Texas Department of Family & Protective Services

Cost Allocation of Federal Funds

Improving Use of Title XIX and Title IV-E Funds

Prepared by

Patrick Leung, PhD
Professor of Social Work
Principal Investigator

University of Houston
Graduate College of Social Work
3511 Cullen Blvd.
Houston, TX 77204-4013, USA

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UNIVERSITY of HOUSTON
GRADUATE COLLEGE of SOCIAL WORK

Texas Department of
Family and Protective Services

Research Team

Patrick Leung, PhD
Professor of Social Work
Principal Investigator

Carl Valentine, MSW
Consultant

Monit Cheung, PhD, LCSW
Professor of Social Work
Director of Child & Family Center for Innovative Research
Co-Principal Investigator

Micki Washburn, PhD, LMSW, LPC-S
Assistant Research Professor
Co-Investigator

Linda Marie Olson, MSW
Sarah Patron
Anna Blum
Graduate Research Assistants

University of Houston
Graduate College of Social Work
3511 Cullen Blvd.
Houston, TX 77204-4013, USA

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Executive Summary

The Department of Family and Protective Services (DFPS) and the University of Houston have worked collaboratively to fulfill the roles and responsibilities to respond to the requirements of 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017, Article II, Rider 41. Rider 41 requires the completion of a report that evaluates: 1) how Medicaid and IV-E can be best used by DFPS in the 2020-21 biennium; 2) the impact implementation would have, including subsequent cost to the state; and 3) any required steps to implement these findings. The University of Houston prepared this report to analyze the use of funds available under Title IV-E and Medicaid of the Social Security Act and identify additional opportunities in the current financing system of DFPS services to fund services in the 2020-21 biennium.

DFPS is a large agency with a budget of $2 billion annually consisting of five programs: Statewide Intake (SWI), Child Protective Services (CPS), Investigation, Prevention and Early Intervention Services (PEI), and Adult Protective Services (APS). The largest program that has earned most of the federal entitlement funding is Child Protective Services with a budget of $1.7 billion, receiving about $352.7 million entitlement revenue annually ($345 million - Title IV-E and $7.7 million Medicaid administration).

Nine categories of findings were generated from past and current documentation provided by DFPS, as well as from interviewing DFPS staff who are responsible for billing, financing, and implementing services. Additional information was drawn from state reports and quality service review reports from Texas's neighboring states. This report provides recommendations with funding strategies that can maximize the use of federal funds in these nine categories:

1. **IV-E Foster Care Eligibility**:
   Assessing children eligible for title IV-E is the single most important step DFPS can take to increase federal funding for children. From 2011 to 2017 IV-E foster care eligibility dropped 14.5%. For each 1% annual decrease in IV-E eligibility, there is a $6 million loss in federal revenue (see Note 1 on the last page of this report). DFPS should complete a case review of a significant sample of children found to be ineligible for IV-E, drawn from each of the eleven DFPS regions, determine if any of these cases could have been IV-E eligible, interview a sample of eligibility staff and frontline workers about the eligibility process, and incorporate findings in policy, practice and training materials. Conduct additional face-to-face eligibility training in each DFPS region for all frontline staff and eligibility workers.

2. **Medicaid Rehabilitative Funding**:
   Introduce Medicaid Rehabilitative funding in the specialized residential treatment and child placing agencies as a Medicaid carve-out earning an added $40.2 million in federal reimbursement annually because 100% of children are Medicaid eligible versus 29% are IV-E eligible by using a combination of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and DFPS becoming a Title V Maternal and Child Health provider to limit cost based Medicaid services to DFPS children and providers.

3. **Treatment Directors in Residential Treatment**:
   Require full time Treatment Directors that are Licensed Practitioners of the Healing Arts in all residential treatment facilities. This would enable all residential treatment facilities to claim Medicaid reimbursement for rehabilitative services they provide were such a program to become available in Texas. Current DFPS licensing standards require a Treatment Director for all facilities serving over 25 children or when more than 30% of the children need treatment services. Only two of the three options for Treatment Director credentialing require a licensed practitioner of the healing arts. This step is expected to also assist the State in meeting the anticipated residential treatment requirements of the new federal *Family First Prevention Services Act* ("*Family First*").

4. **RMTS**:
   Strengthen the Random Moment Time Study (RMTS) through face-to-face training (for the training alone would be expected to increase IV-E eligible results). An increase in the percentage of total IV-E related activity from the current level of 45.9% to the level Texas achieved five years ago, 47.9%, will generate $2 million increased revenue annually.

5. **Claiming the Community Based Care Case Management Function:**
   As Community Based Care rolls out, modify the existing cost report and rate setting process used for congregate care and child placing agencies to ensure continued federal reimbursement for foster care case management. Modification would include capturing costs associated with foster care case management and providing start-up grants on a child-by-child basis for the providers assuming the case management function until the rate reflects the added cost associated with case management. This change will be necessary to ensure the claiming of federal reimbursement achieved by the current DFPS RMTS system.

6. **Administrative Claiming of Contracts**:
   Introduce IV-E and Medicaid administrative claiming for DFPS purchased CPS and Preventive Services. This process should begin with the claiming of IV-E reimbursement for case planning, case management or training activities associated with Adoption Purchased Services contracts. General Revenue is being used to support these contracts and the high Texas IV-E adoption eligibility rate (about 86%) can be applied. Modify the claiming process now used with private congregate care and child placing agencies, and with federal ACF Regional Office approval, implement a cost report/time study claiming process.

The use of Medicaid administrative claiming should be explored with Preventive Service Program contracts where General Revenue is being used, the activity being supported is medically related and a significant percentage of children benefiting from the program are Medicaid eligible. The Georgia county-based Family Connection process for claiming Medicaid administration should be considered.

7. **Improvement in Candidacy Status**:
   Improve the way DFPS determines "candidate" status to increase IV-E reimbursement for children receiving CPS services at home. Current DFPS workers find just 45% of these children "candidates," children at serious risk of foster care absent the provision of preventive services, reducing the IV-E reimbursement Texas receives from 16% for foster care to just 7% for in-home support services. DFPS should significantly increase their percentage of candidates, as Ohio and Rhode Island have done. There are no federal guidelines a state must follow for determining "candidacy." Total in-home administrative activity is about $57 million annually for which DFPS receives $4 million IV-E reimbursement at the current level of 45% "candidacy." An increase to 60% "candidacy" would generate $5.3 million (an increase of $1.3 million).

8. **Foster Care Training**:
   Claim 75% FFP training reimbursement for all the time new workers spend in the classroom and on the job training until they complete the six-month new worker training program, resulting in net new Federal funding of $18 million. New workers would earn 24% FFP (Federal Financial Participation) associated with training rather than the 16% associated with foster care activity and 7% associated with support of children living at home. The fiscal impact was based on a Fiscal Year 2018 20.2% estimated annual worker turnover rate as reported by DFPS. Such a program would require that new workers carry a reduced caseload during the training period. There are no federal guidelines defining "reduced caseload." DFPS has already used graduated caseloads for new workers making the recommended use of IV-E training for both formal and on the job training during the new worker training period more easily implemented.

9. **Community Partnership Training**:
   Continue and extend IV-E supported training to DFPS community partners including courts, attorneys, CASA volunteers, police, public health, mental health, and private contract agencies providing CPS related services. Federal Fostering Connections legislation provides 75% FFP for community partners training. This step can increase funding for DFPS's public community partners at no added cost to DFPS, by allowing public partners to claim IV-E reimbursement for training that is related to foster care or children at risk of foster care. The new IV-E revenue earned by the partners can be used to develop collaborative trainings of interest to both DFPS and the partners.

Cost Allocation of Federal Funds

Improving Use of Title XIX and Title IV-E Funds

Introduction

The Department of Family and Protective Services (DFPS) and the University of Houston have worked collaboratively to fulfill the roles and responsibilities to respond to the requirements of 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017, Article II, Rider 41. Rider 41 requires the completion of a report that evaluates: 1) how Medicaid and IV-E can be best used by DFPS in the 2020-21 biennium; 2) the impact implementation would have, including subsequent cost to the state; and 3) any required steps to implement these findings. The research team of the Child and Family Center for Innovative Research at the University of Houston, led by Principal Investigator Dr. Patrick Leung, prepared this report that evaluates the use of funds available under Title IV-E and Medicaid of the Social Security Act, and to identify additional opportunities from other funds in the current financing system of DFPS services to fund services in the 2020-21 biennium budget.

