FFTA – MAINE CHAPTER

THERAPEUTIC FOSTER CARE IN MAINE 2012

The Maine Chapter of the FFTA submits this information regarding the delivery of treatment (aka "therapeutic") foster care (TFC) in Maine to Maine's DHHS in the interest of preserving appropriate funding for this service. As private agencies charged with meeting the needs of youth with complex behavioral and social needs, providers of TFC in Maine are proud of the partnership we have with the Department and are pleased to share the goal of ensuring the ongoing availability of this service for Maine's youth and families.

Since we also share the goal of the Department to continue to fund the treatment related components of this service under the Medicaid program, this white paper will be organized primarily to address the concerns expressed by CMS as we understand them. It should NOT, however, be inferred from this focus on *treatment*, that safe placement and the establishment of permanency outcomes for youth served by these programs is not also a fundamental goal of all TFC programs. The focus here, however, is on the medically necessary treatment that occurs in these programs that facilitates the achievement of those desired outcomes.

We will begin with a description of the treatment components of the TFC model adapted in part from a North Carolina draft of a service definition for TFC. The description is adapted to include unique aspects of the service as it's delivered in Maine. Then a chart illustrating the service components that we believe should be funded under the Medicaid program, the justification for these beliefs and the credentials of individuals performing those functions in the Maine TFC model. We will then list the concerns that CMS has identified and what we believe to be simple talking points to address those concerns. Lastly, we have included attachments from our National Association, including a rationale for **Permitting Bundled Payments for Treatment Foster Care** that has been presented and accepted by the National CMS office, a relevant definition of Medical Necessity adopted by the State of Oklahoma (and approved by CMS), and **The Case for Ensuring Access for Certain Youth Through EPSDT.**

Service Definition – Medically Necessary Treatment

TFC provides services for children with a principal diagnosis of mental illness or serious emotional/behavioral disorders and who also may have co-occurring disorders including developmental disabilities or substance-related disorders[1]. TFC provides a structured environment with a specially

[1] TFC also serves medically fragile youth, though this is a small fraction of the individual youth served by these programs in Maine.

trained and clinically supervised therapeutic foster family. This family facilitates the development of skill acquisition and use of strategies and supports that address therapeutic treatment, prevention, recovery and behavior change consistent with age and development for each child served. TFC Services are necessary to assist the child in improving and maintaining functioning across life domains.

Each child referred for TFC service receives a comprehensive assessment, completed by a licensed Master's level Clinical Counselor or Clinical Social Worker. This assessment is used to, in consultation with the youth, parent/guardian, specialized foster parents, and other involved professionals and community members, derive an Individualized Treatment Plan (ITP)that identifies measurable goals and objectives for that youth. The clinician responsible for the assessment is similarly responsible for the clinical oversight and supervision of the case. In Maine TFC, the treatment team is rounded out with a private agency case manager (whose primary function is to coordinate services on the ITP and oversee day to day service delivery), agency rehabilitation worker (when a need is identified on the ITP), and the Specialized Foster Parents, who, in Maine, are required to hold a Specialized Foster Care license which requires more training and experience than the license held by traditional foster care families.

Intervention strategies used by team members include but are not limited to: role modeling in all social contexts, anger management, communication and conflict resolution skill development, crisis avoidance/planning/intervention, behavioral de-escalation, recovery, reinforcement of skill acquisition in the home and community, transition and discharge planning, etc., and self-advocacy.

