LB 1173 Statutory Workgroup Meeting
MINUTES
July 11, 2023

The Nebraska LB 1173 Workgroup as established by the Nebraska Legislature met July 11th at DHHS offices, 5220 South 16th Street, Lincoln Nebraska, and via Zoom for the purpose of conducting business consistent with the statutory language of LB 1173, having given notice through release to news media and official public notices published in the Lincoln Journal Star.

The meeting was called to order at 2:01 PM CST. John Stephen from The Stephen Group, the consultant hired pursuant to LB 1173 to assist the Workgroup in meeting its deliverables, called the meeting to order and advised that the meeting was held as a public meeting and was being recorded.

LB 1173 Voting Workgroup members present: DHHS Division Director of Children and Family Services (Interim) and DHHS CEO Danette R. Smith; DHHS Division Director of Behavioral Health (Interim) and DHHS Division Director of Developmental Disabilities Tony Green; Commissioner of Education designee LaDonna Jones-Dunlap (virtual); Alexis Zendejas, Omaha Tribe of Nebraska; DHHS Director of Medicaid and Long-Term Care Kevin Bagley; State Court Administrator and representative of the State Judicial Branch designee Kari Rumbaigh; Stephanie Pospisil, Ponca Tribe of Nebraska (virtual); DHHS Director of Public Health Charity Menefee.

An LB 1173 Voting Workgroup Member representative for Winnebago and Santee Sioux Nations were absent.

LB 1173 Ex-Officio (Non-Voting) Members present: Bryson Bartels (virtual); Deb VanDyke-Ries, (virtual); Jaquala Yarbro; Jenny Skala (virtual); Kari Rumbaugh; Ryan Stanton (virtual); Monika Gross; Janece Ferris; Jennifer Carter; Maralee Bradley; Amanda Admas; Teresa Hunter (virtual); Patti Jurjevich (virtual); Heath Phillips; Barbara Robinson (virtual); Jeff Stafford (virtual); and Maureen Larsen (virtual).

Internal DHHS staff present were Larry Kahll; Andrew Keck; Dr. Cedric Perkins; Kasey Boes; Camas Holder; Dr. Alger Studstill; Michaela Hirschman; Jeff Powell; Greg Brockmeier; Lana Verbrigghe; Lori Harder; Carisa Schweitzer Masek; Kathleen Stolz; Remonte Green; Heather Nelson; Michelle Nonemaker; Kristen Smith; Thomas Janousek; Sara Morgan

Others present were: Felicia Kellum, Annie E. Casey Foundation; Ericka Larson, Unite Us; Sadie Wilson (virtual); John Stephen, The Stephen Group; Richard Kellogg, The Stephen Group; Brooke Holton, The Stephen Group (virtual); David DeStefano, The Stephen Group (virtual); and Lorraine Martinez, The Stephen Group (virtual)

The agenda proceeded as follows.

- **Approval of the Agenda/Minutes (Action Item)**

DRAFT

- **A motion was made by Kevin Bagley to accept the agenda and minutes, with the added amendment, which was seconded by Alexis Zendejas and approved by vote, with all voting aye and none voting nay.**

- **Review of Status Report**
  - No comments or questions were made on the June Status Report.

- **TSG Presentation on Themes**
  - John Stephen from The Stephen Group gave a presentation of Themes that have emerged throughout the LB 1173 Work Group process of meeting with diverse stakeholders across the spectrum of the child welfare system through community forums, conducting individual interviews, and attending stakeholder meetings.
  - Themes presented included Common Themes from the CFS Training Survey; Tribal well-being; Prevention focused across all sectors of DHHS; Access to early education; Community resources; Cross agency collaboration; Cultural competency; Parenting and child development education prior to birth; pre-natal support; care and support groups for teens/parents after birth; Services for transitioning youth amongst many others.
  - Jennifer Carter, Inspector General inquired regarding the training if there a way to parse out whether the content was actually some of the concern that was being raised or the real life, application of the content. It was discussed that the training findings would be part of the final report and were validated through supervisors as well as the field.
  - Kari Rumbaugh, Assistant Deputy Administrator · Nebraska Administrative Office of the Courts and Probation advised that there may be additional details that we know about that could be shared and offered to add additional information. A couple examples include a lot of work ongoing to expand foster care options and crisis response. Further discussion regarding the rollout of statewide mobile response units for youth and adults as well as the Nebraska family help line. Attendees were encouraged to share information with The Stephen Group.