Background: Federal Funds

The opportunities explored in this report are based on two federal programs: Title IV-E Foster Care and Adoption Assistance and Title XIX Medicaid. These two programs have several common features:

1. Each is authorized through the Social Security Act.

2. Each provides federal reimbursement for a portion of the cost of the program, and requires the state to pay a portion of the cost.

3. Each is open-ended, meaning that the federal government guarantees that it will share in the cost of eligible program activities without regard to the state's expenditure level.

4. Each is governed by federal regulations, but offers the states flexibility in services and benefit levels that each state must define in a state plan. In that plan, each state must designate a single state agency to assume responsibility and accountability for the program through which all funding and communication must flow. The plan is submitted to the federal government for approval.

5. Each is considered an entitlement program, meaning that any person meeting the eligibility standard must be provided with the service or benefit.

Services provided under the Medicaid program and maintenance benefits provided under Title IV-E are reimbursed at the Federal Medicaid Assistance Percentage or FMAP. This percentage is determined annually by the federal government based on each state's per capita income ranging from 50 to 80 percent. Texas FMAP rate for FY17 (56.2%) was used for this report. The FMAP for Texas increased to 58.19%, for fiscal year 2019.

There are a number of federal programs that pay a larger portion or all of the cost of eligible services, for example the Social Services Block Grant and the Community Development Block Grant. Other federal programs have higher match rates such as title IV-B – Child welfare Services which has a 25 percent non-federal match requirement. However, a common challenge of using these funds is that they are "capped," meaning each state receives a finite appropriation each year. When that appropriation is exhausted, the federal government no longer participates in the program costs until the next federal fiscal year begins.

Federal Programs Considered

Title IV-E Foster Care and Adoption Assistance

Title IV-E provides federal reimbursement for room, board, and care for eligible children in out-of-home care including children in foster care, children receiving adoption subsidies, and youth receiving permanency care assistance. These maintenance costs are reimbursed at the FMAP rate of 58.19% for fiscal year 2019. For IV-E eligible children receiving IV-E supported foster care school supplies, day care and summer camp are reimbursable as maintenance costs.

Additionally, Title IV-E reimburses states at the 50% FFP level for costs related to the administration of the foster care program. These activities include case management for children in foster care settings, and for children living at home at serious risk of placement absent the provision of preventive services, called "candidates" for foster care. The program provides enhanced 75% FFP for training related to foster care, adoption and guardianship for public agency staff, foster and adoptive parents, private providers of services purchased by the public agency, and for other professional partners such as court personnel, police, judges, attorneys, CASA volunteers, school social workers and guidance counselors, mental health and public health personnel. Recently passed federal *Family First* legislation extends IV-E administrative claiming to preventive services when a state meets treatment requirements in their non-medical residential treatment facilities.

Title XIX Medicaid

The Medicaid program provides for the cost of medical services for low income persons and for the cost of administering the Medicaid program. Services are reimbursed at the FMAP rate and administrative costs are reimbursed at 50% (75 percent when licensed medical professionals are

required). The program consists of mandatory and optional services. Mandated services e.g., physicians services, hospital services, nursing home care, laboratory services, etc., must be included in the state's Medicaid State Plan. Optional services (e.g., targeted case management, rehabilitation services, and prevention services) can be included at the state's discretion.

The Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) which has long been a mandated Medicaid program, underwent a major change through Congressional action in 1989. Congress mandated that all services covered in the federal Medicaid program that were found to be medically necessary for a child must be provided, regardless if the service is included or not in the state's Medicaid Plan. As a result of this change, Medicaid eligible children have access to all medically necessary services described in the federal Medicaid program.

Another Medicaid provision requires collaboration between the Medicaid program and Title V Maternal and Child Health where via agreement Medicaid commits to cost reimbursement for Medicaid services provided by the Title V program, directly or by agreement, for Medicaid eligible children (42 CFR Section 431.615 implementing section 1902(a)(11) and (22)(C) of the Medicaid Act). This regulation sets forth Medicaid State plan requirements for arrangements and agreements between the Medicaid agency and the grantees under Title V. Such services and eligible providers are identified in the Title V Maternal and Child Health (MCH) State Plan. A number of states have established their child welfare program as a Title V grantee in the Title V State Plan, allowing them via agreement to claim reimbursement for Medicaid rehabilitative services provided in congregate care facilities at cost as specified in the agreement: Alabama, Kentucky, Minnesota, Connecticut and Georgia (subsequently Georgia transferred Medicaid claiming to mental health). This is currently not an arrangement being used by Texas.

The Medicaid services program has certain principals that govern the delivery of services:

1. Each service must be offered in an amount, duration, and scope that can reasonably be expected to achieve its purpose;
2. Each service is available statewide;
3. Each service is to be reasonably available to all who meet established criteria of medical need;
4. The client has the right to choose the provider of service; and
5. Any willing and qualified provider can participate.

The following discussion of Medicaid use in residential facilities describes how the combination of EPSDT and Title V MCH Medicaid provisions can modify for children the generic Medicaid requirements stated above, thus avoiding the risk of unanticipated cost. Medicaid services provided through the Title V MCH arrangement avoids the state-wideness requirement, the

exposure to any willing provider requirement and limits service to children selected for service in the Title V MCH program.

Medicaid Administration

Medicaid administration like IV-E administration is claimed by applying the client eligibility percentage to a cost pool of health related administrative expenses. Medicaid administration can include outreach, program eligibility, program development, program management, program monitoring, care coordination, rate setting, training and other program related administrative functions. Medicaid administrative costs can be claimed directly by the state Medicaid agency or through agreement with other public agencies, as is currently in place with DFPS. The scope of activities covered by such agreements are not bound by state-wideness requirements and can be identified as a component of a particular program through a viable cost allocation methodology. Eligible Medicaid administrative activity can also be claimed by a public agency, for private organizations under contract with the public agency.

Eligibility in the Title IV-E Program

Option 1: Focus on Increasing Title IV-E Eligibility Rate

Assessing children's eligibility for Title IV-E is the single most important step a state can take to increase federal funds available for child welfare. The Texas Title IV-E foster care eligibility rate dropped 14.5% from 45.13% in 2011 to 31.62% in 2017 (the average percentage of the IV-E foster care eligibility rates as reported by DFPS on their CB-496 Title IV-E Quarterly Financial Reports). For each 1% annual decrease in IV-E eligibility, there is a $6 million loss in federal revenue. The national average for IV-E eligibility in 2015 was 38.7% (as reported in the Congressional Ways and Means Green Book). A review of the IV-E foster care eligibility rate state by state shows a state's IV-E foster care eligibility rate does not depend solely upon the poverty in the state but rather upon the state's process of determining children entering foster care eligible. Determining IV-E eligibility is complex, requiring skilled and dedicated eligibility staff supported by frontline workers with thorough information about the family, and by the courts with properly worded court orders and timely action.

A review of the reasons children placed with DFPS were not IV-E eligible found 2% (192 of 5,451 cases reviewed) cited citizenship as one of the reasons and 1% (32 of 5,451 cases) cited improperly worded court orders or timely action issues as the basis for ineligibility. The Texas courts have been very supportive of the IV-E eligibility process through the training of court personnel. The primary reason families were found IV-E ineligible was income. Seventy eight percent of the families were found to have excess income (IV-E eligibility must use the income

standard used by the state for determining AFDC eligibility on July 1, 1996). In a review states income standard used for IV-E eligibility, the Aid to Families with Dependent Children (AFDC) Monthly Counted Income Test (family of three July 1, 1996), indicates Texas was 14th in the nation on July 1, 1996 AFDC income standards as reported by Congressional Research Services, while many of the states in the South with lower AFDC income standards in 1996 have achieved higher IV-E foster care eligibility levels as the chart below illustrates.

Table 1 illustrates that the variation of the percentage of IV-E eligible foster care children does not depend solely on poverty levels for the state. The chart further shows there is variation within a state over time. Texas has placed IV-E eligibility with DFPS so that this function is directly responsive to DFPS administrative attention and further the eligibility function has been centralized and automated through their client tracking system, IMPACT[1], to promote statewide uniformity. Frontline workers enter information about the family into IMPACT and eligibility workers run the income question against a number of data bases in their attempt to verify family income. The state routinely reviews a set of records to make certain the IV-E eligibility has been correctly determined.

