State of California—Health and Human Services Agency
Department of Health Care Services

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Mr. James G. Scott, Director
Division of Program Operations
Medicaid and CHIP Operations Group
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 0300
Kansas City, MO 64106-2898

Dear Mr. Scott:

This letter concerns California's implementation of the Family First Prevention Services Act[1] (FFPSA) requirements for Qualified Residential Treatment Programs (QRTPs). California is in the process of planning for its Short-Term Residential Therapeutic Program facilities (STRTPs) and group homes to align with the federal QRTP requirements. Below we outline the intent of the FFPSA, as well as background regarding QRTPs, STRTPs and Institutions for Mental Diseases (IMDs), and information regarding why STRTPs are distinct from IMDs. We request that CMS recognize these distinctions and provide guidance indicating that STRTPs are not IMDs. This guidance will support the state's continued provision of critical CMS-approved Medicaid services to vulnerable children in foster care.

Intent of FFPSA

The intent of the FFPSA is to restrict the use of congregate foster care, unless absolutely necessary, by limiting Title IV-E maintenance payments to specified congregate care settings meeting defined requirements. The definition of QRTPs, one of these specified settings, has surfaced as potentially overlapping with Title XIX's statute defining an IMD. If an STRTP or group home is classified as an IMD, it could result in the loss of federally funded Medicaid coverage for eligible children.

The intent of the FFPSA is to provide an individualized approach to serving foster youth who have been removed from their families due to a court finding of abuse and neglect and who, lacking a family-home caregiver able to meet the needs of the child, require short-term placement in a child care institution (CCI),[2] or what we refer to in California

[1] Public Law (P.L.) 115-123

[2] 45 CFR § 1355.20 and 42 CFR § 435.1010. (*Child-care institution* means a nonprofit private child-care institution, or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the state in which it is situated, or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for

as a children's community care facility. The intent of the law is also to ensure that these community care facilities have the competencies and services necessary to develop and implement a trauma-focused plan for each child to transition to a family-home setting. Additionally, the intent of FFPSA is to increase oversight of placements into congregate care settings to ensure each child's placement into an STRTP is the least restrictive setting, and ensure that children are placed in a setting that provides the most effective and appropriate level of care consistent with a child's short- and long-term goals.

When the Medicaid program was established in 1965, states were required to provide health care coverage to all individuals receiving assistance under Title IV, which included dependent children placed in CCIs. As recently as 2013, CMS noted that approximately 90 percent of children in foster care have been exposed to trauma and reiterated its commitment to working with states to ensure coverage of benefits and service delivery options for children who have experienced trauma.[3] A broad application of the IMD exclusion to QRTPs, as such STRTPs, with more than 16 beds, as suggested in the CMS Technical Assistance Questions and Answers released on September 20, 2019, would jeopardize Medicaid funding, oversight, and quality controls for many vulnerable children who have historically been a priority for the Medicaid program. This expansive interpretation would dismantle the current network of children's residential community care settings, leading to increased placement of children who lack a family-home caregiver into medicalized, hospital-like settings.

The Department of Health Care Services (DHCS) requests that CMS interpret the IMD exclusion as not applicable to STRTPs (or QRTPs) based on the information below. This will enable the State to continue providing CMS-approved specialty mental health services and other Medicaid covered services to children placed in these facilities.

Primary Functions of Foster Care Placements (including QRTPs)

The primary purpose of a foster care placement is to provide 24-hour out-of-home care and supervision to children whose families are unable or unwilling to care for them, and who are in need of temporary or long-term substitute parenting. When a child is in a foster care placement setting, the child or youth is under the care, custody, and control of the state child welfare agency, as a result of being removed from their home or other situation. The goal of the foster care system is to provide stability and permanency for the child, either through a plan of reunification with the family of removal or placement in a different family-based setting. To reach those goals, many youth require additional

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licensing. The term does not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.)

[3] SMD 13-07-11, pp. 1, 11, available at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

supports and a milieu of trauma-informed services[4] and team-based supports at a higher level of placement on a short-term basis. FFPSA authorizes such a setting through the establishment of a QRTP wherein children and youth who have experienced adverse childhood experiences and the acute trauma, including abuse, neglect, and removal from the familial home, can receive intensive services and support which then allow them to transition to the safety and stability of a permanent family and later become successful adults.