DRAFT

- **Medicaid**
  - Kevin Bagley, Director of Medicaid, provided an overview of Medicaid in Nebraska that included current coverage benefits, care coordination and children's behavioral health, pharmacy as well as Therapeutic Family Care, Value-added benefits, and Social Determinants of Health management efforts. Also included was a discussion of the future state and how Medicaid can help support 1173 goals and objectives.
  - Medicaid funding included a mix of federal and state funds; about 60% federal funding for most populations except expansion which is 90% federal funding.
  - Covered services for children include Physical Health; Hospital Inpatient/Outpatient); Physician (including specialists); PT / OT / Speech Therapy; Behavioral Health; Therapies; Crisis Intervention; Pharmacy; Dental; Vision and Early Periodic Screening Diagnosis and Treatment (EPSDT)
  - Service Delivery – Managed Care Organizations (MCO) model with 3 MCOs covering all 390,000 recipients. MCOs manage Care Coordination and Case Management; Physical Health; Behavioral Health and Pharmacy. Currently, dental

is managed by one dental MCO but will be integrated in MCOs 1/1/2024. In Nebraska about 85% of recipients chose not to self select an MCO and are equally distributed among the three MCOs. This distribution model allows for greater collaboration for quality care among the MCOs instead of competition to gain more membership.

- Integration Between CFS and Medicaid include braided funding that can infuse additional federal funds into a program.
- Therapeutic Family Care (TFC) Program where specific services available to children in Tiers 3+ who have functional limitations in ADLs to be rolled out in phases. Phase 1 to launch on October 1, 2023 includes CFS Care Coordination team established to assess children's clinical needs, CAFAS Assessment conducted on children in Tiers 3+ and establish and maintain a child-specific care plan. Phase 2 to launch on January 1, 2024 where crisis stabilization services will begin being offered. Future Phases include identification of additional services payable under this authority, such as respite, and identification additional coverable populations.
- Future opportunities include waivers allowing coverage of social determinants of health (SDOH) addressing areas such as housing supports and food insecurity. Additionally, exploring how to improve coordination with other agencies and programs like Juvenile Justice / Other justice-involved; SNAP / TANF / WIC; FFPSA Related Services.
- Kari Rumbaugh raised the issue around populations beyond those involved in child welfare being able to access services and the future scalability of services to all youth, in particular those who are justice involved. Kevin Bagley indicated that after the initial rollout is it scalable and we miss the mark if we wait until all children are in foster care. Let's test this concept with this group and see what works. We've already started to have conversations around how we would scale this type of work. It's a part of future work that needs to happen. We've all had good ideas that we've all talked about in the meetings that have fallen by the wayside over the course of years, and we want to make sure we don't do that here.

- **MCO Presentation**
  - Heath Phillips, Nebraska Total Care provided an overview of MCO facilitation of the delivery of care in Nebraska. MCOs executing the contract and the benefit of the attribution of members removed the need for MCOs to compete against each other for members allows for true collaboration among the MCOs so we can all excel in Nebraska.
  - Director Bagley concurred sharing that the state outsources this work to the MCOs and as a result the MCOs spend a lot more time trying to get people into services.
  - The presentation moved to Nebraska Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, is also referred to as a Health Check or a Well-Child Visit. This requires MCOs to work to optimize a member's health condition, compensate for a health problem, prevent a serious medical deterioration, and/or

DRAFT

prevent the development of additional health problems. Medical Necessity guidelines for EPSDT are consistent across all three MCOs. Medical services covered by the individual's Medicaid plan are consistent across all three MCOs.