Table 1. Foster Care Eligibility

State	National Ranking on Income Standards	FY 2011 AFDC Monthly Counted Income Test (family of 3) July 1, 1996	FY 2011 IV-E Foster Care Eligibility	FY 2015 IV-E Foster Care Eligibility
Arizona	**10th**	$964	40.5%	34.0%
Texas	**14th**	$751	43.9%	34.1%
Arkansas	**18th**	$705	48.3%	42.6%
Tennessee	**20th**	$677	37.3%	44.8%
Alabama	**22nd**	$673	42.4%	42.6%
Louisiana	**23rd**	$658	36.7%	34.3%
Oklahoma	**25th**	$645	38.8%	45.2%
Kentucky	**36th**	$526	39.5%	42.5%
Georgia	**42nd**	$424	34.4%	28.7%
New Mexico	**45th**	$381	43.0%	50.3%
Mississippi	**46th**	$368	32.6%	23.9%

Source: Data cited from Table 11-5, Estimated Share of Foster Care Caseload Eligible for and Receiving Foster Care Maintenance Payments by State 2015. In Emilie Stoltzfus (October, 2012). Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship Guardianship Assistance under Title IV-E of the Social Security Act. Congressional Research Service.

[1] IMPACT = Information Management Protecting Adults and Children in Texas

The drop of 14.5% in IV-E foster care eligibility from 2011 (45.13%) to 31.6% in 2017 is of significant concern. Because income was indicated as the most frequent reason for a family not meeting IV-E eligibility, this factor should receive further attention at both a policy and practice level. DFPS policy for IV-E income eligibility determination is briefly stated as follows: If the family reported $0 income and the worker noted that on the foster care application, the foster care eligibility specialist runs various inquiries in other data bases to find income. These include WTPY system (SSA benefits), OAG system (child support), TIERS (earned income, TANF, Food Stamps) and Data Broker (earned income). The DFPS income determination policies governing when case documentation or the foster care application indicates that the parent(s) worked but they refused to provide income information follow: Staff follow-up with the caseworker to have them address the income/work reported on the case documentation or application. If the family still refuses to or cannot provide income information, the eligibility specialist certifies the case as Non-IV-E (State Paid) eligible and runs a Data Broker inquiry 6 months after certification to confirm earnings. If the Data Broker results confirm earnings below the application AFDC limits the eligibility specialist changes the child's eligibility to IV-E eligible back to the initial date of certification. If the Data Broker results do not verify the parent's questionable earnings, the eligibility specialist leaves the child as Non-IV-E (State-paid) eligible. (See CPS handbook 1512.2 Unknown Family Income on the Foster Care Assistance Application thru 1530 and Appendix 1530-H)

There are five criteria that must be met for each foster care episode for a child to be determined IV-E eligible:

1. The child must have been removed from the home,

2. The agency has legal responsibility for the child via a court order or voluntary placement agreement,

3. The agency must obtain the required "Contrary to Welfare" judicial findings in the initial court order authorizing removal of the child,

4. The agency has obtained judicial findings of "Reasonable Efforts to Prevent removal" within 60 days of a child's removal, and

5. Establishment of AFDC Relatedness.

The AFDC relatedness requirement and the associated income and resource test are complex in and of themselves. The decision requires answers to: Was the child living with a parent or the specified relative? Was the child deprived of parental support due to absence, incapacity, or unemployment? Did financial need exist in the home? And was the child a citizen? The ADFC relationship can be established in one of two ways: (1) The child would have been eligible if an

AFDC application had been made; or (2) The child was not living with an AFDC specified relative in the month of the court order (i.e., could not have been eligible for IV-E in that month but did live with a specified relative in the prior six months and would have been AFDC eligible in the month of the court order had he or she been living with the relative in that month). States generally find that 7% to 12% of their IV-E eligibility determinations are based upon a reconstruction of the "what if" options described above.

To gather sufficient data to construct the various options under which a child can be considered IV-E eligible is time consuming for both the eligibility worker and the frontline service worker who must gather family related information so that each of the options can be considered while being primarily concerned with a child's safety and wellbeing.

Recommendations

1. Texas Health and Human Services Commission (HHSC) should complete a case review of a significant sample of children found to be ineligible for IV-E drawing cases from each DFPS region to determine if any of these cases could have been IV-E eligible and interview a sample of eligibility staff and frontline workers from each region about the eligibility process and incorporate findings in policy, practice and training materials.

2. Conduct additional face-to-face eligibility training in each DFPS region for all frontline workers and the associated eligibility workers. This would be a powerful way for management to emphasize the importance of IV-E foster care eligibility, and this alone would be expected to improve the state's IV-E foster care penetration rate.

Although there would be significant added cost involved in conducting the case review and the added face to face eligibility training, the expected benefits would significantly outweigh such costs. An increase of IV-E foster care eligibility from the current level of 31.62% to the level attained two years ago 34.56% (DFPS reported average IV-E foster care percentage for FFY 15) would generate approximately $18 million in added revenue for DFPS.

Option 2: Ensure Appropriate Title IV-E Payment Reimbursement

While the hard work of IV-E eligibility is complete, the last hurdle concerns ensuring adequate licensed foster care placement capacity so that IV-E will reimburse DFPS for the foster care maintenance payments. A review of the quarterly CB 496 report for the quarter ending 6/30/17 found the department did not claim Title IV-E for 886 Title IV-E eligible children (9% of all IV-E eligible children in foster care, the difference between 29.07% IV-E eligible and reimbursable and 31.75% IV-E eligible). DFPS reported the majority of these children are placed with relatives to whom no IV-E payments are made or, for a small number of children with complex

needs, children placed via child specific agreements when there is not otherwise placement capacity (e.g., with facilities that are regulated by the state but do not meet the IV-E criteria). Further, DFPS reported its SACWIS system, child care licensing system and contracting are integrated and thus, no payment will process without a contract and a license. Continued focus on ensuring placement is made in a IV-E eligible setting could result in additional IV-E funds.

Recommendation

- Review the cases in a sample quarter (e.g. June 30, 2017 CB-496 Foster Care Quarterly Report) that are found to be IV-E eligible for which IV-E was not claimed to determine if appropriate placement could have been made in a IV-E eligible placement and claimed accordingly.

Medicaid Supported Services in Residential Treatment and Child Placing Agencies

Based on FY 2019 projected data, DFPS will spend $222.4 million on purchased children's residential treatment care and child placing agencies offering treatment services. This includes $175.7 million for residential treatment exclusive of residential facilities serving children with basic needs and $47.4 million for child placing agencies offering treatment services plus over $22 million for projects in Region 3B Blended and Exceptional programs. Predictively, the state will receive $42.1 million in federal Title IV-E reimbursement for these programs. There are two options DFPS should consider to maintain and increase federal entitlement reimbursement for their residential and child placing agencies.

Option 1: Provide Treatment Directors in Residential Treatment Facilities to be Licensed Practitioners of the Healing Arts

Texas Health and Human Services Commission (HHSC) requires Treatment Directors in licensed residential treatment facilities offer three options, only two of which require they be licensed practitioners of the healing arts. If state licensing standards required all residential treatment facilities have a full time Treatment Director that is a licensed practitioner of the healing arts, the facility could claim Medicaid reimbursement for treatment services were such a program to become available in Texas, as recommended below. Further, it is expected this step would assist the state in meeting the federal requirements in the *Family First Prevention Services Act* which states residential treatment services must be appropriate for meeting the needs of the

children placed in these facilities or federal IV-E reimbursement for residential treatment programs would end and the expanded use of IV-E administrative activity for children living at home at risk of foster care (Candidates) would not be available. Federal *Family First* requirements for the Qualified Residential Treatment Program (QRTP) have not as yet be promulgated.

Recommendations

1. HHSC should require residential treatment facilities have a full time Treatment Director that is a licensed practitioner of the healing arts. This requirement would enable all residential treatment facilities to claim Medicaid reimbursement for rehabilitative services they provide were such a program becomes available in Texas.
2. A review of residential facilities may find all or nearly all facilities have Treatment Directors that are licensed as practitioners of physical or behavioral health. The results of such a survey would provide a basis for projecting the cost to providers of this recommendation.

Option 2: Claim Medicaid Reimbursement for Treatment in Children's Congregate Care Facilities and Child Placing Agencies

This option would allow the state to claim Medicaid reimbursement for the treatment portion of congregate care and child placing agency activities not being claimed under Medicaid managed care.

Currently Title IV-E reimburses nearly all DFPS cost in residential child care and child placing agencies for children that are IV-E eligible. If Medicaid eligible activities for Medicaid eligible children in these programs not already being claimed by managed care, were identified and claimed for Medicaid reimbursement while the room and board and care portion of the programs continued to be supported by Title IV-E, federal reimbursement would be substantially increased.

