically exempt sex trafficking or pregnant/parenting facilities from QRTP standards; we are confident the few affected facilities can and should meet the standards.

Ohio is exploring how to promote family based residential treatment facilities (where kids live with parents undergoing SUD treatment); few exist today.

Nebraska: Key Decisions Regarding Special Populations

Contracts in process for the 3 existing programs that meet the requirements to be a licensed residential family-based treatment facility for SA (Omaha, Lincoln, Hastings)

Little discussion among workgroups about the needs of homeless and pregnant/parenting youth, although there is a pending interim study on P/P at NE Legislature

New Mexico: Key Decisions Regarding Special Populations

Conducting analysis of numbers and gap assessment incuding implementing the CSE-IT tool to better understand scope and geographical prevalence of issue, Planning for specialized services through a collaboration with Protective Services and Behavioral Health.

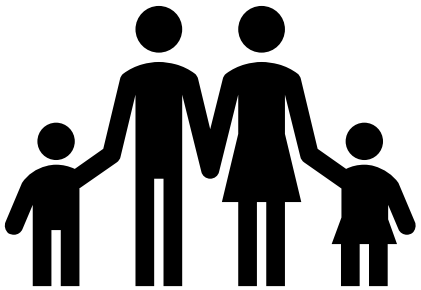
We are simultaneously planning for the implementation of extended foster care. For certain populations of older youth (including youth experiencing homelessness and CSEC youth), we need to be careful that policy decisions that would allow us to provide **preventative** services do not delay more crisis-oriented interventions until after 18 – making them ineligible for extended foster care.

California: Key Decision Regarding Special Populations

- Expanding services and supports to Expectant and Parenting Youth
  - Braiding together IV-E and Medicaid?
  - How broadly is “in-home skills based” programs defined (i.e. does it include sexual health education?)
  - How can we bring proven programs up to an evidence based standard (e.g. EPY Conferences)
- Licensed Residential Treatment Program
  - How can a child be removed from a parent and then placed with that parent in a residential treatment program? In general, if the child can remain with a parent, CA law does not allow that to be a removal
- Are there opportunities to work with homeless youth providers to offer prevention services?

Focus on Kin

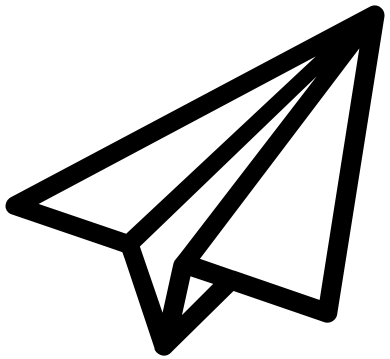
Kinship Navigator Programs



Allows states to receive 50% federal matching funds for expenditures on Kinship Navigator Programs

- Such programs exist in law and have been funded by federal Family Connection Grants
- Would also need to meet requirements of a “promising, supported or well-supported practice,” as defined
- Would be available without regard to IV-E eligibility of the child whose caregiver received the services

Relative Home Licensing Standards Reviews



- HHS Secretary released model home licensing standards in February 2019

- By 3/31/19, each State was required to submit a Title IV-E state plan amendment providing specific detail about:
  - Whether the agency foster family home licensing standards are consistent with the final model licensing standards and if not the reason for the deviation
  - Whether the state agency waives non-safety licensing standards for relative foster families and, if so, how caseworkers are trained to use the waiver authority and whether the agency has developed a process or provided tools to assist caseworkers in waiving these non-safety standards

Where can the child be living while preventative services are provided?