The following services are taken from the list of essential services derived at the stakeholder meetings

Treatment Service	**Justification**	**Provider type/credential/education**	**Possible funding mechanism (Waiver, iSPA, etc.)**
Assessment	Determines medical necessity for the service	Master's level licensed clinician (social worker, counselor)	
ITP development and approval	Necessary to prioritize goals and objectives determined by the assessment.	Master's level licensed clinician (social worker, counselor)	
ITP review and revisions – participant	Review of written and verbal documentation of progress towards goals. Development of further plans.	TFC agency case manager, rehab worker, Specialized Foster Parent	
Case management	Youth referred require complex community resources. Does not manage the child welfare case: manages the	Case Manager – BA/BS level. Specialized training. Clinically supervised by licensed Master's level	

	treatment plan. The work is designed to clinically prepare the child for permanency. Specialized Foster Families require case support for the ITP delivery beyond that provided by public agency.	clinician.	
Milieu Treatment • Behavior management • In home support • Life skills training • Medication monitoring	• Youth with poor impulse control, anger management require shaping interventions, • Needed when impulsive or dangerous behavior exceeds typical adult supervision skills • when skill development requires skilled rehab worker • Many youth in TFC are prescribed psychotropic meds	• Specialized Foster Parent – rehab worker. Under direction of ITP • Rehab worker – working under the direction of licensed Master's level in accordance with ITP • Specialized Foster Parent or Rehab worker • Specialized Foster Parent	
Transportation	Only for medical appointments/therapy	Specialized foster parent	
24/7 supervision	Only when indicated by	Rehab worker	

	ITP or Crisis Plan		
Community integration	When indicated by ITP	TFC agency case manager	
Clinical Supervision	Needed by TFC agency case manager, rehab worker, Specialized Foster parent	Licensed master's level clinician. Can include Board Certified Behavior Analyst in some programs.	
Crisis support and intervention	Specialized Foster Parents need expert consultation/intervention in times of emotional or behavioral crisis	Licensed masters level clinician on call – TFC agency case manager generally the first level of on call and available to go to the scene. Rehab staff available if noted on ITP.	
Discharge planning	To determine when/how a youth achieves treatment goals and is prepared for adjusting to a family without specialized skills.	Overseen by master's level clinician with input from case manager, rehab staff and specialized foster family.	

CMS Concern	**Response**
Medical necessity	• All youth referred to TFC have a DSM diagnosis, determined by a licensed master's level clinical counselor or clinical social worker who have determined that TFC is a needed service. (see EPSDT rationale below)
Qualifications of providers	• TFC ITPs are developed and overseen by licensed master's level clinicians. • These same clinicians provide clinical supervision to the team of paraprofessionals who deliver these services • Case Managers in TFC meet the same qualifications of Targeted Case Managers – a different Medicaid approved service • Specialized Foster Parents are licensed at a higher level (more experience and training required).

Choice of provider	• TFC is an integrated service modality, delivered by a team operating under the direction of an independently licensed clinical professional. Consumers exercise choice in their selection of provider agency.
All children need supervision	• Individuals overseeing children with significant behavior problems such as those in TFC programs require specialized training in behavior management, de-escalation, and crisis management. These needs are assessed to be medically necessary and are documented in the assessment and ITP.

PERMITTING BUNDLED PAYMENTS FOR TREATMENT FOSTER CARE

Preface: There are two primary funding mechanisms for the medically necessary behavioral health service known as Treatment (or Therapeutic) Foster Care. These mechanisms are Medicaid and Title IV-E. Because there is no dedicated funding stream to cover this out of home care and treatment service for fragile foster youth, states frequently cobble together funds utilizing IV-E (for room and board), Targeted Case Management, and rehabilitation services to cover treatment foster care (TFC). On a state by state basis, providers are reimbursed through various methodologies including case rates, day rates, bundled rates, and fee-for- service rates. This paper addresses the utility of a bundled rate for Treatment Foster Care. In TFC, bundled rates are day rates to cover a multitude of treatment services. This paper does not address bundled rates in other out of home placement options, nor services which provide a weekly or monthly bundled rate.