QRTPs/STRTPs

Authorized as a type of Title IV-E eligible CCI, QRTPs serving children in foster care must have a trauma-informed treatment model; the ability to provide care and supervision to youth living with a serious emotional or behavioral disorder or disturbance; a registered or licensed nursing staff and other licensed clinical staff available and on-site, according to the treatment model; and other characteristics such as family outreach, participation, and integration into the child's treatment program; discharge planning; and family-based aftercare services. Each placement in a QRTP requires third-party assessments and court approval of the appropriateness of the placement. Public CCIs may have no more than 25 beds, and private providers have no bed count restriction.

STRTPs are a type of children's residential facility licensed by the California Department of Social Services (CDSS) to provide an integrated, short-term program of specialized supervision, services, and supports, including a specific set of core services that are intended to provide high-quality parental caretaker services, including trauma-focused child-care supervision and developmentally appropriate engagement for youth who temporarily need a higher level of care in order to support their ability to attain permanency in the least restrictive setting. In addition to child care supervision, core services include specialized permanency services, such as family finding and family engagement activities; transition support services for youth; educational supports; physical, behavioral, and outpatient mental health supports; supports for transition-age youth; outpatient specialty mental health services; and guidance regarding serving Indian children. Youth receive a mixed array of services through multiple systems, including but not limited to, child welfare, education, juvenile justice, Medicaid, etc. A multi-disciplinary local entity, the Interagency Placement Committee (IPC), is responsible for assessing a youth to determine if this level of care is necessary. The

[4] Substance Abuse and Mental Health Services Administration (SAMHSA) has explained that a trauma-informed approach means that all people at all levels of the organization or system understand how trauma can affect individuals, families, groups, organizations, and communities. This approach recognizes that trauma is not confined to the behavioral health specialty service sector, but is integral to other systems such as child welfare. According to SAMHSA, a trauma-informed approach is a promising model that promotes resilience in staff and patients. As such, California has pursued policy efforts to move STRTPs and group homes toward a model that a) understands the traumas experienced by a child in the foster care system and b) is equipped to provide the services and supports that child needs.

IPC is also responsible for identifying the necessary services and duration of care for a youth's needs and services plan, with participation and input by a Child and Family Team (CFT). While it is anticipated that children in this care setting, like many children in a family-based care setting, may need intensive outpatient mental health services, children in need of a hospital inpatient level of care are excluded from placement into this care setting.

IMD

Under Title XIX, federal funding is allowed to be claimed for the treatment of mental illness unless the setting it is being provided within is deemed an IMD. An IMD is defined as, "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[5] An institution is an IMD if "its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with a mental disease."[6] In short, the primary function of an IMD is the provision of medically-oriented care and other services to individuals with a mental disease.

Why STRTPs are not IMDs

The CMS State Medicaid Manual Section 4390 provides guidelines to evaluate whether a facility has the "overall character" of an IMD. Below, DHCS addresses each of the Section 4390 criteria in relation to STRTPs and requests CMS' review of these elements in order to provide guidance to California regarding STRTPs.

1) **STRTPs are not licensed as psychiatric facilities.** STRTPs are licensed by the state child welfare agency as unlocked child residential community care facilities. Per the federal child care institution guidelines, STRTPs are primarily engaged to facilitate each child's timely transition to a safe, stable family home environment consistent with the child's permanency plan. As a children's residential facility, an STRTP is licensed to provide integrated, specialized, short-term, 24-hour nonmedical care and supervision, coordinated case management and intensive family finding and engagement, services and supports, and mental health services.

2) **STRTPs are not accredited as psychiatric facilities.** Rather, STRTPs must have nationally recognized accreditation from an agency with expertise in programs for children or youth group care facilities. The accreditation standard required for this model is not the psychiatric facility accreditation standard. The primary role of the STRTP is to provide child care supervision, and while the model is designed to improve a youth's permanency outcomes, it is also intended to prevent a youth's need for hospitalization, including admission to a psychiatric facility. The role of the STRTP, or FFPSA's QRTP,

[5] 42 U.S.C. § 1396a(i)
[6] State Medicaid Manual. Section 4390

is not to diagnose, treat, and provide mental health care, and therefore, accreditation as a psychiatric facility is not appropriate. The three state-identified accrediting entities for STRTPs are the Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission on Accreditation of Healthcare Organizations. However, the accreditation types and levels vary and current statute does not specify what type of or level is required. California has facilities accredited by CARF under a residential certification. Some facilities accredited under COA include certifications for both residential and outpatient mental health services.

3) **STRTPs are under the jurisdiction of the state child welfare authority.** STRTPs are nonmedical community care facilities licensed by the CDSS, which is the State's child welfare authority. That said, DHCS and County Mental Health Plans oversee the Medi-Cal specialty mental health services provided by an STRTP to a Medi-Cal beneficiary and must approve the STRTP's mental health programs within one year of licensure.

