The Family First Prevention Services Act

Qualified Residential Treatment Programs

March 17, 2020

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March 17, 2020
For the
Office of Child and Family Services
Maine Department of Health and Human Services

Today's goals are threefold

1. To understand the reasoning behind the Qualified Residential Treatment Programs (QRTP's) requirements

2. To clarify the requirements for QRTP's

3. To provide an opportunity for input into Maine's implementation of the law

(While the Family First Prevention Services Act has many components, including new funding for preventive family services, new resources for kin, and new requirements for foster families, today's discussion will focus on QRTP requirements only.)

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Since 1978, federal law and policy have clarified specific child welfare values based on common problems and science

Federal law over the years has attempted to:

1. Ensure that efforts are made by caseworkers to **prevent removals** unless absolutely necessary,
2. Ensure efforts to **strengthen families** to prevent the need for removal,
3. Ensure that efforts are made to **place with kin** as a first option for placement,
4. Ensure that there is **stability** while in care,
5. Ensure that any placement is **family-based** unless a therapeutic group environment is essential,
6. Ensure that children's needs for **permanence** are met timely through adoption, reunification, kin permanence, or guardianship, and
7. Ensure that **youth aging out of care have opportunities** to make up for what the system may have failed to provide.

These values have been emphasized through incentives, penalties, instructions, federal reviews, and waiver efforts

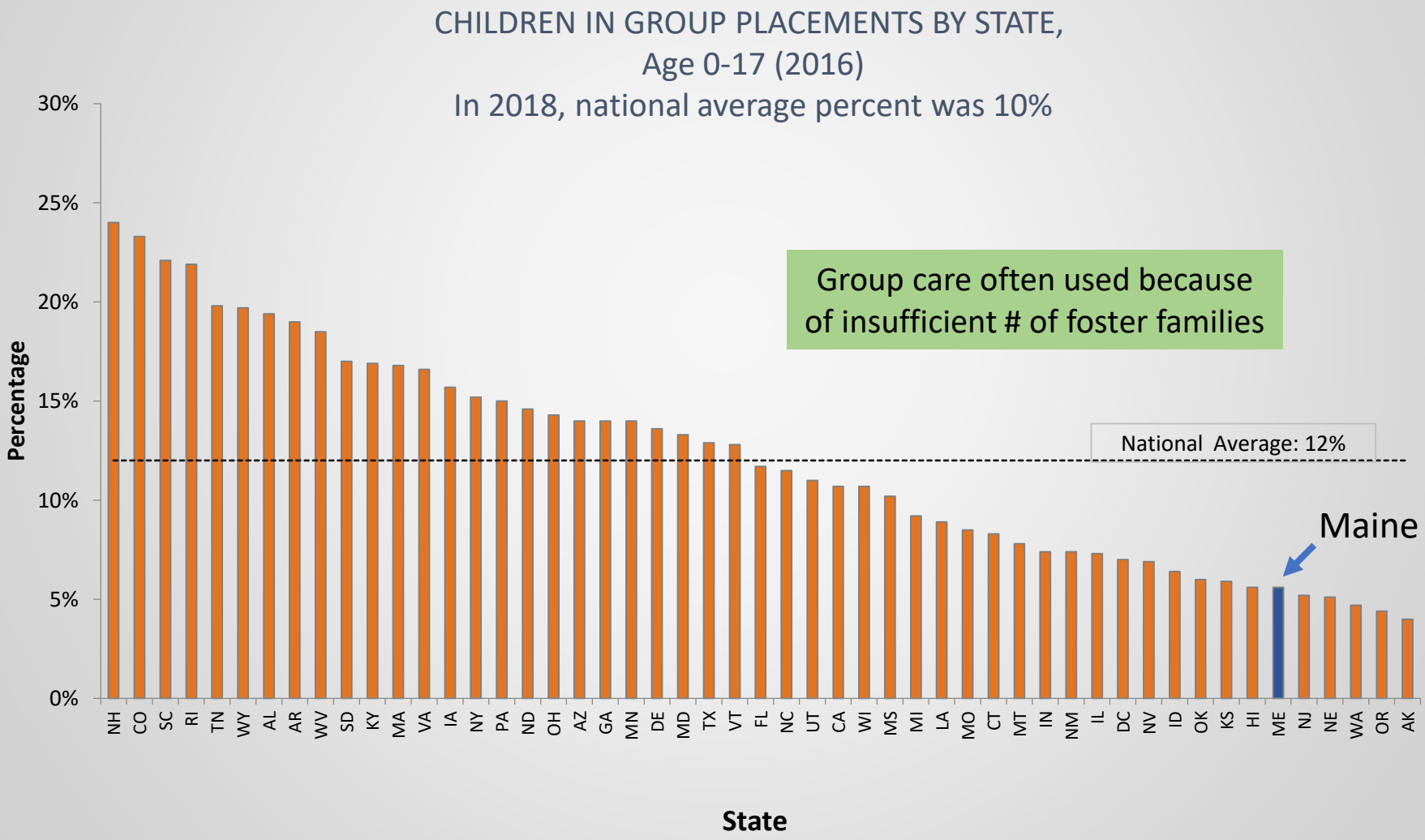
- The addition of new laws and new funding over the years has attempted to overcome problems and address new knowledge.