- In the home of the parent(s)
- In the home of kin caregiver until child can be safely reunified
- In the home of kin caregiver who child will live with *permanently*

Considerations When Children Cannot Remain Safely at Home with a Parent

FFPSA services available are largely directed at the parent

- Mental Health Counseling
- Substance Abuse Treatment
- Parenting Skills Training

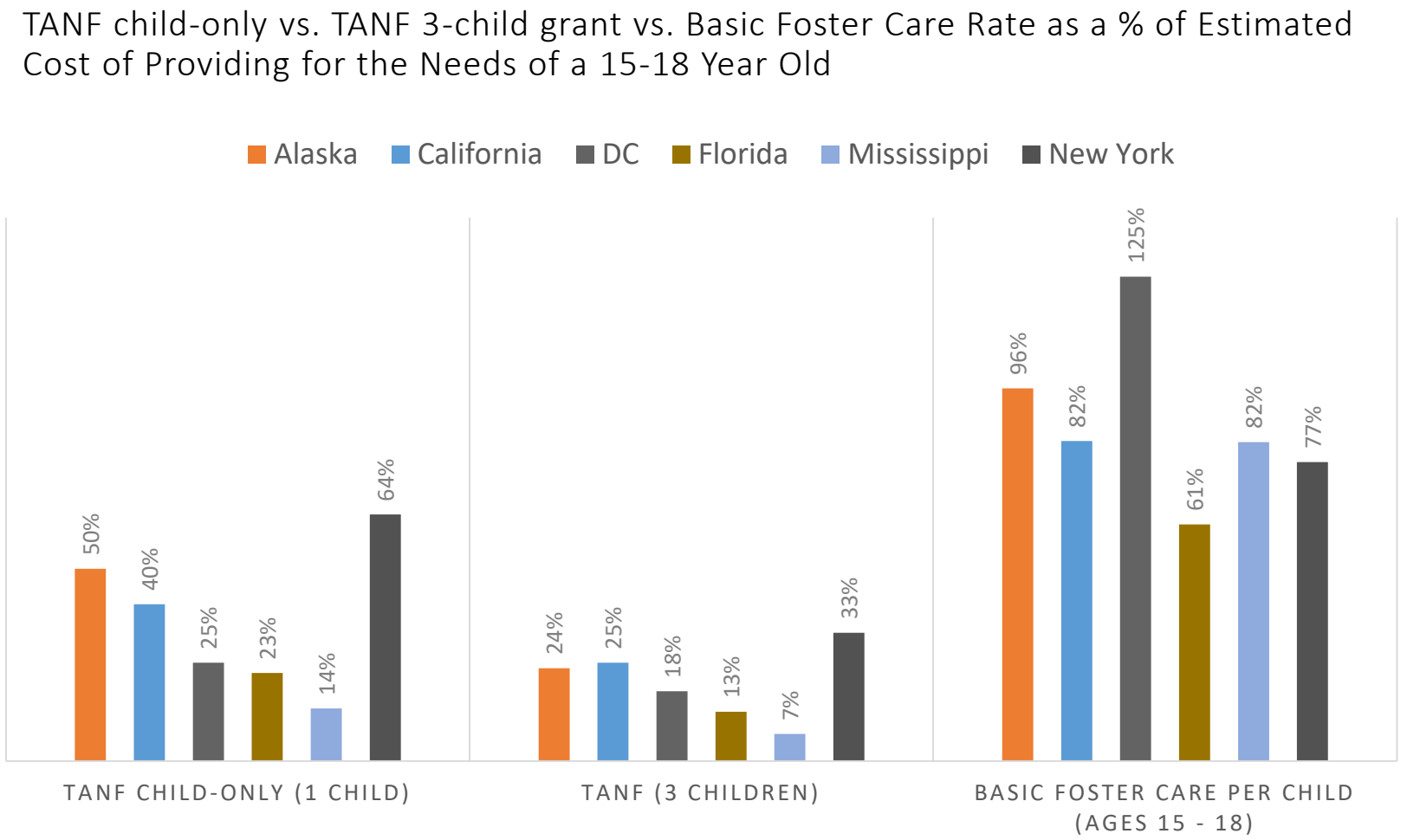
Children in foster care with a relative receive:

- Foster care payments, including adoption assistance and guardianship assistance
- Reunification services
- Case management
- Representation and advocacy by an attorney who is charged with representing the best interest of the child
- Categorical Medicaid eligibility
- Educational supports and rights

FFPSA Creates Two Paths for Youth Living with Kin

	Prevention of Foster Care Through Kinship Care	Placement With Kinship Caregiver Who Meets Licensing Standards
Funding for Caregiver?	**Limited funding** available to support kin caregiver – in most states, TANF is available	**Full foster care funding** – in CA this includes access to specialized care, clothing allowance, infant supplements, etc
Who receives services?	Prevention services **targeted primarily at the bio parent**/home of removal	**Reunification services** offered to the parent while child receives **legal representation** and **case management services**
Duration of services?	Prevention services offered **limited to 12 months**	**No limitation** reunification services while child is in foster care **+ 15 months of post-reunification services**
Permanency options and funding for permanency?	No requirement that the state make a formal placement with the relative if the child is not able to be reunified with the parent – FFPSA allows the prevention strategy to be the **permanent home of the relative without any additional services or funding**	Child is either reunified or can remain with relative through **adoption, guardianship, or as an Fit and Willing Relative** – all options offer **continued funding for kin families (AAP, KinGAP, or continued foster care funding)**
Supports for TAY?	**No eligibility** to receive extended foster care, independent living services, or Education and Training Vouchers	**Eligible** to receive extended foster care (if in care at age 18) independent living skill services (if in care at age 14) or Education and Training Vouchers (if either in care at 16 or adopted/guardianship at 14 or older)
Education rights to promote school stability?	No right to school of origin placements or funding, immediate enrollment, partial credits, etc.	Child has the right to attend their school of origin, the ability to utilize partial credit and immediate enrollment laws – these rights attach to foster care

Reliance on TANF to support kinship families sets families up to fail



Source: 2011 data from GAO Report. Foster Care Payments are from the Annie E Casey Report and the data is from 2011. The monthly cost of care is estimated in the same Annie E Casey report using 2011 data.

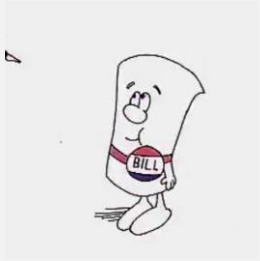
	Voluntary Placement Agreement - allows children to be placed in foster care with kin prior to court ordered removal	**Prevention Plan - allows children to be moved to relatives' home outside of foster care**
Definition	"'voluntary placement agreement' means a written agreement, binding on the parties to the agreement, between the State agency, any other agency acting on its behalf, and the parents or guardians of a minor child which specifies, at a minimum, the legal status of the child and the rights and obligations of the parents or guardians, the child, and the agency while the child is in placement."	Prevention plan must: (i) identify the foster care prevention strategy for the child so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or ***live permanently with a kin caregiver***; (ii) list the services or programs to be provided to ensure the success of that prevention strategy; and (iii) comply with other requirements as the Secretary establishes
Who consents?	Agreement between parent/guardian and child welfare agency	FFPSA is silent on whether Prevention Plan is voluntary
Care, custody and control	Child's placement into a VPA and care, custody and control transfers to child welfare agency	FFPSA is silent on whether the care, custody and control transfers to the state agency
Funding	Children placed in a VPA are eligible for foster care maintenance payments	No funding for children placed with a relative through a prevention plan
Time limits	Limited to 180 days unless there is a judicial determination by a court of competent jurisdiction (within the first 180 days of such placement) that such placement is in the best interests of the child	Prevention plan can be the permanent home of the kin caregiver