4) **STRTPs are not required to have psychiatric or psychological staff.** STRTP staff primarily include direct care staff,[7] a certified administrator, facility manager, and a rehabilitation specialist,[8] all of whom may be considered part of the staffing ratio under certain circumstances. From 7 am to 10 pm, there must be one awake and on duty direct care staff for every three children. From 10 pm to 7 am, there must be one awake and on duty direct care staff for every six children.

Under DHCS' interim STRTP regulations, STRTPs are required to have a half-time equivalent licensed mental health professional for every six children and a psychiatrist available. However, an STRTP's primary purpose is not to treat the mental illness; rather, these facilities are intended to provide direct care and supervision to children living outside of their home and have the capacity to meet therapeutic needs the child may have.

FFPSA further requires that a licensed clinician and a registered or licensed nurse must be available 24/7 but only on-site per the treatment model of the program. Additionally, the needs and care plan for youth in an STRTP is developed through a consensus-driven process conducted by members of the IPC and CFT, which include clinical team members and a clinical assessment, but as part of the overall plan to ensure intensive care coordination and specialized permanency services. Therefore, an STRTP is not an IMD with regard to the staffing composition, the care services, and the development and execution of the multidisciplinary care plan, which are not solely lead by clinical staff.

[7] A "Direct care staff" means an employee of an STRTP who act as the primary caregiver.
[8] The mental health rehabilitation specialist is someone with a baccalaureate degree and four years of experience who is designated by a STRTP to oversee and implement the overall mental health treatment program.

5) The current need for institutional placement of most children in an STRTP results from foster care placement and dependency findings. First, children under the care and supervision of a child welfare agency have been removed from their families due to a court finding of abuse and neglect, and thus, are primarily in need of parental caregiving support and trauma-focused, developmentally appropriate child care supervision and engagement. Placements into an STRTP require a multi-disciplinary independent decision-making process and a court order to ensure the placement is the least restrictive placement for the child.

Second, STRTP admission criteria disallow placement for youth deemed to require inpatient psychiatric admission. A condition for placement into an STRTP includes that the child does not require hospital inpatient level of services or care. While some youth may have a diagnosis, many have disturbances which are not classified by the International Statistical Classification of Diseases and Related Health Problems, 10th Revision or the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Regardless of placement setting, many children who have been adjudicated wards of the state due to parental abuse or neglect need behavioral, mental health, and trauma-focused rehabilitative services; when children require an STRTP level of care and supervision, California should not be precluded from efforts to ensure that those settings are high-skilled and equipped to meet the therapeutic needs of children.

The FFPSA was intended to ensure each placement into a setting that is not a foster family home is the least restrictive placement for the child and to ensure that when a child must be placed into an STRTP, they are served by programs capable of meeting their needs. These residential settings are in no way designed for the primary purpose of diagnosing and treating a mental disease. On the contrary, entrance criteria expressly preclude placement of children who require inpatient care for that purpose. STRTPs are designed to provide for high-quality child care supervision and engagement of children and other parental caretaker services, and to provide transition case planning and permanency services. Children who require an STRTP level of child care supervision frequently have trauma-related mental health and behavioral heeds requiring therapeutic support. States should not be precluded from ensuring that all allowable IV-E placement settings are designed to have high-quality programs that are well equipped to meet the trauma-related needs of children served by a child welfare agency.

Conclusion

The primary purpose of an STRTP is to provide 24-hour substitute (custodial) care and supervision for children in foster care who require intensive services and supports on a short-term basis in order to transition to a family-based setting. As such, these placements should not be considered IMDs, which are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. As this group of children are those with some of the highest needs for care and supervision and other services (perhaps only one of which addresses a mental health diagnosis), as well as the needs presenting as a consequence of their abuse, neglect, and removal, it is clearly an unintentional consequence of the law that the population with the most prevalent acute and long-term health care needs covered by Medicaid would no longer be covered. In passing the FFPSA for the purpose of improving access to high-quality and least-restrictive placements, CMS should operate under the assumption that it was not the intent of Congress to endanger access to and receipt of federal funds associated with the child's Medicaid entitlement.

Accordingly, DHCS requests that CMS provide a determination that acknowledges that the IMD exclusion does not apply to STRTPs. We ask that you respond to this request as soon as possible given that California must incorporate a CMS decision into current Medi-Cal efforts and come into compliance with the FFPSA by October 1, 2021.

If you have any questions or comments, we are available to discuss further.

Sincerely,

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