- The area of science that has been most meaningful to the field has been child and adolescent development:
  - Attachment and trauma
  - Impact of group placements
  - Adolescent brain development

The Family First Act is the most significant federal child welfare legislation since 1980

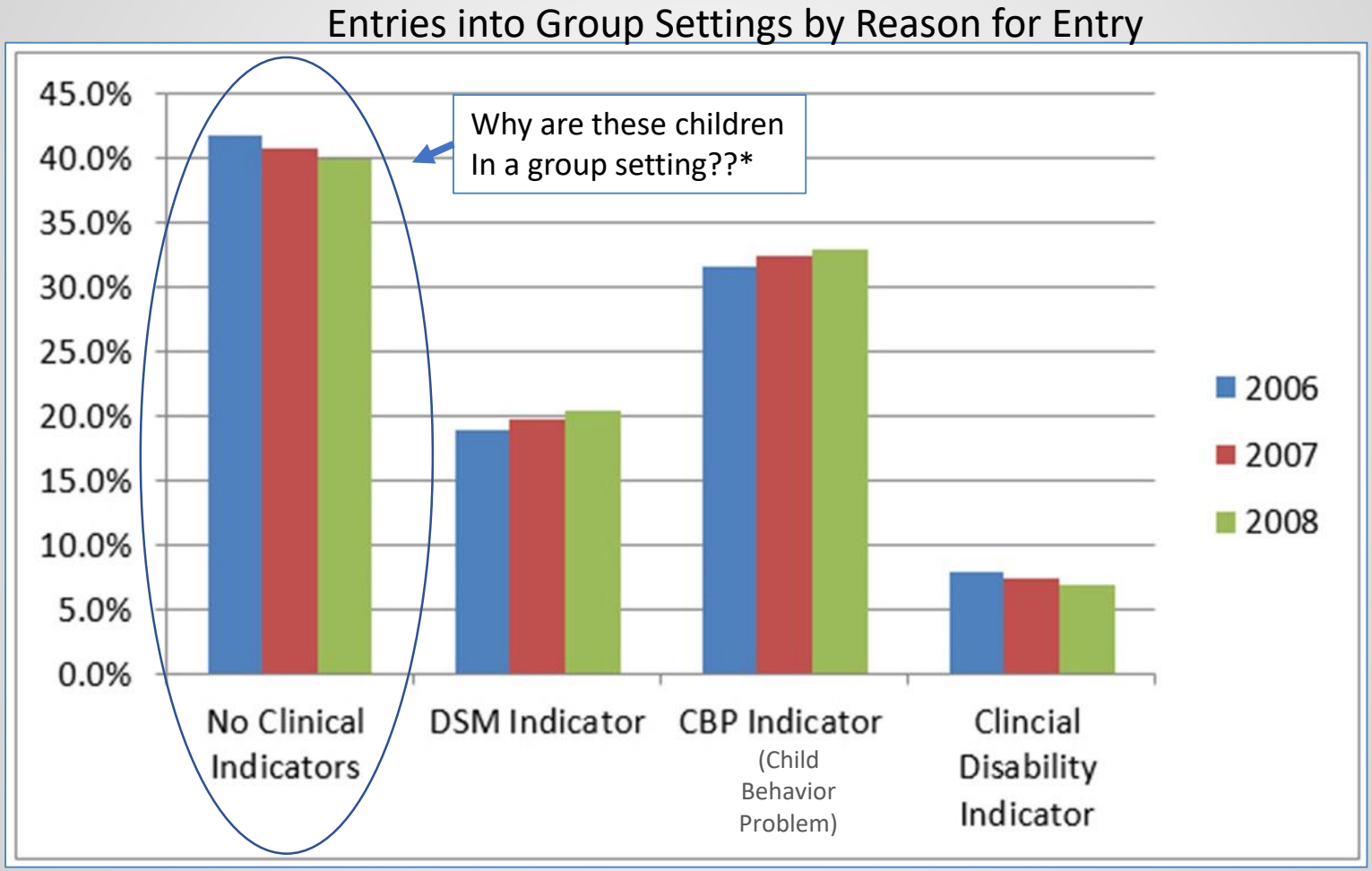
- Substantial changes to federal child welfare financing – new resources available, new restrictions on reimbursement
- Captures many years worth of data and analysis that pinpointed significant practice weaknesses in the states and updates practice based on new knowledge
- It addresses the concern that while Title IV-E reimbursed for placements, it did not reimburse for services to prevent placement and strengthen families
- Was able to be enacted because it assumed that funding reductions in the inappropriate use of group care would be available to fund preventive services
- Inappropriate use of group placements would be addressed through new Qualified Residential Treatment Program (QRTP) requirements

