THE STEPHEN GROUP

LB 1173 FINANCE MODEL

Funding Considerations to Support a Reimagined Child Welfare System

Legislative Work Group Report

Nebraska LB 1173 Finance Model

Funding Considerations to Support a Reimagined Child Welfare System

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Executive Summary

INTRODUCTION

Recognizing the need to strategically re-envision Nebraska's approach to providing child welfare services to children and families, the Legislature passed LB 1173. The legislation was passed with the intent supporting the well-being, permanency, and safety of children and families in Nebraska's communities by comprehensively transforming the state's child welfare system. To accomplish this transformation, the Legislature established the importance of creating strong partnerships among the legislative, executive, and judicial branches of government and community stakeholders in order to develop an intersectoral approach to the provision of child welfare services.

> **"Families don't live according to funding streams. To meet their needs, we must be creative."**
>
> ***Rebecca Jones Gaston, Commissioner***
> *Administration on Children, Youth and Families*
> *2023 Community Collaborations to Strengthen and Preserve Families Federal Grantee Meeting*

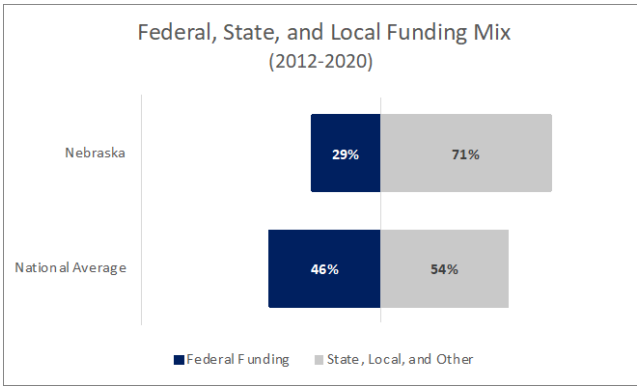
To this end, the legislation established a Work Group responsible for the development of a practice and finance model for child welfare system transformation. As part of this charge, the Work Group was required to evaluate the state's title IV-E claiming practices, identify appropriate steps to optimize federal reimbursement for child welfare system expenditures, and define opportunities and financial mechanisms for providers to pilot innovative solutions to meet program goals.

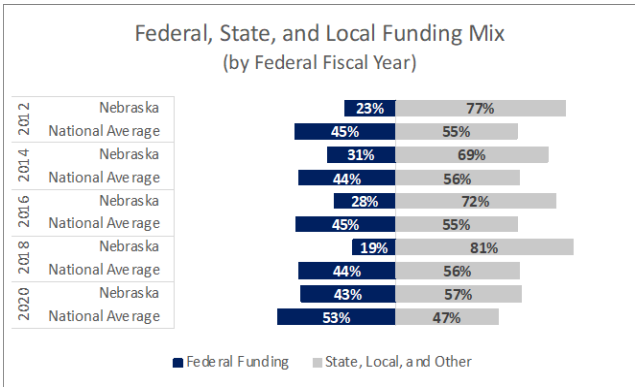
To accomplish these tasks, the LB 1173 Work Group convened a subcommittee comprised of leaders and financial management staff from the various divisions of DHHS, representatives from the Department of Education (NDOE), the Judicial Branch, the State Supreme Court, and Juvenile Probation Services. Together, they consulted with internal and external stakeholders, providers, and others to develop this Financial Model and accompanying recommendations.

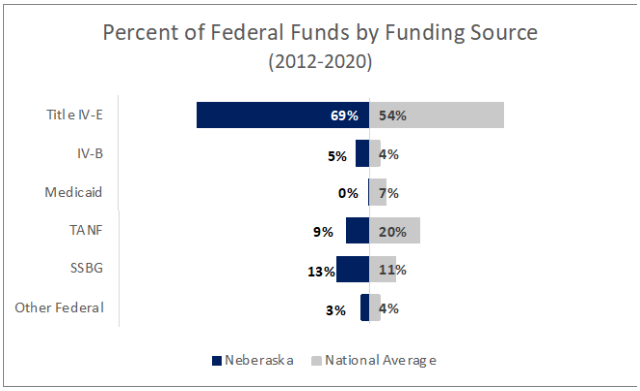
Review of Historical Federal Claims Data by Funding Source

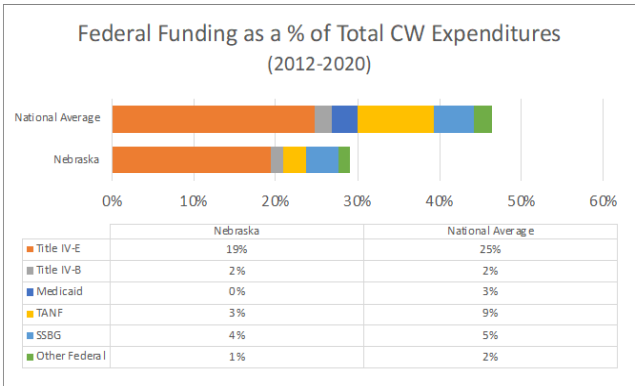
The Work Group assessed Nebraska's ability to effectively utilize available funding to the benefit of children and families by comparing available data depicting the use and mix of federal, state, and local funding sources. According to a biennial survey of state funding

conducted and published by ChildTrends[1,2], Nebraska's utilization of federal grant sources to fund child welfare services has been significantly lower than the national average over the past decade. Data available for Federal Fiscal Years 2012 through 2020 shows the percent of state and local funds expended for child welfare services were 32% higher than the national average. Of total expenditures for child welfare services, state and local funds accounted for a high of 81% in 2018 and a low of 57% in 2020.









The review of expenditure data reported to ChildTrends depicts other states having a more balanced use of federal funds. Specifically, they report higher levels of TANF and Medicaid spending for child welfare services. Additionally, between FFYs 2012 and 2020, CFS was only able to draw an average of nineteen percent (19%) of their total funding from title IV-E reimbursement. This is compared to a national average of twenty-five percent (25%) over the same eight-year period.

[1] https://www.childtrends.org/publications/child-welfare-financing-survey-sfy2020
[2] Expenditure data is reported to ChildTrends via a survey completed by each state.

Claiming for Title IV-E Prevention Services

Signed into law in 2018, the Family First Prevention Services Act (FFPSA) represents the most significant shift in federal funding for child welfare services in recent history. The act increases the focus of child welfare systems towards keeping children safely with family so as to avoid the trauma resulting from placement in out-of-home care. To meet this goal, the law provides families with greater access to mental health services, substance use treatment, and/or parenting skills courses and gives states the ability to access title IV-E federal funds to pay for these services. This significantly shifts how child welfare systems will coordinate and provide services to families and youth. As a result, it changes the role of community service providers, the way courts advocate and make decisions for families, and the types of placements available to youth placed in out-of-home care.

As one of the first child welfare systems in the Nation to receive approval for their Five-Year title IV-E Prevention Program Plan, CFS has recognized the challenges that come with implementing a large scale change to a longstanding service delivery system. While FFPSA allows title IV-E to the provision of preventative services to families and children, the law requires significant intersectoral planning, collaboration, and partnership between child welfare, Medicaid, and other existing federal funding sources to pay for the provision of these services. In particular, the Act is clear in that title IV-E is the payor of last resort for those families that are Medicaid eligible. To date, Nebraska has not realized significant federal reimbursement for the provision of prevention services through title IV-E. Data comparing state FFPSA-related reimbursements is provided in this document, below.

Out-of-Home Care Expenditures

The Work Group also reviewed statewide data related to child intakes, protective investigations, assignment to services (alternative response or in-home), entries to out-of-home care, and children achieving permanency. Though changes to state law and practice have served to significantly reduce the number of children entering care, the overall number of children exiting care has not reduced proportionally during the same time frame. As a result, the number of children in out-of-home care has remained static while those children and youth in care are experiencing increased lengths of stay. Additionally, CFS is serving approximately 1,000 additional children per month through alternative response programming.

This results in increased child welfare cost related to the additional children served while not realizing expected cost savings related to a reduction in foster care placements. We believe a reduction in out-of-home care will eventually result in a $30 million reduction to state expenditures annually, which could eventually be reinvested in prevention and capacity development initiatives described in both the Program and Finance Models. This is described in

more detail in the "Reduction to Out-of-Home Care Expenditures" section of this report. A significant portion of these reinvested funds are likely to be eligible for federal reimbursement.

Additional Findings

In completing this report, the Work Group identified several funding sources have not been used to their fullest potential. Details related to these findings are provided in subsequent sections of this document. In particular, we found:

- DHHS has not expended available TANF funding. As a result, a significant surplus has accrued.
- From 2019 to 2023, $83 million unspent dollars were returned to the Division of Behavioral Health by the RBHAs.
- CFS has not claimed federal reimbursement for eligible agency and provider (child placing agency) administrative costs. Doing so is likely to generate an additional $8-10 million in federal reimbursement annually.

Conclusion

The Work Group concludes CFS has not fully expended, maximized, or leveraged federally available funds to the degree other jurisdictions are able to. As a result, a disproportionate level of state funding has been required to operate the system. Given the availability of unexpended funding, ability to claim additional reimbursement, and potential cost savings to be realized by reducing the number of children in out-of-home care, there appears to be sufficient state funding within the existing budget to strategically transform the child welfare system and improve services to children and families without appropriation of additional state general funds.

The remainder of this section summarizes the:

- Evaluation of title IV-E Claiming Practices,
- Steps to Optimize Federal Reimbursement, and
- Financial Mechanisms to Pilot Innovative Strategies.

Subsequent sections of this document offer a detailed summary of specific initiatives and financial implications related to title IV-E Federal Financial Participation, Cross System Synergy and Collaboration, and Provider Rates and Contracts.

Evaluation of Title IV-E Claiming Practices

Through a review of statewide payment and federal claims data, eligibility determinations, placement data, state regulation and procedures, the Work Group has determined title IV-E

reimbursement has not been effectively maximized and fully realized. In fact, there are several eligible services and activities for which federal reimbursement has not been claimed at all. In particular, we found:

- Title IV-E eligible administrative expenditures have not been claimed for title IV-E Candidates.
- Through the end of FFY2022, no reimbursement for FFPSA title IV-E eligible administrative or training costs has been realized.
- Title IV-E eligible administrative and training expenditures have not been claimed for subcontracted child placing agencies.
- Proactive changes to policy and practice could result in an increase to the title IV-E penetration rate by:
    - Modifying standards related to title IV-E income eligibility determinations,
    - Expand training opportunities for judiciary and staff responsible for ensuring court order language is complete and accurate.
    - Modifying licensing requirements for relative caregivers to the fullest extent possible,
    - Reviewing Tribal foster licensing standards to ensure they meet minimum federal requirements. Accept tribal licensing standards when a tribal child is placed in a home on or in proximity to a reservation,
    - Identifying strategies to reduce placements in ineligible placement settings,
    - Creating a path to dual licensing for residential settings for residential settings serving multiple populations (DD and Medicaid),
    - Increasing the number of licensed relative caregivers by further streamlining the licensing process, providing pay differentials for licensed relative caregivers, and incentivizing child placing agencies responsible for the home when relative caregivers become licensed.

Though aggressive attention to these strategies, we estimate the penetration rate may increase by between eight and twelve percent. This could generate an increase in title IV-E reimbursement for eligible activities of between 45% and 50%.

Steps to Optimize Federal Reimbursement

This report includes several strategies to increase federal reimbursement. To realize a fully reimagined child welfare system, the Work Group recommends prioritizing these strategies in order to leverage a projected reduction in state expenditures over time and allow those funds to be reinvested into a balanced child welfare system, which prioritizes the provision of early intervention and prevention services. These reinvested state funds will then be eligible for

additional federal reimbursement. We recognize this will have to occur over an extended timeframe and understand additional research may be required to fully understand implementation requirements and realize a return-on-investment. Specific steps to take over the next one to two years are listed below. Each of these strategies are described in detail within this document:

- Implement aggressive strategies to improve the title IV-E penetration rate.
- Develop the necessary procedures to claim title IV-E federal reimbursement for all eligible services and activities.
    - Administrative costs related to traditional title IV-E candidacy,
    - Administrative and training costs related to FFPSA implementation and operation,
    - Administrative and training costs incurred by subcontract providers.
- Develop training and capacity development strategies related to FFPSA service expansion, development of provider capacity, and workforce training.
- Conduct an in-depth rate study across all for all services. Create standardized cost based rates, which will be utilized by all state agencies and DHHS divisions.
- Establish performance based contracts with providers in order to increase accountability and improve outcomes.
- Review Tribal contracts, payments, and reimbursements ensure payment equity.
- Focus on child permanency and reducing the number of children in out-of-home care.
- Review Florida's revenue maximization legislation and implement similar statutes and procedures.
- Investigate the potential return-on-investment and, when viable, establish procedures and initiate title IV-E claiming for existing costs incurred for high quality legal representation and juvenile probation services.
- Study the feasibility of transitioning to a highly efficient CCWIS-compliant data management system.
- Create a workgroup including state staff, managed care representatives, and providers to develop strategies and formulas to effectively blend or braid funding sources for evidence-based practices (EBP). Also consider the potential of having an EBP added to as a "named" service in the Medicaid State Plan or having it approved as an In-Lieu-of-Service.
- Create a Community Prevention Pathway to expand services to families identified as having children at risk of entry to foster care before they become known to the child welfare system. Engage local providers to operate these pathways and leverage allowable county funding provided by determining whether it can be certified as match.

- Collaborate with the Department of Education to enhance access to Early Intervention, Prevention, and Crisis Intervention services. Determine whether any local public funding infused into this system can be certified as title IV-E matching funds.

As these steps are completed, state funds are reinvested, and additional federal revenue is realized, remaining strategies included in the Practice and Finance Models can be prioritized and implemented.

Financial Mechanisms to Pilot Innovative Solutions

The Work Group recommends looking to fully utilize existing funding and maximize federal revenue in order to pilot innovative solutions presented in the Practice and Finance Models. In particular there are several innovations which either rely on existing funds or may be cost neutral. These include:

- **Cross-system claiming for Legal and Juvenile Probation Costs.** System expenditures for these services already exist. The only additional investment necessary will be related to the cost of establishing interagency memorandums of understanding, developing claiming protocols, implementing cost allocation strategies (which may require a random moment sample or other means to allocate costs to populations and activities), collecting and aggregating costs, and developing quarterly claims. Any reimbursement claimed should be reinvested into system improvement, service expansion, or staff capacity. It is important to note, title IV-E claiming for Legal and Probation costs are closely tied to the state's penetration rate, taking the steps required to increase the penetration rate will be vital to maximizing the potential of claiming for these activities.
- **Implement 1115 Waivers:** Use 1115 Medicaid Waivers to implement innovative service delivery systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).
- **Expand Access to the Regional Behavioral Health System:** As noted in both the Practice and Finance Models, existing surplus funding may be used to expand eligibility and access to services.
- **Provision of Concrete and Economic Supports to Families:** The Work Group recommends investing surplus TANF funding to offer these supports to families experiencing financial hardship.
- **Development of a Community Prevention Pathway:** As additional title IV-E funds are claimed for eligible activates, available state funds should be reinvested in the implementation of a community-based prevention strategy capable of reaching families before they become involved with the child welfare system. Such implementation may be phased in across the state based on the availability of funds and specific needs of communities. As the pathway is implemented, DHHS should look to leverage any public funds used by the local provider and determine whether it can be certified as match.
- **Invest in the Development of Provider Capacity and Ability to Provide Evidence Based Practices:** For prevention efforts to be successful, provider capacity must be developed in order to offer evidence-based practices, especially in rural or frontier areas of the

state. As noted in this report, when clinical providers of evidence-based practices are training and being certified to provide service with fidelity to the intervention, they often are required to carry a limited number of cases. When staff are primarily reimbursed through billing for Medicaid eligible services, there is often not sufficient revenue to cover an agency's total cost. Investment will have to be made to develop capacity across the state in order to have the requisite number of clinicians capable of engaging and working with families.