Although both Medicaid eligible activity and IV-E eligible activity are reimbursed at the 56.9% federal participation level, nearly all of the children in these programs are Medicaid eligible while only about thirty percent are Title IV-E eligible. Thus, any activity that could be switched from current IV-E reimbursement to Medicaid reimbursement would increase federal reimbursement for such activity by threefold as the tables below illustrates.

Table 2. DFPS Residential Child Care Agency FY 2019 Projected Annual Expenditures (excluding Basic)

Comparing 2019 Projected IV-E Revenue with Revenue when using Title IV-E and Medicaid:

Residential Child Care	Annual Cost ($ millions)	Current IV-E ($ millions)	50% of Cost + 45% of Cost = Total FFP		
			Medicaid FFP ($ millions)	Title IV-E FFP ($ millions)	Total Federal ($ millions)
Intense Residential	41.9	7.0	11.9	5.5	17.4
Intense Plus	4.4	.7	1.3	.3	1.6
Moderate Residential	11.2	2.8	3.2	.8	4.0
Specialized Residential	78.9	15.9	22.4	7.2	29.6
Psychiatric Transition	6.6	.8	1.9	.4	2.3
Emergency Care	32.7	6.5	9.3	2.9	12.2
Total Treatment Residential	**$175.7**	**$33.7**	**$50.00**	**$17.1**	**$67.1**

Note: FFP (Federal Financial Participation) =56.9% for Medicaid and IV-E; Client eligibility for Medicaid =100% and IV-E =29.07%; unallowable = 5% (in this example)

Table 3. DFPS Child Placing Agency FY 2019 Projected Annual Expenditures

Child Placing Agency Cost (46.5% of total CPA Cost, exclusive of 53.5% for Foster Families)

Child Placing Agencies (CPA)	Annual Cost ($ millions)	Agency IV-E ($ millions)	50% of Cost + 45% of Cost = Total FFP		
			Medicaid FFP ($ millions)	Title IV-E FFP ($ millions)	Total Federal ($ millions)
Intense CPA	2.3	.5	.6	.2	.8
Moderate CPA	422.3	3.9	5.7	1.5	7.2
Specialized CPA	16.4	2.9	4.1	1.1	5.2
Treatment Foster Care	6.4	1.1	1.6	.4	2.0
Total Treatment CPA	**$47.4**	**$8.4**	**$12.0**	**$3.2**	**$15.2**

Note: FFP =56.9%; Eligibility =100% Medicaid and 29.07% IV-E; Reimbursement for CPA foster families of $16m Title IV-E continues.

Table 2 and Table 3 show that when half of the cost is claimed for Medicaid reimbursement as a rehabilitative service and 45% of the remaining costs are claimed for IV-E reimbursement as room, board, and care, federal revenue is nearly twice the reimbursement currently being received when only title IV-E is being claimed. The combined model shows a revenue of $82.3 million when both Medicaid/Title IV-E are used – Table 2 Residential ($67.1 m) and Table 3 CPA ($15.2 m) vs. $42.1 million for the current IV-E option (shown in column 2 in both Table 2 Residential ($33.7 m) and CPA ($8.4 m)). The combined Medicaid/ Title IV-E model 50% Medicaid and 45% IV-E would provide $40.2 million new federal revenue for DFPS.

The above illustration of a combined Title IV-E / Medicaid carve-out model has been implemented by many states successfully. Models of particular interest are: Minnesota, Alabama, Kentucky, Connecticut and Tennessee. Participants would continue to receive all other Medicaid supported physical health and behavioral health services through managed care. By establishing a component with Medicaid supported rehabilitative services within the congregate care and child placing agency programs, DFPS would have the added revenue benefits of Medicaid for the treatment component without the added cost if a facility were to become totally Medicaid supported as would occur if the Medicaid State Plan were amended to include a Psychiatric Residential Treatment Facility. If the rehabilitative services component is established as an EPSDT (Early Periodic Screening Diagnosis and Treatment) service – a service program already in the state's Medicaid Plan, that was operated by DFPS as a Title V Maternal and Child Health (MCH) Program provider by agreement with MCH, DFPS could claim Medicaid reimbursement based on cost for a service limited to DFPS children by providers identified by DFPS and described in the Title V MCH State Plan and the interagency agreement involving DFPS, Medicaid and the Title V MCH program. The bundled rehabilitative service package would need to be authorized by a licensed provider of physical or behavioral health. The facilities Treatment Director could authorize the rehabilitative service if the Treatment Director was a licensed social worker or another licensed practitioner of the healing arts.

Currently, there are several categories of congregate care. Providers (except under DFPS's Community Based Care program) are paid on a per-diem rate for each category based on their cost reports. Under each category there are some requirements to provide services including counseling, restorative living skills, social skill development and individual assessments, case plan development and care coordination. In addition as part of the overall *per diem*, providers receive funding supported to cover maintenance expenses, including room and board and overall supervision. All but counseling, educational services and fund raising are currently IV-E reimbursable activities, which constitutes about 95% of all cost. The current system requires providers to bill Medicaid for the child's physician and behavioral health services such as counseling and treatment provided by community based providers.

Under a combined Title IV-E / Medicaid rehabilitative service system, the maintenance expenses of room and board would be claimed by IV-E and overall supervision would be bundled into a Medicaid reimbursable *per diem*. The allocation to Medicaid, Title IV-E and non-reimbursable activities would require a revised annual cost report and time study. This process which would have a startup and ongoing maintenance cost would be expected to identify fifty percent or more of all activity as allowable activities within the Medicaid rehabilitative bundle and all but about 5% of the remaining activities as IV-E eligible. Other costs associated with startup although relatively small in light of the new revenue potential would involve establishing new rates for each facility class, establishing a Medicaid claiming process, provider staff training initial and

ongoing on Medicaid service authorization, case plan development, and service documentation, and the development and implementation a utilization review process to guard against downstream audit exceptions.

Recommendations

Implementation of IV-E/Medicaid rehabilitative service system in specialized residential and child placing agency programs would require:

1. Determining if the benefits for extending Medicaid claiming of Rehabilitation Services to Child Placing Agencies would be cost effective.

2. Legislative and Executive authority to implement the new program.

3. Modification of the Title V MCH State Plan to include the DFPS Medicaid service bundle for participating programs.

4. State Medicaid Plan may not need amendment since the Plan already contains the provision of EPSDT services (DFPS practice in the past has involved submitting a Medicaid and IV-E Plan amendments describing the cost allocation process). Other states have submitted the new rate setting methodology delineating allowable Medicaid and IV-E costs for Federal CMS/ ACYF Regional Office approval. The Federal Regional Office approval process would be expected to occur more quickly than a formal Medicaid Plan amendment. Because the cost allocation process is occurring in the private sector, a formal Department Cost Allocation Plan amendment would not be required.

5. Description of the new MCH/DFPS rehabilitative service in state Medicaid regulation and policy materials.

6. Interagency agreement among DFPS, Title V MCH and Medicaid describing the Medicaid service bundle for DFPS children placed in participating programs.

7. Time study methodology being signed off by Federal Regional Office after their review for supporting the DFPS amended Cost Allocation Plan (for allocating foster care payments to Medicaid, IV-E and other fund sources).

8. Regulation and Program Manuals provided by DFPS.

9. Contracts with private providers be modified to reflect participation of program participants.

10. Documentation of private providers and their staff trained on both the recording of rehabilitative services and participation in the time study/cost report process.

11. The time study be conducted to tabulate in a revised rate setting process that would maintain the same *per diem* rate for the contract provider, along with the amount of the *per diem* to be claimed for IV-E and Medicaid reimbursement.

12. Claims for both IV-E and Medicaid with reimbursement returning to DFPS as the Medicaid provider. When DFPS becomes a Title V MCH provider by agreement, it is authorized to submit Medicaid claims on behalf of its private congregate care contractors. Under this arrangement the private contractor submits child specific daily service claims to DFPS and are paid the daily rate as they are today by DFPS, while DFPS in turn submits claims for Medicaid and IV-E reimbursement to the appropriate authorities.