Implications for Child Welfare Systems

- Need to be mindful in using prevention plans for children who cannot remain safely at home with a parent to address:
  - Due process for parent and child
  - Ensuring access to the benefits/services that child may need both short and long term if they are outside of the home
- Due process questions to address
  - *Who is ensuring that reasonable efforts were made to avoid the removal?*
  - *Who is making the decision that the permanent home of the kinship caregiver is in the best interest of the child?*
  - *How is it assured that the child is kept safe from the parent when care, custody and control is not transferred to the child welfare agency?*
  - *How is the legal permanency of the child accounted for?*

Ohio:
Key Decisions Regarding Kinship Caregivers

Licensing: Determine how to establish a streamlined, tailored pathway for kin to become licensed foster caregivers (when appropriate) in order to access additional supportive services for their family and the kin child placed in their home. ***In Ohio, 26% of children in child welfare custody are placed with unlicensed kinship caregivers.***



Pending Federal Legislation: Family First Transition and Support Act (HR 2702/S 1376), if passed, could create a new opportunity to support kinship families

Authorizes new IV-B funds to states

Allowable uses include child care, transportation, legal services, emergency assistance (items such as utilities and housing emergencies) and other services such as family finding and family group decision making.

Nebraska: Key Decisions Regarding Kinship Caregivers

- In NE, 59.6% of children in foster care are placed with relatives or kin, but more work needs to be done to license and support these placements
- Contracts awarded to 2 providers for Kinship Navigator pilot projects starting October 1, 2019
- This legislative session, LB 328 was introduced which would have implemented the FFPSA into state statutes and, among other things, included some due process protections as well as rights and supports for kin caregivers and parents
    - Bill did not advance, but remains in Committee and could be reconsidered next session

FFSPA Implementation Work Streams

Congregate Care Reform

- QRTP Licensing
- Building out exceptions for special populations

Community Based Supports

- **Kinship Care**
- **Community Based Mental Health Services**

Prevention

- Restructuring Front Door Access (SCI, Homelessness Partnerships)
- Behavioral Healthcare Supports for Parents (HB 230, residential stays, MST)

New Mexico:
Kinship Care – Specific Steps We Can Take

Dedicated Staffing

Creation of our first ever kinship care director and a dedicated ICWA unit – to help children who cannot remain with parents stay in their communities with kin.

Family Finding – More than asking

Bringing in outside support to develop real Family Finding – technology that helps us locate kin and training on engagement methodologies to help create permanent connections

Funding + Behavioral Healthcare Supports

Increased funding for grandparents helping grandchildren – including closing the subsidized guardianship loophole + leveraging $ for JJ youth – and dedicated mental health supports for youth in kin placements

Revising Licensing Standards

Based on Generations United and ABA Center on Children and the Law survey of foster care licensing standards to align New Mexico with national best practices.

California:
Key Decision Regarding Kinship Caregivers

How can we continue and advance the work started through Continuum of Care Reform?

- Ensure kin families are prioritized placement who have immediate and equal access to funding, supports and services
- Child-specific approval for kinship caregivers and extended family members who are unable to be approved as a resource family to care for any child
- Investments in up-front family finding and retention

Can we get clarification from the feds to allow us to utilize VPAs for kin while also claiming IV-E prevention dollars to help rehabilitate the parent so the child can return home?

- Voluntary placement with kinship would allow kin placements to access necessary supports and services while also providing prevention services mainly targeted at the parents.

Restrictions on Use of Congregate Care

Overview of Congregate Care Changes

With respect to congregate care, FFPSA primarily:

- Changes the list of valid placement types for federal payment “beginning with the third week for which foster care maintenance payments are made on behalf of a child”
- Creates a new placement type called a Qualified Residential Treatment Program (QRTP)
- Defines who QRTPs may serve and the types of services that they must offer to children and youth in care
- Places numerous requirements on QRTPs to be eligible for federal reimbursement, including nurse/clinical staffing, trauma informed models of care, post-discharge planning and support, accreditation, etc.
- Sets forth requirements on when and how children are to be assessed for placement in QRTPs, and who may do it

