THE STEPHEN GROUP

NEBRASKA TREATMENT FAMILY CARE AND FOSTER CARE RATE ANALYSIS

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THE STEPHEN GROUP

Nebraska Treatment Family Care and Foster Care Rate Analysis

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2. Executive Summary

The Nebraska Department of Health and Human Services, Division of Children and Family Services (DCFS) engaged The Stephen Group (TSG) to evaluate three recommendations by the Foster Care Reimbursement Rate Committee (FCRRC) regarding adding a fourth level of reimbursement for high needs children, adopting the Nebraska Caregiver Responsibility tool and adopting the Treatment Family Care service definition and rate setting structure.

In evaluating these recommendations, TSG interviewed numerous DCFS staff, providers, FCRRC members and other stakeholders. TSG also reviewed historical and real-time data, Nebraska regulations and recent reports and analyzed best practices in other states and survey results.

After completing these evaluations, the following report offers these analyses of the FCRRS recommendations.

2.1. Adding a Fourth Level of Reimbursement for High-Needs Children

DCFS should consider establishing a level of care between the existing Intensive and recommended Specialized tiers. We found that fewer than 10%, or roughly 200 children, meet the criteria of high needs. Additionally, existing children receiving services through Letters of Agreement (LOA) were doing so at a level below the rates proposed by the FCRRC.

We found that the LOA process is ad hoc, and crisis driven, which has unnecessarily driven up costs. DCFS also has no standardized process to identify when to use a LOA or what the specific expectations are for care for children receiving service at this level.

Given all the aspects within the existing LOA structure that would lead to higher costs for the state, and that LOA costs are still below the proposed Specialized tier, a new tier, slightly below the existing LOA average, with clearly defined expectations of care and a standard process, would achieve the goals of better care for high needs children, fewer LOAs, removing barriers to permanency while reducing state costs.

Moreover, in adding an additional level of care, DCFS should work carefully to ensure all criteria are clearly established to ensure compliance to receive federal reimbursement. This consideration should drive the development of the methodology for creating this level of care.

2.2. Adopting Nebraska Caregiver Responsibility (NCR) tool

The NCR would benefit by conducting a normative scoring process to assure the instrument is valid for the purpose of assigning levels of care. Currently, the tool delineates level of effort on the part of the parent, without addressing the clinical needs of the child and treatment plans and available coverage options for parental education and use are not currently attached to the NCR. Harmonizing these two components would lead to better outcomes for children.

TSG strongly recommends that an independent standardized Evidence-Based assessment process and instrument for behavioral health needs and services covered by Medicaid be implemented. This approach would offer standardized assessments that would inform decision-making over the arc of a child's engagement with DCFS and would identify progression (or regression).

Additionally, there should be regular audits to ensure fidelity to the NCR for staff and supervisors. This would support consistent application of the tool and help support identifying the appropriate level of care for children.

2.3. Adopting Treatment Family Care Service Definition and Rate Setting Structure

The FCRRC's recommendation to adopt a Treatment Family Care model is sound. However, there are improvements that DCFS should integrate into the adoption of Treatment Family Care. This should start by identifying and implementing best practices from states that have seen success in implementing similar models. This report includes a number of best practice models nationally for DCFS to consider during this process.

Utilizing best practices in adopting Treatment Family Care would provide additional service definition criteria, clear expectations of providers and foster parents, enhanced training and accountability, education and outreach on covered Medicaid benefits, enhancement to the Medicaid service delivery system, cross agency data integration, continued division collaboration, and a continued focus on removal of barriers to permanency.

2.4. Additional Findings Recommended for Further Review

1) TSG found that existing maintenance per diems are established based on a rational approach and sound methodology and appear to be reasonable in nature. Also, administrative support rates fall within an expected range.
2) Nebraska is not claiming Title IV-E reimbursement for many expenditures related to LOAs. Such expenditures should be considered reimbursable if a child is placed in a child welfare licensed placement and is determined to be categorically eligible under Title IV-E requirements.
3) The Eastern Service Area serves statistically fewer youth at the Essential Level of Care and a higher number of children and youth at the Intensive Level of Care. While there may be many reasons for this, the discrepancy (24% at the highest levels of care versus 10% for the rest of the state) warrants additional investigation.
4) DCFS has done an extraordinary job over the past few years in significantly decreasing DD out-of-home foster care placements, reducing that number by over 35%.

5) TSG observed that there appears to be a fundamental lack of understanding of the Medicaid Managed Care system in the child welfare community and how to access the benefits and providers the MCOs provide.
6) TSG heard from providers that a covered Medicaid in-home behavioral health service and benefit for high needs children that was adopted by the FCRRC and made as part of their array of essential Treatment Family Care Medicaid Services – Community Treatment Aide – is often not available in Nebraska, even though this Medicaid benefit is required to be part of the Medicaid Managed Care Organization's service network. A review of Medicaid claims data for a four year period, from 2017 to 2020, identified that 51 foster care children out of 7,599 total foster care children with Medicaid claims during this time period, or .67% had claims for Community Treatment Aide (CTA).
7) In analyzing the intersection of DCFS, DMLTC, DPH, DBH and DDD, TSG found that each one of these agencies has its own eligibility system, assessment tools, and funding mechanisms and that there is no integrated case record that could be provided to a multi-disciplinary team responsible for their care with accurate, consistent, actionable information that can be utilized proactively in the placement and treatment process.
8) TSG found DCFS is competing with other Nebraska government entities for beds in the homes of community-based providers, which can allow bidding wars between multiple state agencies, driving up the cost of care.
9) The use of antipsychotics and antidepressants in the child welfare population is not based on a standardized prescription practices model.

3. Scope

The Nebraska Department of Health and Human Services (DHHS) Division of Children and Family Services (DCFS) contracted with The Stephen Group (TSG) to evaluate specific recommendations made by The Foster Care Reimbursement Rate Committee (FCRRC) of the Nebraska Children's Commission (Commission) to the Commission and the Health and Human Services Committee of the Legislature on June 22, 2020.

TSG evaluated the following FCRRC recommendations:

- The development and implementation of a fourth tier of reimbursement for specialized caregiving for children who have exceptional medical, behavioral, or developmental needs which necessitate extenuating caregiving responsibilities.
- The FCRRC recommended DHHS, Saint Francis and Tribal Courts adopt and implement the use of the revised Nebraska Caregiver Responsibility (NCR) Tool. The FCRRC's Nebraska Caregiver Responsibility assessment tool modifications reflected the uniqueness of the specialized level of responsibility and the needs of children and their caregivers achieving permanency through adoption or legal guardianship.
- The FCRRC recommended DHHS Divisions of Medicaid and Long-Term Care and Children and Family Services adopt the recommended Treatment Family Care service definition and rate structure contained in the Report.

In evaluating these three FCRRC recommendations, TSG focused its evaluation on the following questions:

1. Are the FCRRC's recommendations the best strategies and process for Nebraska to meet the needs of the target population(s) to lead to better outcomes and increased permanency?
2. Do the FCRRC's recommendations take into consideration the most important implementation factors facing Nebraska and is the current "Single Agreement" process the most efficient and cost-effective method to build a system of care and wrap-around for the target population(s)? If not, have other states come up with more effective models to achieve improved outcomes at reasonable costs?
3. Are there lessons learned or gaps identified that other states have taken into consideration in rolling out similar models to achieve design, implementation, and outcomes success; and,
4. Are there improvements that can be made to the recommended structure, model, rates, tools, and service definition and process that could improve outcomes, including outcomes related to essential Medicaid services that are a critical part of the new Treatment Family Care overlay.

4. Methodology

As part of this project, TSG conducted a detailed literature review, stakeholder engagement, state-by-state best practice survey, and Nebraska-specific data analysis, culminating in a report to DCFS detailing significant objective findings and realistic actionable recommendations.

TSG was also able to review and analyze Medicaid data for high needs children, particularly related to Medical, Behavioral Health and Pharmacy claims. This analysis also provided insight into important Medicaid utilization, access, and network capacity issues that will be important for both DCFS and the Division of Medicaid and Long-Term Care (DDMLTC) to consider in adopting or further modifying the FCRRC recommendations going forward.

TSG worked with DCFS to collect available documentation and data including from DHHS sister agencies and stakeholders interviewed. In addition, TSG conducted independent research specific to Nebraska's current health and human services landscape and identified applicable child welfare best practices from TSG's national expertise. TSG utilized the following tactics in drafting this final report:

1. Review of FCRRC Decision-Making Criteria and Information
    - Interviewed FCRRC members;
    - Reviewed FCRRC reports and meeting minutes dating back to 2014;
    - Analyzed survey results.
2. Nebraska Regulatory Analysis
    - Reviewed LB 541 including history, related FCRRC legislation, and amendments;
    - Reviewed DHHS agency regulations, including: DCFS, Medicaid State Plans, Medicaid Managed Care Organization contracts, DD, and BH.A
3. Literature Review
    - Reviewed more than 100 Nebraska-specific reports, many provided by DCFS.
4. Data Review
    - Reviewed DCFS level-of-care, placement, and Letters of Agreement (LOA) data.
    - Reviewed and analyzed Medicaid claims data for foster care children and youth
5. Stakeholder Engagement
    - Regular cadence of project meetings with DCFS;
    - Conducted 13 structured interviews, including: FCRRC members; DHHS Agency Staff (DCFS, DBH, DD, DMLTC); Probation and Court Improvement Project Administrator; child welfare providers (KVC, Omni, St. Francis Ministries); and associations (Child Saving Institute, Nebraska Foster and Adoptive Parent Association)

6. Multi-State Best Practices Research and Analysis

- Reviewed criteria including Title IV-E agency practices, foster care levels of care and rates, Medicaid system opportunities specific to children in foster care and multi-system youth including Managed Care Organization (MCO) contracts.
- Incorporated findings from Child Trends and other national state by state foster care rate reviews.
- Incorporated findings from Florida, Georgia, Kentucky, Texas, Ohio, Michigan, and Washington, related to their Therapeutic Foster Care models.

5. Assessment Findings

5.1. Findings Related to the Recommended Specialized (4th Tier) Level of Care

5.1.1. Title IV-E Maintenance and Administrative Support Rates: Federal Requirements

When implementing any Title IV-E rate setting system, a structured payment process for Child Placing Agencies must be carefully established as it will be eventually used to claim federal reimbursement. As a result, there are multiple factors that must be considered when developing the methodology. This section briefly describes some key points related to Title IV-E, the federal funding source for foster care maintenance and administrative costs.

Research completed in the development of this report found that every rate setting system reviewed cited federal guidance around cost standards and indicated their approach to rate setting was firmly grounded in these standards. To meet federal requirements, cost must be considered "reasonable" in nature. A "reasonable" cost is identified within *OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.* Within the confines of OMB guidance, costs must be:

- allowable,
- reasonable, as defined above, but;
- must also be appropriately "allocated" to all benefiting programs or services; and
- be net of any applicable credits.

Federal documents offer the following guidance surrounding the allocation of costs to program or service and applicability of credits:

"Allocable costs.

a. A cost is allocable to a particular cost objective, such as a grant, contract, project, service, or other activity, in accordance with the relative benefits received. A cost is allocable to a Federal award if it is treated consistently with other costs incurred for the same purpose in like circumstances and if it:
    1) Is incurred specifically for the award.

2) Benefits both the award and other work and can be distributed in reasonable proportion to the benefits received, or
3) Is necessary to the overall operation of the organization, although a direct relationship to any particular cost objective cannot be shown.

b. Any cost allocable to a particular award or other cost objective under these principles may not be shifted to other Federal awards to overcome funding deficiencies, or to avoid restrictions imposed by law or by the terms of the award."

"Applicable credits.

a. The term "applicable credits" refers to those receipts, or reduction of expenditures, which operate to offset or reduce expense items that are allocable to awards as direct or indirect costs. Typical examples of such transactions are purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds, and adjustments of overpayments or erroneous charges. To the extent that such credits accruing or received by the organization relate to allowable cost, they shall be credited to the Federal Government either as a cost reduction or cash refund, as appropriate.
b. In some instances, the amounts received from the Federal Government to finance organizational activities or service operations should be treated as applicable credits. Specifically, the concept of netting such credit items against related expenditures should be applied by the organization in determining the rates or amounts to be charged to Federal awards for services rendered whenever the facilities or other resources used in providing such services have been financed directly, in whole or in part, by Federal funds.

Title IV-E Administrative (Support) Payment

Federally Allowable administrative costs under title IV-E are defined in 45 CFR 1356.60(c)(2) as those "*costs necessary for the administration*[1] *of the foster care program:*

1. *Referral to services;*
2. *Preparation for and participation in judicial determinations; Placement of the child;*
3. *Development of the case plan;*
4. *Case reviews;*
5. *Case management and supervision;*
6. *Recruitment and licensing of foster homes and institutions;*
7. *Rate setting;*
8. *Proportionate share of related agency overhead;*
9. *Costs related to data collection and reporting.*"

[1] "Administration" in this context must be differentiated from "administrative costs" and is federally defined as those activities required to "execute the state Title IV-E Plan

Administrative Payments related to the cost of social services, including counseling and therapy, may not be part of the Foster Care Maintenance or Administrative Payment.

Social Services Payment

Allowable administrative costs do not include the cost of social services provided to the child, the child's family or foster family that provides counseling or treatment to ameliorate or remedy personal problems, behaviors, or home conditions. "Social services" are not allowable as maintenance payments under any circumstances, regardless of what type of person provides them. Examples of unallowable "social services" are: counseling and therapy to help with a child's adjustment at the institution; counseling and therapy to help a child resolve the problem(s) for which he or she was placed; counseling and therapy with the child and his or her biological family to resolve the difficulties that led to the need for placement; counseling and therapy to plan for the return of the child to the community; and psychological or educational testing, evaluation, and assessment.[2]

The Social Services portion of cost is subject to an allocation of staff and agency administration costs. In many jurisdictions this is determined through an annual time study. As with all items of care and for costs of administration and operation, the critical factor is the activity being performed and not the title or position of the performer.