Priority Area 1: Enhance Title IV-E Federal Financial Participation

Title IV-E Income Eligibility: AFDC Lookback

Every year, states receive progressively less federal financial assistance for children removed from their home and placed in foster care. In 1998, 53 percent of the children in foster care were eligible for federal support through title IV-E. By 2005, the percentage had declined to 46 percent. Since then, the number eligible for federal financial assistance has continued to decline. Recent data indicates the average percentage of children eligible for federal assistance under title IV-E is approximately 41 percent. According to ChildTrends[3], Nebraska has the lowest title IV-E eligibility rate in the nation, 18%.

Recommendation

> *Legislatively advocate to eliminate the federal linkage between Title IV-E eligibility requirements and 1996 AFDC income standards.*

A child's eligibility for title IV-E foster care maintenance payments is based on multiple criteria. First, responsibility for the child's care and placement must rest with the state or tribal child welfare (title IV-E) agency. Additional eligibility criteria are related to:

- the child's age;
- how and why the child was removed from the home:
    - for children involuntarily removed from the home the court must find that the home was "contrary to the welfare of the child" and the state made "reasonable efforts" to prevent the child's removal;
- the placement setting and foster care provider for the child (placement must be licensed by the child welfare agency);
- the title IV-E agency's timely and continued "reasonable efforts" to achieve permanency for the child;
- the child's citizenship or immigration status; and
- the income, assets and other characteristics of the home from which the child was removed.

Eligibility factors related to income, assets, and characteristics of the home are linked to each state's AFDC eligibility limits in place as of July 16, 1996. Generally, this is referred to as the "AFDC Lookback." Among other AFDC-related factors in place at that time, the child must have

[3]ChildTrends (2023), Child Welfare Financing SFY 2020, A survey of federal, state, and local expenditures.

been removed from a family with income that is below the "need standard" established by the state under the AFDC program, without adjustment for inflation, and as determined using the income counting rules in effect under that program on that date. Further, the child must have been removed from a family with assets of no more than $10,000, as determined using the asset counting rules under the AFDC program.

A state must apply a two-part income test to determine whether in the month that the court proceeding to remove the child from the home is initiated, or in the month a voluntary placement agreement is signed, the child would have been considered needy under the state's AFDC program. The first step is to determine that the gross income in the home from which the child is to be removed does not exceed 185% of the state's 1996 need standard. Provided this test is met, the state must next determine that the countable income in the home of the child was 100% or need standard. Generally, counted income of a family applying for AFDC included the family's gross (earned and any unearned) income minus up to $90 in wages, childcare costs up to $175 (or $200 for child younger than age two) for an employed member of the assistance unit; and up to $50 in child support.

1996 AFDC income "need standards" for a family of three varied widely from state-to-state; from a low of $320 / month (Indiana) to a high of $2,034 / month (New Hampshire). By in large, a significant percentage of children nationally are determined to be ineligible for federal financial assistance as a result of the family's income at the time of removal.

Nebraska's 1996 need standard for a household of three was $364 per month, the third lowest in the nation. For Nebraska to receive federal reimbursement for out-of-home care costs related to a child removed from a family of three persons, the household's gross monthly income may be no more than $674 (185% of the need standard) and, total countable monthly income be no more than $364. To put this into perspective, as a result of inflation, Nebraska's AFDC lookback income standard is only 17.5% of the 2023 federal poverty standard. Income standards for families of more than three are slightly higher. For instance, Nebraska's standard for a family of four is $435 per month, 19.5% higher. Approximately fifty percent of Nebraska children placed in out-of-home foster care are ineligible for Federal title IV-E assistance as a result of this standard.

There have been multiple attempts to legislatively delink the AFDC lookback from title IV-E eligibility standards. To date, such efforts have not met with any success at the federal level. Nebraska legislators should collaborate with representatives from similarly affected states and continue to advocate for changes to this outdated, archaic eligibility requirement.

Revenue Maximization State Law and Department Policy

As the Nebraska Department of Health and Human Services (DHHS) looks to create intersectoral partnerships supporting the LB1173 Child Welfare Practice Model, steps should be taken to ensure federal funds are fully reimbursed. In support of these efforts, a work group spearheaded by DHHS should review and, if necessary, revise interagency agreements, state laws, and department policy to ensure they are aligned with efforts to maximize federal financial participation. In doing so, DHHS will ensure activities, such as the Provision of High Quality Legal Services, title IV-E Claiming for Child Welfare / Probation Cross-Over Youth, expanded partnership with the Nebraska Department of Education, and the implementation of a Community Prevention Pathway, which may involve the use of local public funds are able to leverage these local dollars to their fullest extent.

Recommendation

> *Ensure state law and department policies align with and support efforts to maximize federal financial participation through the certification of local funds as match.*

Title IV-E, unlike Temporary Assistance for Needy Families and the Child Care Development Block Grant, maintains restrictions on the type of funds that may be used as match for reimbursement. The costs must be expended by the agency receiving the title IV-E grant or Medicaid, or another public agency, or a county-based agency that has an interagency agreement in place. A public agency may use certified public expenditures to leverage title IV-E reimbursement when those funds are paying for title IV-E eligible costs and are not used as match for other federal funds. No private provider funds can be used to match title IV-E expenditures, unless the private provider transfers funds to a public agency. The department must ensure that any local agency funds are handled in a manner to ensure title IV-E, specifically, the provisions outlined in 42 Code of Federal Regulations (CFR) 433.50 and 45 CFR 235.66(b) (1-3).

45 CFR § 235.66 Sources of State funds.

(a) *Public funds.* Public funds may be considered as the State's share in claiming Federal reimbursement where the funds:
- (1) Are appropriated directly to the State or local agency, or transferred from another public agency (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under §§ 235.60–235.66;
- (2) Are not used to match other Federal funds; and
- (3) Are not federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

(b) *Private funds.* Funds donated from private sources may be considered as the State's share in claiming Federal reimbursement only where the funds are:
- (1) Transferred to the State or local agency and under its administrative control;
- (2) Donated without any restriction which would require their use for the training of a particular individual or at particular facilities or institutions; and
- (3) Do not revert to the donor's facility or use.

A public agency, or "local government," is defined by sections 472, 474(a)(1), and 474(a)(3)(C) of the Social Security Act, as a county, municipality, city, township, local public authority, school district, intrastate district, council of governments (whether or not incorporated as a non-profit corporation under state law), any other regional or interstate government entity, or any agency or instrumentality of a local government. The local match process currently applies to all counties having local public agencies that meet the federal requirements pursuant to 42 CFR 433.51 – Public Funds as the state share of financial participation, and 45 CFR 235.66 – Sources of State Funds provisions of services to eligible children. The local match process enables public agencies to use expended, publicly appropriated local funds as a match for earning federal funds. It is important to note, in certain, specific circumstances 45 CFR 235.66 provides for the consideration of private funds the state's share when such funds are transferred and placed under the administrative control of the state or local agency, are transferred without restriction or designation of their use, and do not revert to the donor if not expended. Though these restrictions may be limiting, DHHS and collaborating intersectoral and community partners should investigate the feasibility and potential of pursuing such arrangements when circumstances permit.

409.017 Revenue Maximization Act; legislative intent; revenue maximization program.

(3) (h) Each agency, respectively, shall annually submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives, no later than January 1, a report that documents the specific activities undertaken during the previous fiscal year under this section. The report must include, but is not limited to, a statement of the total amount of federal matching funds generated by local matching funds under this section, reported by federal funding source; the total amount of block grant funds expended during the previous fiscal year, reported by federal funding source; the total amount for federal matching fund programs, including, but not limited to, Temporary Assistance for Needy Families and Child Care and Development Fund, of unobligated funds and unliquidated funds, both as of the close of the previous federal fiscal year; the amount of unliquidated funds that is in danger of being returned to the Federal Government at the end of the current federal fiscal year; and a detailed plan and timeline for spending any unobligated and unliquidated funds by the end of the current federal fiscal year.

409.26731 Certification of local funds as state match for federally funded services.

The Department is authorized to certify local funds as state match for eligible Title IV-E expenditures more than the amount of state general revenue matching funds appropriated for such services by the General Appropriations Act. Title IV-E funds provided to the state as federal financial participation consequent to certified local matching funds shall automatically be passed through to the local entity that provided the certified local match. Notwithstanding the provisions of section 215.425,

Florida Statutes, all such federal funds earned for the current fiscal year as a result of using certified local match, except for up to five percent of such earnings that the Department is authorized to retain for administrative purposes, shall be distributed as set forth in this section and this process shall not impact the Department's allocation to any district. All the provisions of this section are based upon federal approval of the provisions as specifically limited in this section and shall not become effective if any further modifications are required of the state, unless and until federal approval has been obtained. The Department shall annually prepare a report to be submitted to the Legislature no later than January 1, documenting the specific activities undertaken during the previous fiscal year pursuant to this section.

Florida Revenue Maximization Act

In considering this recommendation, DHHS may look to legislation and policy implemented in the State of Florida. The state's Revenue Maximization Act, Section 409.017(3)(h), was implemented with the intent to authorize the use of certified local funding for federal matching programs in order to maximize federal funding local preventive services and local child development programs in this state. Through the legislation, the Legislature expects that state agencies will take proactive approach to accessing federal reimbursement.

Further, the Act supports the legislative intent of being revenue neutral with respect to state funds.

The Act establishes the authority of the Department to certify publicly appropriated, local funds as state match for eligible title IV-E expenditures. This statute gives the Department the authority to reimburse local governmental agencies with federal dollars for expenditures that are determined allowable and reimbursable under title IV-E, on behalf of dependent children who are eligible under title IV-E of the Social Security Act.

Title IV-E Eligibility Documentation

As previously mentioned, Nebraska's title IV-E Penetration rate is the lowest in the nation. While this can be largely attributed to the AFDC lookback, or need standard, there are several strategies the state should consider to increase the number of children who are ultimately determined to be title IV-E eligible. A review of national title IV-E penetration rates, AFDC needs standards, and poverty rates indicates there are several states in similar situations, each of which have a higher penetration rate. Indiana and Delaware both have slightly lower needs standards and slightly higher poverty rates but higher penetration rates. In particular, Indiana's penetration rate is 8% higher than Nebraska's.

Recommendation

> *Reinforce efforts to improve documentation supporting Title IV-E eligibility and increase the penetration rate.*

State	1996 AFDC Standard (Family of 3)	AFDC Standard StDev from National Avg.	IV-E Penetration Rate	Poverty Rate	% Placed with Relatives
Indiana*	$320	-1.223	26%	12.91%	35%
Delaware	$338	-1.165	20%	11.44%	7%
Nebraska	**$364**	**-1.080**	**18%**	**10.37%**	**34%**
Mississippi	$368	-1.067	35%	19.58%	30%
New Mexico	$381	-1.024	42%	18.55%	29%
Kansas	$403	-0.953	19%	11.44%	32%

Though Nebraska CFS presently has a performance improvement plan designed to increase the penetration rate, the rate has only experienced marginal increases over the last several years. Key strategies included in the plan include:

1. Increase the number of title IV-E eligible foster families who are available to take placement of youth in foster care. The increase in the number of eligible homes, will increase Nebraska's title IV-E penetration rate.
2. Increase the number of CFS families that DHHS is able to verify income for the month the removal petition is filed. The increase in the number of verified incomes will increase the accuracy of the information and in turn, may increase Nebraska's title IV-E penetration rate.
3. Increase the number of CFS families that DHHS is able to verify immigration status. The increase in the number of CFS families that immigration status can be verified may increase Nebraska's title IV-E penetration rate.
4. Implement a process to reduce any potential errors for the 2024 Federal Review.
5. Increase reasonable effort language in permanency hearings. The increase in the reasonable effort language, will increase the number of youth who are eligible for title IV-E.
6. Ongoing and new CFS Workers will understand the importance of IV-E, how it impacts their work and why it is important for DHHS in drawing down IV-E funding to pay for CFS Services and positions.
7. Work with tribes to determine tribal capacity to meet licensing regulations for tribal homes in meeting licensing standards. The increase in the number of eligible homes, will increase Nebraska's title IV-E penetration rate.
8. High Quality Legal Representation will allow DHHS to explore drawing down IV-E funds with the potential for reinvestment into pre-petition, candidate for foster care type legal work.
9. Implement training opportunities for staff that can enhance skills. This training could be a joint project with the Court Improvement Project (CIP) that DHHS is able to draw down IV-E funds.

The Work Group supports and recommends CFS further these efforts by implementing strategies to:

- Increase the number of licensed relative caregivers.
- Develop a process to claim title IV-E reimbursement for high-quality legal representation and probation activities related to serving cross-over youth (addressed in detail within the *Cross-System Collaboration* section of this document)
- Further partnership with the state's Court Improvement Project to reinforce the inclusion of required language in court orders.
- Continued training for staff related to the importance of title IV-E eligibility, documentation requirements, and the fiscal and programmatic impact of a lower-than average penetration rate.

- Review the client income documentation and verification requirements and compare them to other jurisdictions to ensure the process is streamlined and simplified to the greatest possible degree. Other jurisdictions, such as Alaska[4], have revised income verification and financial resource procedures to permit a signed income affidavit from the parents be acceptable documentation. Since approximately 50% of children are not eligible as a result of the family reportedly exceeding the income standard, adopting a similar approach in Nebraska may serve to increase the penetration rate.

Efforts to train staff, attorneys and judiciary on IV-E eligibility related issues, promote licensing of relative caregivers are reimbursable to the department as title IV-E administrative costs (50% FFP) or training costs (75% FFP). The Work Group recommends that DHHS should continue to leverage these federal funds to support efforts to increase the statewide penetration rate.