Placement Types Eligible for IV-E Funding

- FFPSA cuts off federal IV-E funding after two weeks for children who are placed in congregate care programs, with four exceptions:
  - "Qualified residential treatment programs" (QRTPs)
  - Specialized settings for pregnant or parenting youth
  - Transitional housing programs for youth 18 and older
  - Programs providing support services to CSEC youth
- Limits the number of children that can be served in a "foster family home" to six, unless the home:
  - Allows parenting youth in foster care to remain with their children
  - Allows siblings to live together
  - Allows a child with a meaningful relationship with the family to remain with the family
  - Allows a family with specialized skills to care for a child with a severe disability

	QRTP (federal law)
Eligible youth	"Children with serious emotional or behavioral disorders or disturbances"
Treatment/ staffing requirement	Licensed or registered nursing staff and other licensed clinical staff who are available 24 hours/7 days a week
Timeline for assessment	Assessment by a "qualified individual" must be completed within 30 days after placement is made, or federal funding will be cut off

	QRTP (federal law)
Who does the assessment?	"Qualified Individual" - trained professional or licensed clinician who is not an employee of the state agency and who is not connected to or affiliated with any placement setting in which children are placed by the state
Court Oversight	Within 60 days of a QRTP placement, juvenile court must: • Consider assessment by the qualified individual; • Determine whether the needs of the child can be met through placement in a family home or, if not, whether placement of the child in a QRTP provides the most effective and appropriate level of care in the least restrictive environment; and • Approve or disapprove the placement
Post-Discharge Support	QRTP must provide discharge planning and family-based aftercare support for at least 6 months post-discharge

QRTPs Classification by Center for Medicaid Services (CMS)

- Federal Center for Medicaid Services (CMS) does not allow “institutions for mental disease” (IMDs) to receive Medicaid funding for most institutional care for individuals under age 65
- IMDs are defined as any “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services”
- Since QRTPs (a new federal definition) are required to have 24/7 nursing staff and are only allowed to serve children and youth with “serious emotional or behavioral disorders or disturbances” there is concern that QRTPs may be defined as IMDs by CMS

Implications for Child Welfare Systems

- Since a DSM diagnosis may in many cases be required in order for a child to be served in a QRTP, child welfare systems must ensure that all children who face these underlying challenges are adequately screened and diagnosed.
    - Especially true for crossover youth who may have been served in the juvenile justice system.
- States need to consider strategies for recruiting and retaining foster families to serve a wide variety of needs.
- What happens if QRTPs are defined as IMDs?

Ohio – Key Congregate Care Decisions: IMD, PRTF, FFPSA, QRTP, and FFP... OMG

For the first time ever, FFPSA implementation will produce a national inventory of congregate care facilities that all may all meet the federal definition of "institution for mental disease" (if they have 17+ beds on a campus)

This exposure could cause the federal Medicaid agency (CMS) to broadly classify many QRTPs as IMDs

Classification as an IMDs "turns off" Medicaid's federal financial participation (FFP) within the facility and for the kids placed there, which could cause a funding crisis and lead to program closures