QRTP requirements are based on data showing inappropriate use of group care in many states



Source: Analysis completed by Annie E Casey Foundation using AFCARs FFY2016 data

A study completed by the US Children's Bureau revealed the number of children placed in group care with no clinical indicators



*More likely to be young children.

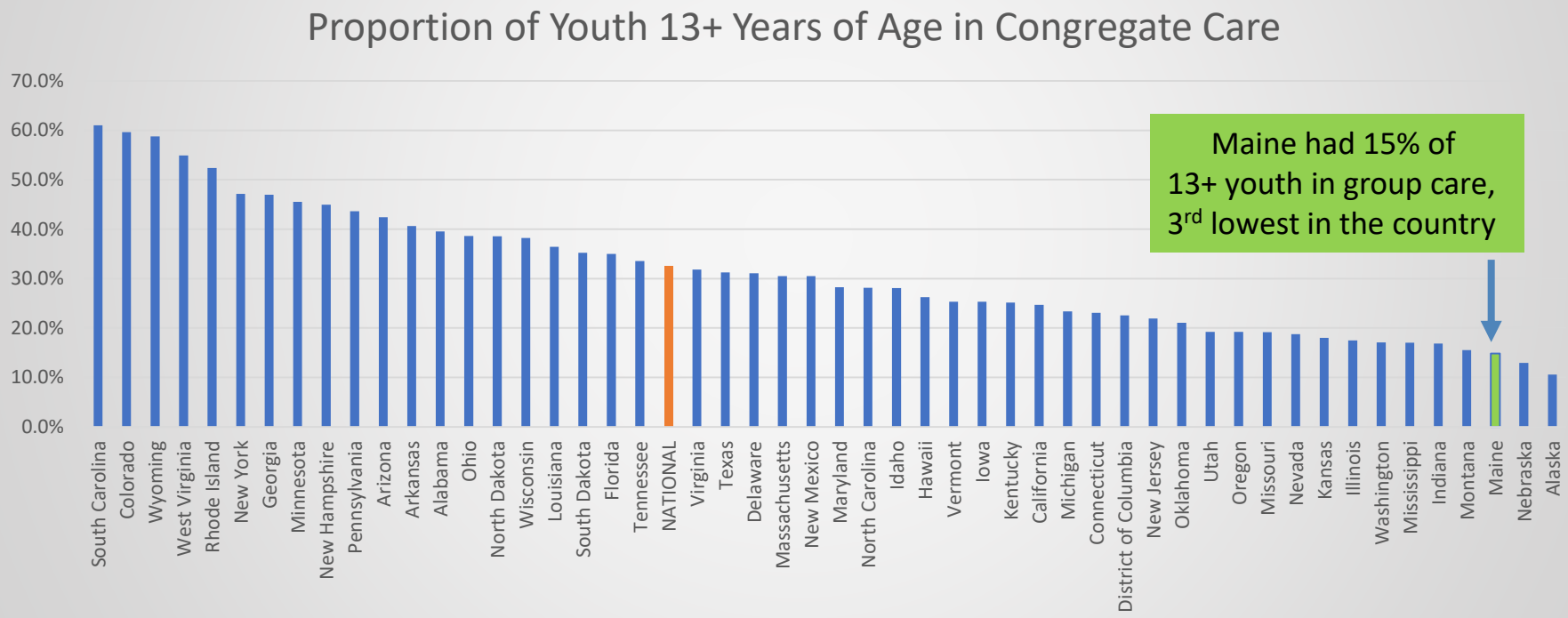
USDHHS, ACF, Children's Bureau, "A National Look at the Use of Congregate Care in Child Welfare", May, 2015.