Maintenance Payment

Though maintenance payments (payment to the foster parent for daily care and supervision of the child) are paid separately, it is important to have a complete understanding of what these costs include. In any rate setting methodology established for CPAs, those costs related to foster care maintenance must be separated from the "administrative payment" made to the CPA. The term "foster care maintenance payments" means payments to cover the cost of:

1. Food,
2. Clothing,
3. Shelter,
4. Daily supervision,
5. School supplies,
6. A child's personal incidentals,
7. Liability insurance with respect to a child,
8. Reasonable travel to the child's home for visitation, and
9. Reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement. [3]

[2] Federal Administration for Children and Families; Children's Bureau Child Welfare Policy Manual
[3] Social Security Act Sec. 475 (4)(A), [42 U.S.C. 675]

As stated in the legislative history of P.L. 96-272, "*payments for the costs of providing care to foster children are not intended to include reimbursement in the nature of a salary for the exercise by the foster family parent of ordinary parental duties*."[4] Therefore, basic maintenance payments to foster parents are intended to reimburse foster parents for the cost of those items listed above (food, clothing, shelter, personal incidentals, travel, and school supplies.)

Although Congress did not intend that salaries be paid under title IV-E to foster parents for ordinary parental duties, "daily supervision" is one of the items included in the definition of "foster care maintenance payments" in section 475(4) of the Social Security Act.[5] Since foster care maintenance payments are not salaries, foster parents must often work outside the home and a foster family parent who is working while a foster child is not in school will have to arrange for some form of alternate care, such as day care, for the daily supervision of the child. As a result, daily supervision" in family foster care may include the cost of childcare. Therefore, according to the Code of Federal Regulations (CFR 1355.20), daily supervision includes the cost of licensed childcare[6] when:

- Work responsibilities preclude foster parents from being at home when the child for whom they have care and responsibility in foster care is not in school, and
- The foster parent is required to participate, without the child, in activities associated with parenting a child in foster care that are beyond the scope of ordinary parental duties, such as attendance at administrative or judicial reviews, case conferences, or foster parent training.

Further, certain categories of children, including those with physical or emotional disabilities, may require more day-to-day supervision and attention than those without such conditions. Therefore, a supplement to the basic maintenance payment for a particular child is justified when the child has greater than usual needs for the items included in the definition, as determined by the State agency.[7]

5.1.2. Child Placing Agencies: Rate-Setting Models in Other States

Models for other states were reviewed to determine whether there were features or functionality which should be considered when developing a payment structure for administrative rates paid to child placing agencies. Methodologies were reviewed for ease of

[4] p. 5, House of Representatives, Report No. 96-900, April 23, 1980.
[5] Federal Administration for Children and Families; Children's Bureau Child Welfare Policy Manual
[6] The State of Nebraska pays the cost of childcare independently of the foster care per diem rate when the foster parent meets eligibility critiera.
[7] Federal Administration for Children and Families; Children's Bureau Child Welfare Policy Manual: https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp_pf.jsp?id=8

use, application of cost limits / determination of reasonable costs, whether the issue of "profit" is addressed, and audit requirements. In some cases, reports were designed to simply capture costs – the methodology to establish rates in these cases was not always clear or transparent to the provider. Other reports clearly captured costs and included a methodology to allocate costs into activity areas related to child placing agencies.

In reviewing rate models and approaches, TSG looked to materials and information from:

- California,
- Ohio,
- Wisconsin,
- Michigan,
- Indiana,
- New York,
- Kentucky,
- Illinois, and
- North Carolina.

Information regarding the processes and components used to establish provider rates in these states is included in Appendix A.

Considerations and Barriers in Reviewed Rate Setting Systems

Several factors were identified as playing a role in the validity of rates established when implementing a cost-based reimbursement system:

- **Rates sufficient to cover the cost of service:** In many instances, rate processes reviewed have not historically covered the full cost of service. In some cases, such as California, this is because rates were not updated or adjusted frequently enough. In other cases, such as Indiana, such an occurrence may be a byproduct of the rate setting process as retroactive costs and service units are used to establish prospective rates.
- **Frequency:** Frequency across methodologies varied, not only in terms of reporting intervals, but also in terms of establishing rates. In some states, cost reports are submitted annually but not used to establish rates with any regularity.
- **Cost adjustments and rate modifications:** Rates set using historical costs or applied to a multi-year period should be adjusted for changes to the cost of providing services or Cost of Living (COLA). A COLA should be based on available data and applied to cost or rates in a manner that aligns them with the time period the rate will be paid. If the rate covers multiple years, applying a COLA at regular intervals is acceptable and reasonable.

- **Variability in rates from period to period**: When rebasing payment rates on actual costs and utilization frequently, a variance in payment rates between time periods may result in excessive variability in payment. This may have a negative impact on the provision of quality services and create animosity between the paying agency and CPA. Some state associations recommend that three-year average be applied for the census calculation in each cost report, with the exception of cost reports for new programs and for those providers who have justification to request an administrative review based on the provider's unique circumstances.
- **Determination reasonable costs**: The definition of reasonable costs is federally established and gives considerable discretion to the paying agency within guidelines set by the federal government. Decisions regarding the establishment of reasonable costs are policy decisions and are not a function of the cost report itself. "Reasonable costs" are typically defined as, those a prudent person would incur in a similar circumstance. Given this, different rate methodologies have established various upper-end caps or limits to ensure cost is reasonable in nature. Caps vary across the methodology from almost non-existent, to fairly restrictive. Caps are most typically applied to:
    - Agency administration including executive leadership, finance and accounting, human resources, information technology, and overhead.
    - Fringe benefits (limited to a percent of reported salaries),
    - Indirect costs (definitions of indirect costs vary considerably),
    - Staffing-ratios may be considered in rate-setting methodologies. The application of such caps may be prudent in some situations but must be carefully constructed in order to not negatively impact case supervision, recruitment and other client-based activities provided by the CPA.

5.1.3. Nebraska's Current System of Rates to Include Recommended 4th Tier

Nebraska's foster care Title IV-E Maintenance and Administrative rates are established by a statewide committee representing stakeholders, foster parents, advocates, and providers. In developing their approach to setting rates, the committee looked to surrounding states to identify best practices and establish a comparative baseline. Given variances between states in provider contractual expectations, established age-ranges for children, and disparity in service criteria, the committee did not determine that any one state offered a valid, reliable standard against which the methodology could be directly compared. Based on their research, internal discussion, and concurrence among members, the committee has established a reasonable approach to establishing both administrative support and maintenance rates for three primary levels of care funded by the state and the recommended "Specialized" level of care.

Nebraska Foster Care Maintenance and Administrative Rates

Current foster care maintenance and administrative support rates are rates for the coming two years (July through June) are depicted in the chart, below. Rates will increase by two percent (2%) in July 2021 and July 2022. Current year rates are used for each of the analyses presented in the following sections.

		7/1/20 - 6/30/21	7/1/21 - 6/30/22	7/1/22 - 6/30/23
Foster Care Maintenance				
Essential	Age 0 - 5 years	$20.81	$21.23	$21.65
	Age 6 - 11 years	$23.93	$24.41	$24.90
	Age 12 - 18 years	$26.01	$26.53	$27.06
Enhanced	Age 0 - 5 years	$28.61	$29.18	$29.76
	Age 6 - 11 years	$31.73	$32.36	$33.01
	Age 12 - 18 years	$33.81	$34.49	$35.18
Intensive	Age 0 - 5 years	$36.41	$37.14	$37.88
	Age 6 - 11 years	$39.54	$40.33	$41.14
	Age 12 - 18 years	$41.62	$42.45	$43.30
Agency Supported Foster Care				
Essential Level		$22.64	$23.09	$23.55
Enhanced Level		$29.30	$29.89	$30.49
Intensive Level		$40.33	$41.14	$41.96

Title IV-E Maintenance Rates

Maintenance rates were based on USDA expenditure data with increases added at each level of care to compensate for the foster parent's need to provide additional supervision and care of the child. A fourth level, Specialized, was recommended by the committee in the past year. This rate was added to match rates paid by the private provider in the Eastern Service Area (ESA) and the Department of Juvenile Justice. Maintenance rates established by the committee are depicted in the following table:

Age	Essential	Enhanced	Intensive	Specialized (New Level)
0-5	*$22.26*	*$29.76*	*$37.26*	*$77.75*
6-11	*$26.06*	*$34.56*	*$42.06*	*$82.55*
12-18	*$28.73*	*$36.23*	*$44.73*	*$84.22*

While Nebraska's rates are not equivalent to those established by other states due to variances in level of care service definitions and variances in age ranges, the overall range (low to high) of

rates calculated by the committee appear to be reasonable in nature when compared to other jurisdictions.

For example, the state of Indiana's rates are based on a study of foster parent expenditures completed by Ball State University[8]. The University determined that both common sources, USDA Expenditure Data and the M.A.R.C. (MARC) Study, used to calculate foster per diem payments present certain limitations which can lead to misrepresentations in the calculation of the per diem. As a result, the university determined their approach, "*represents the most comprehensive analysis of costs associated with foster child care to date. The approach is designed to capture true incremental costs of foster care that are allowable under Title IV-E of the Social Security Act, with particular attention to disaggregation of individual cost elements. This permits varied uses of the data in the administration and management of foster care and related services".* Since completion of the study in 2011, rates have been adjusted regularly by the State to account for inflation and the increased cost of living. Presently, foster parent per diems paid by the State of Indiana are as follows:

Age	Foster Care	Foster Care with Services	Therapeutic Foster Care	Therapeutic Plus
0-4	*$21.59*	*$29.36*	*$41.50*	*$65.25*
5-13	*$23.44*	*$31.17*	*$43.31*	*$67.06*
14-18	*$27.05*	*$34.72*	*$46.86*	*$70.61*

In addition, current rates in Ohio and Texas are in the following ranges:

- Texas: $27.07 to $92.43 / day
- Ohio[9]: $34.45 – $73.69 / day

In addition, TSG compared Nebraska's rates to national averages to assess the reasonability of rates established by the committee. In doing so, TSG reviewed multiple sources and ultimately relied on *Basic Foster Care Rates* from a 2012 report published by ChildTrends examining national foster care rates. As their report was published in 2012, TSG adjusted their calculations through the application of a 2% annual COLA. The following table provides an adjusted average of nationally "Basic" foster care per diems calculated by ChildTrends by age of child. Rates at higher levels of care are based on the variance between Nebraska's existing levels of care. Please note, the following levels of care may not directly coincide with Nebraska's established levels. As such, they are simply intended to be a comparative analysis against which Nebraska's current rates may be assessed for reasonability.

[8] 2001, Ball State University, Foster Care Cost Survey of Indiana, https://www.in.gov/dcs/files/SurveyMethodReport081611.pdf
[9] Ohio rates based on average per diem payments made by Child Placing Agencies, as reported to ODJFS at assessed levels of care.

	Basic	*Mild Therapeutic*	*Therapeutic*	*Therapeutic +*
Age 0-2	*$26.54*	*$39.05*	*$69.81*	*$125.96*
Age 3-5	*$27.28*	*$39.33*	*$70.10*	*$126.24*
Age 6-8	*$29.97*	*$42.02*	*$72.79*	*$128.93*
Age 9-11	*$31.05*	*$43.10*	*$73.86*	*$130.01*
Age 12-14	*$32.60*	*$44.66*	*$75.42*	*$131.56*
Age 15-17	*$33.15*	*$45.20*	*$75.96*	*$132.11*

On average, ChildTrend's report determined that states paid an average of 70% to 76% of the expected per diem. Applying this factor to the calculated rates generates the following estimates.

	Basic	*Mild Therapeutic*	*Therapeutic*	*Therapeutic +*
Age 0-2	$20.52	$32.57	$63.33	$119.48
Age 3-5	$20.73	$32.79	$63.55	$119.69
Age 6-8	$21.88	$33.93	$64.69	$120.84
Age 9-11	$21.73	$33.78	$64.55	$120.69
Age 12-14	$23.80	$35.85	$66.61	$122.76
Age 15-17	$24.20	$36.25	$67.01	$123.16

Given this research, TSG finds there is no single best practice identified against which Nebraska's Title IV-E Maintenance per diems can be assessed. Instead, we compared the calculated rates to ranges across multiple states. In this, we find rates calculated by Nebraska's Rate Committee to be reasonable and within expected ranges for each level of care. We recommend the Committee continue their work and monitor these rates on a regular basis to ensure they appropriately reimburse foster parents for their level of effort and commitment to children placed in their care.

Title IV-E Administrative Support Rates

Administrative support rates are based on required staffing levels within three primary categories, case management, supervision, and recruitment/licensing. Staffing ratios and average salaries for each position have established for each level of care and are used to calculate a daily direct staff cost. To this cost, fringe benefits, overhead and a Cost-of-Living Adjustment (COLA) have been added to arrive at the daily administrative payment rate. As shown in the following table, rates for each of the primary levels of care have been established based on agreed upon staffing ratios and salaries. Given an approximate distribution of children by Level of Care (LOC) (based on the NCR Tool) over an extended period of time, the average administrative rate paid by the state is $30.08.

Level	Rate	Approximate % @ LOC	Weighted Rate
Essential	*$26.92*	*60.26%*	*$16.22*
Enhanced	*$32.16*	*28.44%*	*$9.15*
Intensive	*$41.73*	*11.30%*	*$4.72*
Specialized	*$78.95*	*N/A*	*N/A*
Blended Daily Rate	-	***100%***	***$30.08***

As with Nebraska's Title IV-E Maintenance Rates, the comparison of administrative support rates paid by Nebraska to child placing agencies proves difficult due to variances in service definitions, contractual expectations, and established levels of care. With this in mind, TSG looked to several states (Indiana, Minnesota, and Ohio) to determine whether Nebraska's rates appear reasonable in relation to service expectations established by the state.