Licensing of Relative & Non-Relative Caregivers

When children are unable to remain in the safe care of their parent(s), grandparents, other family members, or kin frequently step forward to provide a temporary or permanent stable, loving home for them. Child welfare law and policies prioritize placing children with grandparents, relatives, or close family friends, known as kinship care. In compliance with 42 U.S.C. 671, states must "consider giving preference to an adult relative over a nonrelated caregiver when determining placement for a child, provided that the relative caregiver meets all relevant state child protection standards."

Recommendation

> *Increase the percentage of relative and fictive kin caregivers licensed as foster parents by continuing to implement and support strategies to streamline and expedite the licensing / approval process and incentive them to become licensed caregivers.*

According to the Annie E. Casey Foundation, more than 2.5 million children across America are placed with a relative or kinship caregiver. In foster care, research indicates such placements positively affect a child's well-being and permanency outcomes. Children placed with relatives or kin demonstrate fewer behavioral concerns, are less likely to disrupt from their placement, express higher satisfaction with their placement, are less likely to run away, are more likely to remain connected with their siblings, maintain their

[4] Original recommendation and example included in Casey Family Programs, "*Initial Report: Assessment of Title IV-E Eligibility and Federal Claims*", January 2019

cultural identify, and achieve better permanency outcomes. Further, children placed with relative caregivers are reported to have more positive mental health outcomes as an adult. However, relatives who foster or adopt as kin caregivers typically have far lower incomes than other adoptive or foster parents. As a result, it is critical these caregivers have access to all the financial resources they are eligible to receive.[5]

While a large percentage of children in foster care are placed with relative or kinship caregivers, only a small percentage of these caregivers have historically been licensed as foster parents. In 2017, only five percent of children in relative or kinship care nationally were residing in a licensed home.[6] While relative caregivers are sometimes hesitant to become licensed due to additional involvement of child welfare workers in their lives and additional level of scrutiny in their homes, there are also systemic barriers impacting their ability to become licensed. These barriers typically include:

- Criminal record,
- Financial stress,
- Unemployment,
- Childcare cost,
- Housing insufficiency,
- Conflicting family obligations,
- Poor communication with child welfare department,
- Department misplaced or lost paperwork,
- Paperwork expired (prior to the licensing process being completed),
- Child's caseworker unhelpful,
- Child's caseworker gave poor advice, and
- Licensing home study process took too long[7].

The ability to claim title IV-E reimbursement for children placed in relative care is inexorability tied to the licensed status of the setting where they are place. As a result, states fund a significant portion of these placements without financial assistance from the federal government. With the passage of the Family First Prevention Services Act, child welfare agencies were permitted to adopt less burdensome licensing standards for relative and kinship

[5] Evan B. Donaldson Adoption Institute. *Never Too Old: Achieving Permanency and Sustaining Connections for Older Youth in Foster Care,* July 2011.

[6]https://www.americanbar.org/groups/publicinterest/childlaw/resources/childlawpracticeonline/childlawpractice/vol-36/july-aug-2017/kinship-care-is-better-for-children-and-families/

[7] Maureen Riley-Behringer & Jamie Cage (2014) Barriers Experienced by Kinship and Non-Relative Caregivers During the Foster and Adoptive Parent Licensure and Home Study Process, Journal of Public Child Welfare, 8:2, 212-238, DOI: 10.1080/15548732.2014.893223

foster family homes to alleviate delays and barriers in the licensing process and expedite access to federal financial resources for placement with those family caregivers.

States, including Nebraska, have implemented policies and practices, especially streamlining and expediting training requirements and waiving non-safety related foster home requirements, to encourage and facilitate licensing of relative and kinship caregivers. At any given time in Nebraska, approximately eighty-one percent of children (500) who otherwise meet title IV-E eligibility criteria are residing with unlicensed relative or kinship caregivers. While the percentage of children placed with licensed relative and kinship caregivers in Nebraska has increased over the past several years, other states have made more significant progress in this capacity. For instance, in Florida, over 42% of children placed with relatives or kin are in licensed settings; more than twice the rate in Nebraska.

Increasing the percent of licensed relative caregivers should remain a key focus of CFS throughout the implementation of the LB 1173 Finance Model framework. Strategies to continue and/or be considered include:

- Provide one-time financial incentives to relative and kinship caregivers if they chose to complete licensing requirements,
- Eliminate or establish a lower per diem for unlicensed kinship caregivers,
- Provide financial supports to cover the cost and ameliorate issues in the home of a prospective relative caregiver, which may impact their ability to comply with requirements of the licensing home study,
- Provide childcare to facilitate access to training for relative/kinship caregivers,

Finally, In September 2023, the Administration for Children and Families published a final rule in the Federal Register (88 FR 66700)[8,9]. This rule amends regulations to: (1) allow a title IV-E agency to adopt one set of licensing or approval standards for all relative or kinship foster family homes that is different from the licensing or approval standards used for non-relative foster family homes; (2) require that during a title IV-E agency's periodic review in accordance with section 471(a)(11) of the Act, the agency review foster care maintenance payments to ensure that children receive the same amount of FCMP whether placed in a licensed or approved relative, kinship, or unrelated foster family home; and (3) align the definition of "foster family home" with changes made by Public Law 115-123, the Family First Prevention

[8] https://www.federalregister.gov/documents/2023/02/14/2023-03005/separate-licensing-standards-for-relative-or-kinship-foster-family-homes
[9] https://www.acf.hhs.gov/sites/default/files/documents/cb/ACYF-CB-IM-23-07.pdf

Services Act, to limit the definition of a foster family home to the "home of an individual or family," and to require that the foster parent reside in the home with the child.

This change, which becomes effective on November 27, 2023, allows a title IV-E agency to claim title IV-E federal financial participation (FFP) for the cost of foster care maintenance payments (FCMP) on behalf of an otherwise eligible child placed in a relative or kinship licensed or approved[10] foster family home when the agency uses different licensing or approval standards for relative or kinship foster family homes and non-relative foster family homes. In addition, the rule would amend the requirement that title IV-E agencies provide a licensed or approved relative and kinship foster family home the same amount of foster care maintenance payment that would have been made if the child was placed in a non-related foster family home[11].

The Work Group recommends CFS review current requirements related to the licensing or approval of relative or non-relative "fictive kin" caregivers and revise state licensing regulations to place as few burdens on such families as possible, consistent with ensuring the safety and well-being of children in foster care.

Incentivize Licensing of Relative Caregivers

Over the last two years, CFS has provided incentives to relative caregivers choosing to become licensed. Initially subsidized through COVID Relief funding, these incentives have now been largely eliminated. Given the potential for federal reimbursement for title IV-E eligible children placed with approved relative caregivers, strategies to financially incentive providers to place children in these settings when available and appropriate should be implemented.

During the course of discussion, the LB1173 Financial sub Work Group discussed the potential of establishing tiered payment rates for licensed and unlicensed caregivers. Providers involved in this

Recommendation

> *Implement strategies to incentives both caregivers and providers when relatives become licensed and integrate evidence-based Kinship Support services into child placing agencies in order to support additional federal claiming.*

[10] The terms "licensed" and "approved" are generally used interchangeably as they related to placement with relative caregivers.

[11] https://www.federalregister.gov/documents/2023/02/14/2023-03005/separate-licensing-standards-for-relative-or-kinship-foster-family-homes

discussion indicated they frequently see unlicensed relative caregivers require increased support and services because:

- They are not familiar with child welfare practice, available resources, and legal requirements, and
- Have not received training related to the care for children who have experienced trauma, establishing parental boundaries, and creating trust-based relationships.

In particular, the following strategies have proved to be effective in Nebraska and other jurisdictions:

- Provide one-time incentive payments to relative caregivers when they are licensed or approved.
- Eliminate or reduce payments to unlicensed caregivers. For instance, Florida is transitioning to a tiered payment rate with reduced payment to relatives who do not become licensed.
- Incentivize providers to license relative caregivers by offering additional payment or bonuses when relative caregivers become licensed.
- Establish a contractual measure requiring child placing agencies to obtain a waiver of licensing requirements for relative caregivers, which clearly documents the reason the family has chosen to not pursue licensing.

Finally, CFS should continue to implement an evidence-based Kinship Caregiver program approved by the title IV-E Federal Clearinghouse and ensure the program is integrated into or collaborates with child placing agencies in order to provide additional supports to relative caregivers regardless of their licensing status. The cost of providing these services to caregivers is eligible for reimbursement under FFPSA, even when the child is not otherwise title IV-E eligible.

Children Placed through Letters of Agreement and with Shared Living Providers

Nebraska CFS and Juvenile Probation Services (JPS) continues to use Letters of Agreement (LOAs) to place and establish payment rates with providers for difficult to place children. Similarly, children are also placed with Shared Living Providers (SLPs). Maintenance payments for children who would otherwise be eligible for federal reimbursement under title IV-E are not being claimed for LOA or SLP placements. Federal reimbursement for the cost of these placements is not available as the providers are not licensed by CFS. Further, placement in these settings may also be detrimental as often the child is placed in a home without

specialized training, there is a lack of provider accountability, and providers are not contractually held to therapeutic or child welfare permanency-related outcomes.

During a 2021 review of LOA placements completed by TSG[12], CFS staff and leadership indicated they do not have a standardized process outlining when the agency should enter into an LOA, including threshold criteria regarding children that would trigger consideration of an LOA's necessity. Thus, LOAs do not correspond to a given level of care. The placement is what it takes to incentivize the agency and foster parent to take on the challenge of caring for children who require extensive, intensive supervision due to medical, behavioral, mental health diagnosis or other complex needs. Further, at the time of the review, CFS staff reported that the LOA process is ad hoc, and crisis driven. Providers use this as leverage to drive up costs and CFS has no standardized process to identify when to use a LOA or what the specific expectations are for care for children receiving service at this level. This has resulted in higher costs for the state and reduced permanency outcomes for children in care.

Recommendation

> *Reduce the number of children placed through LOAs or with SLPs and implement policies and procedures to ensure eligible Title IV-E maintenance and administrative costs are federally claimed for eligible children and youth who are.*

Though CFS has taken steps to reduce the number of children placed through LOAs by adding a level of care (tier) to the foster care payment structure and receiving a waiver to cover the cost of Medicaid-eligible children placed in Therapeutic Foster Care[13]. CFS must focus on eliminating any remaining barriers to receiving federal payment for children placed in these settings. Specific strategies to be considered may include:

- Establish a dual license process for providers licensed by other divisions within the state,
- Phase in contractual requirements requiring providers paid under an LOA to become licensed,
- Limit placement with SLPs to those youth who have developmental disabilities,
- Create a standardized process for establishing acuity-based payment rates outside the normal payment level which clearly outlines how the payment was calculated and

[12] Nebraska Treatment Family Care and Foster Care Rate Analysis, 2021, The Stephen Group, LLC.

[13] Nebraska's Treatment Foster Care Services is scheduled to be implemented in late 2023 and will be a wrap-around model of care that provides intensive, highly coordinated, trauma- informed, and individualized services to children and youth in foster care (CYFC), up to age 19 who have complex mental health and/or substance use disorders that are causing functional impairment to a degree that puts them at risk of meeting criteria for placement in a more restrictive setting (e.g., psychiatric residential treatment facility.

identifies which portions of the rate are related to title IV-E maintenance or administration and whether additional payment may be justified for the provision of other wraparound supports or services.

- CFS may consider reviewing the process on the child-specific rate setting process Indiana uses when placing children of acute behavioral or medical needs who require supervision in excess of the typical caregiver ratio. Though used with licensed providers, the process developed by the Indiana Department of Child Services (DCS) Rate Setting Unit clearly justifies the payment of rates outside established payment limits, documents the processes used to calculate those rates, and supports the reasonable nature of these rates and supports federal claiming of foster care maintenance and related administrative costs for title IV-E eligible children.

Develop QRTP Residential Capacity in the State

To support placement of children of higher acuity and levels of need, CFS may desire to collaborate with residential providers to fund the development of one or more Qualified Residential Treatment Programs (QRTPs). Doing so may not just serve to reduce the number of children placed through LOAs, but may also reduce the number of children placed out-of-state.

Develop Strategies to Support Multi-Agency Licensing and Access to Residential Settings

To further support claiming, CFS should consider co-developing a process to license homes serving youth also served through the Division of Developmental Disabilities and the Division of Medicaid and Long Term Care. This may support federal claiming for children placed in homes for children with more acute or specific programmatic needs. For instance, the State of Indiana has implemented state policy which permit title IV-E approved Residential Treatment Facilities to also be Medicaid reimbursable Psychiatric Residential Treatment Facilities (PRTFs). Further, the state also developed a separate set of program standards and licensing requirements for DCS funded residential settings capable of serving children with developmental disabilities. As licenses for both these residential setting are issued by the title IV-E agency, the state is able to claim federal reimbursement for an eligible child.

Title IV-E Administrative Cost Claiming

CFS has not claimed federal reimbursement for all eligible title IV-E administrative costs. This includes expenditures related to both traditional title IV-E candidacy and administrative costs for eligible expenses incurred by contracted child placing agencies. Federal reimbursement for these costs may be claimed for the current quarter and retroactively for the seven (7) previous quarters.

Federal financial participation (at a rate of 50%) may be claimed for administrative costs expenditures necessary for the proper and efficient administration of the title IV–E plan as identified at 45 CFR 1356.60(c). Reimbursement is available regardless of whether the child is actually placed in out-of-home foster care and becomes eligible for title IV-E foster care benefits. Such costs include:

- The determination and redetermination of eligibility, fair hearings and appeals, rate setting and other costs directly related only to the administration of the foster care program under this part are deemed allowable administrative costs under this paragraph. They may not be claimed under any other section or Federal program.
- The following are examples of allowable administrative costs necessary for the administration of the foster care program:
    - Referral to services;
    - Preparation for and participation in judicial determinations;
    - Placement of the child;
    - Development of the case plan;
    - Case reviews;
    - Case management and supervision;
    - Recruitment and licensing of foster homes and institutions;
    - Rate setting; and
    - A proportionate share of related agency overhead.
    - Costs related to data collection and reporting.

Recommendation

> *Implement fiscal procedures to ensure all eligible and reimbursable Title IV-E administrative costs are claimed for foster care candidates as well as for child placing agencies.*

Reimbursement is limited to those individuals reasonably viewed as candidates for title IV-E foster care maintenance payments consistent with section 472(i)(2) of the Social Security Act.

A candidate for foster care is federally defined as a child who is at serious risk of removal from home as evidenced by the title IV-E agency either pursuing his/her removal from the home or making reasonable efforts to prevent such removal. It is important to note, a child may not be considered a candidate for foster care solely because the title IV-E agency is involved with the child and his/her family. In order for the child to be considered a candidate for foster care, the title IV-E agency's involvement with the child and family must be for the specific purpose of either removing the child from the home or satisfying the reasonable efforts requirement with regard to preventing removal.

