NACBH News 11/20/19

Family First Transition Act Introduced

The Family First Transition Act was introduced in both chambers on November 5, with strong bipartisan support from the Senate Finance Committee and House Ways & Means Worker & Family Support Subcommittee. S 2777 and HR 4980 have identical language (requiring no conference negotiations if passed without amendments, as expected) and track with the draft summary released in September. As we reported then, the bill has three main provisions:

Phase-in of the 50% "well-supported" requirement for IV-E prevention services reimbursement: This provision would delay the requirement for two years, through fiscal year 2021, and then allow spending both "supported" and "well-supported" programs to count toward the 50% requirement in FYs 2022 and 2023. This would allow states to receive IV-E reimbursement for a wider range of prevention services while HHS builds up the clearinghouse, before the 50% "well-supported" requirement resumes October 1, 2023.

Transition funding to help states implement the Family First Prevention Services Act: This would provide a total of $500 million in one-time, flexible funding to support states' implementation of FFPSA, to reduce the adverse fiscal effects of startup costs, waiver transition, and improving foster care safety and quality. After a 3% set-aside for tribes, the funding would be distributed, without a match or any other reservations, using the same formula as is used to distribute title IV-B Part 1 funding.

Short-term funding certainty for states with IV-E waivers that expired September 30, 2019: This provision would provide temporary grants to the jurisdictions (22 states, D.C., and one tribe) whose IV-E waivers expired at the end of FY 2019, to ameliorate the significant loss of funds as they transition away from those waivers. The grants would be provided separately from IV-E reimbursement, to make up a portion of the difference, as follows:

- In FY 2020, not less than 90% of the amount the jurisdiction negotiated to receive under its waiver for FY 2019, and
- In FY 2021, not less than 75% of the jurisdiction's negotiated amount for FY 2019.
- This temporary, guaranteed funding would be in addition to the transition funding provided to all states.

We will keep you posted on the bill's progress.

NACBH News 11/6/19

CMS Issues Q&A on 1115 Waivers of IMD Exclusion

On November 4, the Centers for Medicare and Medicaid Services (CMS) issued technical assistance Q&As for states that wish to seek Section 1115 waivers to serve adults with serious mental illness or children with serious emotional disturbance in otherwise excluded Institutions for Mental Diseases (IMDs).

As earlier reported, CMS announced this new demonstration opportunity in November 2018, at that time increasing access only for adults. In late September, CMS expanded the demonstration authority to allow states to apply for waivers for children in Qualified Residential Treatment Programs (QRTPs). In the September 25 NACBH News, we described two requirements that limit the usefulness of this waiver authority:

- QRTPs covered by the waiver must comply with federal Medicaid regulations governing the use of seclusion and restraint in Psychiatric Residential Treatment Facilities (PRTFs). Those regulations don't specify 24/7 on-site nursing, but seem to require it, e.g., to receive a physician's order, to monitor a child during the intervention, and to evaluate the child afterwards.
- States have to achieve an average length of stay (ALOS) of no more than 30 days for all persons served in IMDs covered by the waiver.

This week's Q&A provides more detail on length of stay (LOS) limits and reporting:

- An IMD admission is limited to no more than 60 consecutive days, as long as the state continues to achieve a statewide ALOS of no more than 30 days.
- States may not claim for any part of a stay (beginning at admission) that exceeds 60 days.
- States must report on the ALOS in annual monitoring reports and in mid-point assessments.
- If a state is exceeding 30 days ALOS at a mid-point assessment, from that point forward, the 60 consecutive day limit for an individual admission is reduced to 45 days. If subsequent annual monitoring reports demonstrate ALOS up to 30 days, the state may resume claiming for stays up to 60 days.

Additional detail on the November 2018 and September 2019 CMS guidance was reported earlier and not repeated here. Please email Pat Johnston with any questions or to make sure you have accessed complete information using the links above.

Family First Prevention Services Act Update

According to our friends at the Chronicle of Social Change, 11 states and the District of Columbia will implement the Family First Prevention Services Act (FFPSA) this fiscal year. The Administration for Children and Families (ACF) approved D.C.'s plan last week, and is reviewing plans from five states now: Arkansas, Kansas, Kentucky, Maryland, and Utah. Six additional states have not yet submitted their plans: Alaska, Nebraska, North Dakota, Virginia, Washington, and West Virginia.