These states were selected because cost data is collected annually from each contracted provider and administrative reimbursement rates are established based on the allowability of these expenditures under Title IV-E.

The limitations of this approach are based in variances to the contractual expectations placed on the child placing agencies and the acuity of children placed through these agencies. For instance, Indiana primarily uses child placing agencies to work with foster parents and children of higher need and acuity. The state internally recruits, licenses, and manages a significant number of foster homes to care for children at a "basic" level of care who don't require high levels supervision, behavioral supports, or therapeutic treatment. The State of Ohio permits child placing agencies to define individual levels of care for their programs, which leads to significant variability across the state. Within the context of these limitations, TSG sees the value in completing a comparative analysis to these states as their payments represent the actual cost of care provided by organizations in each state.

- **Indiana**: Indiana's rate methodology establishes a single administrative payment per provider regardless of the child's level of care. Across the thirty (30) providers operating in the state, these rates range from, $32.20 per day to $118.85 per day. Statewide, the administrative payment averages $55.02 per day of care. Again, this rate is likely higher than it would be if the private agencies handled all foster placements meeting the state's basic level of care. The state does not publish identifying data indicating whether individual providers care for youth of certain acuity or diagnosis. Therefore, a direct comparison to Nebraska's rates is not possible. Rather, this comparison is meant to assess whether Nebraska's rates appear to be reasonable and fall within an expected range of rates.

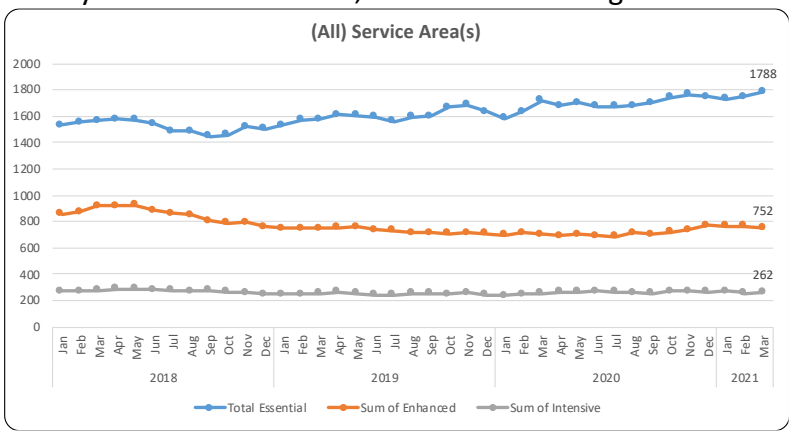
- **Ohio**: In reviewing Ohio's rates, TSG assessed levels of care identified by each agency and associated each with one of five presumed levels of intervention and child acuity. The average payments at each level were then blended using the percent of children typically placed at each level. Through this approximation, we calculated administrative support rates ranging from $35 per day at a basic level to $98 per day at the highest level of care. The calculated, blended administrative rate, for the state is approximately $39 per day.
- **Minnesota**: Though more difficult to assess due to the way statewide data was provided, 2020 rates paid to child placing agencies in the State of Minnesota ranged between the upper $20 to the mid $30 for basic levels of care and as high as mid $80 for therapeutic levels of care.

Based on our review of Title IV-E requirements, FCRRC's recommended rates at all levels of care, and a comparative analysis to cost-based rates calculated in other states, we find that rates established by the committee appear to be within the range expected for such services. In general, we find administrative support rates to be calculated on a rational methodology and to be generally reasonable in nature.

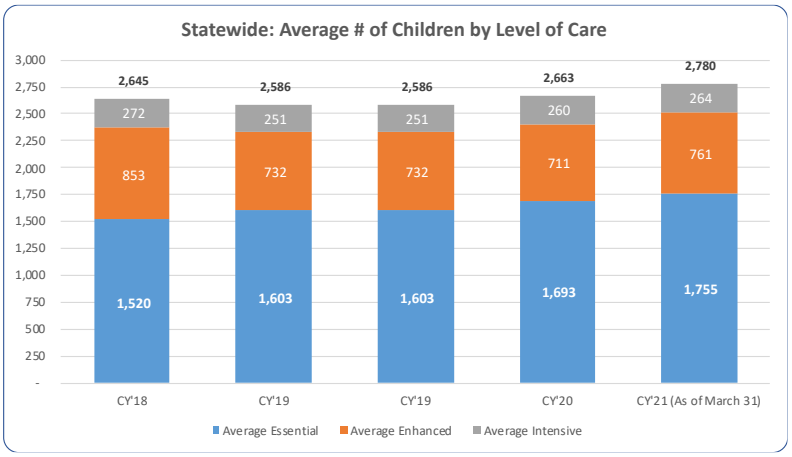
Finally, during TSG's interviews with child placing agency providers, several noted the need to "supplement" state payments with external funds in order to meet expenses associated with the operation of their child placing activities. It is recommended that the Rate Setting Committee continue to work diligently within its membership to continually assess staff ratios, direct expenditures, and administrative overhead percentages used to establish rates and determine whether they adequately reflect time and efforts associated with each Level of Care and compensate providers for the cost of services provided.

5.2. Findings Related to Data Analysis of High Needs Children and Youth in Foster Care

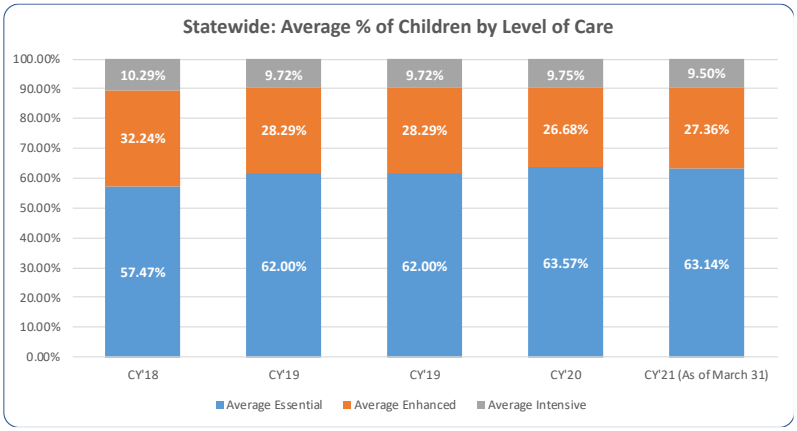
In any given month during the current calendar year across Nebraska, there are an average of 2,780 children and youth residing in the three (3) established levels of foster care. The distribution of children and youth across the three (3) levels of foster care has not changed substantively. At a statewide level, the percent of children determined to fall within each level of care has remained relatively stable over the past five (5) calendar years and no single level appears to be impacted disproportionately by the recent increase in volume.



As depicted in the following table, a comparison of the number and percent of youth in each level of care by Service Area illustrates a statistical dissimilarity of Level of Care determinations across the state using the Nebraska Caregiver Responsibility (NCR) Tool. (*The Chi-Squared statistic is 175.169. The p-value is 0.000. The result is significant at p < .05*)



While the Central and Southeast areas are statistically similar to each other as well as to the statewide average (*The Chi-Squared statistic is 1.493. The p-value is 0.837587. The result is not significant at p < .05*), we find that the Eastern Service Area serves fewer youth at the Essential Level of Care and a higher number of children and youth at the Intensive Level of Care. This variance is statistically significant when compared to the Statewide average (*The Chi-Squared statistic is 48,054. The p-value is 0.000. The result is significant at p < .05*)



	Average # Foster Youth Served Per Month (January – March 2021)	Essential	Enhanced	Intensive
Central	301	61.53%	29.93%	8.54%
Eastern	1,130	51.49%	34.24%	14.27%
Northern	563	77.75%	19.41%	2.84%
Southeast	484	62.88%	26.86%	10.26%
Western	302	81.55%	14.70%	3.76%
Statewide	2,780	63.14%	27.36%	9.50%

While there may be programmatic, geographic, or demographic reasons leading to these results, the variance is significant enough to warrant additional investigation and research surrounding the validity, consistency of use, and interrater reliability of the NCR.

5.3. Findings Related to Letters of Agreement for Specialized Rates

Specialized Letters of Agreement (LOAs) are sometimes used by DCFS, St. Francis and Probation where special agreements on rates are negotiated beyond the existing three original levels of care that require more exceptional, or specialized caregiving needs of children outside of the NCR and where there are a limited number of providers and foster caregivers to care for the children. As noted by the FCRRC in its June 22, 2020 Report, DHHS is in some cases "accessing a caregiver and network through the Enhanced Family Home model used by the DHHS Division of Developmental Disabilities" where "[t]he reimbursements range varies extensively."

Many of homes are unlicensed under child welfare and, as such are not reimbursable under Title IV-E. This results in significant fiscal loss to the state which would be mitigated through the use of DCFS licensed placements.

5.3.1. DCFS

DCFS staff and leadership acknowledged to TSG they do not have a standardized process outlining when the agency should enter into an LOA, including threshold criteria regarding children that would trigger consideration of an LOA's necessity. Thus, LOAs do not correspond to a given level of care. They are just what it takes to incentivize the agency and foster parent to take on the challenge of caring for children who require extensive, intensive supervision due to medical, behavioral, mental health diagnosis or other complex need. DCFS has previously tried to implement contracts with criteria such as SMI diagnosis, I/DD diagnosis, exceptionally aggressive or sexually acting out behavior, or exceptional medical needs, specific expectations of the caregiver, desired outcomes, or contract and quality monitoring. However, providers balked at the inclusion of such criteria and DCFS staff reported the current contract template was negotiated as a result. To its credit, DCFS leadership is currently working closely with its field staff and reviewing LOAs as well as a revised contracts to include criteria as described here.

As it currently stands, the template's only requirements of foster parents are to provide:

- Structured care and supervision;
- Basic needs;
- Family visits;
- Youth-specific plan of care to meet behavioral health and educational and vocational goals;
- Monthly written youth progress reports to DCFS worker.

The template's only requirements of DCFS and Probation regarding oversight and monitoring are to:

- Develop plan of care;
- Monitor plan of care through regular team meetings; and,

- Withhold payment if reports are not provided.

5.3.2. St. Francis

St. Francis currently uses a standardized form and process identifying criteria for specialized placement. St. Francis reported to TSG that they require specialized training through Omni Behavioral Services of their foster care parents for high-needs children. St. Francis reported five percent of the 1700 children in their care are placed above the Professional Foster Care rate. They indicate their goal for children at this rate is short term and often used for children discharging from or waiting for a congregate care placement. However, they also reported to TSG that they focus on "permanency from day one with these higher-level placements." The St. Francis service agreement indicates foster care homes must be licensed, but they acknowledged to TSG they do utilize non-licensed homes through the DD system when necessary.

5.3.3. Probation

Probation leadership indicated a very small percentage of children or youth on probation that are also in Foster Care are served through LOAs. They tend to utilize the DD Enhanced Family Homes when they need a higher level of care due to either the children's cognitive functioning or if they have been removed from other placements due to behavior. Probation negotiates these rates separately with each provider based on DD rate structure as posted and based on the specific needs of the child. Probation visits these single agreement homes on a monthly basis and describes their monitoring as continuous but not formalized. Probation reported to TSG they have success reducing the rate with providers as the child improves. Probation is currently working to formalize their workflows and processes.

5.3.4. Accountability

During interviews with DCFS, private agency, and Probation staff, TSG learned the LOA process has morphed into a crises-driven system where placement providers have driven up rates by bidding agencies against one another, threatening to or terminating placements when their rate demands are not met, and resisting licensing requirements that would bring in federal funding to improve the overall child welfare system. According to stakeholders, the contracts require no specialized training of foster parents, no meaningful outcomes related to permanency, and no quality measures beyond security and supervision. While the contracts require regular monitoring by DCFS caseworkers and regular reporting by foster parents to receive payment, stakeholders said that neither of these take place in a standardized manner. Stakeholders reported there is a significant difference between the LOA contracts being utilized by DCFS as was confirmed by our review of several of these documents as provided by DCFS.

5.4. Findings on Data Analysis Related to Letters of Agreement Process

The statewide placement of children and youth becomes disproportionally greater when additional child specific LOAs and a Professional Levels of Care are included in the comparison. Using twelve months of placement data, the following table includes youth at the three (3) standard levels of care as well as additional youth placed at a Professional level care in the Eastern Service Area (ESA) and through Letters of Agreement (LOAs) statewide.

	ESA	Remainder of State	Statewide
Essential	41%	68%	58%
Enhanced	35%	22%	27%
Intensive	15%	6%	9%
Professional	4%	0%	1%
Special (LOA)	5%	4%	4%

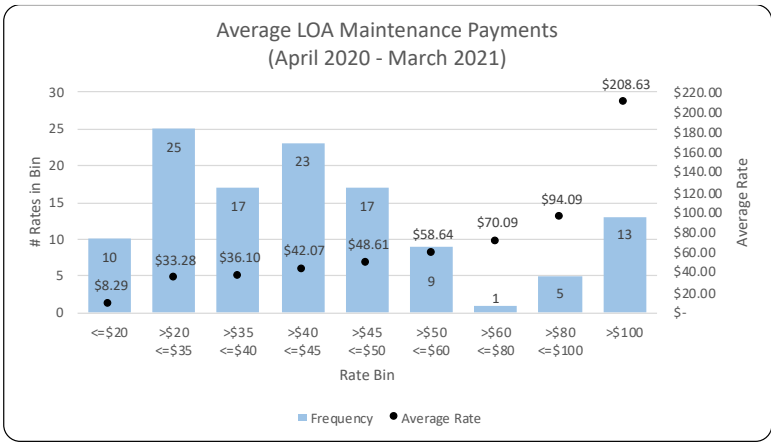
The ESA clearly serves a far-greater number of children at the highest levels of care (24%) when compared to the remainder of the state (10%). Again, while there may be valid reasons for such a variance, this finding reflects the need to standardize the means (tool, training, and ongoing validation) for determining appropriate levels of care for youth placed out-of-home.