There are three acceptable methods to document a child is a candidate for title IV-E foster care benefits. These methods are described in the Federal Child Welfare Policy Manual[14] at Section 8.1D, Question #2:

1. A defined case plan which clearly indicates that, absent effective preventive services, foster care is the planned arrangement for the child.
    a. The decision to remove a child from home is a significant legal and practice issue that is not entered into lightly. Therefore, a case plan that sets foster care as the goal for the child absent effective preventive services is an indication that the child is at serious risk of removal from his/her home because the title IV-E agency believes that a plan of action is needed to prevent that removal.
2. An eligibility determination form which has been completed to establish the child's eligibility under title IV-E.
    a. Completing the documentation to establish a child's title IV-E eligibility is an indication that the title IV-E agency is anticipating the child's entry into foster care and that s/he is at serious risk of removal from home. Eligibility forms used to document a child's candidacy for foster care should include evidence that the child is at serious risk of removal from home. Evidence of AFDC eligibility in and of itself is insufficient to establish a child's candidacy for foster care.
3. Evidence of court proceedings in relation to the removal of the child from the home, in the form of a petition to the court, a court order or a transcript of the court's proceedings.

Should the title IV-E agency determine that the child is no longer a candidate for foster care at any point prior to the removal of the child from his home, subsequent activities will not be allowable for reimbursement of costs under title IV-E.

CFS also reports not claiming for title IV-E eligible administrative expenditures for contracted child placing agencies (CPAs). Department leadership reports claiming for these costs was previously done, but was stopped as a result of auditor concerns questioning the rate methodology and determination that expenses incurred by the CPAs were clearly related to title IV-E administrative activities. The Work Group recommends financial management staff review all claims in relation to the methodology to set administrative payment rates used by the Rate Setting Committee to determine whether there is sufficient documentation and justification to claim these expenses on an ongoing basis. A review of these rate setting documents indicates there is a high probably that a claim for these expenditures can be made.

[14] https://www.acf.hhs.gov/cwpm/publichtml/programs/cb/lawspolicies/laws/cwpm/policydsp.jsp?citID=79

As previously mentioned, the state will have the ability to claim expenditures for the current quarter and retroactively for the seven (7) previous quarters.

A review of title IV-E administrative claims submitted by Nebraska for the past three federal fiscal years indicates the state has not claimed federal reimbursement for expenditures related to children and youth considered to be foster care candidates. CFS has recently initiated administrative claims for candidacy-related expenditures for the quarters ending March and June 2023. Federal financial participation (FFP) was approximately $1.5 million for quarter ending March 2023 and $2.3 million for the quarter ending June 2023. The department should seek retroactive claims for the eligible periods prior to January 2023. FFP for these periods may total as much as $7.5 to $10 million. Going forward, continued reimbursement for these administrative costs may total $6 to 8 million annually.

Leverage Training Opportunities to Create a Pathway to Child Welfare Employment

Since the late 1980s, the training provision of title IV-E of the Social Security Act has been a major public funding source supporting both staff training and the opportunity for current and prospective employees to earn BSW and MSW degrees. Using these federal funds to support social work education has been instrumental in educating and encouraging workers to pursue child welfare careers. Training opportunities may be short-term or long-term; long term includes degree education for those preparing for child welfare work.

The federal government provides enhanced federal match of 75 percent for title IV-E eligible training and universities typically provide the required match through expenditures on faculty, overhead, and curriculum development. Funds may be used for direct financial assistance (stipends) to students, salaries and benefits of university instructors, curriculum development, materials and books, field instructors, distance education, and evaluation of the program. The department should continue to look to leverage funding to develop the capacity and capabilities of the child welfare force, in terms of both the number of workers and knowledge workers bring to the field. In doing so, the department may also look to work in partnership with other entities, such as Managed Care Organizations (MCOs) to develop training programs capable of benefiting multiple fields. Ultimately, increased investment in staff and their professional development will serve to increase recruitment and retention of qualified staff, lessen turnover, reduce cost, and improve outcomes.

Training can look to create multiple entry points and pathways for individuals at different points in their lives and careers. Specific innovations the state may look to include:

- Engaging youth while still involved in secondary education to educate them and promote the benefits of pursuing working in child welfare,

- Providing training to persons with lived experience to develop peer mentors,
- Working with undergraduate students to promote education in social work or other related fields capable of working in child welfare,
- Establishing ongoing educational opportunities for current workers.

Implementation of a Modern Child Welfare Information System

The Administration for Child and Families (ACF) published the new federal Comprehensive Child Welfare Information Systems (CCWIS) rule to promote the development of modern information systems better positioned to support the needs of child and family service systems. Traditionally, SACWIS systems were large, cumbersome data systems which were difficult to tailor to the specific needs of a state. These systems are now outdated and not aligned with current child welfare policy and practice. In Nebraska, staff frequently describe difficulties using N-Focus (the state's data management system), accessing information, and extracting reliable, up-to-date, usable data capable of driving system-wide performance and improving outcomes.

Recommendation

> *Invest in a modern child welfare system capable of streamlining work efforts, supporting staff, providing real-time accurate data, and informing decision making.*

The advent of CCWIS served to promote the use of a modular system with an integrated information framework capable of being modified to support the unique needs of jurisdictions using the system. Ultimately, a CCWIS compliance system can serve to improve child welfare outcomes by enhancing data interoperability, promoting system modularity, and improving data quality. Overall, a modern CCWIS system is capable of:

- Providing child welfare staff with up-to-date, real time information to inform and support decision-making,
- Supporting cross-departmental collaboration among human service, health, and education agencies
- Encouraging innovation,
- Facilitating communication with courts and legal services, and
- Promoting continuous quality improvement.

Because CCWIS systems are modular in nature, system modifications and improvements can be readily made when policies or workflows change or are updated. In total, transition from SACWIS to CCWIS will serve to better support workers and outcomes by improving workflow

and offering access to data capable of driving performance and outcomes for children and families.

As part of its child welfare transformation efforts, the Work Group recommends CFS consider investing in the modernization of the current N-Focus system, by either updating the system or transitioning to a CCWIS-compliant data framework. The Work Group recommends hiring an experienced firm to complete comparative and cost-benefit analyses of these options to determine the most efficient path forward.

Fully Implement title IV-E Claiming for Prevention Services

Though Nebraska has one of the earliest FFPSA implementation dates in the nation (10/1/19), the state has reported comparatively low expenditures and federal reimbursement for services since this time. During the first two federal fiscal years (FFY'20 and FFY'21) Nebraska was eligible to claim federal reimbursement for approved prevention activates, the department did not submit claims for any services, training, or administrative services[15]. During FY'2022, CFS reported serving an average of 719 children per quarter and received federal reimbursement of $47,892. There were no federal claims submitted by the state for eligible training or administrative expenditures[16].

In comparison during FFY 2022,

- North Dakota served an average of 60 children per quarter and received $164,314 in federal reimbursement.
- Iowa served an average of 373 children per quarter and received $5,172,317 in federal reimbursement. It is important to note that while only $312,810 in federal reimbursement was received for the provision of evidence-based interventions, ***the state was able to receive FFP totaling $4,850,507 for administrative expenditures of $8,896,315 during the fiscal year.***
- Kansas served an average of 905 children per quarter and received $4,864,108 in federal reimbursement. The majority of this reimbursement, $4,208,234 was for the direct provision of evidence-based services.

[15] Federal Title IV-E Programs Expenditure and Caseload Data, Federal Fiscal Years 2020, 2021, and 2022. Retrieved from, https://www.acf.hhs.gov/cb/resource-library?f%5B0%5D=type%3Areport
[16] https://www.acf.hhs.gov/sites/default/files/documents/cb/fy-2022-title-iv-e-prevention-services.xlsx

- Illinois claimed administrative and training costs in excess of $52,000,000 while incurring only $328,093 in expenses for evidence-based services to an average of 1,290 children per quarter.

The following table provides an overview of all states receiving FFP for prevention services during Federal Fiscal Year 2022. It is important to note, some jurisdictions may have funded implementation activities and services using other funding sources such as Medicaid, Family First Transition Act (FFTA) funding, or American Rescue Plan Act of 2021 (ARPA) funds, which were available as a result of the COVID-19 pandemic. Therefore, it may not be fully reflective of total state expenditures for prevention services or related administrative or training activities. Finally, the Average Number of Children Served reported in the data represents the average number of children served per quarter rather than a unique count of children served per year. As a result, the calculated FFP per Child Served may be overrepresented. The value is shown only for comparison, rather than as a representation of actual federal reimbursement per child.

State	Plan Effective Date	EB Service Expenditure	Average # of Children Served per Quarter	Agency Expenditures		Total Expenditures and Federal Reimbursement		Avg. FFP / Avg # Children Served / Quarter
				Administration	Training	Total	FFP	
Arkansas	Oct 2019	2,820,931	405	826,196	-	3,647,127	1,823,565	4,500
Wash. DC	Oct 2019	2,468,144	465	12,485,232	-	14,953,376	7,409,012	15,951
Illinois	Oct 2021	328,093	1,290	51,608,013	589,647	52,525,753	26,262,880	20,355
Iowa	Oct 2020	643,620	373	8,896,315	-	9,539,935	5,172,317	13,885
Kansas	Oct 2019	7,798,059	905	1,293,341	18,405	9,109,805	4,864,108	5,378
Kentucky	Oct 2019	19,177,971	2,220	8,046,425	579,200	27,803,596	13,926,335	6,272
Maine	Oct 2021	178,255	9	290,074	-	468,329	234,167	26,019
Maryland	Oct 2019	-	-	1,481,436	-	1,481,436	740,718	N/A
Michigan	Oct 2021	-	233	629,622	-	629,622	314,811	1,350
Nebraska	Oct 2019	71,112	719	-	-	71,112	47,892	67
N. Dakota	Apr 2020	247,330	60	81,293	-	328,623	164,314	2,750
Ohio	Oct 2021	2,459	15	74,440	13,195	90,094	45,048	3,054
Oklahoma	Oct 2021	-	159	226,095	-	226,095	113,048	713
Tennessee	Apr 2021	56,700	2	-	-	56,700	28,350	16,200
Utah	Oct 2019	812,820	117	1,743,143	53,140	2,609,103	1,304,554	11,126
Virginia	Jul 2021	334,465	12	2,791,688	237,739	3,363,892	1,682,974	146,346
W. Virginia	Oct 2019	61,501	5	-	-	61,501	30,752	6,150
Total		**35,001,460**	**6,987**	**90,473,313**	**1,491,326**	**126,966,099**	**64,164,845**	**9,184**

It is important to note, administrative expenditures may include the cost of implementing data management systems to facilitate required data collection and federal reporting. These systems may be an integral part of the state's strategy to implement or expand their Comprehensive Child Welfare Information System (CCWIS).

As the Practice Model is implemented and a reimagined child welfare system realized, the Work Group believes it is imperative that expenditures for all eligible prevention services are federally claimed.

Priority Area 2: Cross-System Synergy and Collaboration

High-Quality Legal Representation of Children and Families

The Children's Bureau provided guidance to title IV-E agencies in 2017 emphasizing the importance of high quality legal representation in helping ensure a well-functioning child welfare system. This guidance cited numerous studies and reports pointing to the importance of competent legal representation for parents, children, and youth in ensuring that salient information is conveyed to the court, parties' legal rights are protected and that the wishes of parties are effectively voiced. There is evidence to support that legal representation for children, parents and youth contributes to or is associated with:

Recommendation

> *Expand the availability of high quality legal services to children and families by implementing a process to claim federal reimbursement for eligible activities.*

- Increases in party perceptions of fairness;
- Increases in party engagement in case planning, services and court hearings;
- More personally tailored and specific case plans and services;
- Increases in visitation and parenting time;
- Expedited permanency; and
- Cost savings to state government due to reductions of time children and youth spend in care[17].

In 2019, the Children's Bureau issued revised and new federal policies allowing title IV-E agencies to claim federal financial participation (FFP) for administrative costs of independent legal representation provided by attorneys representing children in title IV-E foster care, children who are candidates for title IV-E foster care, and their parents for "preparation for and participation in judicial determinations" in all stages of foster care legal proceedings. These policies were further clarified in 2020, verifying administrative costs for paralegals, investigators, peer partners, or social workers may be claimed as title IV-E foster care administrative costs to the extent they are necessary to support an attorney providing independent legal representation to prepare for and participate in all stages of foster care legal

[17] *Twenty Years of Progress in Advocating for a Child's Right to Counsel*, https://www.americanbar.org/groups/litigation/committees/childrens-rights/articles/2019/spring2019-twenty-years-of-progress-in-advocating-for-a-childs-right-to-counsel/.

proceedings for candidates for title IV-E foster care, youth in foster care and his/her parents and for allowable office support staff and overhead expenses.

Under these expanded policies title IV-E agencies may claim administrative costs for preparation for and participation in judicial determinations by an attorney providing independent representation to a child in title IV-E foster care, and his/her parents. Such activities and expenses must be necessary to carry out the requirements in the IV-E plan. (See 45 CFR 1356.60(c)(2)(ii). Examples of foster care legal proceedings include:

- Hearings related to judicial determinations that it is contrary to the welfare of a child to remain in the home;
- Hearings related to a child's removal from the home;
- Hearings related to judicial determinations that the agency provided reasonable efforts to prevent removal and finalize the permanency plan;
- Permanency hearings
- Hearings related to progress on case plans; and
- Appeal proceedings related to judicial determinations required under title IV-E.

Additionally, federal reimbursement is available for administrative activities for agency or independent attorneys to prepare for and participate in judicial determination for all stages of foster care legal proceedings. Examples of foster care legal proceedings include:

- Independent investigation of the facts of the case, including interacting with law enforcement;
- Meeting with clients or making home or school visits;
- Attending case planning meetings;
- Providing legal interpretations;
- Preparing briefs, memos, and pleadings;
- Obtaining transcripts;
- Interviewing and preparing their client and witnesses for hearings;
- Hearing presentation;
- Maintaining files
- Supervising attorneys, paralegals, investigators, peer partners or social workers that support an attorney in providing independent legal representation to prepare for and participate in all stages of foster care legal proceedings; and
- Appellate work in reference to foster care legal proceedings.

During the course LB1173 Work Group activities, community forums, and focus groups, state court representatives, judiciary, attorneys, and tribal representatives have all expressed the need to pursue claiming for eligible legal services in the state.

The Work Group recommends CFS immediately look to implement policy supporting claiming for legal services to children and families across the state. Doing so will require careful planning, policy development, modifications to the department's Cost Allocation Plan, creation of cost collection and data management processes, statewide training for participating attorneys, implementation of a cost allocation process or random moment sample (RMS) for participating attorneys and staff, and ongoing quality management efforts to verify the accuracy of cost data collected and resulting claims for Federal Financial Participation (FFP). As part of the implementation strategy, CFS and participating legal service providers should consider a reinvestment strategy, which will require federal reimbursement be used to expand the availability of legal services to children and families. This is a central strategy in Florida's recently created legal claiming implementation strategy.