The Executive Summary of D.C.'s plan addresses only prevention services, and that may be the extent of what they're planning to implement this year. Our understanding is that Kentucky is taking the same approach – implementing only the prevention piece this year. We wouldn't be surprised to see that replicated elsewhere although, on the congregate care side, Arkansas has already begun establishing Qualified Residential Treatment Programs (QRTPs). Under the law, states may exercise the new authority to use IV-E funds for prevention services without making any changes on the congregate side other than to stop claiming IV-E reimbursement for children in congregate settings not covered by FFPSA.

Of the remaining 39 states, seven are expected to delay for one year (Colorado, Delaware, Georgia, Indiana, Iowa, Oregon, and Pennsylvania), and 32 for the maximum allowable two years (Alabama, Arizona, California, Connecticut, Florida, Hawaii, Idaho, Illinois, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Wisconsin, and Wyoming).

ACF continues to work its way through a long list of policy questions raised by states, most recently, two related to allowable IV-E administrative claiming. The federal Child Welfare Policy Manual will be updated to confirm that states may claim the administrative match for conducting and documenting evaluations of prevention services.

Much remains to be answered – and even asked! We look forward to a wide-ranging discussion at NACBH's upcoming Emerging Best Practices Conference, and the lengthy follow-up list that will certainly come out of it.

NACBH News 9/25/19

CMS Issues Q&A About QRTPs, IMDs, Section 1115 Waivers

Quoting from the cover email, last Friday the Centers for Medicare & Medicaid Services (CMS) issued a "technical clarification question and answer document focused on a type of residential setting recently defined in statute called a Qualified Residential Treatment Program (QRTP) for foster care children. These programs provide a trauma-informed model of care to address the needs of children with serious emotional or behavioral disorders or disturbances. This document clarifies that QRTPs may be included in the section 1115 demonstrations described in the State Medicaid Director Letter on Opportunities to Design Innovative Service Delivery Systems for Adults with Serious Mental Illness or Children with Serious Emotional Disturbance, issued in November of 2018.

The Q&A document identifies the statutory basis and definition of a QRTP, explains the Medicaid Institution for Mental Diseases (IMD) payment exclusion, discusses the intersection of a QRTP and the IMD exclusion, and explains how states may include QRTPs in a section 1115 SMI/SED demonstration to ensure Medicaid coverage for services provided to Medicaid enrolled children residing in QRTPs." NACBH is pleased to see this policy guidance from CMS headquarters, the first since the Family First Prevention Services Act passed in February 2018. It answers some questions, raises others, and helps us shape next steps in advocating for more effective Medicaid and child welfare policy.

In brief:

- While "CMS has not made a determination that all QRTPs will be IMDs," they imply that states are expected to determine whether any QRTPs with more than 16 beds are subject to the IMD exclusion. They reference a "current practice" of states determining which facilities are IMDs according to CMS' existing statute, regulation and sub-regulatory guidance. We're not aware that states are actually doing this, or that there is any federal oversight of it. The sub-regulatory guidance that NACBH has seen on how to determine whether a facility is an IMD is a bit murky. We will ask for links to all relevant documents.

- The statement that "QRTPs that are 16 beds or fewer would not meet the statutory Medicaid definition of an IMD" implies that CMS will amend a historical practice of cumulatively counting the beds owned and operated by the same entity, even if separately licensed and located, and using the total bed count in an IMD determination. We will inquire whether any change to that practice is anticipated.

- The Q&A allows for the possibility that a QRTP could meet the requirements of a PRTF and, therefore, not be subject to the IMD exclusion. While technically true that a facility could meet all QRTP and PRTF requirements, for billing purposes, it would seem necessary to be one or the other. As "inpatient psychiatric" settings, PRTFs have been paid a Medicaid per diem to cover room, board and active treatment. QRTPs are going to be separately reimbursed by IV-E or other non-Medicaid payer for room and board, and by a payer other than IV-E for treatment, in some cases Medicaid. It's difficult to word this elegantly, but more guidance may be needed around this both-and scenario.

- The Q&A dispenses with the suggestion that QRTPs be an exception to the IMD exclusion, by pointing out that QRTPs are federally defined as child care institutions. Adding QRTPs to the Psych Under-21 benefit is one administrative remedy that was floated by some advocates, which NACBH regarded as unworkable precisely because QRTPs are not "inpatient psychiatric" settings. QRTPS are not required to use physicians in any capacity and are only required to use nurses to the extent that their trauma-informed model dictates. It's difficult to make the case that that's an inpatient setting.