In reviewing LOAs established for regions of the state outside the ESA TSG determined:

- There were: 120 new, amended, or renewed LOAs between April 2020 and March 2021.
- Children placed through these LOAs averaged 13.72 years of age.
- 8,643 days of care covered by these LOAs during the twelve (12) month period reviewed.
- Maintenance and Agency Support (Administrative) payments for this period totaled $810,061.

Maintenance rates paid in addition to the Intensive LOC rate for this period ranged from $7.80 to $209.20/ day. Of these payments:

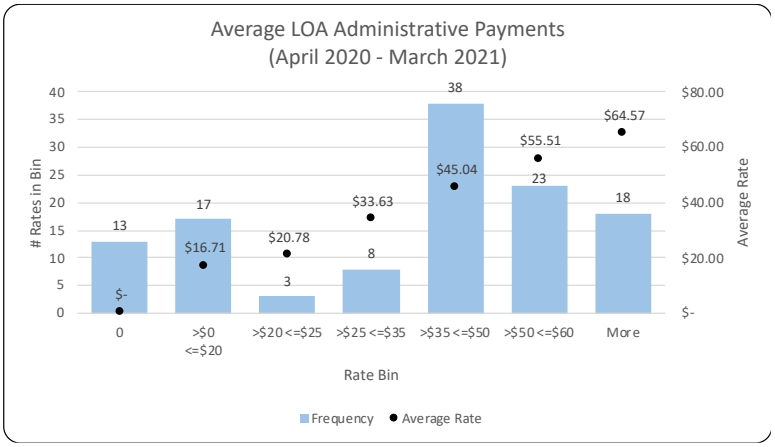
- 92 of 120 (77%) of LOA maintenance rates were less than or equal to $50/day, of these:
    - 29% (35 LOAs) were less than or equal to $35 / day in additional per diem,
    - An additional 14% (17 LOAs) were between $35 and $40 per day,



- And 33% (40) fell between $40 and $50 per day

LOAs with maintenance rates less than or equal to $50 day support 4,158 of 8,643 days of care of care (48%).

Of the remaining LOAs, those with additional maintenance costs of more than $50 per day are primarily associated with three (3) contracted agencies in the southeast service area.



Additionally, agency support (Administrative) payments fall proportionately within ranges similar to the excess maintenance payments. Of the administrative support rates paid through the LOAs during the twelve (12) months reviewed:

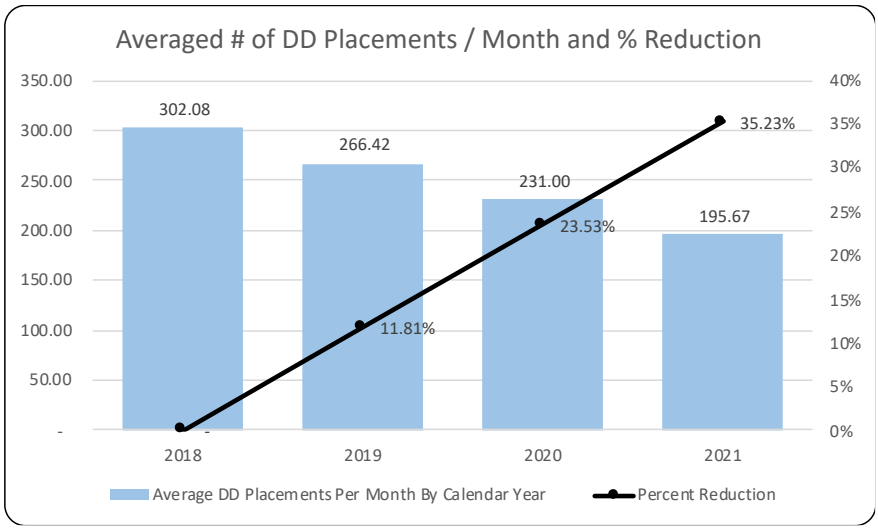
- The average payment above the Intensive level per diem was $39.74 per day
- 34% (41) of the administrative payments were less than $35 per day
- An additional 32% (38) fell between $35 and $50 per day

5.4.1. LOA Data Analyzed Supports Consideration of an Additional Level of Care

DCFS should consider establishing a LOC between the existing Intensive and recommended Specialized tiers. As reflected in the LOA data analyzed, payments for a significant percentage of existing LOAs fall below the proposed Specialized ("Professional") Maintenance and Support Rates. This finding supports the recommendation that a tiered rate (LOC) between the existing Intensive LOC and proposed Specialized (LOC) is reasonable as caregivers are currently willing to accept a rate below the proposed $80 tier. The addition of both an interim LOC and implementation of the proposed Specialized LOC will support improved permanency outcomes as adoption subsidy payments will be able to be made at these higher levels in accordance with state policy.

5.5. Findings Related to Developmental Disability Out-Of-Home Foster Care Placements

In reviewing the data related to the LOAs for specialized placements at DCFS, it must be noted that DCFS has done an extraordinary job over the past few years in significantly decreasing DD out-of-home foster care placements. Over the last four years there has been a:



- 35.23% decrease in the number of DD Children placed in out-of-home settings
- 11% decrease to the percent of DD placed in Agency Supported Homes
- 23% increase to the percent of DD children in approved relative foster homes
- Near elimination of the use of Youth Rehabilitation Treatment Center Placements

5.6. Findings Related to Nebraska Caregiver Responsibility Tool

In its recommendations, the FCRRC made modifications to the Nebraska Caregiver Responsibility (NCR) Tool that reflected the uniqueness of the specialized level of responsibility for new higher level 4th tier rate and the needs of children and their caregivers achieving permanency through adoption or legal guardianship. More specifically, the FCRRC recommended:

- Implement the use of the NCR at DHHS, Saint Francis and in Tribal Courts.
- Develop revised training curriculum for the most recent version of the NCR for case managers and supervisors.
- Assimilate components of the NCR Specialized Level of Care with service definitions and vouchers for Juvenile Probation.
- Utilize the NCR Specialized Level of Care to minimize letters of agreement and reduce permanency barriers.

TSG believes these are sound recommendations and realizes that the NCR Tool is unique to the State of Nebraska and has been developed after a very through stakeholder process identifying all necessary and significant aspects of the foster care caregiver responsibility. TSG's evaluation, however, found aspects of the process and use of the NCR that could be improved.

5.6.1. NCR Does Not Focus on the Child's Clinical Treatment Needs

The NCR determines the Foster Care Maintenance Rate for caregivers of foster children. Each level describes the intensity of care that the caregiver will provide the foster child. The variance in expectations for each level is detailed in the NCR Tool (See Appendix B attached to the June 2020 FCRRC Recommendations report). The first level (LOR1) is considered essential for all placements and the minimum expectation of all caregivers, LOR2 is a higher level of care, and LOR3 is the highest level of care. Each level includes the responsibilities of the previous level along with other duties. Payment increases as the caregiver responsibility increases. Payment level decreases when caregiver responsibility decreases. Thus, the NCR Tool is intended to tease out the caregiver's level of effort and determine the level of care based on the amount of supervision / interaction the foster parent provides and there may not be a correlating diagnosis associated with a level of care.

Nebraska, however, is unique in that the level of care is based on the amount of care, supervision, coordination, transportation, and interaction a foster parent is required to provide rather than on a diagnosis or assessment of the child. Thus, the NCR does not take into consideration the treatment plan identified clinical needs of a child placed at a more intense level of care. Any information about the trauma related, behavioral health, developmental disabilities, substance abuse disorder, medical/pharmacy needs of the child/youth are external to the NCR document and not specifically detailed in the NCR document.

Moreover, in reviewing the NCR, the domains have a definition of what is expected of the foster parent(s) for each domain at each current level of care. What is missing is what is the child/youths presenting strengths, needs, preferences, and current treatment plan(s), if any. Effective outcomes related to the comprehensive treatment needs and funding coverage for children/youth with the highest-level needs do not appear to be attached to the NCR for the parents' education and use. "Treatment plan" is mentioned three times in the NCR, but it simply says parents need to follow the treatment plan. "Treatment plan" and Medicaid are not mentioned in the instructions on completing the NCR. So, if the case worker does not have detailed information about the child's treatment plan(s) foster parents are agreeing to the NCR levels without this critical information.

In addition, the lack of an independent standardized child/youth Evidence Based assessment process and instrument for Behavioral Health (such as the CANS, CAFAS, ANSA -over 18) services, which are covered Medicaid benefits through Managed Care Organizations, results in the loss of comparable standardized assessments and data that, over time, could have a direct impact on the level of need for Medicaid paid Treatment Family Care Services, DCFS levels of care, and also result in the loss of tracking child/youth progress and regression through individual case and aggregate data.

When the FCRRC made their original recommendations in 2014, the CANS behavioral health assessment tool was recommended to be completed along with the NCR. The decision was

made at the time by DCFS that, instead of completing a CANS assessment along with the NCR, they would utilize the Family Strengths and Needs Assessment (FSNA). However, the FSNA is not a treatment plan and not all children coming into care will have a treatment plan, especially since the first NCR is to be completed within 30 days of placement and DCFS may not have a lot of information about the child at the time. Children or youth who have been in DCFS placement for quite some time should have treatment plans. We believe DCFS should revisit this issue with the Foster Care Rate Reimbursement Committee.

5.6.2. No Assessment Fidelity Surrounding NCR Use

While the approach in using the NCR seems innovative, unique and the result of significant work by stakeholders, the NCR Tool has not been research informed, normed, validated, or evidence-based like the CANS Assessment has. Moreover, we have heard from DCFS Leadership that the Tool is also used inconsistently in the field, staff are not all trained to use the tool in the same manner with the same understanding of the criteria at each level.

Moreover, DCFS policy requires additional documentation in a narrative on the NCR under the section "Outline of Caregiver Responsibilities" for the additional care that the foster parent has committed to provide the supports a Level 2 and Level 3 ranking in each level of responsibility. The rule states that the documentation must describe the specific activities that the foster parent(s) will engage in that meet the definition of Level 2 or Level 3***, including the intensity and frequency of those activities***. DCFS Administration has found that when there are these levels with use of the NCR, documentation is often not being provided, nor is it being requested by CFS Specialists or Supervisors. DCFS Administration, therefore, should ensure that DCFS case workers and supervisors are adhering to this policy and should consider audits as part of its quality control process and also provide on-going training for case workers and supervisors on just what the expectations are related to proper documentation prior to committing to a higher level of care, including the recommendations of the FCRRC.

5.6.3. NCR Continuous Monitoring

The NCR also requires a process statewide for continuingly monitoring the levels of care at a 6-month interval with proper documentation of such a review to ensure the child is not being placed at a higher level of care and to assist with permanency planning. The policy was changed a few years ago to once every 12 months after DCFS staff complained that they were having to complete the NCR too often. DCFS Administration recently changed the policy back to a 6-month review. We believe DCFS Administration is correct to require, at the minimum, a 6-month review of the NCR, especially where a new higher rate tier is implemented, to ensure rate accountability and provide the best opportunity for timely moving the child or youth to a lower level of care as part of the permanency planning process.

5.7. Findings Related to Child Placing Agency Level of Effort and Contract Expectations

Contracts between the Department and child placing agencies (CPAs) should clearly set forth expectations related to regular visitation with the child. Such expectations should be based on acuity of need and the child's determined level of care. Presently, though payment rates at each established level of care are based on progressively lower staff to child ratios, no such expectations are contractually established. While such expectations vary in other states, our review of contracts indicates that such requirements are common.

- **Ohio**: As a county-managed child welfare system, individual jurisdictions in the state independently develops separate contracts with CPAs. While each contract varies, several do contain specific language related to the frequency of visits with the child or youth. Typically, this is the only aspect of care specified by the level of child acuity.
- **Indiana**: The State has clearly established expectations for visitation by level of care. Presently, child placing agencies are required to:
    - Maintenance Payments Only (Basic Level of Care): If the Contractor is receiving a maintenance payment with no Enhanced Supervision payment, the Contractor shall ensure one visit with the Child at the foster home monthly and weekly telephone contact with the foster parent(s).
    - Enhanced Supervision: If the Contractor is receiving an Enhanced Supervision
    - payment, the Contractor shall ensure the following minimum:
        - Enhanced Supervision category Foster Care with Services: visits at least every other week with the Child and with the foster parents, with at least every other one being in the foster home;
        - Enhanced Supervision Therapeutic: at least weekly visits with the Child and with the foster parents, with at least every other one being in the foster home;
        - Enhanced Supervision Therapeutic Plus: visits at least twice a week with the Child, with at least every other one being in the foster home, and a weekly visit with the foster parent(s).
- **Michigan**: The State of Michigan has some of the most comprehensive child placing agency contracts reviewed as part of this project. State contracts include visitation and related quality requirements. (See Appendix B) CPA expectations for enhanced foster care (EFC) are contractually defined as follows:
    - Level 3: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth several times per week unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays severe impairment, which may include

causing property damage in the school or home, destructive or aggressive behavior towards self or others, intense mood irregularity, and/or distorted thinking. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist multiple times per week, participating in wraparound services and therapy with youth, using de-escalation techniques, responding to emergencies at school, and implementing crisis safety plan when needed.