It is important to note, federal reimbursement is linked to both the state's title IV-E (traditional) candidacy and eligibility penetration rates. Given the present low nature of the eligibility penetration rate, it will be imperative CFS focuses on increasing the rate in order to fully realize the potential benefits of the program. As there will be initial and ongoing administrative cost associated with the claiming effort, it is recommended a cost / benefit analysis be completed to provide a clear indication as to whether and when federal reimbursement to the state will exceed the cost of implementing the claiming process.

TITLE IV-E CLAIMING FOR JUVENILE PROBATION SERVICES

In every jurisdiction, child welfare agencies serve a population of youth involved in both the child welfare and juvenile justice systems. Typically referred to as "crossover youth", they face unique challenges as a result of their involvement in multiple system which frequently result in significantly negative outcomes. In particular, studies have found[18]:

- Maltreated youth are 47% more likely than their peers to become involved in the juvenile justice system due to their increased risk of arrest and case petition.
- Crossover youth's cases are also more likely to be petitioned by the court than those of non-crossover youth.

[18] *Improving Multisystem Collaboration for Crossover Youth*, https://crownschool.uchicago.edu/student-life/advocates-forum/improving-multisystem-collaboration-crossover-youth.

- Crossover youth face harsher court outcomes and are more likely to be removed from their homes or detained.
- Crossover youth are more likely to come from challenging familial circumstances and are more likely to be younger at first entry into the juvenile justice system.
- Crossover youth are more likely to suffer from substance abuse, have mental health issues, and face educational difficulties.
- Crossover youth are less likely to receive appropriate treatment or face service interruptions in the event they ineligible for certain services when transitioning between systems.
- Female crossover youth, who are at greater risk of pregnancy, have access to few gender-specific programs that address their specific needs.

Recommendation

> *Improve outcomes for crossover youth involved in both child welfare and juvenile probation services by enhancing collaboration between CFS and JPS and claiming Title IV-E for reimbursable administrative functions.*

As a result of these barriers, crossover youth are more likely to experience recidivism and face difficulties as they transition to adulthood. This leads to additional burden of cost on public systems in both the short- and long-term.

LB1173 Work Group members, including the Judicial Branch, Juvenile Probation Services Division (JPS) staff, and the University of Nebraska Law Center, have all expressed the need for improved collaboration between child welfare and juvenile probation services in the state. For those youth involved in both systems, title IV-E reimbursement is available for youth adjudicated delinquent if they meet all of the federal foster care criteria and are placed with a foster family or in a residential childcare institution that meets the definition in federal law. In addition, reimbursement is available for 50% of the cost of title IV-E administrative (such as salaries of caseworkers and administrators, office space, etc.) and 75% of the training costs associated with the serving these children. These eligible expenses are presently being incurred by JPS and title IV-E reimbursement should be considered if it is able to generate a return on the investment necessary to compile the claiming documentation.

To support improved outcomes for these vulnerable and often underserved youth, there must be improved collaboration between CFS and JPS. Financially, such collaboration can cover a portion of the probation officers' activities of and preventing the need for out-of-home placement by providing community supervision of youth on probation.

Requirements and limitations related to claiming reimbursement for JPs-related activities are similar to those described in the *Legal Services* section of this Financial Framework. Given there are only 125 to 150 crossover youth identified in the state at any given time, the opportunity for federal reimbursement is likely to be limited by the current title IV-E penetration rate. A review of recent title IV-E eligibility determinations in the state indicated that none of the crossover youth placed in out-of-home care were determined to be title IV-E eligible. In order to capitalize on this opportunity, CFS will likely first have to ensure administrative claiming for traditional title IV-E candidacy costs and claiming for FFPSA eligible prevention services are fully developed and implemented. It is again recommended a cost / benefit analysis be completed to verify at what point claiming opportunities will exceed required implementation costs.

Additional Financial Resources to Consider for Crossover Youth

In addition to expanding title IV-E for this population, CFS and JPS should work collaboratively with staff the Division of Medicaid and Long Term Care to ensure claiming under the following Medicaid services is also realized to the largest possible extent.

Targeted Case Management (TCM) permits federal reimbursement program for probation departments, public health clients, public guardian clients, aging and adult services, outpatient clinic patients and at-risk children and adults. This reimbursement would be additional funding that the State could use to expand their services or maintain current services. TCM is defined as reimbursable services which assist an eligible person that is provided access to needed medical, social, educational and other services. TCM reimburses for health services provided to at risk children or adults on probation.

Medicaid Administrative Claiming provides a quarterly reimbursement for Medicaid related activities provided to youth on probation. The quarterly revenue allows the probation department to improve the public's access to the Medicaid Program, improve the use of Medicaid Services by the eligible Medicaid population, and improve the delivery of Medicaid Services. Examples of reimbursable activities include outreach, eligibility determination, and referring, scheduling, monitoring care, arranging transportation, and providing translation services.

Create Medicaid Blended and/or Braided Funding Strategies for FFPSA Interventions

FFPSA was passed with the intention of leveraging existing Medicaid payment for mental health, substance abuse, and in-home parenting services when the family is Medicaid eligible. The Act is clear in that jurisdictions are to consider title IV-E the "payor of last resort" when coordinating the provision of these interventions. However, claiming Medicaid reimbursement provides a set of challenges which CFS and providers must work in collaboration with The

Division of Medicaid and Long Term Care and contracted Managed Care Organizations to overcome.

Nebraska CFS has worked to braid funding for Family Centered Treatment (FCT) and Healthy Families America (HFA), two evidence-based services included in the State's Title IV-E Prevention Plan. Presently, therapeutic components of FCT are being billed to Medicaid and MIECHV and TANF funding is being accessed to support the provision of HFA. However, it will be critical to expand efforts to blend and braid funding to support the provision of evidence-based prevention services provided under through FFPSA.

Nationally, Medicaid reimbursement has not traditionally covered the full cost of providing the service and, therefore, frequently results in a lack of capacity for therapeutic services to children. Given the intent to significant increase access to such interventions within the proposed Practice Model, this lack of capacity will become significantly more impactful as CFS looks to serve more families with a broader array of evidence-based prevention services across the state. LB 1173 Work Group members and providers have expressed this concern, alike. In order to build capacity for evidence-based services, rates must be structured to support the practice, so that more providers can implement them with fidelity and achieve the model's proven results[19].

Recommendation

> *Maximize reimbursement for Medicaid eligible services by creating collaborative strategies and opportunities to include specific interventions as named services in the State's Medicaid Plan, blend and braid funding sources, claim interventions as an in-lieu-of (ILO) service, obtain Medicaid waivers, or access other third-party payment sources.*

For the purposes of this LB 1173 Financial Model Framework, a Medicaid covered service assumes that all recipients of the service are:

1. Medicaid eligible. *However, under FFPSA, services may be offered to families that may have private insurance and/or be uninsured or underinsured. For those that do not meet Medicaid eligibility requirements other funding sources should be considered.*
2. Services billed meet all the requirements of the current Medicaid State Plan.

[19] The Stephen Group would like to thank Andry Sweet, President and CEO, Children's Home Society of Florida, for providing additional insights related to barriers and strategies related to the implementation of Medicaid-funded services and blended and braided funding.

3. Providers delivering services are Medicaid providers and contracted with Medicaid MCO plans.
4. Services are pre-authorized by Medicaid Managed Care plan.
5. Service limits have not already been exhausted in the prior twelve months .
6. Recipient meets "Medical Necessity."
7. Non-clinical services (i.e., home visiting) may have "in lieu of services" that may be reimbursable by the health plan.

If any of these assumptions is untrue, it is presumed the cost of services will **not** be reimbursed by Medicaid. In addition, there are requirements of the evidence-based practices (EBPs) that fall outside the traditional "coverage and limitations" of the Medicaid scope of services. In particular, several practice areas have been identified which may not be funded through traditional Medicaid reimbursement rates but are required under FFPSA. These include:

- **Service requirements**: activities beyond the scope of service reimbursed by Medicaid.
- **Staffing requirements**: Provider/practitioner requirements that may preclude the service from being Medicaid reimbursable. Practitioner credentials and salary requirements that are not possible within the current Medicaid rate structure.
- **Training and supervision requirements**: Case consultations and supervision activities beyond the basic accreditation, regulatory and licensing standards.
- **Fidelity monitoring requirements**: Activities to support fidelity to the EBP.

Examples of each of each of these factors include:

1. **Service Requirements** (beyond traditional therapy approaches and outside Medicaid coverage and limitations). Typical examples of non-reimbursable activity include:
    a. Sessions in excess of Medicaid daily limits (Medicaid),
    b. Sessions in excess of Medicaid annual limits (i.e., weekly sessions)
    c. On call responsibilities (24/7): this is not typically a requirement for community mental health outpatient services, but is for several EBPs.
    d. Caseload limits: for a traditional community mental health outpatient service model, caseloads are generally 20-30 clients. This supports bi-monthly visits (26 sessions/year) and all of the associated travel, documentation, management and supervision.
        i. With many EBP's caseloads are capped at lower levels (i.e., 10-12, meaning providing more services and greater intensity to fewer clients), but this also means more services that will be beyond the scope or limitations of the Medicaid program.
        ii. There may be activity in one or all of the following areas:

1. Crisis intervention/after-hours support
2. Collateral contacts (school, day care, other agencies involved in the child's case)
3. Care coordination (necessary in cases where no case manager is assigned, i.e., in home family support, prevention).
4. Participation in multi-disciplinary staffing/case reviews in consultation with other professionals involved in the case.
5. Requirements for parent education, support groups, socialization events, etc.
6. Requirements for community resource development and networking

e. Additional documentation requirements: If any of the services are covered by title IV-E under FFPSA, there are documentation requirements regarding services delivered to eligible title IV-E populations. Further, other jurisdictions have found that Medicaid documentation requirements are different than the intervention-specific documentation requirements supporting training and fidelity components of the model. These conflicting requirements can be burdensome, interfere with the clinician's ability to effectively implement the model to fidelity, and ultimately reduce the ability of the clinician to provide services to families.

2. **Staffing Requirements** (outside of the required provider qualifications of Medicaid), this affects what services are reimbursable and expenses not covered by the Medicaid rate.
   a. Staffing qualifications less than Medicaid State Plan: For several EBP's, such as Family Centered Treatment (FCT) and Multisystemic Therapy (MST), the practice requires services to be provided by a "bachelor degreed professional" or, in some cases, a "paraprofessional". However, under Nebraska's current Medicaid State Plan, a master's level clinician must provide or supervise the service in order for it to be reimbursed by Medicaid. This is true even if the evidence-based intervention does not require this level of education to provide the service[20]. As a result, service capacity is severely limited due to a lack of qualified providers.
   b. Staffing qualifications exceed Medicaid State Plan: Medicaid requires a master's degree or licensed clinician for most community behavioral health services. The rate supports an annual salary for the clinician of approximately $40K. However, once a clinician is trained in an evidence-based practice, to be competitive, they

[20] Please refer to Section 4.D. of the Practice Model Supporting Documentation, "*Medicaid State Plan Amendments Should Be Considered to Reduce Barriers and/or Cover Additional Services as Part of a New Child Welfare System*" for additional information and specific examples where other states have relaxed such requirements.

should be making a significantly higher salary. Unless the rate for Medicaid is increased for EBPs, costs will likely have to shift to other funding sources, or may result in higher turnover, which affects EBP fidelity.

3. **Training and Supervision Requirements** (beyond traditional therapy approaches)
    a. Training costs: These are hard costs of the training (paid to the EBP developer).
    b. Trainee time in training: This is the time that therapists must spend in training for the EBP that may not be covered under the current Medicaid rate structure.
    c. Additional supervision requirements: Under normal accreditation standards and Medicaid requirements, master's level clinicians receive monthly 1:1 supervision and monthly group supervision. Several of the EBP's require weekly supervision.
    d. Requirements for on-site Train the trainers and or Site Credentialing: Some EBP's require (or strongly encourage) sites to develop their own train the trainer capacity and/or be credentialed as a provider "site". These are additional costs not covered under the current Medicaid rate structure.
4. **Fidelity Monitoring Requirements**
    a. Case consultations: This is the time that practitioners must spend in case reviews and consultation in pursuit of their credentials with the EBP, including review of video-taped sessions and reflective supervision with an EBP trainer, to assess treatment fidelity.
    b. On Site Reviews: These are reviews of a provider site to assess organizational compliance and treatment fidelity. This requires practitioner and management preparation and participation in reviews that are not covered by the current Medicaid rate structure.
    c. Board certification review: Practitioner application or presentation to board for final approval of certification.
    d. Data collection and submission: Several EBPs require the submission of data for ongoing evaluation of outcomes and treatment efficacy. This is also required for treatment fidelity monitoring.

As a result, it is important that, in planning to expand access to prevention services funded through FFPSA, CFS' approach to cost allocation planning and revenue maximization considers the following:

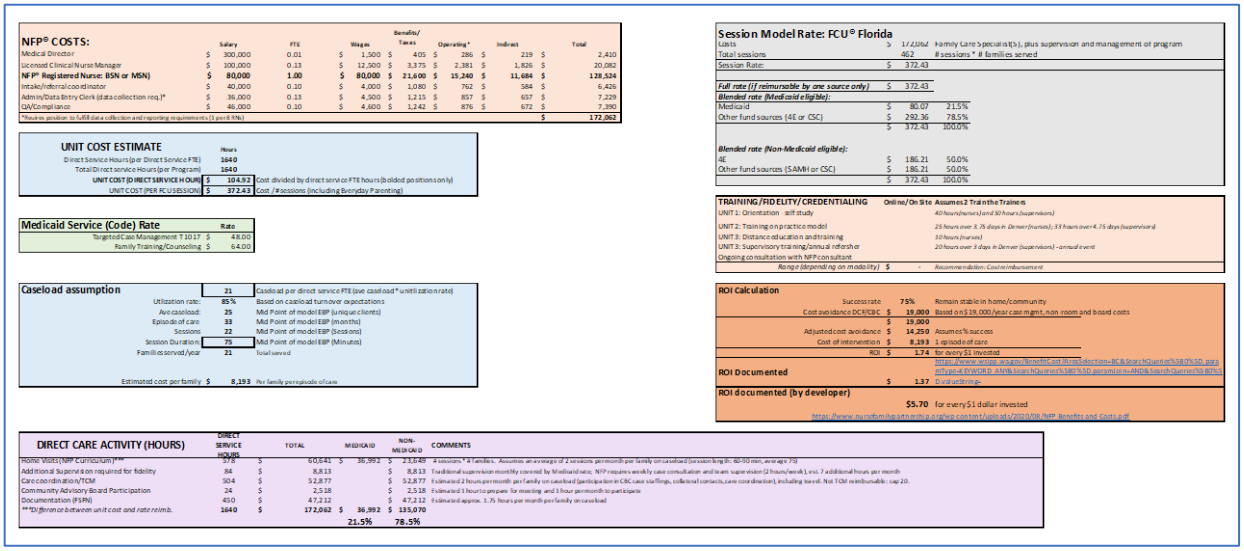
- Evidence-based practice requirements, including staffing, service delivery, training and supervision and fidelity monitoring responsibilities to support model fidelity,
- Funder requirements including client eligibility, provider eligibility, and service reimbursement coverage and limitations, and

- Identification of opportunities to blend and braid funding sources. This will involve close intra-agency collaboration with the Division of Medicaid and Long Term Care.