CBP = Child behavior problem

The federal longitudinal study looked at children who entered care in 2008 and followed them for 5 years

- Of children 12 and younger:
  - Represented 31% of children who experienced group care.
  - 21 states had percentages of children in group care that were above the national average of 31%.
  - States ranged from 6% to 69% of children 12 and younger who experienced group care.
- Of children 13 and older:
  - About half experienced a group care placement at some point.
  - About one quarter entered group care as their first placement.
  - More than 4 in 10 entered due to a behavior problem with no other clinical indicator.

In 2018, the national average of children 13 and older in group care 33%



AFCARS, 2018 data

Family First offers huge opportunities for preventing the need to place children in foster care

- Opportunity for open-ended, federal reimbursement for services to prevent entry into foster care for all children at risk of foster care without eligibility requirements.

- Opportunity to beef up kin and foster family resources

- Opportunity (and restrictions) to:
  - Reduce the use of group placements used inappropriately,
  - Improve quality of residential treatment,
  - Group placements used solely for lack of foster families won't be reimbursable, nor will group placements that are non-therapeutic

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Basic requirements for QRTPs address licensing, accreditation and staffing

- QRTP is one of 4 federally reimbursable (through Title IV-E), non-foster family placement settings for a child removed from their family and involved with the child welfare system.
- QRTPs must be licensed as a child care institution by the state child welfare agency (or designated state licensing authority).*
- QRTPs must be accredited by the Council on Accreditation (COA), the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF)**
- QRTPs must have registered or licensed nursing and other clinical staff onsite consistent with QRTP trauma-informed treatment model, and available 24/7***.
- Criminal background checks required for adults working in QRTPs and other group settings.

*In accordance with section 471(a)(10) of the Social Security Act.
**Or another independent not-for-profit accrediting organization US HHS approves.
***These staff do not have to be directly employed by the QRTP.

The Family First Prevention Service Act requires a trauma-informed treatment model in all QRTPs

- QRTPs must have a trauma-informed treatment model:
  - That is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances, and
  - Be able to implement the necessary treatment identified in the child's assessment.
  - EXAMPLE: If the assessment recommends a specific trauma-informed treatment program, such as Trauma-Focused Cognitive Behavioral Therapy, or intensive child and family therapy such as Trauma Systems Therapy, the QRTP must be able to provide it.

Although trauma informed treatment is required, Title IV-E federal reimbursement is not available for treatment costs

- Title IV-E reimburses “maintenance” costs only, which include;
  - Room and board,
  - Supervision,
  - Case management and
  - Allocated indirect costs for eligible children.
- This coverage did not change with the new law.
- Federal reimbursement through Title IV-E continues to be unavailable for clinical services, research and educational costs.