  - Level 2: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth more than weekly unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays moderate impairment, which may include persistent non-compliant or irresponsible behaviors, sexually inappropriate or delinquent behavior, angry outbursts, or frequent mood disruption. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist each weekly, using positive behavior supports, transporting the youth to needed treatment, and incorporating treatment plan components in the home.
  - Level 1: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth at least weekly unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays mild impairment, which may include occasional disobedience, argumentative or annoying interaction with caregiver, problems at school or in relationships, or emotional distress. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist weekly, attending Family Team Meetings at a higher frequency, exercising good control when provoked, providing consistency and predictable behavior towards the youth, and setting realistic expectations for the youth.

- **Pennsylvania**: Child placing agency expectations are established through county-specific contracts. An example of these requirements is included in Appendix C and include a description of:
  - Children qualifying by level of care,
  - Visitation requirements, and
  - Child therapeutic, medical, and behavioral health services requirements.

5.8. Findings Related to Treatment Family Care Recommendation

Therapeutic Foster Care, or Treatment Family Care (TFC), as identified by the FCRCC in its recommendations, is an "intensive, treatment-focused form of foster care provided in a family-based setting by trained caregivers, with the addition of case management and behavioral health services and clinically based supervision" and it is " designed to serve children who have

behavioral or emotional disorders or medical conditions that cannot be adequately addressed in a traditional foster home" and who might otherwise be placed into higher cost residential settings.[10] Although TFC programs can vary, most state programs incorporate elements of evidence-based models that have been thoroughly assessed and have demonstrated improved outcomes. [11]

TFC is currently used as an effective alternative to higher cost placements, including congregate care, in a number of states and evidence has shown that children in these foster care placements, with properly trained foster parents, are more likely to receive an array of comprehensive wraparound and behavioral health services than children placed in more restrictive settings.[12] Also, studies have found that models of TFC are associated with decreased drug use over time, reduced rates of post-treatment felony charges, greater reductions in depressive symptoms, as compared to congregate care models, and lead to more cost-effective care than congregate care.[13]

The FCRRC identified the Treatment Family Care model as a wraparound in home treatment service in a foster or family home providing specialized caregiving to a child with behavioral health needs who is at risk of, or stepping down from, out of home congregate treatment placement. It uses blended funding to support the caregivers and prevent placement disruption. The rate structure identified in the recommendation include Medicaid wraparound in home services, Agency Supported foster care providing specialized support to foster parent caregivers. The following rate components were taken into consideration by the FCRRC:

- Medicaid wraparound services previously known as "Community Based Alternative to Residential" treatment which are now unbundled were used to develop the service components using the current Medicaid rates. This includes weekly in home Community Treatment Aide (CTA) hours, individual therapy sessions, family therapy, an Initial Diagnostic Interview (IDI) and clinical consultations.
- Therapist and clinical supervisor salary considerations for licensed child placing agencies providing the service.
- Respite to be arranged, trained, and coordinated by the licensed child placing agencies providing the service up to 4 days per month.

[10] Office of Assistant Secretary for Planning and Evaluation & Office of Human Services Policy, U.S. DHHS, Patterns of Treatment/Therapeutic Foster Care and Congregate Care Placements in Three States, Research Brief, August 2019.
[11] Office of the Assistant Secretary for Planning and Education [ASPE], U.S. Department of Health and Human Services [HHS], 2018; Bishop-Fitzpatrick et al., 2014; Harold et al., 2013; Rhoades et al., 2013.
[12] Office of Assistant Secretary for Planning and Evaluation & Office of Human Services Policy, U.S. DHHS, Patterns of Treatment/Therapeutic Foster Care and Congregate Care Placements in Three States, Research Brief, August 2019.
[13] Id.

The FCRRC Recommendations Report of 6/22/2020 included the TFC service package designed to provide integrated community based rehabilitative services for children/youth with high needs in a more organized approach to coordinated care than presently exists in Nebraska. We understand that the model is based on a modified approach to a High-Fidelity Wrap Around approach to foster care children and youth with high needs for behavioral health and co-occurring conditions. The service model is defined as follows: [14]

> TFC is an all-inclusive rehabilitative model of care that provides intensive care for youth provided by trained and supported treatment parents. TFC must be a community based behavioral health program under the clinical direction of a psychiatrist, psychologist, or LIMHP. TFC is a Medicaid eligible, highly supportive, and individualized approach serving youth ages 20 and younger who have a history of trauma in addition to complex mental health or substance use disorders that are causing functional impairment. Children and youth with co-occurring developmental or intellectual disabilities and/or who are medically fragile are included. The youth have a history of psychiatric residential or inpatient treatment, or have been unsuccessful in remaining at home with outpatient services, and are clinically identified as requiring out of home treatment at the TFC level. This level of care will address the symptoms that affect the-daily functioning of the youth and prevent further regression. This service requires intensive involvement and frequent contact between members of the treatment team. It is intended to provide a high degree

Treatment Family Care Medicaid Services include[15]:

- Initial diagnostic interview
- Certified Treatment Aide
- Individual Therapy Session (child)
- Family Therapy Sessions
- Clinical Consultation

All current Medicaid covered benefits are available through the Heritage Health Managed Care program in Nebraska. The specific units recommended include:

- 6 hrs of CTA @ 11.98 per 15 minute increment (Medicaid Rate)
  - 6 hrs x 4 to equal an hour = 24 (15 minute sessions per week)
  - 24 x $11.98 = $287.52 per week
- 2 Individual therapy sessions per week (60 min. session with LMHP)
  - 2x $112.08 (Medicaid Rate) = $224.16 • 2 Family sessions per week (potentially one with foster family and one with birth family)
  - 2 x$90.42 (Medicaid Rate) = $180.84

[14] Microsoft Word - FCRRC 2020 Legislative Report DRAFT 06.12.2020 (nebraska.gov), p.84
[15] Ibid, p. 15

    - 1 IDI (Initial Diagnostic Interview – 1x)
  - $125.52 (Medicaid Rate)/4 months = $31.35 (Anticipated 4 months ALOS)
    - Clinical Consultation ($42.31-$87.25/hr Medicaid rate)
  - 2 hrs/month @ $87.25 = $174.50/4.5 wks = $38.77

The FCRRC recommendations for this grouping of services include a recommended bundled day rate of $108.95 and a weekly rate of $762.64. Currently the MCOs do not pay bundled rates. The FCRRC recommended that DMLTC adopt the service definitions and rate structure of the recommended Treatment Family Care model.

FCRCC's recommendation leading to the implementation of a Treatment Family Care model is sound. The committee reports looking to national standards, including those established by the Family Focused Treatment Association (FFTA), in recommending the new Intensive level of care. The definition of Medicaid wraparound services to be provided through the model is consistent with similar therapeutic foster care models in other states, and the provision of these services as a therapeutic overlay, for children at any level of foster care will promote placement stability and lead to better outcomes for children in care. Most importantly, the TFC model will promote and enhance permanency outcomes for children with acute needs and behaviors.

The proposed rate of $108.95 per day is based on therapeutic components and interventions provided at current Medicaid rates (Medicaid overlay to current LOCs). Florida's rate, for example, is $87.30 – 135.80 per day based on acuity of child and paid in addition to base (maintenance) rates. This is paid through Medicaid waiver with care and supervision paid by child welfare and claimed to Title IV-E as appropriate. TSG finds the service expectations, therapeutic overlay, and rate recommended by the committee to be reasonable.

Beyond the provision of training and an enhanced payment to foster parents, the addition of therapeutic services, and provision wraparound supports, it is critical that a child or youth's unique conditions or individual circumstances leading to the need for treatment are critically assessed. This requires the use of a comprehensive, normed, and valid assessment tool which is administered with a measurable degree of fidelity. Further, the assessment must result in the development of a planned approach to treatment which identifies the skills and responses necessary to equip the youth and their families with the ability to deal effectively with the conditions leading to the need for treatment. To this end, the department should ensure the expansion of foster care to a therapeutic model is based on a solid foundation of child and family assessment, individualized treatment planning, outcome monitoring, and continuous improvement at the case-specific level.

The FCRRC did not comment on or recommend which behavioral health assessment instrument should be used to determine strengths, needs, and service intensity of the child/youth for

Treatment Family Care services which, by contract, reverts to MCO requirements for behavioral health assessment. The current Heritage Health MCO contracts specify ten instances when "assessments" are required, however there are no provisions for the use of a specific behavioral health assessment instrument, such as the CANS and CAFAS, in the document.[16] The FCRRC recommendations report of 7/22/2020 does not include recommendations concerning behavioral health assessment processes. The responsibilities of the TFC provider treatment "team" and "licensed clinician" are detailed in the FCRRC recommendations. However, treatment team members are not delineated nor is a process and timeline of communication with DCFS and the family mentioned.[17]

In addition to the wraparound Medicaid benefits included in the FCRRC's definitions, there are also an array of additional behavioral health benefits that are currently part of Heritage Health and must be available through MCOs to DCFS children with high complex behavioral health needs who under 20 years of age statewide. They include:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- Psychiatric residential treatment facility (age 19 and under).

Outpatient assessment and treatment:

- Partial hospitalization.
- Day treatment.
- Intensive outpatient.
- Medication management. FCRRC
- Outpatient therapy (individual, family, or group).
- Injectable psychotropic medications.
- Substance use disorder treatment.
- Psychological evaluation and testing.
- Initial diagnostic interviews.
- Sex offender risk assessment.
- Community treatment aide (CTA) services[18].
- Hospital observation room services (up to 23 hours and 59 minutes in duration).
- Parent child interaction therapy.
- Child-parent psychotherapy.
- Multi-systemic therapy.
- Functional family therapy.

16 71165(o4)awd.pdf (nebraska.gov)
17 Microsoft Word - FCRRC 2020 Legislative Report DRAFT 06.12.2020 (nebraska.gov), p. 84
[18] TSG was informed during interviews with stakeholders that this service is unavailable due to a lack of MCO contracted providers.

- Peer support.

Rehabilitation services

- Day treatment/intensive outpatient.
- CTA services.
- Therapeutic group home

Therapeutic Group Home (ThGH) is described as the delivery of an array of clinical, treatment and related services, including psychiatric supports, integration with community resources and skill-building taught within the context of a home-like setting. ThGH treatment shall focus on reducing the severity of the behavioral health issues that were identified as the reasons for admission. Most often, targeted behaviors relate directly to the client's ability to function successfully in the home and school environment (e.g. compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts).

All of these benefits are already factored into the MCO monthly per member per month capitated payment. Any benefits that are covered services would have inherit utilization in the base data that would be then included in the development of capitation rates (current and future) – unless an explicit program change is introduced expanding or restricting service, at which point an adjustment for the program change would be made in developing the capitation rates.

Respite serves are provided to all eligible Nebraskans through the Lifespan Respite program which is a program not managed by Medicaid although the program does extend to Medicaid patients. It is also a service available to children and caregivers through the A & D program

5.8.1. MCO Supports in Place

Currently, MCOs in Nebraska report that they have the following supports in place for foster children under their contracts:

- Care Management and/or Clinical Coordinator assigned to all Foster Children.
- Meet with DCFS and Juvenile Probation monthly to staff foster care cases and discuss option for services and placements.
- Make outreach calls to the foster parents of new children and youth in the Foster Care program to offer care management.
- Provides phone outreach to foster parents of all children and youth discharged from the emergency room or hospital with a primary diagnosis of mental illness or substance abuse disorder to follow up on the change in condition and assess for additional needs or services.
- Provides a texting education program to children and youth identified as having gaps in child or adolescent well visits or immunizations.

- Clinical Coordinators also participate in treatment team meetings with Behavioral Health providers, Psychiatric Residential Treatment Facilities or other Residential Treatment providers, Probation and Caseworkers upon request
- Completes phone outreach for children and youth newly prescribed an antipsychotic medication
- Per contract each MCO has a psychotropic drug oversight program that reviews antipsychotic usage and prescribing patterns. Antipsychotics require prior authorization for children and youth and often reviewed by a licensed child and adolescent psychiatrist.
- Pharmacies have medication checks in place for medications prescribed to foster children including antidepressants, antipsychotics, and antianxiety.

5.8.2. Assessments for High Needs Children

Foster children are designated for the MCOs by a special indicator. MCOs have supports around foster children. Each MCO has specific criteria to identify complex needs along with working directly with DCFS, Juvenile Services, and providers to identify high needs children and youth. Comprehensive medical and behavioral health assessments are a covered benefit under Medicaid.

5.8.3. Behavioral Health Medicaid capacity in the rural areas of the state

DMLTC works with providers that have concerns regarding rates. As a rural state there are areas with provider capacity needs for all patients. DMLTC has worked to support the use of telehealth to support the care needs.

5.8.4. Medicaid process of accountability with MCOs

- Monthly and annual reviews of contract requirements.
- DMLTC discusses with the MCOs any concerns raised from providers, patients, families, advocates, or Division partners regarding service needs.

5.8.5. Knowledge of the above Medicaid Benefits

DMLTC maintains a provider website that includes the service definition of all covered behavioral health benefits available to all Medicaid covered children and youth. The MCO's coordinate care for children and youth. The provider relations department, within each MCO, has information on the services that are available to children and youth.
TSG observed through multiple stakeholder interviews including an interview with DMLTC staff that there appears to be a fundamental lack of understanding of the Medicaid Managed Care system in the child welfare community and how to access the benefits and providers the MCOs are to provide. Specifically, there seems to be a general lack of knowledge among the

interviewed stakeholders regarding: the federal regulations that restrict what the Medicaid system can and cannot pay for (absent federal approval of a Medicaid State Plan amendment, waiver, or Performance Improvement Project); the limitations in the Medicaid electronic encounter and claims systems that requires specific information to process a claim; and the MCOs' prior authorization requirements, network adequacy requirements, and grievance and appeal processes.