It is recommended CFS collaborate with the Division of Medicaid and Long Term Care, as well as Medicaid Managed Care Organizations and providers to convene a statewide work group capable of analyzing each evidence-based practice to be implemented, identify the components of the service, which is billable to Medicaid, and develop strategies for maximizing the Medicaid reimbursement for eligible services components. An example of an approach taken by the State of Florida for Nurse Family Partnership is provided, below, and an example of an In-Lieu-of Service (ILOS) recommendation for Functional Family Therapy (FFT) developed by Florida's FFPSA Blended and Braided Funding Work Group, made up of state child welfare and Medicaid staff, provides, and managed care organization representatives, is included as an attachment to this document.

In addition, it is recommended the Medicaid State Plan be revised and, where possible, education requirements be relaxed for service professionals in order to maximize workforce capacity and service accessibility for evidence-based services such as FCT and MST.

Finally, the Work Group also recommends DHHS look to invest in developing provider capacity to provide evidence-based practices across the state. As it is difficult for providers to recoup the cost of recruiting, training, and credentialling staff to provide evidence-based services with fidelity to the individual model, DHHS must seek to work with contracted providers to develop the staff capabilities required to provide prevention services to families, especially in remote, rural areas of the state.



NFP® COSTS:

	Salary	FTE	Wages	Benefits/ Taxes	Operating*	Indirect	Total
Medical Director	$ 300,000	0.01	$ 1,500	$ 405	$ 286	$ 219	$ 2,410
Licensed Clinical Nurse Manager	$ 100,000	0.13	$ 12,300	$ 3,375	$ 2,381	$ 1,826	$ 20,082
NFP® Registered Nurse: BSN or MSN)	**$ 80,000**	**1.00**	**$ 80,000**	**$ 21,600**	**$ 15,240**	**$ 11,684**	**$ 128,524**
Intake/referral coordinator	$ 40,000	0.10	$ 4,000	$ 1,080	$ 762	$ 584	$ 6,426
Admin/Data Entry Clerk (data collection req.)*	$ 36,000	0.13	$ 4,500	$ 1,215	$ 857	$ 657	$ 7,229
QA/Compliance	$ 46,000	0.10	$ 4,600	$ 1,242	$ 876	$ 672	$ 7,390
*Nurses position to fulfill data collection and reporting requirements (1 per 8 FNs)							$ 172,062

UNIT COST ESTIMATE

	Hours	
Direct Service Hours (per Direct Service FTE)	1640	
Total Direct service Hours (per Program)	1640	
UNIT COST (DIRECT SERVICE HOUR)	$ 104.92	Cost divided by direct service FTE hours (bolded positions only)
UNIT COST (PER PCUSESSION)	$ 372.43	Cost / # sessions (including Everyday Parenting)

Medicaid Service (Code) Rate

	Rate
Targeted Case Management T 1017	$ 48.00
Family Training/Counseling	$ 64.00

Caseload assumption

	21	Caseload per direct service FTE (ave caseload * until zation rate)
Utilization rate:	85%	Based on caseload turnover expectations
Ave caseload:	25	Mid Point of model EBP (unique clients)
Episode of care	33	Mid Point of model EBP (months)
Sessions	22	Mid Point of model EBP (Sessions)
Session Duration	75	Mid Point of model EBP (Minutes)
Families served/year	21	Total served
Estimated cost per family	$ 8,193	Per family per episode of care

Session Model Rate: FCU® Florida

Costs	$ 17,2062	Family Care Specialist(s), plus supervision and management of program	
Total sessions	462	# sessions * # families served	
Session Rate:	$ 372.43		
Full rate (if reimursable by one source only)	$ 372.43		
Blended rate (Medicaid eligible):			
Medicaid	$ 80.07	21.5%	
Other fund sources (4E or CSC)	$ 292.36	78.5%	
	$ 372.43	100.0%	
Blended rate (Non-Medicaid eligible):			
4E	$ 186.21	50.0%	
Other fund sources (SAMH or CSC)	$ 186.21	50.0%	
	$ 372.43	100.0%	

TRAINING/FIDELITY/CREDENTIALING	**Online/On Site**	**Assumes 2 Train the Trainers**
UNIT 1: Orientation - self study		*40 hours (nurses) and 30 hours (supervisors)*
UNIT 2: Training on practice model		*25 hours over 3.75 days in Denver (nurses); 33 hours over 4.75 days (supervisors)*
UNIT 3: Distance education and training		*10 hours (nurses)*
UNIT 3: Supervisory training/annual refreshor		*20 hours over 3 days in Denver (supervisors) - annual event*
Ongoing consultation with NFP consultant		
Range (depending on modality)	$ -	*Recommendation: Cost reimbursement*

ROI Calculation

Successrate	75%	Remain stable in home/community
Cost avoidance DCF/CBC	$ 19,000	Based on $19,000/year case mgmt, non room and board costs
	$ 19,000	
Adjusted cost avoidance	$ 14,250	Assumes % success
Cost of intervention	$ 8,193	1 episode of care
ROI	$ 1.74	for every $1 invested
		https://www.wsipp.wa.gov/BenefitCostWebSelection=BC&SearchQuerie%5B0%5D.parameter=&SEARCH_ANY&SearchQuerie%5B0%5D.parameter=ANDBSearchQuerie%5B0%5D.value&tmp=
ROI Documented		
	$ 1.37	
ROI documented (by developer)		
	$5.70	for every $1 dollar invested
		https://www.nursefamilypartnership.org/wp-content/uploads/2022/08/NFP-Benefits-and-Costs.pdf

DIRECT CARE ACTIVITY (HOURS)	DIRECT SERVICE HOURS	TOTAL	MEDICAID	NON-MEDICAID	COMMENTS
Home Visits (NFP Curriculum)**	57.8	$ 60,641	$ 36,392	$ 23,649	# sessions * # families. Assumes an average of 2 sessions per month per family on caseload (session length: 60-90 min, average 75)
Additional Supervision required for fidelity	84	$ 8,813		$ 8,813	Traditional supervision monthly covered by Medicaid rate; NFP requires weekly case consultation and team supervision (2 hours/week), est. 7 additional hours per month
Care coordination/TCM	504	$ 52,877		$ 52,877	Estimated 2 hours per month per family on caseload (participation in CBC case staffings, collateral contacts, care coordination), including travel. Not TCM reimbursable; cap 20.
Community Advisory Board Participation	24	$ 2,518		$ 2,518	Estimated 1 hour to prepare for meeting and 1 hour per month to participate
Documentation (FSPs)	453	$ 47,212		$ 47,212	Estimated approx. 3.75 hours per month per family on caseload
** *Difference between unit cost and rate reimb.*	**1640**	**$ 172,062**	**$ 36,392**	**$ 135,070**	
			21.5%	78.5%	

PROVISION OF CONCRETE SUPPORTS

Factors related to poverty, resulting in economic and material hardships, including the inability to meet basic housing, nutrition, transportation, and medical needs are significant predictors of future child welfare involvement. Increased access to economic and concrete supports is associated with decreased risk for neglect and physical abuse. A growing body of research-based evidence has demonstrated that alleviating economic insecurity and providing resources parents need to thrive has a strong positive correlation preventing child maltreatment, involvement with the child welfare system, and placement in out-of-home care.

Recommendation

> *Fund the provision of concrete supports to families experiencing material hardships to lessen the impact of poverty and other financial stressors which ultimately lead to their involvement with child*

For instance, a study published in 2021[21] found that States' total annual spending on local, state, and federal benefit programs per person living below federal poverty limit, which included the sum of (1) cash, housing, and in-kind assistance, (2) housing infrastructure, (3) childcare assistance, (4) refundable Earned Income Tax Credit (EITC), and (5) Medical Assistance Programs, was inversely associated with all maltreatment outcomes. For each additional $1000 states spent on benefit programs per person living in poverty, there was an associated -4.3% difference in reporting. 4.0% difference in substantiations, -2.1% difference in foster care placements, and -7.7% difference in fatalities. In 2017, extrapolating $1000 of additional spending for each person living in poverty ($46.5 billion nationally, or 13.3% increase) could have resulted in 181,850 fewer reports, 28,575 fewer substantiations, 4,168 fewer foster care placements, and 130 fewer fatalities. In Kentucky, a statewide investment in prevention services totaling $9.6 million over a three-year period (SFY'19 through SFY'21) resulted in decreased out-of-home care expenditures of $58.1 million annually; a 6:1 return on the state's investment. In 2022, Kentucky's state budget includes $1,000 in flexible funds for families participating in Kentucky's family preservation program to meet concrete needs and prevent removal.

Rather than to continue citing additional research and outcomes, we recommend reviewing the following, linked document developed by Chapin Hall at the University of Chicago. The

[21] Puls HT, Hall M, Anderst JD, Gurley T, Perrin J, Chung PJ. State Spending on Public Benefit Programs and Child Maltreatment. Pediatrics. 2021 Nov;148(5):e2021050685. doi: 10.1542/peds.2021-050685. Epub 2021 Oct 18. PMID: 34663680.

document provides a comprehensive summary of national research demonstrating the impact of providing economic and concrete supports to families: https://www.chapinhall.org/wp-content/uploads/ECS-and-FFPSA-BriefFINAL-4.13.23.pdf

Evidence related to the impact of providing of such supports is strongly supported by the inclusion of multiple evidence-based programs on the title IV-E Clearinghouse which include the provision of, or referral to, concrete and economic supports to families[22]. Further, the tie between poverty and child welfare has been reinforced in multiple states, including Texas, Kentucky, Washington, Vermont, and Montana, where recent policy changes preventing or limiting the ability to remove children for solely poverty-related factors have been implemented.

As part of an expanded prevention strategy, CFS should implement prevention programs through FFPSA and leverage available funds, such as the TANF surplus, to ensure families do not become involved with child welfare services solely due to poverty-related or economic factors. Investment in the provision of these resources will serve to ultimately play a significant role in reducing child welfare expenditures in the state.

Investment of TANF Surplus

The Temporary Assistance for Needy Families (TANF) block grant is the primary source of funding for states to provide basic cash assistance for families with children when they face a crisis or have very low incomes. The program was established with the statutory purpose of increasing state flexibility in meeting four goals:

1. To provide assistance to needy families with children so that they can live in their own home or the homes of relatives;
2. To end the dependency of needy parents on government benefits through work, job preparation, and marriage;
3. To reduce the incidence of out-of-wedlock pregnancies; and

Recommendation

> *Leverage existing TANF surplus funds to fund the implementation of innovative services to promote primary, secondary, and tertiary prevention services to at risk families and children.*

[22] Ryan, J. P., & Schuerman, J. R. (2004). Matching family problems with specific family preservation services: A study of service effectiveness. Children & Youth Services Review, 26(4), 347–372.

4. To promote the formation and maintenance of two-parent families. States may use TANF funds in any manner "reasonably calculated" to achieve any of these goals.

An updated study published by the Center on Budget and Policy Priorities found states only spend a little more than one-fifth of their combined federal and state TANF dollars on basic assistance for families with children. States continue to use their considerable flexibility under TANF to divert funds *away from* directly supporting families and toward other, often unrelated, state budget areas. Cash assistance to families struggling to make ends meet by way of short-term concrete supports can improve children's long-term outcomes while also providing parents with the assistance they need to remove barriers and move to self-sufficiency. In doing so, states could also promote racial equity and child well-being[23].

Education Collaboration to Provide Early Intervention, Prevention, and Crisis Intervention

As described in the LB 1173 Practice Model report, the vast majority of reports to Nebraska's Child Abuse and Neglect Hotline come are generated through the education system. Though a significant number of these reports are subsequently screened out, these families frequently present risk factors, which may be effectively addressed through an enhanced system of primary and secondary prevention services. The Work Group recommends CFS partner with the Nebraska Department of Education (NDE) to expand services to families demonstrating risk factors for abuse and neglect across the state to provide an access point to prevention services. This pathway could be, in part, funded through FFPSA as many of these families would potentially meet an expanded definition for eligibility under the program. As part of the prevention funding strategy, funding provided by public agencies other than CFS should be reviewed to determine whether it is able to be certified as matching funds to draw down title IV-E FFP.

Recommendation

> *Enhance partnership with the Nebraska Department of Education to expand the provision of intervention and central navigation services to children and families in crisis.*

Additionally, in the LB 1173 Practice Model Report, we support implementation of the full-service community schools (FSCS) pilots, which support site coordinators in the school systems capable of providing central navigation, readily identifying the changing needs of students, and coordinating access to community resources to address those needs. As identified in our

[23] Azevedo-McCafferty, D., Safaw, A., To Promote Equity, States Should Invest More TANF Dollars in Basic Assistance, Retrieved from https://www.cbpp.org/research/income-security/to-promote-equity-states-should-invest-more-tanf-dollars-in-basic#ftn1 July 13, 2023.

Report, these Pilot initiatives have provided very positive outcomes for children and youth in the school system.

According to NDE, costs for these services total *$125,000 per school.* FSCS are specifically effective in providing tailored wraparound services to schools with higher concentrations of poverty. If the FSCS model were implemented statewide in schools where more than 60% of students qualify for free or reduced price lunch, for example, NDE estimates the total cost would be **$18,500,000**. However, significant cost efficiencies could be achieved through partnership with local school districts and regional coordination of the most rural sites, thereby reducing the total investment needed to expand this very effective program.

The Work Group has recommended as a strategy in the Practice Model the FSCS model be expanded. Additional families could also be served by providing funding for direct early intervention services that may require major policy changes at the federal, state, and local levels. During our LB 1173 Community Forums, stakeholders identified how effective the Early Development Network (EDN) services are in terms of a family-centered, early identification/assessment and case management service coordination function. The NDE Office of Policy and Strategic Initiatives has recommended a study to establish a reasonable case rate for EDN services and, based on the study, implement the recommendations to provider greater access to EDN services for families. The NDE has estimated that this enhancement could cost $5,000,000. This service coordination enhancement should be considered as part of the LB 1173 Practice Model implementation.