13. Developing and monitoring of Medicaid service documentation to avoid potential audit risk.

14. Reports as requested by DFPS management, Medicaid and legislative oversight committees.

Implementation of a Medicaid rehabilitative component in congregate care non-medical and specialized child placing agencies would normally take from one to two years. When a new benefit is added to Medicaid, particularly when that benefit involves a residential setting, the process of negotiating with CMS can take from 18 months to two years negotiating with CMS. While this negotiation process is under way, the redesign of the cost report, time study process and its implementation and the subsequent rate setting process can be expected to take a year. Development of a Medicaid claim processing system although similar to the process currently in place for title IV-E and new rules for DFPS and HHSC are also time consuming, If this process were given priority within DFPS and the HHSC Medicaid Program, this time frame could be shortened.

In summary, the addition of a Medicaid rehabilitative component within the non-medical treatment residential and specialized child placing agency foster care programs would increase federal reimbursement for DFPS by over $38 million per year. Risks of uncontrolled cost associated with required service provision for any eligible client by any willing provider would be resolved through use of the proposed design of placing the program, managed by DFPS, within the Medicaid claiming authority of the Title V MCH program. The key to success will rely on training private provider child care staff on service documentation and the monitoring of service delivery by DFPS.

Administrative Claiming

Background

Texas dramatically increased their investment in the CPS program administration in June 2017 by jumping quarterly expenditures from $52 million to $62 million as reported in the DFPS quarterly CB-496 Foster Care Financial Reports, a 20% increase, which supported an increase in the number of CPS workers, a reduction in the size of caseloads, and an increase in the salaries for CPS caseworkers. At the same time DFPS increased by over 50% their investment in staff training to over $18 million annually as reported in DFPS quarterly CB-496 Foster Care Financial Reports. This increase in investment and staff training was driven by the growing increase in the number of children in foster care and families receiving CPS services for children remaining in their home. (June 2016 there were 32,084 children in foster care and 14,804 families receiving CPS services, in June 2017 there were 33,043 children in foster care (5%, increase), and 17,836 families receiving CPS services for children living at home (20% increase). Federal entitlement funding has also increased over this period while other federal funding has remained constant or decreased placing greater demand on state General Revenue to support the growing costs of the Child Protective Program. The following discussion explores steps DFPS can take to increase federal entitlement funding for CPS administration.

Cost Allocation and Time Study

The DFPS Expenditure report for State Fiscal Year 2017 reported that the Department receives about $111.3 million annually for administrative claims from federal entitlement programs ($101.4 million from IV-E and $9.9 million from Medicaid). Foster Care is the largest category in Title IV-E federal administrative reimbursement as shown in the following table of SFY 2017 expenditures:

1. $81.2 million for the child foster care program (About $4 million of which supports staff serving children living at home at serious risk of foster care called foster care “candidates”)
2. $7.6 million for foster care training
3. $11.9 million for the administration of the adoption assistance program
4. $0.7 million for the administration of the permanency care assistance program

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$101.4 million Total federal IV-E reimbursement administrative expenses in FY 2017

The claim is driven by three components: the client eligibility percentage, the allocation of caseworker time from a Random Moment Time Study (RMTS) conducted quarterly, and the cost pools allocated to the business of administering the program. Texas uses three time studies, one for Statewide Intake, one for Child Protective Services and one for Adult Protective Services.

The client eligibility percentage is applied to the results of the administrative cost allocation process. A change of one percentage point up or down in the foster care client eligibility rate will result in a change in federal reimbursement for administrative costs of $3 million annually. Current IV-E client eligibility for foster care administrative cost is about 31.7%. The IV-E client eligibility rate for adoption assistance is about 84% and the client eligibility rate for guardianship is about 67% but because the administrative costs associated with these programs are relatively small, the focus will be on foster care eligibility and the CPS RMTS.

The RMTS is operated by a web response system. Roughly 10,000 randomly selected notifications of moments are sent by emails each quarter to SWI, CPS, APS workers. Regional staff follow-up with staff by phone or text message. Seasonal and temporary workers are excluded. Observable moments are requested from filled DFPS CPS positions during working hours (8:00 AM to 5:00 PM). For each RMTS moment, the system identifies the participant that occupies the eligible position as well as their supervisor and unit facilitator. The participant is able to enter their response into the RMTS system to record their activity at the moment of the study. The response is supposed to be made immediately but this is not always possible. The respondent has up to 48 hours to provide a response. If there is no response within 48 hours, a prompt is provided and in addition to a response the worker must document the reason for the delay. If there is no response within 72 hours it is classified as a missed observation. RMTS staff reviews every observation submitted from participants to ensure their description fully supports the activity code chosen. The State RMTS Office keeps track of performance at a regional level based on a 100 point percentage scale. Any region scoring below 90 percent is subject to additional training. If a region scores below 90 percent for a consecutive quarter they are subject to technical assistance training from Central Office. A web response cannot be changed. A great deal of effort has been invested in the development and maintenance of the web-based RMTS system. A thorough understanding of the strengths and short-comings of this system is very important if it would be used for cost allocation for both public and private workers performing CPS functions.

Recommendations

1. Review the results of the quarterly Quality Service Reviews over the past several years to identify problems;
2. Interview a sample of CPS workers and Human Service Technicians about their experience with the RMTS;
3. Review the RMTS study results over the past several years to see if allocation percentages have changed; and
4. Conduct a special face-to-face RMTS training in each of the eleven DFPS Regions. This would be in addition to the face to face training currently provided to regional coordinators to help them better understand what activities fall under the various activity codes. Other

states that have taken this step have found training improved the performance score and increased federal reimbursement.

A review of the average RMTS results over the six-year period 2011 through 2016 shows a slight reduction of IV-E eligible responses related to IV-E eligible activity, 47.9% to 45.9%, a two percent reduction. The stability of the results is commendable.

1. Code A Investigation generated a 25% response. This percentage is high and does not earn IV-E or Medicaid reimbursement. Within the front end process there are a number of activities occurring: safety assessment, development of a safety plan, family needs assessment, need for service, need for food or medical care, service referral, as well as investigation to determine if abuse or neglect has occurred, assessing the need for out of home care and determining placement type if that is required. It is only investigation of abuse or neglect and counseling that IV-E will not fund. Even though the RMTS already separates out many non-investigative case management activities, this allocation process should be reviewed to make certain non-investigation activities have been fully excluded from this Code and this difficult allocation process stressed in the RMTS training.

2. Code H Case Management for children in foster care, the largest IV-E related code dropped one percent over the six year period from 23.3% to 22.3%. Code L, Other Foster Care Activities recorded 1.91% of the responses. In other states the combination of foster care case management and other foster care would generally range from 25% to 30%. States use different approaches to case management. In Texas for a child in conservatorship who is placed in paid care, the state provides legal case management and a child placing agency or other provider is typically providing the foster care case management.

3. Code I Case Management for children at home has dropped about two percent from 8.7% to 7.0%. Each percentage of change represents about $3 million in IV-E reimbursement, with the exception of Code I where just 45% of the children receiving services at home are determined to be at serious risk of placement, absence of provision of preventive services, i.e., "candidates," reducing the federal reimbursement value of this code by over 50%. The percentage of “candidates” should be higher so that responses to this Code would yield more revenue. As the percentage of time workers spent supporting children living at home increases, the importance of increasing the percentage of children found to be "candidates" will become more urgent.

4. Code P Training has increased from 2.98% to 3.7% reflecting the increased investment DFPS has made in training. This is the only IV -E eligible code for which the state receives the enhanced FFP rate of 75%.

Results from the face to face training should increase IV-E revenue by $2 million (RMTS activity would be increased by 4% from 45.9% to 49.9% of CPS RMTS activity).
See a discussion of administrative claiming when the legal case management function under the Community Based Care Implementation Section of this report.

Candidates

Currently, Texas finds 45% of the open CPS cases with children living at home to be foster care "candidates"; children living at home determined by the frontline CPS worker to be at serious risk of foster care absent the provision of preventive services. The state currently supervises about 18,000 children living at home, with about 8,000 children (45%) determined by DFPS as IV-E "candidates." DFPS receives about $4 million in federal IV-E administrative reimbursement annually for children determined to be "candidates." CPS workers opening the case because of findings of abuse or neglect try to prevent removal of the child from home (placement) by providing case management, referrals to service, and direct provision of service as appropriate and resources allow.

Caseworkers supporting families to prevent removing children from the home may struggle with describing the children as foster care candidates when the goal is to ensure they remain at home. Federal auditors have determined declaration of "candidacy" cannot be done as boiler plate language placed in all newly open CPS cases supporting children at home. Rather, the candidacy status needs to be determined by the state, based upon case assessment but there are no federal guidelines as to how this should be accomplished. DFPS frontline CPS workers now determine candidacy for each new case and then designate an indicator for children who are candidates.