Family First offers reimbursement for specialized placements that do not have to meet QRTP standards

- Opportunity to reimburse **parent/ child substance abuse** residential treatment: Title IV-E will cover board and care, supervision costs of children of adults in substance abuse treatment.
- Opportunities for reimbursement for victims and youth at risk of **sex trafficking:** Residential treatment programs specializing in sex trafficking are reimbursable outside of QRTP requirements, but must have a highly specialized treatment program.
- Opportunity to improve services for **pregnant and parenting** foster youth. Residential programs for pregnant and parenting teens are reimbursable outside of QRTP requirements.
- Assumption is that programs for these specialized populations will not be used inappropriately.

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New restrictions on intake and assessment will limit a child's access to residential settings

- To gain access to residential treatment an assessment must determine that the child's needs **cannot be met in a less restrictive, family-based setting** because of their emotional or behavioral disorders or disturbances.
- Assessment must have been completed by a "Qualified Individual" within 30 days of placement.
- A Qualified Individual cannot be associated with the public agency or the residential program.
- The Qualified Individual must use an age-appropriate, evidence-based, validated, and functional assessment tool to assess the child's needs and strengths.
- During the assessment, the Qualified Individual must work with a "family and permanency team" assembled by the agency.

Assessment documentation requirements for placement in a QRTP are significant

- The assessment must:
  - Determine if family members or another appropriate placement can meet the child's needs,
  - Determine the least restrictive setting consistent with the child's permanency plan, and
  - Be consistent with the child's short and long-term goals.
- The assessment must document why:
  - Having the child/youth live with a foster family or one of the other acceptable non-family foster home settings cannot meet their needs, and
  - Why QRTP is the most effective and appropriate level of care. (Lack of foster families is *not* an allowable reason.)
- A DSM diagnosis is not required for placement into a QRTP for Title IV-E funding (but is required for Medicaid reimbursement).

The assessment process is more family-centered than was required in the past

- The assessment must:
  - Document the **family and permanency team's placement preference**,
  - Acknowledge the importance of keeping siblings together, and
  - If family preference is different from the assessor's, **document the reason why the preferences of the child and the team are not recommended**.
- The assessment must develop a list of child-specific short- and long-term mental and behavioral health goals.
- At each status review and permanency hearing, evidence must be submitted that the placement in the QRTP **continues to be necessary and is meeting the child's needs**.

Federal reimbursement for QRTP placements involves strict timelines

- If the assessment has not been **completed within 30 days**, Title IV-E reimbursement of maintenance costs is unavailable for the entire placement episode.
- If the assessment does not support the QRTP placement, the state has **30 days to move the child** to an eligible placement or will lose federal reimbursement.
- If the state decides to forego completion of an assessment, the state can still place into the QRTP, but will receive **federal reimbursement for 14 days only**
- Federal reimbursement for a child who no longer needs the QRTP level of care and is ready for reunification or other family-based setting can be **claimed for only 30 days** after that determination is made while awaiting the lower level of care.

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The new law focuses attention on youth and family voice and family-centered practice during the placement process

- The state is required to establish a Family and Permanency Team for each child/youth.
- The team shall consist of all appropriate biological family members, relatives, and fictive kin.
- The team shall include appropriate professionals who are a resource to the family (e.g., teachers, medical or mental health providers who have treated the child, clergy, etc.)
- The state must document all reasonable and good faith efforts to identify and include all such individuals in the child's plan.
- If the child is 14 or over, the Team shall include members selected by the child.

- The state must provide evidence that meetings are held at a time and place convenient for family.
- If reunification is goal, the state must provide evidence that the reunification parent provided input.

The new law requires families be involved in the treatment process as well

- QRTPs must to the extent appropriate, and in accordance with the child's best interests:
  - Facilitate participation of family members in the child's treatment program,
  - Facilitate outreach to family members, including siblings, document how outreach is made (including contact information),
  - Maintain contact information for any known biological family and fictive kin of the child, and
  - Document how family members are **integrated into the treatment process**, including post-discharge, and how sibling connections are maintained.