The Work Group recommends DHHS work directly with the NDE and other intersectoral agency partners to support the braiding and blending of available funding to support:

- Mental health for families, educators, and students,
- School nurses, school psychologists, social workers, and other non-academic support staff to provide services in schools,
- Full-Service Community Schools

COMMUNITY RESPONSE PREVENTION PATHWAY

Multiple states have begun to leverage FFPSA funding to create and promote Community Pathways to reach the most vulnerable population of children at risk of entering foster care. These public and private partnerships serve as a gateway to access funded prevention services outside of the traditional child welfare service paths. Within this model, private agencies perform required FFPSA administrative functions including gathering information to support eligibility determination, developing and/or maintaining child specific prevention plans, conducting on-going safety and risk assessments, tracking and transmitting service participation and other data required for federal claiming and reporting, and delivering and/or referring families to identified evidence-based, culturally appropriate prevention services. They also accept responsibility for working directly with at-risk families and children, determining the type of services needed, partnering with service providers, community services, public agencies (TANF, housing, childcare, etc.), law enforcement, legal community representatives, and Tribal partners to enhance cross-system collaboration and improve access to available resources services. The title IV-E agency maintains responsibility for verifying family and child eligibility, collecting and reporting required data to the federal government, and processing claims for federal reimbursement. The development and operation of a Community Response Prevention Pathway is an eligible title IV-E administrative cost under FFPSA and reimbursable to the state at 50% federal financial participation.

Recommendation

> *Leverage existing partnerships and community provider service infrastructures to provide early intervention to families in need and build an effective Community Pathway to prevention services.*

The Work Group has recommended in the LB 1173 Child Welfare Practice Model the leveraging of community providers and the existing infrastructure of the Bring Up Nebraska prevention effort to establish an effective community response pathway to prevention services. DHHS and Nebraska Children and Family Foundation (NCFF) have partnered to develop a network of Community Collaboratives, which serve to keep children safe, support strong parents, and help families address life challenges before they become a crisis. The Collaboratives are well established in their communities and capable of serving as the foundation on which an expanded community can be built. As part of the initiatives, Collaboratives are embedded with several Tribes, which serves to support the provision of culturally responsive services and meet the unique needs of Tribal families.

DHHS and NCFF have partnered to successfully blend a mix of state, local and private funds to serve and support families. In 2022-2023, the Collaboratives operated on a $6.7 million budget.

Of these funds, 48% ($3.25m) were private funds, 35% ($2.3m) were public funds, 8% ($539k) were private funds specifically earmarked for housing efforts, and the final 8% ($521k) came from public community schools. NCFF presently serves approximately 10,000 families and children annually through its system of Community Collaboratives at an approximate average cost of $670 per individual served.

The foundation estimates a $9.2 million investment would expand access to central navigation and support services to families with children at risk of entering out-of-home care and potentially allow the Community Collaboratives to reach an additional 30,000 children and families statewide. Efficiencies of scale associated with the expanded system will reduce the average cost per individual served to approximately $530. The following table provides a description of proposed activities and projected costs.

Activity	Description	Amount
Navigation Services	Increase capacity central navigation staffing	$2,542,713
Support Services	Housing, Utilities, Health Services, Parenting Skills, etc.	6,300,977
Technology Capacity	Expand and standardize client tracking & reporting	216,370
Training	Staff training for EBPs and culturally responsive engagement	115,000
Lived Engagement Stipends	Stipends to youth and parent peer mentors	115,000
Total		**$9,290,060**

As DHHS seeks to expand access to child abuse and prevention services through the development of a Community Response Pathway, as much as 50% of related expenditures may be eligible for federal financial participation (FFP) through title IV-E. Going forward, and as part of the Finance Model, the Work Group recommends a comprehensive assessment be completed to determine:

- Number of additional families and children to be served and the percent of families served through the Community Collaborative who would be eligible for title IV-E funded prevention services under a proposed expanded definition.
- Federal Financial Participation (FFP) available for the provision of title IV-E administrative activities (family / child assessment, case planning, service referral, case management, service referral, etc.), training costs, and the provision of approved evidence-based interventions.
- Determine whether any local funding provided by county governments or public agencies may be able to be certified as match to draw down additional title IV-E FFP.
- How to continue to leverage private investment while maximizing federal financial participation, consistent with some of the strategies outlined in this Finance Framework.

To this end, innovative funding strategies and new fiscal policies may need to be developed to ensure DHHS complies with all federal requirements.

Medicaid Funded Services and 1115 Waivers

The proposed LB 1173 child welfare Practice Model recommends expanding the provision of Behavioral Health services including those for Mental Health, Substance Use Disorder, adults with serious mental illness (SMI), and children with serious emotional disturbance (SED).

In November 2018, CMS issued a "State Medicaid Directors" letter that outlines "existing and new opportunities for states to design innovative service delivery systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The letter includes a new opportunity for states to receive authority to pay for short-term residential treatment services in an institution for mental disease (IMD) for these patients" thereby integrating IMD exclusions with community-based delivery systems – a critical advance for state flexibility at that time. In order for states to receive greater flexibility in the design of their SMI/SED/SUD strategies and benefits they must agree "good quality of care in IMDs, improve connections to community-based care following stays in acute care settings, ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED, provide a full array of crisis stabilization services, and engage beneficiaries with SMI or SED in treatment as soon as possible."

Nebraska has the opportunity to fund the provision of innovative behavioral health services to the child welfare system through the development of Medicaid 1115 waivers and implementation of innovative Medicaid and behavioral health models.

Medicaid 1115 Waivers

State 1115 waiver designs must address: 1) earlier identification and engagement in treatment (including improved data-sharing between schools, hospitals, primary care, criminal justice, and specialized mental health providers to improve communications); 2) integration of mental health care and primary care that can help ensure that individuals with SMI or SED are identified earlier and connected with the appropriate treatment sooner; 3) improved access to services for patients across the continuum of care including crisis stabilization services and support to help transition from acute care back into their communities; 4) better care coordination and transitions to community-based care; and, 5) increased access to evidence-based services that address social risk factors including services designed to help individuals with SMI or SED maintain a job or stay in school. Waivers approved under the expanded spending authorities must be budget neutral.

Options for State Medicaid Managed Care Models for Child Welfare[24]

In 2021 Casey Family Programs and the Center for Health Care Strategies presented the learning experience "Medicaid 401: Introduction to Managed Care in Medicaid for Child Welfare". Five models of how states could address delivery system and payment models for Medicaid services addressing infants, children, youth, and families engaged with Child Welfare were presented as follows:

- **Integrated MCO:** Financing and management of physical and behavioral health care are integrated (even if BH management is subcontracted out by prime managed care contractor). Example: Tennessee
- **Behavioral Health Carve Out:** BH services are financed and managed separately from physical health care. Example: California, Pennsylvania
- **Integrated with a Partial Carve Out:** Financing and management of physical health and an "acute care" behavioral health benefits are integrated and behavioral health beyond "acute" is carved out in a separate financing and management arrangement. (Example: Michigan)
- **Population Carve Out:** Financing/management of BH is in a separate arrangement for a specific population. Example: New Jersey
- **Specialty Managed Care Arrangement for health and behavioral health for a specific child population.** Examples: Texas, Florida, Georgia, Kentucky, West Virginia, and Arizona for the foster care population.

Examples of Innovative Service Delivery Models funded through these strategies are included in the LB 1173 Work Group report accompanying the proposed Practice Model.

Leveraging and Expanding Access to the Regional Behavioral Health System

We have had the opportunity to meet with individuals from the Regional Behavioral Health Authorities (RBHAs) in the community and were presented with details about the value the system could bring to children and families in Nebraska. We have also met with Nebraska Division of Behavioral Health staff and reviewed detailed program and cost information. Through these interactions and review, we believe that there are untapped resources and value that the regional behavioral health system could bring in the future to many children, youth and families that are either in foster care or at risk of child welfare involvement.

[24] https://www.casey.org/media/Medicaid-401-Introduction-to-Medicaid-Managed-Care-for-Child-Welfare-PPT-1.pdf

- The statewide RBHAs are established by Nebraska Revised Statute 71-801-818 and are responsible for the development and coordination of adult and children's publicly funded behavioral health services within their region primarily funded by SAMHSA Block Grant funds, state, funds, local funds, private insurance, and self-pay.
- The population RBHAs serve is any child or adult with a behavioral health need who is not a Medicaid beneficiary. Financial access to services is based on state determined Income Guidelines, private insurance coverage, or self-pay.

> "Regional Behavioral Health Authority services would be more available for low income families if the department's financial guidelines were reviewed and increased to current economic conditions so more people could be served and the Cliff Effect would not hinder individuals and families seeking needed mental health services.
>
> *FOCUS GROUP PARTICIPANT COMMENT*

While there is variation across the RBHAs (some direct deliver services or contract them out to private providers willing to work with them) they all deliver the Professional Partnership Program. This program is designed to assist families with a child experiencing Severe Emotional Disturbance through a fidelity Wrap Around model and is needs/strengths based.

Expansion of the Regional Behavioral Health Authority System offers it the opportunity to be a vital partner in the future child welfare transformation for children and families struggling with Behavioral Health, Substance Abuse Disorder and Serious Emotional Disturbance issues. The delivery system for these services could be anchored in the strengths of Nebraska's Certified Community Behavioral Health Clinics/CCBHCs, Federally Qualified Health Centers/FQHCs, and the Regional Behavioral Health Authorities. The operational model would include a standardized scope of work, Evidence Based Practices, an agreed upon standardized assessment instrument that determines acuity levels and service needs, a standardized treatment planning method, and a direct relationship with or provider of fidelity Wrap Around services. Bi-directional care coordination between these entities and the Managed Care Organizations would be embedded in a Memorandum of Agreement

To support this expansion, DHHS/Medicaid should consider developing and implementing a comprehensive Behavioral Health, IMD Exclusion, Substance Use Disorder, and Serious Emotional Disturbance 1115 Waiver based on a standardized assessment of acuity levels and carved out from the existing managed care program. The covered population would include all eligible infants, children, youth, and adults who upon standardized assessment are determined

to have a high level of acuity/severity/persistence. Services definitions should be evidence-based to the maximum extent possible and include mobile crisis services, inpatient, residential, day programs, outpatient, fidelity Wrap Around services, evidence-based prevention services, and Social Determinants of Health /In Lieu of Services.

In addition, Nebraska Medicaid could consider a waiver administrative platform of an Administrative Services Organization (similar to Alaska, as described in the Practice Model accompanying report). The ASO model could provide the state more direct oversight of and accountability for the behavioral health delivery system for high acuity/high cost infants, children, youth, and adults. An augmented Fee For Service rate for specified services coupled with a single provider revenue cycle (compared to multiple MCOs) could provide an incentive for more credentialed private sector providers[25] to become Medicaid providers.

Finally, Nebraska Medicaid could also consider embedding this waiver within the existing managed care contract model (similar to an approach in Kansas) thereby inheriting the existing strengths and challenges of that system. This approach would also be expedient and rely on the existing MCO capacities for care coordination of high acuity/high costs individuals which, based on community comments across the state, would have to substantially improve.

Thus, the Work Group sees significant untapped potential for the RBHA system to be a pivotal part of the future LB 1173 child welfare system transformation, and identifies the following opportunities for Nebraska to consider moving forward:

- Consider the Professional Partnerships program as the statewide HUB (or a participant HUB with the CCBHCs and FQHCs based on regional variations) for fidelity Wrap Around within the recommendation for a Medicaid BH/IMD/SUD/SED 1115 waiver. Note that currently the RBHA Professional Partnership Program serves approximately 1,000 children on an annual basis at a cost of approximately $6 million of non-Medicaid funds (SAMHSA, state funds) across the state.[26] Further note the need to establish a DHHS system-wide definition of case management services. Presently, children and youth in foster care, who could benefit from Professional Partnership services, are not eligible because CFS case workers are assumed to provide Fidelity Wrap Around services as part of their case management responsibilities. The Work Group, however, believes that this interpretation of the definition of case management may be flawed. We also note that

[25] The Marly Doyle Behavioral Health Center of the University of Nebraska (established by LB 608) reports that there was an increase of 32% of psychiatric prescribers and 39% of psychologists and mental health therapists between 2010 and 2020. https://nebraska.edu/nuforne/marley-doyle
[26] Source: DBH Spreadsheet: 8/29/23

Juvenile Justice Crossover youth are also case managed by staff and, nonetheless, are currently eligible and receiving the Professional Partnership program services.[27]

- RBHAs are well positioned in their communities/region to provide or partner with Mobile Crisis teams based on Paramedic/EMT participation such as the models we learned about in the Kearney and Omaha regions sponsored by Lutheran Family Services.
- Between FY 2019 and FY 2023, DBH provided a total of $435,435 million in SAMHSA Block Grant and state general fund dollars for RBHA services with a total of $351,591 million expended during this time period. Several RBHA directors we spoke with indicated the current state Financial Income Guidelines for RBHA services eligibility was often too high for struggling families whose income was just above current guidelines, falling within the "Cliff Effect."[28] We recommend that DHHS/DBH consider developing a method that balances currently appropriated RBHA funding with new and revised Financial Income Guidelines that are more flexible in managing over or under budget expenditures throughout the Fiscal Year. From 2019 to 2023 $83 million unspent dollars were returned to DBH by the RBHAs. This fact alone leads us to conclude that there is enough funding in the current RBHA system to accommodate important behavioral health services, like the Professional Partnership Program for many more children, youth, and families in Nebraska that are at risk of or system involved and struggling mental illness or substance abuse. Future funding considerations must take this into account so DHHS maximizes available funding before requesting additional funding to meet these needs.

Leverage Increased Public Grant Funding for Home Visiting Services

The Consolidated Appropriations Act, 2023, Public Law 117-328, included a 5-year reauthorization of the Maternal, Infant, Early Childhood and Home Visiting (MIECHV) Program. The language included in the final bill reflected the Child Home Visiting Reauthorization Act of 2022 (H.R. 8876) and, among other stipulations, provides the first-ever funding increase for MIECHV and phases in a state-matching requirement beginning in

Recommendation

> *Ensure expanded MIECHV funding is fully realized through the development and investment of matching funds.*

[27] This understanding comes from several community meetings including caseworkers. We could not find any statute or rule supporting the omission of CFS "wards" of the state from the Professional Partnership program.
[28] "The cliff effect refers to the sudden and often unexpected decrease in public benefits that can occur with a small increase in earning." National Council of State Legislators: https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs

FY24. Under these changes, federal funding will double over the duration of the five 5 years and will be required to provide a 25% match for additional federal funding.

The new law established "base funding" under MIECHV, which will not be subject to the new state match. Nationally base funding was set at $500M in FY23. Matching funds will be available beginning in FY 2024, with increasing amounts through FY 2027. The federal government will contribute 75% of the funding and states and jurisdictions will contribute 25% in non-federal funds. Starting in FY 2025, awardees can apply for additional matching funds. These funds include any matching funds that HRSA did not distribute to awardees in the previous fiscal year, as well as any matching funds that were not used by awardees in prior fiscal years and were returned to HRSA. To apply for additional matching funds in FY 2025, should any become available, awardees must submit a statement expressing interest in receiving additional matching funds by September 6, 2023.