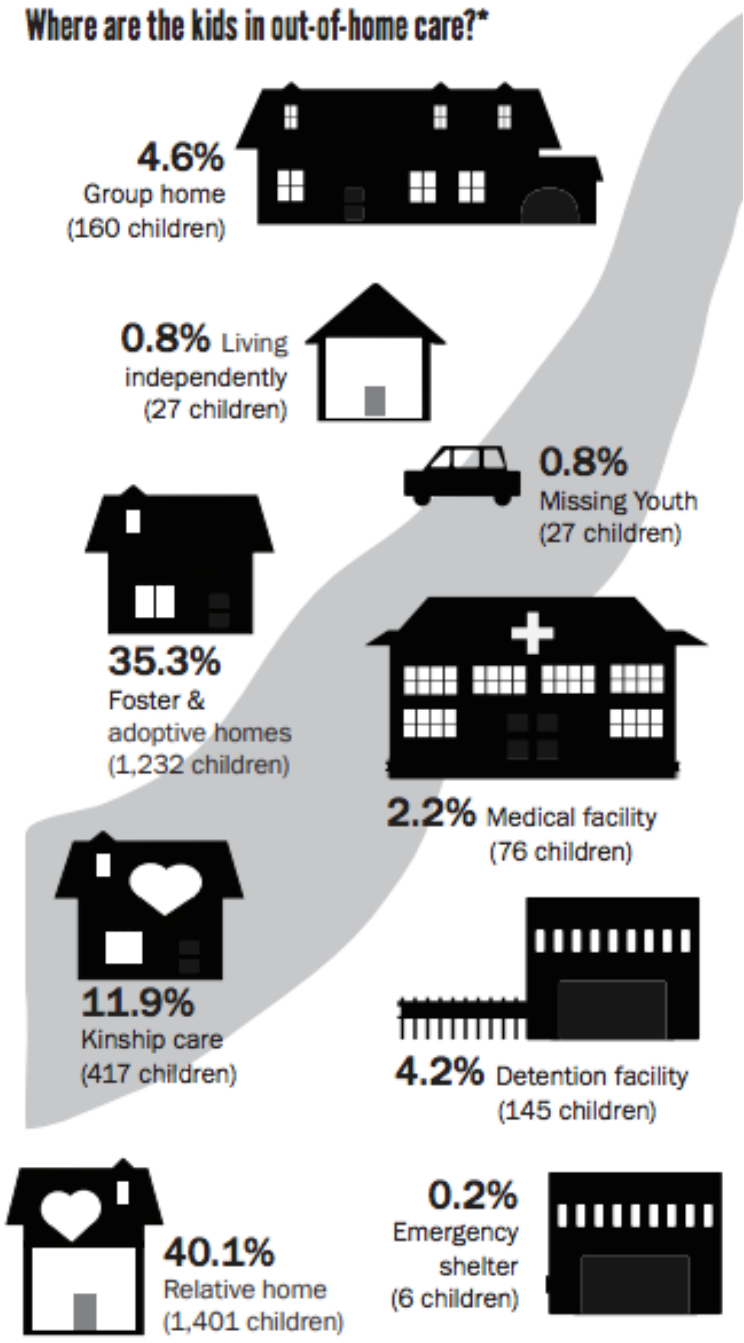
NOSAC is leading a national effort for Congress and HHS to exempt QRTPs from potential IMD classification

Meanwhile, Ohio and other states are exploring adding the Psychiatric Residential Treatment Facility (PRTF) option to their state Medicaid plans for cover and as a means to improve access to residential care

PRTF is a special designation used in about 17 states for congregate care facilities that exempts them from the IMD "no Medicaid" implication, so long as they comply with PRTF program standards, which requires a bit higher level of care than QRTP