- The answer to Question 4 references Medicaid managed care rules that "permit FFP for monthly capitation payments to managed care plans for enrollees that are inpatients in a residential setting that may qualify as an IMD when the stay is for no more than 15 days during the period of the monthly capitation payment and certain other conditions are met." To our reading of the Medicaid managed care regulations, that provision is only applicable to enrollees between the ages of 21 and 64. We will ask CMS for clarification of this.

- The Q&A expands on the November 2018 CMS guidance on opportunities to design innovative service delivery service systems for adults with serious mental illness and children with serious emotional disturbance. Released in response to a 21st Century Cures Act requirement that CMS develop waiver options for states to improve care for these populations, the guidance did not actually offer any additional authority for how states could serve children. With last week's Q&A, CMS is allowing states to apply for 1115 waivers for children in QRTPs that meet the definition of excluded IMDs, with restrictions that make this a dubious option:

    - States have to achieve an average length of stay of no more than 30 days for all persons served in waivered IMDs.

    - The QRTPs covered by the waiver will have to comply with federal Medicaid regulations governing the use of seclusion and restraint. While the regulations do not specify 24/7 on-site nursing, the seclusion and restraint requirements seem to call for that coverage, depending on state scope of practice laws, i.e., to receive a physician's order, to monitor a patient during the intervention and evaluate the patient afterwards. In fact, in order to gain the support necessary to pass Family First, nursing was removed as a requirement for QRTPs (other than to the extent required by the trauma-informed model) because states objected on the grounds of workforce shortages and cost.

NACBH will be following up with CMS and colleague organizations. Please email Pat Johnston with your questions and feedback.

Family First: Draft Bill Under Discussion to Ease States' Transition

As we reported back in the Spring, several bills were introduced earlier this year to ease states' transition to full implementation of the Family First Prevention Services Act. None gained traction, and all attracted some level of opposition from advocates concerned that any flexibility would presage failure.

Last week, the one bicameral, bipartisan bill was scaled back to its highest priority and least objectionable provisions, and introduction of the Family First Transition Act is now expected as soon as this week. The draft proposal includes three provisions to help states, tribes, counties and cities plan for the significant reforms under Family First:

- Phase-in of the 50% "well supported" requirement for prevention services reimbursement
- Transition funding to help states implement Family First
- Short-term funding certainty for states with IV-E waivers that expire September 30

We are posting a summary of the draft proposal in Members Only – with a proviso that things may change before the bill is introduced.

NACBH News 07/31/19

Interaction of Family First and Medicaid

In late June, we learned that a regional CMS office had issued the following reply to an inquiry from the state child welfare agency in Kentucky, which plans to implement Family First this year:

Q: Does the current QRTP description in FFPSA qualify as an IMD?

A: CMS has reviewed the FFPSA definition of a QRTP. We believe that QRTPs that are over 16 beds and do not qualify as an exception to the IMD exclusion under the inpatient psychiatric services for individuals under 21 at 42 CFR 440.160 as a PRTF would be IMDs.

Armed with this – the first clear, federal statement on the issue – we prepared all of our child welfare and Medicaid speakers with our top two questions:

Who will pay for Family First prevention services that are covered by both IV-E and Medicaid, since both programs claim payer of last resort status? [note: We later realized this question was answered by a provision in the SUPPORT for Patients and Communities Act – IV-E is payer of last resort in this scenario.]

Who will pay for health care services of children in congregate settings allowed under IV-E but excluded as Institutions for Mental Diseases under Medicaid?

It was clear from our conversations during the conference that the need to resolve the underlying misalignment between IV-E and Medicaid is finally gaining traction, although we don't have any answers yet. The panel of majority and minority staff leads from Senate Finance and House Ways & Means (the committees with jurisdiction over Family First) acknowledged without elaborating that they're working on unintended consequences that have come to their attention. On the Medicaid side, no one from House Energy & Commerce was available to join us, but we did have an opportunity to voice our concerns to the majority staff lead from Senate Finance. We also pressed the issue with Kirsten Beronio, CMS, knowing she couldn't talk about any ongoing internal or inter-agency policy deliberations, but reinforcing the urgent need to issue guidance for states and providers. Lindsey Browning, National Association of Medicaid Directors, said that Family First is not really on the State Medicaid Directors' radar screens yet, as we all await federal policy clarification. Again, our goal was to establish NACBH as a resource and tenacious advocate, and NACBH members as knowledgeable stakeholders and willing partners.