Other states desiring to more rapidly increase the percentage of "candidates" are removing this decision from the caseworker and conducting a periodic case review of a sample of their CPS caseload of children living at home to determine the candidate percentage. Ohio and Rhode Island are using this approach and finding a high percentage of their open CPS cases supporting children living at home to be "candidates."

The *Family First* legislation provides states the option of receiving federal 50% reimbursement for front end services for mental health, substance abuse, and in-home skill based parenting programs provided "candidates", pregnant and parenting youth in foster care and their parents or kin care takers (without regard to a child's IV-E eligibility status). For Texas to take full

advantage of opportunities offered by *Family First* steps should be taken to increase the proportion of open CPS cases with children living at home found to be "candidates."

Recommendations

DFPS should increase the percentage of IV-E "candidates" so that resources invested in the support of CPS cases with children living at home can receive increased federal IV-E reimbursement that more closely approaches the percentage of federal IV-E support now earned for the time of CPS workers supporting foster care cases. The percentage of candidates can be increased through clearer policy and attention to this issue in new worker training. The percentage of candidates can also be increased by supervisors reviewing cases with their workers and stressing the importance of the candidacy determination. A QA process could be established to review cases where candidacy had not been determined and with documentation and discussion with the worker determine candidacy to be appropriate. These steps should gradually cause an increase in the percentage of candidacy cases.

For example: One hundred dollars spent on foster care case management currently returns $16 FFP from title IV-E ($100 x 31.75% IV-E client eligibility x 50% federal participation rate = $16). One hundred dollars spent on case management for CPS children living at home returns $7 FFP from title IV-E ($100 x 31.75% IV-E client eligibility x 45% candidacy percentage x 50% FFP). In addition to the percentages used for the foster care case management, the "candidacy" percentage of 45% must be applied.

It is recommended that DFPS:

1. Emphasize the importance of the "candidacy" decision for new workers in on-going training;
2. Revise training materials with examples of "candidacy" decisions and the rationale behind such findings;
3. Make the "candidacy" decision an important component of the QA service review process; and
4. If, after several years, DFPS does not experience a significant increase in the proportion of "candidacy" cases, remove the decision from the worker and implement a process similar to the one used by Ohio and Rhode Island.

An increase in the percentage of "candidacy" cases from 45% (the current level) to 60% would generate $1.5 million in new revenue.

Foster Care Training

Training is an enhanced administrative function within Title IV-E, providing 75% FFP for the development, delivery, and evaluation of the training. The enhanced 75% FFP rate pertains to costs associated with the training function and the trainee, those being trained when they are DFPS employees. Title IV-E also supports the training of providers, foster parents, adoptive parents, private agencies providing services for DFPS and professional partners of DFPS including court personnel, judges, CASA volunteers, attorneys representing DFPS children and families, police, health and mental health staff, private social service agency personnel, school guidance counselors and special education teachers, and volunteers providing parenting education for DFPS families. DFPS has developed an extensive array of training courses for DFPS personnel, foster parents, adoptive parent and DFPS service providers.

Title IV-E supports new public worker training at enhanced 75% FFP for both classroom instruction as well as the portion of the initial in-service training program that includes actual work experiences (the worker's salary, fringe benefits, and travel) if the workers is carrying a partial caseload. Federal guidelines do not dictate how long the training can last nor do they spell out criteria for partial caseload. (See Child welfare Policy Manual – Section 8.1H Title IV-E Administrative Functions/Costs, Training – Question 14 and Answer, Issued November 17, 2014.

Title IV-E supports the cost of training at 75% when provided to private sector employees but only supports the associated cost of salary and fringe benefits of private sector trainees at the 50% level, the same level other private agency costs would receive for IV-E eligible activity. Thus, privatization would reduce the IV-E reimbursement for cost associated with private agency staff costs (salary and fringe benefits) while attending IV-E training from 24% to 16%.

Title IV-E reimbursement can support training developed in partnership with the public agencies like the courts, the police, public health or public school staff when these agencies have developed training in collaboration with DFPS, is reflected in an interagency agreement and the training is described in the state's Title IV-E Training Plan.

Title IV-E also supports university-based education for DFPS staff, or persons intending to work for DFPS upon graduation. This program has been developed with Texas University Schools of Social Work for BSW and MSW matriculated students. The program offers a stipend for one or more semesters based on the program participant's satisfactory progress. The program participants must fulfill their repayment obligation to the agency in the form of four months of IV-E eligible agency employment if a DFPS employee or 8 full calendar months if a pre-graduate student, or monetarily repay the agency, for each academic unit the participant received a stipend. An academic unit is defined as a university's session or semester.

DFPS may also claim IV-E reimbursement for stipends to train persons preparing for employment with a private agency at the 50% FFP rate: (1) If that private agency is under contract with the title IV-E agency to perform title IV-E eligible administrative activities and the individual is pursuing educational programs approved by the title IV-E agency; (2) If the person preparing for employment with a private agency under contract with the title IV-E agency is committed to work for a title IV-E contracted private agency for a period of time at least equal to the period of time for which financial assistance is granted if employment is offered within 2 months after training is completed; (3) The title IV-E private contracted agency offers the individual preparing for employment a job upon completion of training unless precluded by contractual provisions or other circumstances beyond the agency's control, and if such agency is no longer operating under a title IV-E contract or cannot offer the individual employment, the title IV-E agency will either identify another title IV-E contract agency to offer employment or release the individual from his or her commitment; (4) The IV-E agency keeps a record of such arrangements; (5) The IV-E agency evaluated the training program; and (6) Any recoupment of funds by the IV-E agency is treated as income. The option of using federal title IV-E reimbursement to support private agency personnel has been described in some detail as an option for consideration as DFPS transitions to private sector case management for their foster care program.

Recommendations

1. Claim 75% FFP IV-E training reimbursement for the cost of time new workers spend in the classroom as well as for the costs while on the job during the new worker training period (Now six months in duration) resulting in net new funding of $18 million annually. New workers would earn 24% FFP throughout the training period rather than 16% FFP associated with foster care administration or the 7% associated with support of children living at home. The fiscal estimate was based upon a Fiscal Year 2018 20.2% estimated annual worker turnover rate. This policy allows claiming for not only the cost of providing the training but also for the salary and fringe benefits of the new worker for both time in the classroom and time on the job for the six month duration of the new worker training. The current new worker training provided by DFPS over a six month period would meet the IV-E new worker training requirements with minor adjustment to assure the gradual building of the caseload during the new worker training period. Expenditures for such staff would receive 24% FFP (75% x 31.7% client eligibility) rather than the 16% (50% x 31.7%) now received for foster care related work and 7% (50% x 31.7% x 45%) received for work related to the support of children living at home. DFPS indicates staff turnover has been reduced to 20.2%annually. DFPS spends $800 million annually supporting CPS direct service staff. If 20.2% of CPS administrative expenditures, $162 million, supports new workers, about two thirds of their time supports children in foster care earning about

$17.3 million in federal IV-E reimbursement and one third of their time supports children living at home earning $3.7 million in IV-E reimbursement for a total of $21 million FFP. If the new workers were in training the whole period they would generate $39 million, an 86% increase. This substantial financial benefit occurs because the 45% "candidate" discount would not be applied to the time workers spend with children living at home during the training period and the 50% FFP for administrative activity would not be applied to the time spent with children in foster care or children living at home. Rather, the entire cost of salary and fringe benefits during the start-up training would be claimed at the 75% level discounted by the percentage of IV-E foster care eligibility.

2. DFPS should extend training opportunities to its community partners. Often such training can be offered at little or no cost for DFPS. DFPS can submit training claims for its community partners and pass federal IV-E reimbursement received for such training back to the submitting agency. The public partners could certify required non-federal match for such claims. The public partners could use this reimbursement to supplement their training when such training was developed with DFPS, included in an interagency agreement, and described in the state's Title IV-E Training Plan. A number of states have developed such training partnerships with their public partners either directly or through agreement with their public university training consortium.

3. Explore use of title IV-E reimbursement to support the training (including BSW and MSW matriculated education) of persons working for or planning to work for a private agency under contract with DFPS to provide IV-E reimbursable activity. As long as such a placement policy is included in the States Training Plan, is found to be in the interest of the DFPS program and has the signoff of the DFPS Commissioner this practice would be expected to meet IV-E requirements.