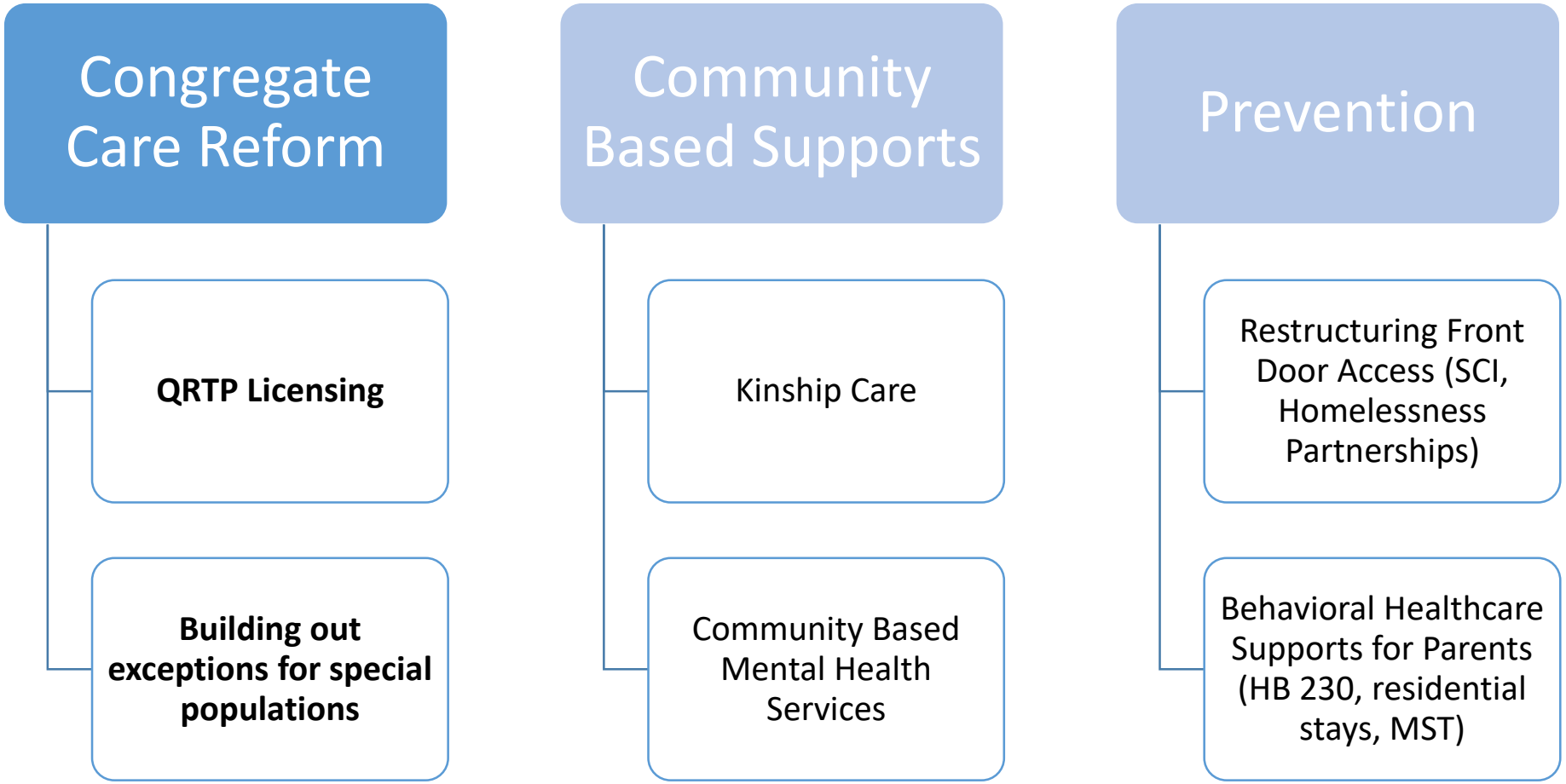
Nebraska Congregate Care

- Nebraska's congregate care rate is relatively low, but work is being done to meet QRTP requirements
- In NE, 59.6% of children in foster care were placed with relatives or kin, but more work needs to be done to license and support



Kids Count in Nebraska, 2018

FFSPA Implementation Work Streams



New Mexico: Building Community Based Mental Health Services

R&D Pilots

- Creating mental health services designed to prevent institutionalization
- Time limited, intensive, strength-based, community-located
- Behavioral support to prevent institutionalization
- Examples include therapeutic behavioral service (TBS), wraparound, and MST.