We were also pleased to hear from John Kelly, Editor-in-Chief of the *Chronicle of Social Change,* on the wealth of state-based information he has collected in his reporting on Family First implementation. He made good use of the opportunity to query us on the IV-E/Medicaid issues, and is planning to cover them soon, both in the *Chronicle* and in a webinar which will include a presentation from NACBH. More details on that as soon as known.

Finally, an update on another recent advocacy push for resolution of the congregate care/IMD conflict. Last week, there was a conference call hosted by the Association of Children's Residential Centers, led by their public policy committee and the National Organization of State Associations for Children (NOSAC), to kick off a "call Congress" campaign. Earlier this month, NOSAC wrote to Senate Finance Chairman Chuck Grassley (R-IA) and Ranking Member Ron Wyden (D-OR), urging immediate action and suggesting two possible administrative solutions. These were offered to the conference call participants for their contacts with Members of Congress.

From NACBH's perspective, while any chipping away at the IMD exclusion is progress, we believe the only real solution is to eliminate the exclusion from the Medicaid law. Without a statutory change, any solution would have to use existing authority. Our view of the challenges posed by the two potential administrative actions:

- Establish QRTPs as "an other setting defined by the Secretary" under 1905(a)(16), inpatient psychiatric hospital services (the "Psych Under-21" benefit). This would be a bit of a stretch, since QRTPs do not require physician direction, and nursing is not required 24/7, on-site, or at all if the trauma-informed model used by the QRTP doesn't call for it. It would be difficult to characterize this as an "inpatient psychiatric" setting.

- Use Section 1115 waiver authority to allow reimbursement of health care services for children in QRTPs (while IV-E or some other source would pay for room and board). The problem with this approach is that 1115 waivers have to be cost-neutral to the federal government, and the only way to demonstrate cost neutrality would expose the illegal FMAP claiming that has been occurring all along.

See also several good one-pagers on our conference resource page: *What is an IMD? What is a PRTF? What is a QRTP?*

Federal Updates: Family First Prevention Services Act

As we reported in the June 19 *NACBH News,* the Administration for Children and Families (ACF) announced a policy, with guidance pending, on allowing transitional coverage of prevention services while the new Prevention Services Clearinghouse has a chance to review and rate (or reject) interventions as promising, supported, or well-supported. On July 18, that guidance was issued.

To receive transitional IV-E payments, the guidance details how states must conduct independent, systematic reviews of the proposed programs and services that are not yet rated by the Clearinghouse, and the documentation they must submit with their five-year plan. On quick reading, it appears that states may propose interventions that have not been subject to randomized control or quasi-experimental studies, which may offer states some temporary flexibility in how they use the new IV-E prevention authority. However, the Clearinghouse standards require either a randomized control or quasi-experimental study in order to review programs and services, so approved transitional coverage may not survive eventual consideration. If the Clearinghouse later determines that a service is not approved, IV-E payments will stop in the following fiscal quarter.

On July 24, ACF announced that two new programs have been rated by the Clearinghouse: Healthy Families America, a home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences, and Methadone Maintenance Therapy, a medication-assisted treatment to reduce the use of heroin and other opioids.

NACBH News 06/19/19

ACF Issues Update on Covered Prevention Services Under Family First Act

On June 6, the Administration for Children and Families (ACF) released a letter acknowledging the still-pending ratings of prevention services for coverage under the Family First Prevention Services Act.

In the letter, ACF Associate Commissioner Jerry Milner says that the Children's Bureau plans to issue guidance in the coming weeks, allowing states to claim "transitional payments" under the new Title IV-E prevention program until the Clearinghouse can review and rate a service or program, if a state submits sufficient documentation.

The guidance will specify what is sufficient documentation. It is not clear whether states will be subject to retroactive recoupment of transitional payments, should the Clearinghouse later determine that a service was not promising, supported, or well-supported.

NACBH News 03/13/18

FAMILY FIRST PREVENTION SERVICES ACT HEIGHTENS CONFLICT WITH THE MEDICAID IMD EXCLUSION

The surprise enactment of the Family First Prevention Services Act (FFPSA) last month has reanimated NACBH's decades-long fight to eliminate the antiquated and discriminatory Institutions for Mental Diseases (IMD) exclusion in federal Medicaid law. By creating in the FFPSA a federal definition of a new type of residential facility that appears to be an excluded IMD – qualified residential treatment programs (QRTPs) – Congress has given national visibility to child welfare institutions that have flown under the IMD enforcement radar since Medicaid was created in 1965.