- QRTPs are required to provide discharge planning and family-based aftercare supports for at least 6 months post-discharge.
- Family and youth voice are emphasized in federal guidance since the Family First Prevention Services Act was passed.*

*See: **ACYF-CB-IM-19-03,** Engaging, empowering, and utilizing family and youth voice in all aspects of child welfare to drive case planning and system improvement. Published: August 1, 2019 and **ACYF-CB-IM-20-02**, Family Time and visitation for children and Youth in out-of-home care. Published: February 5, 2020.

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Ongoing oversight of the QRTP requirements are the responsibility of the courts and the child welfare director

- **Court Review**: There must be a court review of the QRTP placement within 60 days.
- **Continued Nee**d: At every status and permanency hearing, state must submit evidence that:
  - Ongoing assessment confirms continued need for QRTP placement,
  - Specific treatment needs that will be met have been identified,
  - The length of time child is expected to need additional treatment, and
  - Efforts made to prepare child to transition to a family.
- **Duration**: Child welfare director must approve continued need for QRTP placement for placements longer than 12 consecutive months or 18 cumulative months, or for children under 13, placement longer than 6 months, and this evidence must be submitted to US DHHS.
- **Inappropriate Diagnoses**: State must develop procedures and protocols to ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in non-foster family homes as a result of the inappropriate diagnoses.

The law requires attention to its impact on other populations

States will have to certify that efforts to meet federal funding limits on non-family settings **will not increase the juvenile justice population**.

Significant data reporting is required for *all* residential programs (not specific to QRTP)

On an annual basis, for all children **not** in foster family home, **for each placement setting,** the following information is required:

- The range of the child population served
- Numbers of children served
- Ages, gender, race/ethnicity of children
- Special needs, diagnosed mental or physical conditions
- Permanency goal
- Length of placement
- Whether placement was first placement, or number and type of previous placements
- Extent of specialized education, treatment, counseling provided in the setting
- Number and ages of children with APPLA goals

The question of Institutions for Mental Diseases is left to the states

- You may have heard agencies from other states express concern about Institutions for Mental Diseases (IMDs).
- IMDs are a Medicaid category of institutions with more than 16 beds that primarily cares for persons with serious emotional problems.
- IMDs are not eligible for Medicaid reimbursement.
- The question about whether a QRTP, with its focus on therapeutic services, is an IMD.
- There have been Congressional efforts to address this issue, and discussions at federal level.
- Resolution is a non-resolution: Feds decided it's up to the state Medicaid agencies to determine whether an institution is an IMD or not.
- (Only a few states have had an IMD issue with child care institutions.)

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Many questions have arisen and will continue to arise as agencies start grappling with implementation

- Much of what's contained in the law was designed by Congressional policy wonks to address problems they've heard about or data they've reviewed.
- Now it's up to you, the experts, to figure out how to implement their intent.
- While the law is quite detailed, there remain many, many questions.

Public policy is a rather blunt instrument to make important practice changes

- Typically federal law establishes broad goals and parameters, while regulations are used to spell out details.
- The Family First Prevention Services Act is very detailed -- most of the requirements noted are directly from federal law.
- The federal government has issued a number of guidances about the new law, but no regulations. Their interpretation of the law's requirements is likely to be done through plans submitted by each state.
- That means: **what's unclear now may not become clear until Maine submits its plan and receives approval of the plan.**
- The good news is that after hearing from states about the law, Congress passed the Family First Transition Act, which provides each state with one-time, implementation funds requiring no state match. **Maine's share is about $2 million,** but there will be many demands on these funds for requirements in addition to the QRTP requirements.