5.8.6. Access to Medicaid Behavioral Health Services

If there are limited supply of behavioral health services in an area or none exits, per contract, the MCOs are required to ensure an adequate provider network to meet patient needs regarding a specific needed service. Where there are issues where no provider is available after a need is identified, either through DCFS or family or provider, the MCO, is required to work to identify providers that could be added to the provider network to meet the patient needs.

5.9. Therapeutic/Treatment Foster Care Best Practices

Before adopting the FCRCC's recommendations regarding the new TFC model, there are some improvements DCFS and DMLTC should consider based on our state best practice review that could involve additional service definition criteria, covered benefits, the assessment process, data system integration, continued division collaboration, increased regulatory flexibility and clear expectations of providers and foster parents, including training and accountability for outcomes, and removal of barriers to permanency. Key improvements will be identified further in our recommendations section of this Report. We also will highlight here some of the common program themes and practices observed in our state-by-state best practice review (Texas, Michigan, Georgia, Florida, Kentucky, Ohio, and Washington) which are summarized in more detail in the Appendix D to this Report.

5.9.1. TFC Common Themes and Best Practices

The following are some of the common themes and practices we observed for successfully implemented TFC programs in states (see Appendix D for more details on our state best practice review):

- **Innovative, multi-disciplinary treatment services that are evidence-based and research-supported**;
- **An intensive level of service** in a **highly structured environment**;
- **A time-limited program that promotes the stabilization and preparation of children to transition into a less restrictive or permanent placement** successfully;
- **Incentivizing foster parents and child-placing agency** contractors to receive a higher reimbursement rate due to the additional requirements of comprehensive training, an increase in treatment plan reviews, and the ongoing support required following the

discharge of a child from a residential setting or upgrade in level of care due to placement instability and/or mental health, medical or other behaviors;

- **Cross-agency and cross-system collaboration**. For example, in the State of Washington, the following is a required element:
    - Cooperative and collaborative planning between the Division of Children Youth and Family (child welfare agency) and the Health Care Authority (state Medicaid agency), including active stakeholder participation (Foster Parents, Transition Youth, Managed Care Organizations, and Providers) successfully developed the fidelity wraparound WISe program model that provides the necessary Behavioral Health Rehabilitation EBP services that a child/youth needing the Therapeutic/Treatment Foster Care level of care is assessed to need as well as support of the Therapeutic/Treatment Foster parents.
- **A Standard practice for Agency case workers** to follow to initiate this level of foster care;
- **An Operations Manual for Agency staff and providers** that contain an overview of the program and specific operations criteria related to:
    - types of youth served
    - determination of eligibility
    - treatment planning
    - initial assessment process and ongoing assessments
    - case progress notetaking
    - Level changes
    - Description of caregiver partnership, including trauma informed approach
    - Caregiver expectations
    - Training expectations
    - Provider expectations, including staffing requirements
    - Rates

See Appendix E for an example of the Enhanced Family Care Operations Manual that is used in Michigan by the Western Michigan Partnership for Children

- **A requirement for Behavioral Health Specialists to be available** to the Child Placing or provider agency for consult and review of behavioral health services, including medications and duration of service;
- **An embedded philosophy of caregiver partnership** with provider and Agency;
- **Continuous monitoring requirements** for Agency to ensure appropriate level of care and duration to include alignment with permanency planning. Level of care reviews every 90 to 120 days. (Michigan 90 days; Texas every a review every quarter)

- **A clinical assessment tool required** to be used in determining TFC level, that includes connection to treatment planning for child to utilize a valid and tested clinical Assessment instrument either before or within 30 days of placement into TFC
    - In most instances, the completion of the Child Adolescent Needs and Strengths (CANS). Washington requires at least a CANS screen, which consists of a subset of 26 questions, pulled from the Full CANS completed by a CANS-certified screener. Texas requires CANS to be completed within 30 days of entry into foster care. Michigan requires use of a Child and Adolescent Functional Assessment (CAFAS) Scale to be used as their instrument but allows for a 30 day provisional approval until the clinical assessment is submitted and confirmed to justify level of care.
- **Development of an individualized treatment plan** that consists of a structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level. This treatment plan can be developed by the child placing agency, or an independent entity hired by the state, in collaboration with the DCFS case worker, foster parents, MCOs and other necessary members of a multi-disciplinary team.
    - Florida requires that individualized recipient treatment plans must directly address the primary diagnosis(es) that is(are) consistent with the assessment. The provider must document efforts to coordinate services for behavioral health diagnoses outside their expertise that, if treated, would assist meeting the recipient's goals.
- **History of active and supportive Legislative oversight** in partnership with the State child welfare Agency, Medicaid Agency, foster parents, youth in transition, child placing agencies and providers that has created on-going year to year dialogue and problem identification and improvement strategies;
- **Specific methods of accountability** for placement agency providers related to:
    - Access to services and service array
    - Reducing the acuity of need
    - Facilitating placements in less restrictive settings
    - Promoting permanency
    - Practice Model requirements, including staffing
    - Oversight
    - Cross-system collaboration
    - Documentation
    - Data warehouse
    - Performance measures and outcomes

Examples of accountability as follows:

In Texas, child placing agencies must meet the following requirements of service delivery accountability:

- a 24-hour on-call crisis person available to provide in-home crisis intervention and placement stabilization services, available to the child and family;
- a formal respite system, both routine and available upon request, when determined appropriate
- meet standardized caseload sizes to support high needs child or youth population
- Also, providers chosen must have a capacity growth plan with targeted milestones for both the number of Therapeutic foster family homes certified and the number of children served under each contract
- All foster homes and providers delivering this service are licensed by the rules of the state child licensing agency
- Requirement that at least one foster parent who does not work outside of the home and is highly trained to meet the specific needs of this child population;

In Florida, the following conditions must be met before the provider can enroll in Medicaid as a specialized therapeutic foster care services provider:

- The provider's primary clinicians, psychologists, psychiatrists, and foster parents delivering specialized therapeutic foster care services must meet specific education and training requirements.
- The provider must employ or contract with primary clinicians and foster care parents who provide the services. (The primary clinicians and foster care parents are not individually enrolled in Medicaid.)
- The provider has an approved pre-service and in-service training plan for staff providing specialized therapeutic foster care services.
- The foster home is properly licensed in accordance with state law.
- The foster parents have received basic training required of all licensed foster parents and meet all other licensing requirements.
- The provider has a financial agreement with the foster parents that reimburses the foster parents for their therapeutic intervention services.

  - The provider has policies and procedures that promote good therapeutic practice, ensure that therapeutic foster parents are the primary therapeutic agent, provide for appropriate treatment plans and documentation, and protect the rights of recipients and their families.
  - The provider has a program evaluation system to review the process and outcomes on at least an annual basis.
  - The provider has policies and procedures that address the legal school notification requirements.

In Michigan, provider expectations are all included in the Individualized Service Plan (ISP), which is required to be filled out 30 days of authorization of Therapeutic services to include specific additional caregiver responsibilities related to:

  - Increased supervision,
  - Behavior management,
  - Involvement in school
  - Participation in training that specifically pertains to the identified child(ren) placed in the home
  - Additional training needs of the caregiver

- Requirements for providers related to **storing of internal data and reporting out key TFC program performance measures**, such as:
  - Number of adoption placements
  - Number of children returning home
  - Number of children placed with a relative
  - Number of psychiatric admissions
  - Number of residential placements
  - Total discharges
  - Total successful discharges, with a contracted required success rate

  An example of one Texas TFC providers performance management dashboard is included in Appendix F.

- **Requirements for Child Placing Agencies and Foster Parents to be licensed** in accordance with state law and regulation and complete a set number of hours of preservice training specific to specialized therapeutic foster care.
  - In Florida, specialized therapeutic foster parent(s) serves as the primary agent in the delivery of therapeutic services to the recipient and are trained in interventions designed to meet the individual needs of the recipient. Specialized therapeutic foster parents must be available 24 hours per day to respond to

crises or to the need for special therapeutic interventions. Specialized therapeutic foster parents must receive ongoing in-service training from clinical staff to support, enhance, and improve their treatment skills and strengthen their abilities to work with specific children. In-service training should be provided as often as needed, but not less than 12 hours every six months for the highest level of care.

- **Specific Description of the Service**
  - States have specific descriptions of the type of service and service level either in statue or their policies so that providers and foster parents fully understand the type of service that is required for any child in this setting. For example, the Texas description of the specialized service level[19] includes the following:
    - 24-hour supervision to ensure the child's safety and sense of security, which includes close monitoring and increased limit setting;
    - Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
    - Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
    - Therapeutic, habilitative, and medical intervention and guidance that is regularly scheduled and professionally designed and supervised to help the child attain functioning appropriate to the child's age and development.
- **Specific description of characteristics and behaviors that a child or youth exhibits** that identifies the need for this level of specialized services that usually consists of aggressive or potentially dangerous behavior, substance abuse dependency, Intellectually and Developmentally Disabled, a mental illness, or another condition that warrants a high level and specialized service. For example, Texas defines a child needing specialized services as one having severe problems in one or more areas of functioning, which may include:
  Unpredictable non-violent, anti-social acts;
    - Frequent or unpredictable physical aggression;
    - Being markedly withdrawn and isolated;
    - Major self-injurious actions to include recent suicide attempts; and
    - Difficulties that present a significant risk of harm to self or others.

[19] DFPS - Service Levels for Foster Care (state.tx.us)

A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include one or more of the following:

- Severe impairment because of the substance abuse; and
- A primary diagnosis of substance abuse or dependency.

A child with intellectual or developmental disabilities whose characteristics include one or more of the following:

- Severely impaired conceptual, social, and practical adaptive skills to include daily living and self-care;
- severe impairment in communication, cognition, or expressions of affect;
- Lack of motivation or the inability to complete self-care activities or participate in social activities;
- Inability to respond appropriately to an emergency; and
- Multiple physical disabilities including sensory impairments.

A child with primary medical or habilitative needs whose characteristics include one or more of the following:

- Regular or frequent exacerbations or interventions in relation to the diagnosed medical condition;
- Severely limited daily living and self-care skills;
- Non-ambulatory or confined to a bed; and
- Constant access to on-site, medically skilled caregivers with demonstrated competencies in the interventions needed by children in their care.

Michigan – "A child assessed at this level displays severe impairment, which may include causing property damage in the school or home, destructive or aggressive behavior towards self or others, intense mood irregularity, and/or distorted thinking."

- **A direct connection with the state's Medicaid Managed Care Plan** for accessing Medicaid services thereby providing a seamless coordinated approach to meeting the Behavioral Health and general medical needs of children/youth in Foster Care.

5.10. Evidence Based Therapeutic Foster Care Best Practice Training Approaches

The cornerstone of effective foster care parent and clinical provider training is a curriculum based on understanding the trauma experienced by children in the child welfare system, the effects of that trauma on the child's behavior, and how to build a trauma-informed child welfare system. While a thorough discussion of trauma informed care is beyond the scope of this TSG project and report, well-accepted definitions familiar to Nebraska DHHS and DCFS through their work with KVC and the University of Nebraska Center for Children, Families, and the Law (CCFL) include:

Trauma is a life-threatening or extremely frightening experience — for the child or someone they care about — that overwhelms the child's capacity to cope.

Trauma-informed child welfare systems are characterized by a system-wide understanding of how to recognize and respond to the impact of traumatic stress, screening and assessment of children, data systems, workforce development, and evidence-based and evidence-informed treatments. Trauma-informed child welfare systems are distinct from other child welfare systems in that there is a system-wide and coordinated approach to recognizing and responding to trauma. [20]

TSG identified three evidence-based TFC national training approaches for agencies and providers implementing or developing TFC models and approaches that incorporate trauma-informed principles and are used by the various states in developing and sustaining successful TFC programs. Details about these programs are contained in Appendix G and they are summarized below:

5.10.1. Together Facing the Challenge

Together Facing the Challenge" (TFTC) is a training and consultation educational program focused on improving the skills of foster parents and their agency support staff to effectively parent children/youth with high needs for mental health and emotional services and supports. The program was developed by Maureen Murray, LCSW, of the Services Effectiveness research program of the Department of Psychiatry and Behavioral Sciences at the Duke School of Medicine. The TFTC foster parent training program is listed as an Evidence Based Practice by the California Evidence-Based Clearinghouse for Child Welfare. TFTC has been implemented in over 40 agencies in North and South Carolina and more than 60 agencies in over 20 states.

The model focuses specifically on the in-home intervention elements (and creating adequate skill levels to implement these strategies effectively) and on the important role of supervision and coaching in helping foster parents work effectively.

The model is based on eight core values:

- Relationships are Key
- Trauma Informed Practice
- Evidence Based Practice
- Educational Approach
- Intentional Promotion of Physical and Emotional Health
- Respect all aspects of the individual

20 Kelly Murphy, Kristin Anderson Moore, Zakia Redd, Karin Malm, Trauma-informed child welfare systems and children's well-being: A longitudinal evaluation of KVC's bridging the way home initiative, Children and Youth Services Review, Volume 75, 2017,Pages 23-34, ISSN 0190-7409,https://doi.org/10.1016/j.childyouth.2017.02.008.
(https://www.sciencedirect.com/science/article/pii/S0190740917301342)

- Transition to Adulthood
- Professional Growth

The TFTC implementation process is an organized educational experience that is clearly defined, time based, and hands on and leads to an agency certification process.