What FFPSA does:

For a narrative description of what the FFPSA includes, please see three sets of "Cliff Notes" prepared by *The Chronicle of Social Change.* Part One describes services to prevent foster care placements, Part Two, provisions limiting federal financing for congregate care, and Part Three, miscellaneous amendments to kinship navigator programs, family reunification, foster home recruitment and retention, Chafee programs, and others. The Children's Defense Fund has posted a brief summary, a detailed summary, and an implementation timeline of the law's various provisions.

What are the restrictions on congregate placements?

For NACBH, the most critical provisions in the law are restrictions on IV-E reimbursement for children in congregate care, and the unanswered question – which we raised many times with the relevant Congressional committees as the bill was developing – of who will pay for their health care. This section of the FFPSA is titled Ensuring the Necessity of a Placement That Is Not In a Foster Family Home. Beginning in the third week that a child is formally placed in foster care, states may only claim IV-E foster care payments on behalf of a child living:

- in a foster family home licensed or approved by the state,
- with their parent(s) in a licensed, family-based residential substance abuse treatment facility,

or in one of the following child-care institutions:

- a qualified residential treatment program (QRTP), defined below,
- a setting specializing in providing prenatal, post-partum, or parenting supports for youth,
- a supervised independent living setting, or
- a setting providing high-quality residential care and support services to children who have been or are at risk of becoming sex trafficking victims

How the IMD exclusion comes into play:

Any of these four types of child-care institutions could potentially be identified under Medicaid as an excluded IMD. QRTPs would be most likely to fit the federal definition, the other three, less so. In addition, family-based residential substance abuse treatment facilities could fit the definition of an excluded IMD.

States may not legally claim federal Medicaid reimbursement for any health care services provided to residents of excluded IMDs – although we know they do. Enforcement of the IMD exclusion is inconsistent because CMS relies on states to comply against their own financial interest, and difficult

because CMS can't identify from what look like outpatient claims that beneficiaries are, in fact, residing in excluded IMDs.

This is an egregious disconnection of the federal child welfare and Medicaid statutes, which NACBH has raised repeatedly with Congress in advocating for a legislative fix, and with CMS in advocating for regulatory or policy changes. We will follow up in next month's NACBH News with an update on our advocacy plan to address the IMD exclusion.

Additional restrictions on congregate placements:

Children living with their parent(s) in a licensed, family-based residential substance abuse treatment facility:

- The child's case plan must recommend this placement.
- The treatment facility must provide parenting skills training, parent education, and individual and family counseling.
- The treatment and related services must be trauma-informed.
- The placement is limited to 12 months.

Children placed in QRTPs:

- Within 30 days of placement in a QRTP, a qualified individual must assess the child's strengths and needs using an age-appropriate, evidence-based, validated, functional assessment tool to determine if the child's needs can be met with family members, in a foster family home, or one of the other approved settings.
- If the QRTP placement is determined to be appropriate, the reasons must be documented in writing. A shortage of foster family homes is not an acceptable reason.
- Within 60 days of placement, a court must review the assessment and approve or disapprove of the placement.
- If the court determines that QRTP placement is not appropriate, the state must transition the child to an appropriate setting within 30 days. During that time, IV-E reimbursement will continue.
- At every permanency hearing for children remaining in QRTPs, the state agency must demonstrate ongoing assessed need, as well as updated treatment and discharge planning.
- For children under age 13 in a QRTP for 6 consecutive or non-consecutive months, the state must submit to HHS the most recent evidence and documentation supporting the placement, with a signed approval by the head of the state agency.
- The state must do the same for children 13 and older in a QRTP for 12 consecutive or 18 non-consecutive months.

What are QRTPs?

The FFPSA describes the new qualified residential treatment program, to be further fleshed out in state regulations, as a program that:

- Has a trauma-informed treatment model that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.
- Has registered or licensed nursing staff and other licensed clinical staff who:
    - provide care within their state-defined scope of practice
    - are on-site consistent with the QRTP's treatment model, and
    - are available 24 hours/day, 7 days/week.
- As appropriate, facilitates participation of family members in the child's treatment program.
- Facilitates and documents outreach to family members, including siblings, and maintains contact information for any known biological family and fictive kin of the child.
- Documents how family members are integrated into the treatment process, including post-discharge, and how sibling connections are maintained.
- Provides discharge planning and family-based aftercare support for at least 6 months post-discharge.
- Is state-licensed and is accredited by CARF, COA, the Joint Commission, or another independent, nonprofit accrediting organization identified by the HHS Secretary.

Please email pat.johnston@nacbh.org with questions and comments, as we develop more information materials and track the development of regulations and guidance.