The Centers for Medicare and Medicaid define rehabilitation (treatment) services as those services:

- recommended by a physician or other licensed practitioner in order to achieve specific individualized goals and to result in reduction of disability and restoration of the individual to the best possible functional level,
- designed and coordinated to lead to the goal of maximum reduction of physical or mental disability and restoration to the best possible functional level,
- delivered by a qualified provider (as defined in the state plan), and
- a restorative service furnished to a person with a functional loss who has a specific rehabilitative goal toward regaining that function, or a service to maintain functioning, but only when necessary to help an individual achieve a rehabilitation goal defined in the rehabilitation plan.

The TFC provider community is in agreement with the focus of CMS on accountability of service funds, transparency in service utilization, and quality of services provided. However, we are concerned also about the negative impact of unbundling and the current 'contracting option' on the ability to provide cost-efficient, individualized, and quality services for these vulnerable youth. TFC is the least restrictive behavioral health treatment option for these youth (Olmstead Act). Their only other options for intensive mental health treatment are more expensive higher levels of congregate care, including in-patient facilities and juvenile justice retention.

"Forced" or "coerced" unbundling creates its own waste and lack of efficiencies:

1- Unbundling necessitates vastly increased administrative accounting, billing, and charting thus diverting scarce funding to increased administrative function, not medically necessary treatment services.
2- Under the Bush Administration, a number of states began removing therapeutic treatment services from their scope of TFC, fearing that CMS might cut or eliminate TFC services. These changes have resulted in closure of TFC agencies, decreased integration of care for children in the child welfare system (specifically in community based systems of care and wrap-around),

increased referrals to the juvenile justice system and/or institutional levels of care, and blatant inability to offer much needed services to seriously disturbed youth in the foster care system.

3- Many state human services entities 're-claim' reimbursement for case management and care coordination in an unbundled scenario, in spite of the actual case management and care coordination being provided by the TFC agency/treatment staff.
4- As a state claims responsibility for case management, there is an increase in bureaucracy of state function and less individual oversight of individual assessment and treatment plans for each TFC child. (Generally TFC therapists have at least weekly contact with each client and more frequently if necessitated by the needs of the child or foster family.)
5- Unbundling creates a more difficult and less predictable problem for both state entities and for child placing agencies in planning annual fiscal budgets.
6- Some states have intentionally deferred from proposing SPA changes that might implement cost-saving measures, service expansions, or other changes that could improve the quality and cost-effectiveness of their Medicaid plans for fear of losing their ability to provide rehabilitative services, TCM, and bundled rates since the entire state plan would automatically be subject to review and modification.
7- Recruiting and training therapeutic foster parents is a time-consuming process and requires a high level of achievement in understanding specialized, behavioral health concepts and interventions on the part of these prospective caregivers. Some prospective parents feel over-burdened by the additional expectation of 15-minute incremental record keeping. These foster parents are paraprofessionals, although highly trained and supervised. Expectations, such as 15-minute incremental record keeping, hamper recruitment efforts, negatively impact agencies to meet service needs and result in diminished and/or fragmented TFC services. CMS has retracted the "15 minute rule"; however, states are continuing to require such record keeping in unbundled scenarios, fearing audit and recoupment possibilities by CMS.
8- Health care reform is proposing more bundling of services and measurement of outcomes in reform. Hospitals are authorized to bundle "episodes of care". Requiring unbundling of TFC services is counter-intuitive to maximizing defined fiscal allocations with specialized, individualized needs and thereby avoiding more costly levels of acute or residential care for these youth.

In support of accountability for optimum use of scarce fiscal resources, the Foster Family-based Treatment Association (FFTA) would like to underscore the following:

- Biomedical and behavioral health services across the country are moving toward increased community care, reduced residential and in-patient care, and increased emphasis on a medical 'home' for coordination of care. TFC needs the ability to provide coordinated community care and necessary treatment services to these vulnerable youth in the least restrictive, least costly environment available. Bundling of pre-negotiated and medically necessary services allows providers to develop and maintain a specific, unique course of treatment for each individual child while encompassing interventions in the home and community on an intensive 24/7 basis.