- Health plans provide a combination of written and oral methods designed to inform all EPSDT eligible individuals and/or their families about the EPSDT program within sixty (60) days of enrollment or as specified in State regulations establishing mandated timeframes.
- Provider and Member Collaboration Health plans, members and providers work directly together in multiple ways to ensure members needs are met. Providers and members sit on various MCO committees to give feedback and inform MCO practices on service accessibility and working with health plans efficiently to meet member needs timely. Providers are able to request prior authorization for services covered under EPSDT when that is required. MCOs, providers and family members participate in member care coordination meetings when needed. MCOs have care management resources available for family members to work with to develop comprehensive and individualized care plans that support their provider identified treatment plans. 'No Wrong Door' approach for providers and families to interact, receive referrals from MCOs.
- Care Management provides direct support to members with complex health concerns, such as illnesses that require coordination of many services and children with special health care needs. Care Management teams can include Registered Nurses, Social Works, Behavior Health Counselors, and Community Health Workers. Together, they help educate and empower members to be successful in complex systems.
- MCO's support care coordination with other DHHS Divisions, Probation, Providers and Community Resources. DHHS Collaboration includes complex care coordination and regular service delivery meetings across departments including Child and Family Services, Division of Behavioral Health and Division of Developmental Disabilities. MCO's regularly interact with Juvenile Justice services when they are involved in a member's care supporting resource identification and coordination as well as medically necessary treatment.
- Jaquala Yarbro commented about how work is being informed and that community based organizations (CBOs) are not at the tables informing policies or services. How do we involve CBOs upstream in the work? Director Bagley discussed forums that Medicaid uses to solicit feedback from the community acknowledging that these forums may not include everyone and encouraged CBOs to directly engage with Medicaid. Additional MCO and DHHS discussion ensued emphasizing the willingness and need for more interaction with the community partners.

- **TSG Presentation on Medicaid Best Practices**
  - Lorraine Martinez from The Stephen Group provided an overview of Medicaid Best Practices that included Front End Collaboration and State Medicaid Innovations; MCO Foster Care Best Practice and Opportunities for Nebraska Medicaid/MCO

DRAFT

- Front End Collaboration overview included OhioRise; New Hampshire's Wraparound Model and State Medicaid Innovations in Wisconsin, Colorado, Florida and New Hampshire.
- MCO Foster Care Best Practice overview included Texas STAR HEALTH/Centene – Superior Health Plan; Arizona Aetna/Mercy Care and Anthem/Amerigroup
- Nebraska LB 1173 Medicaid Opportunities highlighted included Utilize Community Collaboratives to improve community well-being and increase competitive advantage amongst MCOs; Require MCOs to identify at-risk families pre and post-CFS involvement; Consider including housing support requirements to improve members' health as well as additional waiver/state plan considerations addressing SdoH. Additionally, Medicaid and MCO Training Considerations for Child Welfare Staff such as CFS Staff/MCO Coordination established touchpoints, CFS Staff/MCO Coordination established touchpoints and CFS Staff/MCO Coordination established touchpoints.
- Immediate MCO Opportunities for Nebraska include identifying at-risk families before CFS involvement, MCOs can enhance family preservations and permanency efforts, provide education on Medicaid to CFS caseworkers.
- Jaquala Yarbro commented that Collaboratives are not CBOs and CBOs are trying to work with the Collaboratives to make them more inclusive regarding the full spectrum of the perspective of those with lived experience. Jaquala shared her experience that Collaborative are system partners working with child welfare and social services agencies and her perspective that in trying to work with the Collaboratives the CBOs tend to get pushed out of those environments because we see things differently. Jaquala shared an example regarding the use of psychotropic medication in youth and cited statistic from the Foster Care Review Office Report that 95% of the youth on juvenile probation in Douglas county are on at least one psychotropic drug and that black kids are 90% of those kids as well as they're only 5.4% of the population. What's healthy depends on who you are and where you are. CBOs can be included further upstream and provide this perspective to inform the work.
- Barbara Robinson of Robinson Family Advocacy Center and a lived experienced person stated that she is a contracted visitation services provider. She would like to do more visitation services and family support. It's very hard, because I didn't go to school to do that. Because of the life that I have and the experiences that I have. I want to change the direction of the children and the families that are in the system. I want the Government to understand that the system is to help them rebuild their family. I want the system to understand that as well. Barbara asked what is planned to give a lived experience person more of a platform? How will it give people with lived experience more of a platform to help turn it around. We are the ones that will be able to it, improvise, emphasize, and identify. When a person is not doing what they're supposed to, or when a person is struggling, or when a case manager is