Purchased Services

Child Protective Services

DFPS contracts out several categories of Child Protective support services (DFPS 2017 Expense Report):

Adoption Purchased Services	$12.1 million
Post Adoption Purchased Services	$4.5 million
PAL Purchased Services	$8.5 million
Other CPS Purchased Services	$43.5 million

Title IV-E federal administrative reimbursement may be available for the case planning, case management, case monitoring or training activities associated with the provision of the above

services. The *Family First Prevention Services Act* broadens the scope of allowable activities for which IV-E reimbursement could be available once the state addresses the *Family First* requirements. Some portions of adoption services and post adoption services could potentially be reimbursable if the activities meet the evidence based requirements of *Family First*. PAL is funded with federal Chafee Act funds and is limited in scope to specific assessments and skill building. Other CPS Purchased Services include a wide array of supports, most of which are not casework related.

For programs where IV-E eligible activity is found, a Title IV-E claim can be developed based upon cost report/ time study data. The cost allocation process could be a direct claim if the work were all foster care related or if the purchased services provide a wide variety of supports most of which are not case work, or time is split between foster care, adoption, guardianship or in-home support case management, training, other IV-E allowable activities and counseling or other non-IV-E allowable activity, a cost report/ time study cost allocation process would need to be implemented by private providers providing CPS related work for DFPS. The claiming methodology would be described in the contract with the private providers and in the State Title IV-E Plan and would need ACYF federal regional office approval (a less rigorous process that the one required for the Department's PACAP). Because many of the providers might be small agencies having only a few staff who would provide IV-E eligible activity, the study could be undertaken on an annual basis for a group of providers reducing the number of activity observations required for a particular provider to achieve statistically reliable results.

For example, if there were fifty private contractors with one or more staff providing some adoption related case management, training or other adoption related IV-E allowable administrative activities, the costs associated with the staff would need to be identified in a cost report and a time study (random moment or day log) developed and implemented annually that would provide statistically reliable results at the 95% +/- 5% confidence level. If the day log option was selected, participants would record their time in fifteen minute intervals during the work day for the duration of the statewide time study. If 2,500 random moments would be necessary for such a study to be statistically reliable with some over sample to protect against possible problems that would make some of the day logs unusable, and each day log was equivalent to 2.5 random moments, 1,000 day logs would be needed to create reliable report of IV-E eligible time. If 200 workers were identified as time study participants the time study would need to be conducted over a five day period. The results would be applied to the accumulated cost pool of annual costs associated with time study participants and the resultant statewide IV-E related cost would be multiplied by the title IV-E subsidized adoption eligibility percentage to develop an IV-E claim federally reimbursable at 50%.

Recommendations

1. Analyze a sample of the adoption purchased services contracts to estimate the activity that could be IV-E allowable. If the result of this study suggests a IV-E claim would be cost effective a proposed claiming methodology, similar to the claiming methodology now used with congregate care and child placing agency providers should be developed and, submitted for ACYF Regional Office approval. With ACYF approval, modify the state Title IV-E Plan to include the claiming methodology, obtain support of the contract providers, implement an initial time study and cost report, and if cost effective as predicted, modify DFPS rules and regulations related to adoption purchased services and provider contracts to incorporate the time study cost report process. There will be cost involved in developing the claiming option for adoption purchased services but the benefits would be expected to outweigh such cost. Once in place the same methodology could be explored for all purchased service contracts with a potential of claiming IV-E administrative activities. A revenue estimate cannot be developed for this recommendation until the initial study is completed.

2. If the claiming of IV-E related adoption activity in contracts is successful, extend this process to other contracts that provide IV-E eligible administrative activity. To the extent such contracts are identified, add them to the cost report time study described in adoption related recommendation above. The inclusion of foster care, or guardianship related contracts or contracts related to "candidacy" would require modification of the cost report time study process above to adequately distinguish these activities because of their unique IV-E eligibility percentage which would need to be appropriately applied. This exercise would become relevant as the state rolls out Community Based Care and moves to implement the new FFPSA legislation that allows IV-E claiming of services provided for "candidates", pregnant or parenting youth in foster care, and their parents or relative kin care takers. A revenue estimate cannot be developed for this recommendation without the explorative process described above.

3. Medicaid administrative reimbursement should also be considered for CPS purchased services. Although most of the children receiving these services are Medicaid eligible and participants in a Medicaid managed care program, because they are either in foster care or in open protective cases, health related outreach and education, care management and information and referral could be identified and claimed using a claiming system similar to the one described above for IV-E above, approved by CMS, reflected in the interagency agreement between DFPS and HHSC (the single state agency for the Texas Medicaid program) and implemented with appropriate supporting DFPS policy and regulation.

Preventive Service Program

DFPS spent over $100 million annually on prevention programs, including the following (DFPS 2017 Expenditure Report):

STAR	$23.2 million
CYD	$7.3 million
Child Abuse Prevention Grant	$2.2 million
Other At Risk Prevention	$25.4 million
Home Visiting Program	$31.1 million
At Risk Prevention	$3.4 million

Upon review to this category of programs it was determined it would be difficult to apply federal entitlement funding. Few if any of the children benefiting from these programs are in foster care or in an open CPS case, (the criteria necessary for IV-E administrative support), and, Medicaid - supported service would be difficult to use because, although substantial proportion of children and family participants in these programs are Medicaid eligible, they obtain Medicaid-supported services through managed care organizations.

There are opportunities for federal reimbursement under Medicaid administration. The state of Georgia has creatively made use of Medicaid administrative funding for many years to support the health related aspects of its county-based child collaborator, Family Connection. Medicaid administration can also support health related training. The amount of Medicaid administrative funds provided can be limited via contract, can be limited to one or more providers, one or more types of activity, but there needs to be a cost report system in place that clearly identifies the cost of eligible activity to which the Medicaid eligibility percentage of the population benefiting from the Medicaid activity is applied. Upon audit, Medicaid must be assured they are only supporting the portion of the program directly related to the administration of Medicaid.

Recommendations

1. Determine the cost/benefit of claiming Medicaid administration with one of the more sophisticated private providers offering health related preventive services

2. If the initial study demonstrates claiming Medicaid administration would be cost effective, proceed to develop a Medicaid administrative claim. Unless the Medicaid related administrative cost can be isolated by the provider through their cost report process, a proposal describing the time study/ cost report claiming system similar to the

claiming system described above for purchased Protective Services would need to be developed, approved by the federal CMS Regional Officials, incorporated in DFPC policy and regulations, and implemented.

Implementation of Community Based Care

DFPS is in the process of purchasing Child Protective Services legal case management services through implementation of Community Based Care. Throughout this discussion of steps that could be taken to maximize federal IV-E and Medicaid reimbursement, comments have been made regarding the implications for entitlement program claiming under Stage II of Community Based Care. The greatest concern rests with the transfer of the complex cost allocation process, now achieved through use of the cost report/RMTS process described in the DFPS Public Agency Cost Allocation Plan (PACAP). Although eligibility, investigations functions and initial Statewide Intake (SWI) functions will remain with DFPS, as well as caseworker support of children remaining in their homes, the CPS legal case management functions are being contracted out to the private sector with an oversight contract management function remaining with DFPS.

To maintain the federal entitlement funding DFPS now receives, there is a need to identify by program (foster care, adoption, or guardianship) and by functions, e.g., administrative cost related to: Medicaid eligibility and outreach, IV-E eligibility and eligibility support, coordination and monitoring of Medicaid supported services, sex trafficking, legal case management, case management for children living at home, adoption prep and support, adoption case management, guardianship case management, counseling, court related activity, training, other foster care activities, general administration and paid leave. This is done through the RMTS process. The management of the RMTS web-based system within DFPS requires on-going training, management and QA. This web-based system within DFPS in its current form could not be implemented in a combined public/ private cost allocation process. The current RMTS system is not able to allow an outside user. To use the existing RMTS for a combined public/ private cost allocation process there would need to be an added investment in infrastructure to support such a study.

An alternative strategy would make use of the current cost reporting and rate setting process used by DFPS with congregate care and child placing agencies. In essence the only additional cost to the existing rate setting process would be the addition of legal case management. As the Community Based Care evolves to include legal case management participating providers will experience added cost which would be reflected in annual cost report and time study results which would identify the added administrative costs associated with case management. Federal

IV-E and Medicaid claiming would continue on a child by child per diem basis as is the practice today. Those agencies with added cost due to the addition of case management would have rates assigned that reflect such added cost. DFPS could provide start-up grants to support the case management function until such costs would be reported in their annual cost reports and reflected in subsequent rates. Title IV-E and Medicaid claims could be based upon cost allocation driven by a daily time log system administered by participating private agencies. This process would accommodate the rollout and a case management system that would apply to some but not all of the children being served by a particular private agency. This process would need ACYF and CMS Regional Office approval and be reflected in agency policy, regulations and provider contracts.