- In the health care reform bills HR 3590 and HR 4872, Congress and the President recognized that policies which utilize bundled payments and greater integration of health care services are important to both cost control and quality improvement techniques.

- Bundling allows states and provider agencies to more accurately predict annual budget costs to tax payers and to service providers.

- Therapeutic foster care agencies (typically called "child placing agencies") are state licensed entities and therefore must meet state standards and requirements for the privilege of operating in that state. Only medically necessary services are billed to Medicaid; furthermore, each state's negotiated SPA determines (and limits) which medically necessary behavioral health services will be reimbursed by Medicaid. (Room and board are NEVER Medicaid reimbursed expenses in TFC.) States - through their departments overseeing child welfare and through their Medicaid administrative offices - have the ability and responsibility to audit agencies for meeting licensing and operating requirements, for quality of services, and for appropriate billing and reimbursement practices. Finally, transparency and accountability are again addressed by CMS through oversight of the SPA and through auditing of state Medicaid administrative entities and/or state child welfare administrative offices.

Summary: If Treatment Foster Care is forced into the extreme accounting procedures as required through unbundling of services or the current contracting option, providers will cease business and high needs children will lose access to community based care, forcing migration to higher and more expensive levels of care or they will be left with no adequate behavioral health care at all.

FFTA's Recommendations:

- ✓ Allow for the bundling of TFC services as defined and negotiated within individual state SPAs.
- ✓ Revise the 'contracting option' (see attached) and apply the recommendations for negotiation if/when states request modification to the SPA.
- ✓ Require states to license Child Placing Agencies.
- ✓ Require states to conduct annual quality control audits of CPAs and to address rate reviews based on current levels of reasonable and efficient pricing.
- ✓ Require agency providers of Medicaid reimbursable services to have NPI numbers.

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317:30-5-741. Coverage by category

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(a) **Adults**. Residential Behavior Management Services are not covered for adults.

(b) **Children**. Residential Behavior Management Services are provided in residential foster care programs for certain children and youth authorized by the designated agent of the Oklahoma Health Care Authority. The children and youth designated for this program have special psychological, social and emotional needs, requiring more intensive, therapeutic care than can be found in the traditional foster care setting. The designated children and youth must continually meet medical necessity criteria to be eligible for coverage in this program. The medical necessity criteria is continually met for initial requests for services and all subsequent requests for services/ extensions. Medical necessity criteria is as follows:

(1) Any DSM-IV AXIS I primary diagnosis, with the exception of V codes and adjustment disorders, with a detailed description of the symptoms supporting the diagnosis. Children with a provisional diagnosis may be admitted for a maximum of 30 days. An assessment must be completed by a Mental Health Professional as defined in OAC 317:30-5-240(c) within the 30 day period resulting in a DSM-IV AXIS I primary diagnosis with the exception of V codes and adjustments disorders, with a detailed description of the symptoms supporting the diagnosis to continue RBMS in a foster care setting.

(2) Conditions are directly attributed to a mental illness/serious emotional disturbance as the primary need for professional attention.

(3) It has been determined by the inpatient authorization reviewer that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(4) Evidence that the child's presenting emotional and/or behavioral problems prohibit full integration in a family/home setting without the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff, preventing the child from living in a traditional family home.

(5) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(6) The legal guardian/parent of the child (DHS/OJA if custody child) agrees to actively participate in the child's treatment needs and planning.

The Case for Ensuring Access to TFC for Certain Youth Through EPSDT:

Therapeutic Foster Care (TFC):

Therapeutic Foster Care provides services in a least-restrictive, home-based environment for children with special mental and behavioral health needs (Olmstead decision). TFC is a medically necessary service for certain custody youth who are referred from state human services programs or other eligible youth as determined by Medicaid rules.

Following referral and clinical assessment dictating the need for additional services above traditional foster care, TFC ensures access to necessary mental health and rehabilitative services, utilizing clinically validated programs and treatment protocols, which are individualized for each child or youth.