DRAFT

giving the a person a runaround. Doing the work that I'm doing now. I still get some backlash from some case workers.

- Alger Studstill, DCFS Deputy Director of Protection and Safety, responded acknowledging there were opportunities to improve and that the 1173 work is highlighting how we can have everyone working together with more people in the room. We need everyone to keep showing up and keep challenging us. Part of it is training. How do you actually work with people and individuals of lived experience, understanding that we all bring a level of experience to the work. Have different approaches based on different experiences. An example is in the eastern service area where a family council is being put together with just family. We want to hear the voices of biological parents, foster parents, adoptive parents. Starting to have conversations at that level is the first piece and the second is quality with supervisors in the field providing oversight as well as outreach to families.
- Barbara Robinson stated my question is how can you add more people with lived experience? What is what's needed for that? I want to be able to add other mothers, other fathers who have done been through the system, and who has overcame addiction, who don't view the system as the enemy.
- Alger Studstill shared information about the ways the various departments seek to bring lived experience in and offered that it is a work in progress and something they are trying to be more intentional about.
- CEO Smith added that it takes monumental effort to get systems to come to a table and to look at the work in a different way. And what we are seeing right now is that people are awakening and looking at the work in a different way. We haven't been able to necessarily bring the right people to the table. Everybody sitting in this room has an interest of having people who I call unusual suspects sitting at the table with us and helping us look at how policy and how we can imagine the system to be different. And in Nebraska, to my knowledge of 4 and a half years here, we've not been able to achieve that until we come this legislative. There is a group of people in this room that are willing to hear those voices in a different way because of the legislation. The second thing is that there is a willingness to listen, learn and explore things that are very different than what they're accustomed to. What I'm asking you to do with this group is to offer us some grace to allow people to be inside of wanting to do this work in a different way. It just simply takes time to move and a systems transformation. To Alger’s point, 30 people are showing up every month. So there's an interest. We just got to figure out what the first priority is to get other people at the table, that both are and will be very different than all those of us in the room. Know that people are really, really listening to you. Jaquala, you're being heard. It's not just being heard. There's really action behind the scenes. You may not see it, but trust me, there is action and it just takes time for it to materialize.
- Jaquala Yarbro reiterated her earlier points and stated it is well past time to have these conversations about, how do we include community based organization and

DRAFT

for administrative level further upstream? How do we deal with the community based organizations collectively, so that it's easier for us to help navigate as well.