5.10.2. Pressley Ridge

Pressley Ridge was founded in Pittsburg in 1832 and was the first agency serving abandoned, neglected, and orphaned children west of the Alleghenies. Today Pressley Ridge provides a range of services and supports through 70 innovative programs to over 10,000 children and families annually in Pennsylvania, Ohio, West Virginia, Maryland, Delaware, North Carolina, and Virginia. The organization is headquartered in Pittsburg, is non-profit, and has an active Board of Directors.
The essential components of Pressley Ridge's Treatment Foster Care (PR-TFC) Pre-Service Curriculum includes:

- Lessons for prospective treatment foster parents for children with emotional and behavioral issues about the following areas:
- Roles and responsibilities of a treatment parent
- Safety and supervision of children in foster care
- Appropriate discipline of children
- Normal child developmental stages
- Effects of traumatic experiences on children's development
- Psychiatric diagnoses of children in foster care
- Separation and loss that children in foster care experience
- Effective Parenting competencies: social rewards, active listening, behavior management techniques, motivation systems, skill teaching
- Managing conflicts in parent-child relationships
- Managing crisis situations

5.10.3. Treatment Foster Care Oregon

The Treatment Foster Care Oregon (TFCO) program was developed as an alternative to institutional, residential, and group care placement for adjudicated teenagers with histories of chronic and severe criminal behavior. The two main goals of TFCO are to create opportunities for youth to successfully live in a family setting and to simultaneously help parents (or other long-term family resource) provide effective parenting. The rationale for TFCO is that adolescent adjustment can be enhanced by the extent to which parents are able to effectively supervise their teenager, follow through with consequences when necessary, and promote positive involvement in school and other normative activities.

Community foster families are recruited, trained, and closely supervised to provide TFCO-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; separation from delinquent peers along with access to prosocial peers; and an environment that supports daily school attendance and homework completion.

TFCO utilizes a behavior modification program based on a three-level point system by which the youth are provided with structured daily feedback. As youth accumulate points, they are given more freedom from adult supervision. Youth are provided weekly meetings with an individual therapist who provides support and assists in teaching skills needed to relate successfully to adults and peers. Family therapy sessions help parents prepare for the youth's return home and help them become more effective at supervising, encouraging, supporting, and following through with consequences. Case managers closely supervise and support the youths and their foster families through daily phone calls.

Throughout the six- to nine-month placement in foster homes, there is an emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Aftercare services remain in place for as long as the parents want, but typically last about one year.

The certification application process involves a thorough evaluation of several components of an agencies TFCO program, including coding and evaluating treatment parent and clinical staff meetings, and a fee is charged for this process.

5.11. Medicaid Service Delivery Best Practice Models for High Needs Children

The following consists of some of the highlights of best practice Medicaid service delivery models we observed in states where Therapeutic Foster Care Medicaid services are paid through Medicaid Managed Care Plan(s), like Nebraska Heritage Health.

- **An independent agency that is doing assessments, treatment planning, responding to crisis prior to and during removals to foster care and working collaboratively with the Medicaid Managed Care companies to implement the Medicaid covered portions of the Treatment Plan (NJ System of Care).**
- **A statewide Medicaid Managed Care approach involving MCOs focusing exclusively on the comprehensive Medicaid services covering the entire foster care population**, such as single Managed Care Plan (TX., OK, KY, WV, FL., WA.).
- **Integration of physical and behavioral health** services
- **Critical and focused attention on behavioral health services**
- **Specialized service coordination**

- **Network and Access to Care requirements** that are continuously reviewed and monitored to ensure timely access to services
- Specialized language **requiring the Network to have providers who are specialized in treating victims of child abuse** and neglect and exploitation
- Specialized language **requiring the Network to have providers who specialize in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and other Evidence Based treatments**
- **Requirement for MCOs to encourage Providers to use Evidence Based Practices** and promising practices that are demonstrated through research to be effective with these traumas, such as TF-CBT, PCIT, CPP, and TBRI, and to address risk factors and stressors that influence future Abuse, Neglect, and Exploitation
- **Specific requirements that MCOs are to be responsive to inquiries and requests from the State child welfare agency**, including its staff, and caregivers
- **MCO case managers required to provide information** to state child welfare agency staff and caregivers upon request;
- **Requirement to provide intensive case management wraparound services**, including specific requirement that intensive case managers **complete training in the National Wraparound Implementation Center's Wraparound Practice model** and must incorporate wraparound process planning or other approved models in developing a plan that addresses the child's or youth's unmet needs across life domains.
- **Specific definition of Wraparound service requirement** that is connected to services for children and youth of high needs.
    - Washington Wraparound model described as follows:

    Wraparound with Intensive Services (WISe): "Wraparound with Intensive Services (WISe)" means a range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program serves children and youth under the age of 21 who are experiencing mental health symptoms that are causing severe disruption in behavior, and/or interfering with functioning in family, school, or with peers requiring: the involvement of the mental health system and other child serving systems and supports; intensive care collaboration; and ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement.

- Requirements that the **case manager** meet with the child within few days of coming into service (7 days in Texas) and "**must take steps that are necessary to assist the child or youth in gaining access to the needed services and service providers**, including:

  - Creating a treatment plan based on standardized assessments that are then shared with caregivers and MCO case managers.
  - Making referrals to potential service providers.
  - Initiating contact with potential service providers.
  - Arranging, and if necessary, to facilitate linkage, accompanying the child or youth to initial meetings and non-routine appointments.
  - Arranging transportation to ensure the child or youth attendance.
  - Advocating with service providers.
  - Providing relevant information to service providers.
  - Monitoring the child's or youth's progress toward the goals set forth in the plan."

- Can **offer individualized services to members in high needs** based on Medical Necessity, Functional Necessity, cost-effectiveness, the wishes of the Member, Member's Legally Authorized Representative (L.A.R.), or Medical Consenter, as applicable, and the potential for improved health status of the Member.
  - Washington: The MCO does not have to receive HHSC approval for Case-by Case Services and does not have to provide such services to all MCO Members. MCO has the discretion to offer Case-by-case Services, which are not included in the Capitation Rate. The MCO must maintain documentation of each authorized Case-by-case Service provided to each Member
- Requirement to **contract with Providers with Telemedicine capabilities** to increase access to specialty care.
- **Waiver of Prior Authorization** for certain services.
  - Texas STAR Health: The MCO will not require a PA for all outpatient medication management services, and a PA will not be required for the first ten outpatient BH sessions, to include the initial evaluation.
- MCO must **recognize the intensive or ongoing need** for these services often present among the high needs children population, and **should not be unnecessarily burdensome** (Texas STAR Health)
- MCO **required to be part of "Team Based" philosophy** developing cross system care plan
- Requirement for a CANS Assessment, or similar tool, within 30 days of a child coming into care to be used in developing the treatment plan, and as part of the determination of level of care
- Requirement to **enter results of CANS Assessment in statewide child medical file accessible to state child welfare agency and providers**.

- Behavioral Health Assessment System (BHAS): "Behavioral Health Assessment System (BHAS)" means an online Child and Adolescent Needs and Strengths **(CANS)** data entry and reporting system that provides CANS data in real time to clinicians, supervisors, agency administrators, and AH-IFC administrators, as well as HCA staff, for quality improvement purposes. The reports in this system are explicitly designed to provide on-demand, multi-level feedback and are updated in real-time. (Wash.)

- **Care management responsibilities include moving the member to a less intensive Level of Care** Management as warranted by member improvement and stabilization.
- Provision **allowing MCO to pay for behavioral health services to high needs children not only in offices and clinics, but also in schools, homes, and other locations as appropriate**
- Requirement of **Electronic Health Record (EHR) of provider available to State child welfare department through MCO**

  The MCO must contractually require behavioral health providers to provide the following information for the Health Passport (Texas STAR Health EHR):

  1. primary and secondary (if present) diagnosis;
  2. assessment information;
  3. brief narrative summary of clinical visits/progress;
  4. scores on each outcome rating form(s);
  5. referrals to other Providers or community resources;
  6. evaluations of each Member's progress at intake, monthly or as significant changes are made in the treatment plan; and
  7. any other relevant care information.
- The requirement for the **assessment and treatment planning entity to have a Behavioral Health Services hotline**, answered by a live voice, staffed by trained personnel and available 24 hours per day, 7 days a week, toll-free throughout the state which addresses routine and crisis behavioral health calls.

- Requirement that **MCO offer clinical provider training programs in topics related to child welfare and trauma informed car**e;
  - An example is the Kentucky SKY Program: Aetna Clinical Providers Training Program Curriculum, which provides for provider training related to:
    - Review of Medical Consent, Information, and Timeliness. Medical consent requirements. Specific medical information required for court requests and judicial review of medical care. Required timelines for services and assessments

- Aging Out Process and support available through Aetna Family First Prevention Services Act and other federally mandated services and programs impacting Kentucky SKY enrollees
- Behavioral Health Resources. Screening for and identification of Behavioral Health disorders. Evidence-based Behavioral Health treatment interventions. Specific Behavioral Health and Physical Health needs of the Kentucky SKY populations
- Trauma-Informed Care
- Children Adolescent Needs & Strengths (CANS)
- Crisis Intervention Services
- High Fidelity Wraparound
- The impact of Adverse Childhood Experiences (ACEs)
- Neonatal Abstinence Syndrome
- Appropriate utilization of psychotropic medications
- Substance Exposed Infants
- Training for Youth Transitioning
- The Care Coordination Team
- Sex Trafficking 101
- Supporting LBGTQ Youth
- Performance Measures and Health Outcomes

5.12. Findings Related to State Agency Collaboration

Through extensive structured interviews with numerous DHHS leaders and staff, supplemented by interviews with private providers, TSG found that less than 10 percent of the children in DCFS' out-of-home care are considered children or youth with high needs, complex medical conditions and/or hard to place. At any one time, this group represents approximately 200 children. While a small percentage of the overall children and youth in out-of-home care, numerous stakeholders shared with TSG how the system of care in Nebraska struggles to address their needs. Within just DHHS, specific aspects of these children's custody and care is spread across DCFS (for placement) and licensing of foster parents, DMLTC (for Medicaid benefits), DPH (for licensing of the individuals and facilities caring for them), DBH (to assist with meeting their behavioral health needs), and DDD (to assist with I/DD waiver services and in some cases for placement even without an I/DD diagnosis).[21]

TSG found that each one of these agencies has its own eligibility system, assessment tools, and funding mechanisms and that there is no integrated case record that could be provided to a

[21] CFS licenses the foster parents but Public Health licenses the Child Placing Agencies; DD certifies the EFH.

multi-disciplinary team responsible for their care with accurate, consistent, actionable information that can be utilized proactively in the placement and treatment process.

TSG found, however, that new leadership at both DCFS and DMLTC has been meeting regularly to discuss a number of these intra-agency issues of importance and this provides an opportunity for continued close collaboration on a systemic, proactive level going forward for children in need of a crisis placement.

The most significant opportunities TSG found for improved DHHS agency collaboration pertaining to DCFS' hardest-to-place children and youth are:

- Data sharing including assessment tools and treatment history across agencies so as to minimize trauma and inform decision making;
- A need for meaningful, close, proactive collaboration that includes DHHS' private partners (i.e., MCOs for DMLTC , Child Placing Agencies/St. Francis for DCFS);

In addition to needed DHHS inter-agency coordination, TSG found DCFS is competing with other Nebraska government programs – including the Administrative Office of Probation – for beds in the homes of community-based providers. In the worst cases, these providers pit the agencies against one other, driving up the cost of placing a child through negotiated Letters of Agreement (LOAs) and demanding children be removed from their homes if the agency placing them asks for documentation of services provided, requires licensing, or encourages the provider to consider permanency at a lower payment rate.

TSG also found:

- DCFS children are not eligible for the professional partnership wraparound behavioral health services provided through the Regional Behavioral Health Authorities (RBHAs) because of their Medicaid eligibility;
- DPH licensing standards viewed as barriers for otherwise qualified placement providers (i.e., DD providers, relative and kinship providers)

5.13. Findings Related to Criteria and Definition of Children with High Needs

Stakeholders interviewed by TSG were unable to provide data regarding the specific categories that the approximately 10 percent of children at the highest levels of care fall into – medically fragile, I/DD, severe mental illness (SMI), part of a sibling group, etc. Probation staff did indicate that all DCFS children who are dual wards are placed at a level three or higher based on a risk assessment that presumes they are a risk in community placement. DCFS and private agency staff indicated that very few medically fragile children were in long-term out-of-home care. Collectively, stakeholders identified hard-to-place children as teenagers (the average age for a child in an LOA with DCFS is 14 years of age) who were post-termination of parental rights with

a significant history of behavioral health diagnoses and physical or sexual aggression leading to placement disruption.

There are multiple ways to define high needs children in the context of the child welfare system and the term means something different to different groups of program staff. Some identify this as the population with behavioral health diagnoses. Others take a broader approach to include those with behavioral health or physical health issues. To some, the population includes children and youth with more intensive or specialized authorized levels of care which dictate the amount of foster care payments. Others consider it a practical issue of placement and define high needs children as anyone with challenging diagnoses, behaviors, and other characteristics whose placements break down frequently and require new placements frequently. Another perspective is to define high needs children as those who drive foster care and health costs.

These children consume a large amount of human resources in DCFS and in the therapeutic and medical community. Depending on the definition one uses, the composition and size of the high needs population varies significantly. Coming to a common understanding of the definition of this population is important in the design of solutions to improve the provision of care.

In Texas, caseworkers capture a number of child characteristics in their SACWIS system and this information is helpful to begin the process of identifying children with high needs. While there are dozens of individual indicators, over time, child welfare agency management reporting created certain composite indicators that group together related characteristics to facilitate easier reporting. One indicator is also used in identifying eligibility for adoption assistance. These indicators include emotional, learning, medical, physical, and special needs. Some individual characteristics are included in multiple composite indicators (i.e., a child with bipolar disorder would have both the “emotional” and “special needs” indicators). The listing of individual characteristics mapped to the composite indicators is shown in Appendix H and, as DCFS moves forward on implementation of a new therapeutic system of care for high needs children and youth, we recommend that DCFS consider a similar process for caseworkers to capture child characteristics in the N-focus system.