It is estimated that 425,000 children and youth in the United States reside in out-of-home care. Approximately 42,000 of those youth are in TFC. As a treatment methodology, Therapeutic (or Treatment) Foster Care is an evidence-informed approach requiring highly trained providers/clinicians and foster parents. TFC produces both superior outcomes for children and substantial fiscal cost savings when compared to institutional treatment approaches of in-patient facilities and other forms of congregate care.

Therapeutic foster care services may include: individual, family, and sibling therapy; crisis intervention and crisis support; age appropriate social, communication, and behavioral skills; medication monitoring; case management; and other intensive community services needed to correct or ameliorate conditions for children with mental illness, severe emotional or behavioral disorders, medically fragile conditions, or other developmental disabilities.

All states (with the exception of Iowa) offer some level of Therapeutic Foster Care Services. Some states refer to TFC as Intensive Foster Care, Intensive Family Treatment, Therapeutic Foster Boarding Homes; some states provide TFC services within a system of Levels of Care (i.e. Level III, Level IV).

States typically reimburse for TFC through Rehabilitation and specific behavioral health services, which are guaranteed services for eligible children under EPSDT.

TFC is a evidence-informed treatment service. FFTA practice guidelines include a requirement for trauma-informed treatment and training for both providers and foster parents.

Benefits of Ensuring Access to Medically Necessary Services:

By definition, TFC children and youth have a mental health diagnosis and/or severe behavioral issues, yet can be effectively treated clinically with specialized home-based services when such medical assistance is available.

1- TFC vs. Institutional/Congregate Care: TFC has demonstrated effectiveness for both child welfare and juvenile delinquency youth in the of amelioration of mental and behavioral health problems and in returning child/youth to maximum functioning levels with parents, kin, or other permanent placements.

2- TFC provides an ecologic look at children and their families through: examination of the multiple needs of youth and families; multi-faceted approach to treatment; strengths-based and available/needed resources assessment; active involvement of the health and educational communities; on-going connections with kin, family, and siblings; and intensive in-home services.

3- Research shows that key mediators which may influence outcomes to treatment are 1) the type and amount of supervision the youth receives, 2) consistency and perceived fairness of discipline, 3) presence and quality of a relationship with a mentoring adult, and 4) lack of association with deviant peers. Treatment services provided to youth in a foster home with specially trained parents provides each of these mediators in clear contrast to the conditions inherent in institutional care.

TFC and Implementation of Fostering Connections to Success and Increasing Adoptions Act (2008), The Child and Family Services Improvement Act (2011) and the Affordable Care Act Medical Home provision (2010)

The Fostering Connections and Increasing Adoptions Act, as enacted by Congress in the fall of 2008 (P.L. 110-351), made significant steps forward for vulnerable children and youth in several key areas, including improving the care and coordination of physical and mental health services for children in foster care. Examples of areas of the Fostering Connections law, which would be strengthened and furthered by creating a new TFC Medicaid category, are: Sec. 205 - Health Oversight and Coordination Plan, Sec. 206 - Sibling Placement, and Sec. 402 - Promotion of Adoption of Children with Special Needs.

The Child and Family Services Improvement Act of 2011 (S 1542/HR 2883) further amends Fostering Connections to direct the states to also monitor a child's emotional trauma associated with child maltreatment and removal from the home. States are to include within the health oversight provisions, tracking of prescription medications and the protocols for the appropriate use and monitoring of psychotropic medications. (Title 1, Sec. 101)

The Affordable Care Act Creates a Medicaid state option to provide assistance in a medical home (deemed "health home" in the law's provision) for coordinating care to individuals with chronic, including behavioral health conditions, who are enrolled in a state's Medicaid plan.

Establishing TFC as a specific EPSDT available service would build upon implementation of these laws by providing direct, individually assessed clinical treatment as well as facilitation of wraparound services for TFC children and youth through the coordination of services, resources, and requirements of state child welfare, mental health, health, and Medicaid entities.