- **Finance Update**
    - David DeStefano from The Stephen Group provided an update on Finance Workgroup activities and the four primary objectives developed by the Finance Work Group for the Finance Plan.
    - Subcommittees formed around three major topics: Title IV-E Revenue Maximization; Cross-Department Synergy and Collaboration; and Provider Rates and Contracting. Recommendations have been developed by each of those subcommittees and discussed with the overall 1173 finance work group. We are in on process and on track to have a preliminary draft of fiscal framework for presentation during next month's LB1173 Workgroup Meeting.
    - Recommendations will include continuing what they're doing and continuing to work toward increasing that Title IV-E penetration rate. A lot of opportunity exists there to free state funds and move to a front end system that is funded out of some of those state revenues that would be freed up.
    - A new child trends report released just a couple of days before the last work group meeting. We are in the process of analyzing the data in that it has a new look at Federal funding mixes from about 2020 period that has changed a little bit from Nebraska for 2018. We'll have that for presentation later this month, early next month.
    - Cross-Department Synergy and Collaboration a couple of key focuses: how do we claim for those high quality legal services; how do we look at increasing claiming for all residential placements; are there opportunities to claim that we're not currently claiming and how do we bring juvenile probation services into title IV-E, claiming for any of those things to really have a significant return on investment, because those are all tied to the Title IV-E penetration rate, that penetration rate is going to be a critical piece of making any of these other recommendations in those claiming opportunities successful.
    - We're integrating more and more providers into the Provider Rates and Contracting meeting. Great feedback and great comments, and great compliments to this Administration for your willingness to collaborate here. Hear their concerns, come to the table with them. that was specifically cited by multiple providers in multiple forms. We're coming up with 4 key recommendations around contracts and rates using cost-based rates with periodic rate updates to those cost-based rates all leading to performance, based contracting and all contracting will lead to an upstream focus on prevention keeping families together, whether it be on the reunification or prevention side through all 4 of these recommendations, as it even ties into the performance based contracting. The Stephen Group provided CEO Smith with some recommendations around TANF reinvestment. And the concrete and economic supports families need were one of the things that were recommended in that report back to the to the CEO. We will look to integrating these components into our finance model because they're critically important to family success.
- **Future State Discussion**

DRAFT

- Carisa Schweitzer Masek, Deputy Medicaid Director and Tom Janousek, Deputy Director Behavioral Health presented the highlights of the Therapeutic Family Care Program (TFC).
- TFC Comprehensive Care Coordination (CCC) is Phase 1 of the rollout. The CCC team hired as DHHS CFS staff will consist of RNs and LCSWs trained to conduct CAFAS, develop person-centered plan of care and provide on-going interdisciplinary care coordination.
- This team will be trained to understand the needs of these individuals - do they need additional training on how to do escalate situations? Do they know how to deal with their neighbors. Also, an understanding of social supports. The score on the assessment determines the medical necessity. It will start out with Level 3, 4, and 5 kids.
- It's important that we start with that standardized assessment because in the long term that will end up being a baseline. In the future, that assessment can be used not just for children that are in the therapeutic program, but also children that are in tier one and two and alternative response children and those that known to the probation system before they ever enter foster care.
- The CAFAS will be used to make sure that children are in need of mental health care and if they are not appropriate for that mental health care, they're getting routed into, maybe some of the social determinants of health resources. There has been a lot of feedback from our conversations with providers that there's a lot of times where we put some kids in the process to get a mental health assessment, and they have to wait a long time to get that mental health assessment when they really just need access to some level of economic resources.
- Once it's determined that that child needs a mental health assessment then the child will be tracked through our system so that we're continually relaying that information back to the case managers, probation and parole staff and the individuals that work in alternative response. As they go through the services, we continue to track them.
- TFC Crisis Response Service (CRS) 24/7 is Phase 2. CCCs will work with TFC program youth and families to develop a crisis plan. Crisis Response providers will be Medicaid enrolled and contracted with CFS as a provider of crisis services. Individual/Foster family has Choice in who provides services and the crisis plan, and crisis response provider of choice, will be documented in the plan of care.
- CAFAS and BH services related to lower levels of care – Levels 1, 2 and Alternative Response. The future state design also included reference to the intent for CAFAS Assessments to be used in the future to also assess BH needs of children in Levels 1, 2 and those families in the Alternative Response system. This Assessment will help guide the future BH response system.
- A suggestion was made to add a suicide screening to the CAFAS assessment if it doesn't already exist.

DRAFT

  - A question was asked about whether there was a plan in place to reduce the overrepresentation of children of color. DHHS responded that the system is set up to collect the data so that more informed decisions can be made. One thing we want to make sure of is that we don't lose track of the children and that they get the care that they need.
- **Adjourn**
  - The Workgroup adjourned the meeting at 4:15 PM CST.
  - The next workgroup meeting will be held August 3rd at 5220 South 16th Street, Lincoln Nebraska from 2 to 4 PM CST.

DRAFT