State has lots of decisions to make in order to implement the Family First law

- There are many areas that states must plan for: preventive services, foster family services, QRTPs, as well as significant reporting, oversight and evaluation requirements.
- States have until **October 1, 2021** to meet QRTP requirements. But may want to begin sooner to have access to prevention funds. Plan must be submitted and approved for funding to begin.
- **Important** to note is that if states are planning to claim residential care to Title IV-E, states do not have access to new federal funding for preventive family services until they comply with QRTP requirements.
- Specific to QRTP, the first decision is whether to claim residential treatment to Title IV-E:
  - Some states are choosing to discontinue claiming federal funds for residential treatment settings in order to bypass QRTP requirements.
  - Others are choosing to claim all residential treatment through Psychiatric Residential Treatment Facilities (PRTFs) under Medicaid.
  - Each state is looking at their current level of federal funding of residential treatment.
  - Estimate that with Maine's higher federal reimbursement (~64%) and high percent of kids who are IV-E eligible (about 55%). **In Maine, about one-quarter to one-third of every dollar spent is federally reimbursed.**

Other decisions must be made regarding the details of the QRTP requirements

- How will **assessments** be done, who will do assessments and what tool will be used?
  - Assessments must be independent, timely and use a validated tool.
- Who will be responsible for identifying the **Family and Permanency Team** members, inviting them, documenting the process, and the outcome of the meeting?
  - Who will prepare materials for the court initially, and for ongoing reviews?
- Who will track **timelines** to ensure erroneous federal claims are not made when timelines are not met for the assessment process or court reviews?
- How will state set up procedures and **protocols** to ensure that inappropriate diagnoses do not occur?
- How will state **collect and analyze data** required for each residential program and monitor length of stay so director approvals and federal submissions are timely?
- How will required 6-month **aftercare** be organized? Who will provide it?
- Will the **state support** the changes providers need to make with some of the federal implementation funds?

Residential providers have many decisions and changes to make as well

- Because of the time required, **accreditation** is the most urgent concern. COA standards for residential treatment are available on the COA website. (Also see: accreditationguru.com)
- Do you have a **treatment model** that is delineated in a manual and training program for new staff? Is it a trauma-informed treatment model? Have you implemented the model with fidelity?
- If you have several **programs or populations** on one campus, will you look toward meeting QRTP requirements for all of them?
  - If you have a behavioral health program as well as a program for trafficked youth or pregnant or parenting youth, or if you serve the juvenile justice population, will you meet QRTP for all of them?

Residential programs may need to re-think their treatment models

- How will you address **family involvement** in the treatment process, (which may be difficult in rural areas, where family lives a distance from program)? How will you address family contact? How will you address **sibling contact**?
  - The involvement of family and ongoing family contacts will have to be documented in the case plan.
- With new statutory limitations to duration of treatment, will your treatment model support **short-term** treatment*?
  - 12 months for youth 13+
  - 6 months for children under 13
- Your work with each child in residential treatment will be to address the short- and long-term **goals identified in the assessment**.

*In 2008, 24% of children 13 and older spent more than 1 year in group settings. 38% of children under age 13 spent more than 6 months in a group setting. USDHHS, ACF, Children's Bureau, "A National Look at the Use of Congregate Care in Child Welfare", May, 2015.

Each agency needs to compare their current practice to the QRTP requirements and accreditation requirements

- At each court review, you will have provide evidence that:
  - Ongoing assessment confirms continued need for QRTP placement,
  - Specific treatment needs that will be met have been identified,
  - The length of time child is expected to need additional treatment, and
  - Efforts made to prepare child to transition to a family.
- What about discharge planning and aftercare???
  - 6 months of aftercare is required for children returning to family.
  - Are you prepared to work with families in their communities?
  - Does it mean changes in the geographic areas you serve?
  - Would you want to contract for the service? If so, how will you ensure that there is consistency in treatment process?

Family-based aftercare support is required of QRTPs, but definition is unclear

- "Family-based aftercare support" is not defined in the law.
- But aftercare may only include clinical services allowable under Title IV-E, which are only for family reunification or kinship, not for lower levels of placement. (Medicaid clinical services would have to be used for lower levels of care.)

- Federal funding for prevention services for children at risk of placement, includes those returning home from placement (because they're still at risk of placement), but not children going to lower levels of care (because they're already in placement).
- It's possible the federal government will define aftercare consistent with services to prevent placement, meaning mental health, substance abuse, in-home parent skill-based, and kinship navigator services.