The amendment of the current cost allocation, rate setting process used with private congregate care and child placing agencies to include the costs associated with legal case management would not require the level of federal review required for changes in the Department's Cost Allocation Plan (PACAP).

Recommendations

In the process of planning the continued expansion of Community Based Care to include legal case management, it is recommended that DFPS:

1. Modify the existing cost report and rate setting process used for private congregate care and child placing agencies to include costs associated with legal case management, and provide start up grants on a child by child basis for the agencies assuming the case management function until their rates reflect the added costs associated with case management. (Child by child start-up grants are suggested because the initially roll-out process will affect some but not all the children placed with a given provider at a particular time).

2. Continue to provide new worker and on-going worker training for private case workers either directly or through agreement with the public university consortium. The reduction of federal financial participation from 75% associated with public workers' salaries and fringe benefits while in training to 50% associated with IV-E related purchased administrative activity could be offset by the increase IV-E revenue generated if the new worker training was provider by a public university where IV-E revenue would be increased through the application of the university's federally approved indirect rate the direct cost of training and the university allows most of the IV-E revenue so earned to be used to offset training cost.

Conclusions and Overall Recommendations

This cost allocation study aimed to analyze the use of funds available under Title IV-E and Title XIX Medicaid of the Social Security Act and identify additional opportunities in the current DFPS financing system to fund DFPS services in the 2020-21 biennium budget.

Nine categories of findings were generated from past and current documentation provided by DFPS, as well as from interviewing DFPS staff who are responsible for billing, financing, planning, and implementing services. Additional information was drawn from state reports and quality service review reports from Texas's neighboring states. This report provides recommendations with funding strategies that can maximize the use of federal funds in these nine categories:

1. **IV-E Foster Care Eligibility**:
   Assessing children eligible for title IV-E is the single most important step DFPS can take to increase federal funding for children. From 2011 to 2017 IV-E foster care eligibility dropped 14.5%. For each 1% annual decrease in IV-E eligibility, there is a $6 million loss in federal revenue (see Note 1 on the last page of this report). DFPS should complete a case review of a significant sample of children found to be ineligible for IV-E, drawn from each of the eleven DFPS regions, determine if any of these cases could have been IV-E eligible, interview a sample of eligibility staff and frontline workers about the eligibility process, and incorporate findings in policy, practice and training materials. Conduct additional face-to-face eligibility training in each DFPS region for all frontline staff and eligibility workers.

2. **Medicaid Rehabilitative Funding**:
   Introduce Medicaid Rehabilitative funding in the specialized residential treatment and child placing agencies as a Medicaid carve-out earning an added $40.2 million in federal reimbursement annually because 100% of children are Medicaid eligible versus 29% are IV-E eligible by using a combination of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and DFPS becoming a Title V Maternal and Child Health provider to limit cost based Medicaid services to DFPS children and providers.

3. **Treatment Directors in Residential Treatment**:
   Require full time Treatment Directors that are Licensed Practitioners of the Healing Arts in all residential treatment facilities. This would enable all residential treatment facilities to claim Medicaid reimbursement for rehabilitative services they provide were such a program to become available in Texas. Current DFPS licensing standards require a Treatment Director for all facilities serving over 25 children or when more than 30% of the children need treatment services. Only two of the three options for Treatment Director credentialing require a licensed practitioner of the healing arts. This step is expected to also assist the State in

meeting the anticipated residential treatment requirements of the new federal *Family First Prevention Services Act* ("*Family First*").

4. **RMTS**:
   Strengthen the Random Moment Time Study (RMTS) through face-to-face training (for the training alone would be expected to increase IV-E eligible results). An increase in the percentage of total IV-E related activity from the current level of 45.9% to the level Texas achieved five years ago, 47.9%, will generate $2 million increased revenue annually.

5. **Claiming the Community Based Care Case Management Function:**
   As Community Based Care rolls out, modify the existing cost report and rate setting process used for congregate care and child placing agencies to ensure continued federal reimbursement for foster care case management. Modification would include capturing costs associated with foster care case management and providing start-up grants on a child-by-child basis for the providers assuming the case management function until the rate reflects the added cost associated with case management. This change will be necessary to ensure the claiming of federal reimbursement achieved by the current public RMTS system.

6. **Administrative Claiming of Contracts**:
   Introduce IV-E and Medicaid administrative claiming for DFPS purchased CPS and Preventive Services. This process should begin with the claiming of IV-E reimbursement for case planning, case management or training activities associated with Adoption Purchased Services contracts. General Revenue is being used to support these contracts and the high Texas IV-E adoption eligibility rate (about 86%) can be applied. Modify the claiming process now used with private congregate care and child placing agencies, and with federal ACF Regional Office approval, implement a cost report/time study claiming process.

   The use of Medicaid administrative claiming should be explored with Preventive Service Program contracts where General Revenue is being used, the activity being supported is medically related and a significant percentage of children benefiting from the program are Medicaid eligible. The Georgia county-based Family Connection process for claiming Medicaid administration should be considered.

7. **Improvement in Candidacy Status**:
   Improve the way DFPS determines "candidate" status to increase IV-E reimbursement for children receiving CPS services at home. Current DFPS workers find just 45% of these children "candidates," children at serious risk of foster care absent the provision of preventive services, reducing the IV-E reimbursement Texas receives from 16% for foster care to just 7% for in-home support services. DFPS should significantly increase their percentage of candidates, as Ohio and Rhode Island have done. There are no federal guidelines a state must follow for determining "candidacy." Total in-home administrative activity is about $57 million annually for which DFPS receives $4 million IV-E

reimbursement at the current level of 45% "candidacy." An increase to 60% "candidacy" would generate $5.3 million (an increase of $1.3 million).

8. **Foster Care Training**:
   Claim 75% FFP training reimbursement for all the time new workers spend in the classroom and on the job training until they complete the six-month new worker training program, resulting in net new Federal funding of $18 million. New workers would earn 24% FFP (Federal Financial Participation) associated with training rather than the 16% associated with foster care activity and 7% associated with support of children living at home. The fiscal impact was based on a Fiscal Year 2018 20.2% estimated annual worker turnover rate as reported by DFPS. Such a program would require that new workers carry a reduced caseload during the training period. There are no federal guidelines defining "reduced caseload." DFPS already uses graduated caseloads for new workers making the recommended use of IV-E training for both formal and on the job training during the new worker training period more easily implemented.

9. **Community Partnership Training**:
   Continue and extend IV-E supported training to DFPS community partners including courts, attorneys, CASA volunteers, police, public health, mental health, and private contract agencies providing CPS related services. Federal Fostering Connections legislation provides 75% FFP for community partners training. This step can increase funding for DFPS's public community partners at no added cost to DFPS, by allowing public partners to claim IV-E reimbursement for training that is related to foster care or children at risk of foster care. The new IV-E revenue earned by the partners can be used to develop collaborative trainings of interest to both DFPS and the partners.

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Note 1:

The basis for the $6 million value (a low estimate) given to each IV-E foster care eligibility percentage federal revenue gain or loss is based upon the total IV-E federal reimbursement Texas received annually from its foster care program as reported on the Foster Care CB -496 Quarterly Report (claim form) (Column B "Current Quarter Claims Federal Share") submitted to ACYF divided by the foster care IV-E penetration rate for the covered quarters. We used the most recent quarters for Foster Care CB-496 Quarterly Reports: 3/31/16; 12/16/16; 3/31/17; 6/31/17 for a total of $207,100,710 federal reimbursement received for these four quarters divided by the IV-E foster care eligibility for 2017 for the two 2017 quarters (31.627%) and (32.22% for the two 2016 quarters) from the annual Title IV-E Foster Care Penetration Rates provided by DFPS. The IV-E foster care eligibility quarterly rate is determined from Section D of the Foster Care Quarterly CB-496 by dividing line 42 "The number of children in placement – Title IV-E Funded Administrative Costs" by line 43 the "Number of children in placement –Any Payment or Administrative Cost." The resultant value of one percentage point change from dividing the total federal reimbursement for IV-E foster care claims for the four quarters by the percentage of IV-E eligible foster care children in placement with IV-E supported administrative costs for the corresponding years is 6.49%. The figure was rounded down to $6 million for each gain or loss of IV-E foster care eligibility as a conservative estimate.