5.14. Other Findings

- The State is currently identifying gaps in services for Families First Prevention Services Act Evidence Based Programs related to its PPFSA plan and has hired a contractor to assess gaps. There is no current focus on EBPs specifically designed for high complex need children. DCFS should add this as an item of focus with the FFPSA planning, since a number of these children will be reunified and continue to meet the FFPSA candidacy definition.

- The use of antipsychotics and antidepressants in the child welfare population is not based on a standardized prescription practices model. For example, antipsychotic prescription practices have been described as "overprescribed".. Drug utilization practice uses four or more antipsychotic scripts as the standard for drug utilization concern. Second opinions are not required for the use of two or more antipsychotic agents simultaneously as in several best practice states. Logically, the children/youth exhibiting the most difficult behaviors are likely to be prescribed multiple agents with MD/NP not having access to a standardized behavioral health assessment. This could have the effect of children prescribed multiple agents in LOA cases and prescription practice changes during the crisis continuum without continuity of care and safe age-related prescribing practices.

6. Recommendations

6.1. Recommended Rate Improvement

6.1.1. Data and Practice Supports the Addition of an Interim Rate Tier

In assessing the recommended Specialized level of care TSG compared the proposed Title IV-E Maintenance and Administrative payments to those paid through current Letters of Agreement (LOAs). We find that a significant portion of the rates paid through the LOAs fall below these proposed rates. This finding supports the need to establish a level of care above the current Intensive level but lower than the proposed Specialized level. We also find that:

- Many hard-to-place children in Nebraska foster care are being placed without the benefit of competition and performance based contracting, which is driving up costs unnecessarily. Moreover, some of the placements are with providers that are not licensed under the child care licensing requirements, which, if licensed under such regulations, would bring in federal funding to improve the overall child welfare system in the state.
- The Letters of Agreement system is a crises-driven system, and the contracts require no specialized training of foster parents, creating barriers related to permanency, and no quality measures beyond security and supervision. While the contracts require regular monitoring by DCFS caseworkers and regularly reporting by foster parents, we were informed neither of these activities take place in a standardized manner.
- CFS- at this time, does not have a standard process that outlines when to execute an LOA, what criteria must first be met, what specific expectations are for the care of the child, what the desired outcomes are and how the LOA will be monitored from a contract and quality oversight manner. DCFS leadership is currently working closely with the field and reviewing LOAs over a certain dollar amount.
- Providers indicate it is unclear what documentation related to the child's needs is being used in the resolution of crisis incidents that require an LOA.

- Nebraska is not claiming Title IV-E reimbursement for expenditures related to LOAs. Such expenditures should be considered reimbursable if a child is placed in a child welfare licensed placement and is determined to be categorically eligible under Title IV-E requirements.
- Finally, it has been determined that foster parents are not eligible for Adoption Assistance Subsidies as a level commensurate with current payment as a "professional foster parent" (in the ESA) or payments through an LOA.

Based on our review of Title IV-E Maintenance rates, Administrative Support Rates, and LOAs TSG finds:

- Existing maintenance per diems are established based on a rational approach and sound methodology,
- Maintenance per diems appear to be reasonable in nature
- Administrative support rates fall within an expected range.
- LOA payments are not being claimed to Title IV-E.
- Significant % of youth on a LOA fall below the proposed minimum (professional) maintenance rate – national research indicates small increases to per diems lead to enhanced placement stability and improvements to reported child behavior.

As a result, we recommend implementing the Special level of care proposed by the Rate Setting Committee and establishing an interim level of care between the current Intensive Level and the proposed Special Level.

Implementing these levels of care will serve to significantly reduce the number of LOAs executed in the state while supporting permanency options through higher adoption subsidies for children with more acute needs.

6.2. Recommended NCR Improvements

The Nebraska Caregiver Responsibility tool[22] was developed by the FCRRC and is defined as:

> "This tool is used by the Nebraska Department of Health and Human Services (NDHHS) to determine and modify the amount of financial assistance for eligible children. This tool is based on the Nebraska Caregiver Responsibility Tool that is used to determine foster care maintenance payments by NDHHS."

In reviewing the NCR and its use across the state, TSG finds:

- The NCR would benefit by conducting a normative scoring process to assure the instrument is valid for the purpose of assigning levels of care.

[22] Ibid, p. 44

- The NCR process would be considerably improved if the child/youth's medical, behavioral health, developmental/physical needs treatment plan process was included in a standardized manner, while conducting the NCR assessment process with the family/caregivers. Independent assessment information about the trauma related, behavioral health, developmental disabilities, SUD, medical/pharmacy needs of the child/youth provided through the MCOs are external to the NCR assessment process and are not specifically detailed in the NCR document. Aligning these efforts would achieve far better results.
- TSG strongly recommends that an independent standardized child/youth Evidence Based assessment process and instrument for Behavioral Health (such as the CANS, CAFAS, ANSA -over 18) needs and services covered by Medicaid and the MCOs be implemented in DCFS and/or MCO service delivery networks to provide a singular valid Behavioral Health assessment, determination of strengths, needs, level of intensity, and treatment plan by all entities involved with the child/youth. This approach will provide comparable standardized assessments and data that, over time, would have a direct impact on the level of need for Medicaid paid Treatment Family Care Services, DCFS levels of care, and valid data to assess child/youth progress and regression, support for step up or down decisions, and connections to pathways to permanency.
- DCFS should ensure that staff and supervisors are adhering to NCR policy, including receipt of documentation and should also conduct spot audits to assure continued adherence to an effective policy when determining the highest level of care.

6.3. Recommended Contract Improvements For Child Placing Agency Expectations

TSG recommends the state collaborate with the contracted Child Placing Agencies to develop service, worker / child visitation, performance, and outcome expectations by level of care and integrate these expectations into child placing agency contracts.

6.4. Recommended TFC Improvements:

There are a number of improvements DCFS should consider to the FCRRC recommendations regarding Treatment Family Care and its future program implementation. A number of those improvements have already been identified in state best practice review findings and are contained in this Report. Some of these improvements would involve additional service definition criteria, clear expectations of providers and foster parents, enhanced training and accountability, education and outreach on covered Medicaid benefits, enhancement to the Medicaid service delivery system, cross agency data integration, continued division collaboration, and a continued focus on removal of barriers to permanency.
Before implementing a TFC program in Nebraska, DCFS should:

- Consider the common themes and implementation factors identified in our state best practice section for:
  - Successful Therapeutic Foster Care model programs for providers and foster parents;
  - Evidence based training models for agencies and providers; and,
  - Medicaid service delivery models that assure the most effective approach and positive outcomes for high needs children and youth in foster care.
- Clearly identify to the provider, child placing agency, foster parent and stakeholder community all pertinent covered Medicaid benefits, including those recommended by the FCRCC to be included in the Wraparound benefit model, and those not included, but still covered under the Medicaid State Plan.
- Ensure that providers, child placing agencies, foster parents and stakeholders are educated about the role of the Managed Care Organizations in carrying out Medicaid covered benefits for high needs foster care children through their state contracts, especially concerning care coordination, case management, network adequacy and timely access.
- Consider the adoption of a TFC Operations Manual to guide Agency Staff and Providers of TFC services,– see Appendix E for examples from other states.
- Work with DMLTC to adopt a Treatment Family Care Medicaid Service Coverage and Limitations Handbook for providers – See Appendix I for examples. The Handbook should contain an overview of the therapeutic foster care program, specific qualifications of providers, enrollment standards and requirements, specific covered, limited and excluded services, the provider reimbursement fee schedule and descriptions and instructions on how and when to complete forms, letters, or other documentation.
- Work with DMLTC, as part of cross-agency data integration collaboration to improve data reporting and performance dashboards on Medicaid, pharmaceutical, and behavioral health claims for all foster care children, and use that data to inform program or policy changes;
- Implement a standard process for caseworkers to capture child characteristics in the N-focus system.
- Clearly identify, with process elements defined, the role of the licensed clinician responsible for the involvement and coordination of individual child/youth treatment teams.
- Clearly identify TFC licensed clinician responsibility to include DCFS and MCO on the treatment team
- Clearly identify the composition of individual child/youth treatment teams.

- Require a behavioral health functional assessment as part of the Initial Diagnostic Interview process. The Initial Diagnostic Interview "will identify TFC as the level of care needed"[23] and "the treatment team will develop the comprehensive treatment plan within 30 days of admission".[24] Basic service expectations of the IDI are detailed in Title 471, chapters 20 & 32. The Initial Diagnostic Interview requirements do not include requirements for a behavioral health functional assessment ("behavioral" is not mentioned in the IDI state plan service definition).
- Consider the use of a standardized behavioral health assessment instrument, such as the CANS or CAFAS, in the development of the comprehensive treatment plan (due within 30 days of IDI generated treatment plan) by licensed clinicians and, over time, be normed to be used as the tool used to identify the Treatment Family Care Services or other level of care for Behavioral Health services.
- Clarify the role of the TFC provider in real time crisis situations specific to the child, youth and family. This role is unclear and should be defined in terms of 24-hour coverage, reporting responsibilities to DCFS and the child/youth's MCO, and coordinated with crisis services.
- Ensure that a standardized training module be used by all TFC providers and that DCFS be included in determining the most effective training model to be used for this purpose. The TFC services model includes a 20-hour initial training on Behavioral Health to TFC involved parents but does not specify what training module will be used and whether TFC providers will use the same or different training materials and content.
- Work with DMLTS to ensure they review the TFC recommended bundled rate methodology so that the services are individualized. The TFC model recommends a bundled rate however this implies that all children/youth eligible for TFC will require the same level of care regardless of individual presenting problems, strengths and need for services.
- Meet with the FCRRC, and include DMLTS, for the purpose of reviewing, revising, and agreeing on the TFC rate paying methodology, use of a tiered standardized Behavioral Health assessment tool that will drive duration and levels of care and lead to step down, and role identification in real time child/youth/family crisis situations and their resolution.

For TFC to be successful, however, there will need to be an adequate supply of providers of targeted services. TSG consistently heard that there are significant gaps in the availability of MCO behavioral health providers, especially Certified Treatment Aides and Therapeutic Group

[23] Ibid, p. 84
[24] Ibid

Homes. We were unable to assess the degree, if any, of MCO network access issues. We recommend that DCFS, DMLTS, DBH, and the MCOs work together to develop a data-based method to address the question of behavioral health network adequacy.

7. Framework for successful implementation of Alternative Behavioral Health TFC

Therapeutic Foster Care is a level of care designed for the highest need children/youth with significant Behavioral Health and social functions needs that include proclivity to crisis driven events. Currently there is not a standardized CMS/Medicaid definition of Therapeutic Foster Care as noted in a June, 2019 MACPAC Report on Therapeutic Foster Care.[25] This report noted that:

- "Therapeutic foster care represents an important set of services, many of which are already coverable in Medicaid. Because the needs of this vulnerable population are varied, individualized assessments should determine which services are necessary and appropriate. A uniform definition could limit the ability of states and providers to tailor services to address these needs.
- Additional federal guidance could help states design or improve the coverage and provision of therapeutic foster care services. Such guidance could inform states of their options to cover therapeutic foster care services within the existing benefit design flexibility in Medicaid, as well as provide ways to coordinate effectively with other agencies serving the same high-need children and youth."[26]

A DHHS report on "State Practices in Treatment/Therapeutic Foster Care" listed the following standardized components of TFC[27]:

- Individualized Treatment Plan
- Treatment team planning meeting at least every 30 days
- Specialized training and credentialing of caregivers/staff
- Additional training for TFC Foster Care parents
- Access to Behavioral Health Services, including in-home
- 24/7 crisis support
- Structural activities to connect the child/youth to the community

The State Best Practices section of this report includes detailed information of the requirements of the Texas, Washington, Michigan, Georgia, and Florida models of Medicaid reimbursed

[25] Report to Congress on Medicaid and CHIP June 2019 (macpac.gov)
[26] Ibid, p. 2 of Chapter 4
[27] State Practices in Treatment/Therapeutic Foster Care (hhs.gov)

Therapeutic Foster Care. These models can be used to launch a successful framework for implementation in Nebraska.

7.1. Recommended Framework for Implementation of Therapeutic Foster Care Model in Nebraska

- DCFS, DMLTS, DBH, DDD, and the FCRRC should meet to discuss options for developing a Medicaid reimbursable model of Therapeutic Foster Care in Nebraska and make a decision on how to move forward on the FCRRC recommendation.
- A Project Work Team should be appointed by the parties to include a brief Mission Charter, Project Team members, a Project Work Plan, including timeline tasks and deliverables. In developing the Project Work Plan, we recommend that the agencies allow for significant time for legislative, rule or policy changes and review by stakeholders.
- Considerations, at a minimum, should include:
    - TFC Service Model Definition
    - Eligibility Criteria based on standardized Best Practice Assessment tools
    - Standardized behavioral health assessment process
    - Qualifications for TFC Program provider agencies
    - Role of TFC parent as a provider of Medicaid TFC services (licensing/training)
    - Determining the treatment planning and intensive case management process
    - Service Authorization process
    - Service Limits based on identified individual plan outcomes
    - Payment Model developed across Medicaid and IV E
    - Identified Roles of other state agencies
    - Communication and Implementation Strategy
    - How TFC will function relative to the existing Levels of Foster Care
    - Licensing/Certification requirements
    - Title IVE and Medicaid funding will be structured to assure Federal compliance requirements are met, maximize all sources of Federal funds, and decrease reliance on state only funds for current Letters of Agreements
    - Identified standardized quality and outcomes measures for the TFC service (Individualized Treatment Plan would include case specific outcomes)
    - Attention to Permanency integrated into TFC Treatment Plan
    - Draft Implementation plan with Tasks, Responsible Entities, and Timelines
    - Impact on state budget, if any, and participating state agencies/divisions