Data Driven Decisions

- Rolling out CANS with ACES subpart for all youth to drive services, referrals, placements, and rates
- CSE-IT
- Differential Response, Structured Decision Making

California Key Decision Points: QRTPs

Evaluate existing eligibility criteria and any potential changes needed to conform with FFPSA	Avoid unintended consequences of youth ending up in higher levels of care
Who will be the qualified individual?	IPC or individual? If individual, somebody from DMH or placing agency? Do we need to pursue a waiver (given restrictions that qualified individual cannot be associated with placing agency)?
CFTs vs. permanency team requirements	Amending statute and/or policy to conform with new requirements
Court hearing	Does it fit within existing hearing or do we need a new hearing? Is hearing required every time a child is moved or only the first placement in a QRTP?
Nursing requirements – how to structure it so not cost prohibitive and won't cause effective programs to shut their doors	

California Key Decision Points: Specialized Placements for CSEC and EPY

- Will CA develop additional, non-family placements to support EPY or CSEC youth? Two of the exceptions to restrictions on congregate care include:
  - Specialized settings for pregnant or parenting youth
  - Programs providing support services to CSEC youth
- What circumstances would we want to develop additional types of housing for EPY or CSEC youth?
- Criteria for determining when a youth needs a specialized placement setting versus family setting?
- What program models can be developed to support these populations?

California: What Does it Take to Create Alternative to Congregate Care and Invest in Foster Parent and Recruitment and Retention?

California's Continuum of Care Reform (CCR)

- $130 million in investments just for foster parent recruitment and retention in 3 years
- Total investments of **over $800 million state general fund in last three years** to revise approval system, rate system, child and family teams, equalize supports for kin, and foster parent recruitment and retention

Family First

- $8 million, one-time investment to be distributed across 50 states to recruit and retain foster parents
- No efforts to develop specialized foster homes as an alternative placement for high-needs youth

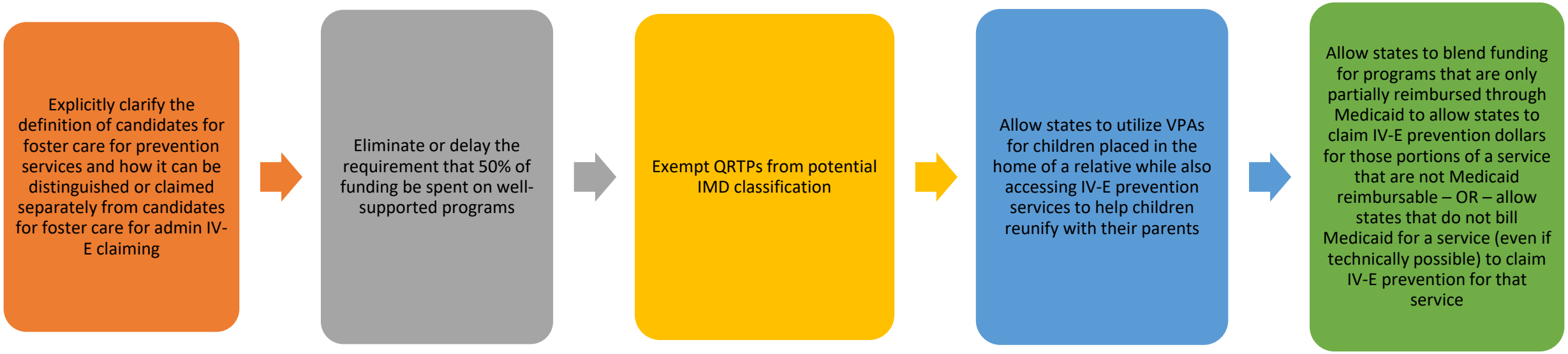
California: Potential Impact of IMD Issue

If QRTPs are considered IMDs, children and youth would not be eligible for Medicaid reimbursement for their medical and mental health treatment while residing in these placements – which would seriously jeopardize their care

In California, this could impact up to **50 residential care programs** that have more than 16 beds

Almost **2,400 California children** could be impacted – about half of the children and youth in residential care in the state

Closing Reflections: Ways to Enhance FFSPA to Allow States to Achieve the Vision of the Reform



Questions?

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