Allowable family-based services are subject to federal standards of evidence

- The Family First Prevention Services Act and the Family First Transition Act require that federal reimbursement for these services will move toward those with evidence of successful outcomes.
- Standards for evidence are being phased-in:
  - For FY22-23, 50% of funding must be for “supported” and “well-supported” programs
  - By FY 2024, 50% of funding must be for “well supported” programs.
- Standards of evidence for these supported and well supported programs are high, but 50% of funds will have to be for these services.
- If more than 50% of funds are for other programs or services (without adequate evidence), they will not be federally reimbursed.

12 services have been reviewed by the standard setting entity: Title IV-E Prevention Services Clearinghouse

Program/Service	Category	Rating
1. Functional Family Therapy	Mental Health	Well Supported
2. Multisystemic Therapy	Mental Health	Well Supported
3. Parent Child Interaction Therapy	Mental Health	Well Supported
4. Healthy Families America	In-Home Parent Skill-Based	Well Supported
5. Nurse-Family Partnership	In-Home Parent Skill-Based	Well Supported
6. Parents as Teachers	In-Home Parent Skill-Based	Well Supported
7. Families Facing the Future	In-Home Parent Skill-Based	Supported
Trauma-focused Cognitive Behavioral Therapy	In-Home Parent Skill-Based	Promising
Methadone Maintenance Therapy	Substance Abuse	Promising
Children's Home Society of New Jersey Kinship Navigator Model	Kinship Navigator	Does not currently meet criteria
Kinship Interdisciplinary Navigation Technologically-Advanced Model	Kinship Navigator	Does not currently meet criteria
Multisystemic Therapy for Child Abuse and Neglect	Mental Health	Does not currently meet criteria

Additional services are currently under review and may or may not make the cut

Mental Health

1. Attachment and Bio-Behavioral Catch-up*
2. Brief Strategic Family Therapy*
3. Child Parent Psychotherapy
4. Incredible Years
5. Interpersonal Psychotherapy
6. Multidimensional Family Therapy*
7. Triple P – Positive Parenting Program

Substance Abuse

8. Brief Strategic Family Therapy*
9. Family Behavior Therapy
10. Multidimensional Family Therapy*
11. Seeking Safety
12. The Seven Challenges

In-Home Parent Skill-Based

13. Attachment and Bio-Behavioral Catch-up*
14. Brief Strategic Family Therapy*
15. Homebuilders
16. Multidimensional Family Therapy*
17. Nurturing Parenting
18. SafeCare
19. Solution Based Casework

Kinship Navigator

20. Ohio's Kinship Support Intervention/ Protect Ohio
21. YMCA Kinship Support Services, YMCA Youth and Family Services of San Diego County

*Included in more than one category.

Providers' ability to collect and analyze data systematically may become more important

- There is an opportunity for states to submit data on services or programs it believes have evidence of success, but much documentation is required. If providers have such programs, these should be discussed with state officials.

- Depending on state automated information system technology, the state may ask you to submit data needed for their annual report to federal government.

- **For each placement setting,** the following information is required:
  - The range of the child population served
  - Numbers of children served
  - Ages, gender, race/ethnicity of children
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  - Permanency goal
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  - Whether placement was first placement, or number and type of previous placements
  - Extent of specialized education, treatment, counseling provided in the setting
  - Number and ages of children with APPLA goals

Conclusions

- Residential providers should review **accreditation** standards and get process of accreditation started if they can. Process can take 12-18 months.
- Residential providers should consider the value and structure of their current **treatment model** and how much fidelity is applied to that model. Is it **trauma-informed**? Is it designed to be **short-term and goal-oriented**?
- Residential providers should consider their **family and youth engagement** and how much energy and attention is paid to family involvement in the treatment process itself and ongoing contact with family members.
- Providers should think about the various programs on their campuses and what the new requirements might mean for each of them (or not).
- Providers should think about their physical location relative to their client population and what that might mean for **aftercare**. Providers should think about what aftercare might consist of for children returning to family through reunification or returning to live with relatives, or going to a lower level of care.
- Providers might want to consider their current **service array** and whether it is broad enough to ensure ongoing viability with new emphasis on preventing placement.

Questions and comments?

Thank you

For more information or technical assistance contact:

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