In Nebraska base funding for MIECHV increased by approximately $500,000, from $1.2m to $1.7 million. Matched funds available to the state are estimated to be approximately $775,000 in FFY'24, $1.12m in FFY'25, $1.7m in FFY'26, and $2.5m in FFY'27. To draw the down all available funds, the State the match requirement will total approximately $850,000 by Fiscal Year 2027. The state match is above the established maintenance of effort based on non-federal, MIECHV-eligible spending by the MIECHV-lead agency. In Nebraska, the maintenance of effort will be $1.1 million.

As one of the three approved prevention service categories under FFPSA, home visitation is one of the primary means to reduce the likelihood of future involvement with the child welfare system. Home visitation services have been shown to have a positive impact on children, families and communities. Programs like Healthy Families America (HFA) serve to strengths parent-child relationships, promote healthy child development, and enhance family well-being. The program results in fewer low-birth-weight babies, and a reduction in the recurrent of maltreatment. Children participating in the services are less likely to have behavioral issues, or receive special education services. In addition, participating families are less likely to be homeless, are more likely to participate in education and training, demonstrate more positive mental health, and report lower levels of parental stress.

According to the National Home Visiting Center, studies have found a return on investment of $1.80 to $5.70 for every dollar spent on home visiting. This strong return on investment is consistent with established research on other types of early childhood interventions. DHHS should ensure new MIECHV funding is fully realized over the next several years. Further access to MIECHV funded services should be integrated into the state's child welfare prevention model to ensure available funds are fully leveraged and utilized with the most vulnerable populations.

Reducing the Impact of the Benefits Cliff to Support Movement to Self Sufficiency

Access to public assistance benefits is often based on the financial eligibility of the recipient or recipient's household. A "Benefits Cliff" occurs when small increases to the recipient's income result in a significant loss in benefits. In these cases, working a few more hours per week, receiving raise, or adding a second income earner, families may end up losing access to cash benefits, food assistance, Medical benefits, or childcare subsidies. As a result, families end up worse off financially and the goals of economic independence and financial stability are undermined. The threat of encountering Benefits Cliffs forces individuals receiving public assistance to make job and career decisions based on short-term financial considerations. This not only impacts the family, but also hurts businesses who experience turnover, struggle to fill vacant positions, and have difficulty retaining workers. In the aggregate, places undue burden on taxpayers, who bear the cost of the elevated need for public benefits.

While some public benefits programs are subject to strict federal eligibility requirements, others permit state governments to define eligibility. States also have the opportunity to apply for waiver programs to gain additional flexibility. Florida, Colorado, Ohio, and several New England states have made changes to benefit programs with the explicit intention of reducing benefit cliffs facing families.

For example, Ohio's "Benefit Bridge" pilot enabled six counties' departments of Job and Family Services to test approaches to minimize the impact of benefits cliffs. It is largely based on the success of efforts in Allen County, which paired TANF Prevention, Retention, and Contingency supports with job coaching assistance and financial incentives benchmarked to employment goals for a limited number of TANF participants. In addition, in 2021, Ohio increased the initial eligibility threshold for childcare subsidies from 130 percent of the federal poverty level to 142 percent until 2023, allowing more working families to access this important benefit. The subsidy requires copayments, which allow cost-sharing between government and families who earn more while keeping program budgets at reasonable levels.

As poverty is so closely tied to child neglect, reducing the effect of the Benefits Cliff by identifying supportive transitions from public benefits to self-sufficiency can serve to provide necessary supports to families which increase economic independence through employment, promote long-term success for families and children, and improve successful outcomes for families and children. We recommend DHHS review financial eligibility criteria of public benefits programs and conduct a feasibility study to determine the potential cost-benefit ratio of changing eligibility criteria for certain public benefit programs in Nebraska.

Access to Childcare

Nebraska's childcare regulations disregards income guidelines for youth involved in the CW system and provides exceptions for families with other extenuating circumstances. Unfortunately, these exceptions do not apply to children temporarily sheltered with a relative or non-relative kinship caregivers (informal placements) because the child is not formally removed from their primary caregiver by CFS. In many cases, the inability to access subsidies the child would otherwise be eligible for if they had remained with their parents negatively impacts the relative caregiver's ability and willingness to accept responsibility to care for the child. In these instances, the only alternative is to remove the child, which results in increased CFS workloads and expenses which could otherwise be avoided. The Work Group recommends additional research be completed by DHHS to determine what statutory changes would be necessary to permit relative caregivers to access childcare subsidies based on the parent's income (or other other critiera), determine whether these changes are allowable under federal program standards, and develop a plan to implement changes which will support the ability of relatives to care for children informally placed in their care.

Development of Provider Workforce Capacity

Passage of the Family First Prevention Services Act significantly shifted the focus of child welfare systems from a lens of intervention to one of prevention. In doing so, the need and demand to access a different array of evidence-based programs was created. While using rigorously evaluated evidence-based prevention programs, doing so requires a better-trained and a more qualified workforce with specialized or advanced degrees. By 2025, the U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis projects there will be shortages for psychiatrists, clinical, counseling and school psychologists, mental health and substance abuse social workers, school counselors and marriage and family therapists of more than 10,000 full time employees[29].

Given the projected workforce shortfall, recruitment and retention challenges will limit provider ability to implement and sustain the provision of these evidence-based practices and require ongoing investment in professional development as positions experience turnover.

[29] National Projections for Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025, (November 2016) U.S Department of Health and Human Services Health Resources and Services Administration Bureau of Health Workforce National Center for Health Workforce Analysis, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf

It is recommended DHHS seek to use remaining Family First Transition Act (FFTA) funds and title IV-E training funds available through FFPSA to develop a statewide strategy and plan designed to create a qualified workforce, and retool the capacity of community providers to offer evidence-based programs.

Priority Area 3: Provider Rates and Contracts

Provider Rate Setting Process and Frequency

U.S. Child Welfare systems serve millions of children with costs exceeding $26 billion annually. Rates for services, especially for out-of-home maintenance payments, vary substantially across states and over time. Despite being part of a social safety net, foster care maintenance rates have declined in real terms since 1991 in many states, not keeping pace with inflation, leading to lower real rates in 2008 compared to those in 1991[30].

Recommendation

> *Develop and execute a standard rate setting process at regular intervals designed to rebase provider payments based on the reasonable and allowable cost of service provided.*

Considering the impact of recent inflation rates and the subsequent "Great Resignation" on the ability of child welfare programs and service providers to recruit, hire, and retain qualified staff, it is likely that rates have fallen even further behind in the past two years in states, like Nebraska, not engaging in a regular rate setting process. For instance, Indiana utilizes an annual rate setting process for residential care and child placing agencies based on the actual cost of services. Between calendar years 2021 and 2022, the mean payment rate for residential foster care increased by 17% ($395.58 to $464.36 per day[31]) and then by an additional 35%, to $627.05, in 2023[32]. Similarly, child placing agency administrative payment rates increased 5.87%, from $55.02 to $58.25, between 2021 and 2022, and then again by11.48%, to $64.90, in 2023. In Wisconsin, the average administrative payment to Child Placing Agencies increased by 8.5% ($6.25) between 2021 and 2023, the average daily rate paid to residential facilitates increased by 29.5% $139.11, and the average daily rate paid to group homes increased by 29.7% ($68.73).

[30] Goldhaber-Fiebert JD, Babiarz KS, Garfield RL, Wulczyn F, Landsverk J, Horwitz SM. Explaining variations in state foster care maintenance rates and the implications for implementing new evidence-based programs. Child Youth Serv Rev. 2014 Apr 1;39:183-206. doi: 10.1016/j.childyouth.2013.10.002. PMID: 24659842; PMCID: PMC3960086.
[31] Indiana residential foster care rates includes payment for services such as nursing support, education, and independent living, which are outside the scope of traditional foster care maintenance.
[32] It is important to note, the increase between 2022 and 2023 was driven largely by a change in the rate setting methodology and by increases to a small number of outlier rates, both of which were pandemic driven and may be temporary/

For the sake of comparison, summaries of 2021 and 2023 Indiana Residential Treatment Rates by Licensing Category[33] are provided as attachments to this report.

Rate shortfalls affect state Child Welfare agencies' ability to recruit and retain foster parents and to implement effective programs to serve these children. Further, factors affecting sustained funding for existing services, like foster care maintenance rates, are also likely important contextual factors for implementing and sustaining the provision of evidence-based programs. As a result, it is critical that an effective process be developed to review, rebase, and establish provide rates that cover the cost of services while providing a basis for the development of system capacity across the areas of prevention, in-home services, and out-of-home care.

Nebraska providers, as well as state staff, have long discussed the need to review and revise rates across all aspects of the service continuum. Providers report being paid disparate rates for similar services by different Nebraska agencies, such as CFS or JPS, and rates that do not cover the cost of providing the contracted service. With the imminent expansion of prevention services across the state, it is imperative CFS look to ensuring all payment rates are sufficient to cover the cost of providing the service, based on the actual cost of care, and rebased on a regular interval to ensure they are keeping pace with market conditions. Further, state agencies utilizing similar providers to provide similar services to similar client bases, should collaborate to develop a joint approach to establishing rates that are equal regardless as to which agency ultimately funds the service.

CFS should implement a rate-setting period aligned with Nebraska's biennial budget cycle. Intermittent years' cost and resulting rates may be projected using collected cost data and applying a cost-of-living-adjustment (COLA) to compensate for any changing factors, which impact the cost of providing service. States, including both Indiana and Ohio, apply a COLA in their rate-setting model to compensate for the lag between the time provider expenditures were incurred and reported, and the rate for the coming year calculated. A carefully constructed rate setting model, will permit department leadership to develop and submit sufficient budget requests, which are backed by recent cost data and allow providers to be equitably compensated.

The development and implementation of rate setting methodologies are largely the responsibility of the state, as long as federal cost principles and regulations articulated in the Federal Uniform Guidance are followed. Jurisdictions across the country utilize varied models and consider a number of factors when establishing payment rates. While there is not one optimal approach that should be followed, it is recommended a committee including both state staff and providers, be convened to research existing models and jointly create a

[33] Indiana DCS rate data extracted from KidTraks/I-Rate (Indiana's rate and payment system).

new rate setting methodology. Specific components and options used in various rate setting models reviewed[34] include:

- **Calculated Rates**: Standard statewide rates by category of service or provider specific rates by category of service.
- **Cost Report Format**: Models reviewed each used different cost report formats and cost categories. Instructions accompanying each report clearly defined how cost was to be allocated, categorized, and reported.
- **Frequency**: Many states require cost reports to be submitted annually. However, there is no federal requirement related to this standard.
- **Audit Requirement**: Most states required audited financial statements to accompany the report at the time it is submitted. Some states, like Ohio, require the report to be audited by a state-approved independent accounting firm prior to submission. Cost report instructions typically required agencies to follow OMB Uniform Guidance (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards)when completing their report(s).
- **Staffing Ratio:** Rate setting models used in New York and Indiana capitated the number of direct child care and case management staff based on licensing standards and other criteria including type of facility, size of residential units, number of children cared for, and acuity of children in care.
- **Fringe Benefits:** States varied in the decision to capitate fringe benefits. Some had fixed caps based on a reasonable percent of wages, others apply a variable cap which changes annually based on the median fringe benefit rate (by percent) incurred by agencies operating in the state.
- **Administrative Expenditures:** States varied in the decision to capitate administrative expenditures. Some had fixed caps based on a reasonable percent of program cost, others apply a variable cap which changes annually based on the median administrative cost (as a percent of program costs) incurred by agencies operating in the state.
- **Cost of Living Adjustment (COLA):** A variety of methods are used to apply a COLA to calculated rates. Approaches used typically consider the time gap between when reported costs were incurred and established rates based on those costs were made effective. Some approaches were based solely on the inflation rate (Ohio), while others applied a mixed COLA based on the Consumer Price Index (CPI) and Employment Cost Index (ECI). Indiana also applies a Rate Year Adjustment to (typically 50% of the calculated COLA) to cost reports. This additional adjustment allows agencies to invest in expanded services and cover unanticipated increases to expenses.

[34] Rate setting models reviewed include Ohio, Wisconsin, Michigan, New York, Illinois, North Carolina, and Indiana,

- **Profit Margin:** Illinois and Indiana provide consideration to for-profit providers permitting a profit margin to be realized. The profit margin is typically added to a calculated base rate as a percent. Indiana has recently began to provide not-for-profit agencies with an Operating Margin to support standardization of the rate models applied to for-profit and not-for-profit agencies

The Work Group has identified several factors, which should be considered when developing an effective rate-setting system:

1. Costs must be reported through a consistent and easily understood process. Providers must have a solid understanding of federal / state requirements surrounding cost allowability and federal claiming for reimbursement. They should be trained to complete the cost report accurately and a method for validating the accuracy of the report established by the contracting organization. User-friendly systems tended to be "straight line" reporting structures, which also required the least training.
2. The structure of the system should ensure all benefiting services and activities receive an equitable allocation of cost.
3. Determination of cost reasonableness is incumbent on the agency establishing rates. The methodology used may integrate specific checks into the rate system to determine whether costs are in line with expected parameters (for instance, fringe benefits may be limited to a specific percentage of salary) or an external review used to validate costs. In either case, clear guidelines for these determinations must be set and maintained.
4. Limits for specific costs should be considered. While many rate-setting methodologies utilize upper-end limits to fringe benefits and administrative costs, some apply similar factors to direct-care staff ratios and other service-related factors. Caution must be used in applying these caps as factors outside the control of the provider or contracting agency may influence cost.
5. Factors related to cost adjustments must be determined. Applying a Cost of Living Adjustment is typical in most rate setting systems reviewed.
6. Decisions should be made as to how often payment rates will be recalculated and whether performance-based measures revised / renegotiated annually.
7. State agency staff and providers should jointly develop a rate setting methodology and present it to the larger provider community for comment and feedback. Clearly understanding how cost will be used to create payment rates across various levels of care will result in increased provider "trust" and stronger collaboration.

Finally, DHHS may consider establishing a forum to permit providers and other stakeholders to provide regular input to the rate setting process. Indiana, for instance, holds a public comment

period and hearing annually to communicate ideas, suggestions, or other comments regarding the residential foster care (RTSP) and child placing agency (CPA) rate setting process.

The public comment period is open for a minimum of thirty (30) days prior to the hearing. The hearing is held on or about the third Friday in January at an address specified in a notice posted by the department on the department's website. Notice of the public hearing is posted on the department's website for a period of at least thirty (30) consecutive days immediately before the scheduled hearing date. The department also sends electronic notice of the public hearing to providers currently under contract with the department. The hearing is open to the public, and the department accepts comments, suggestions, and feedback related to annual review cost-based rates set by the department.

TRIBAL CONTRACTS AND FUNDING

Tribal members participating in the LB 1173 Work Group identified several concerns regarding the level of child welfare funding available to tribes. Specifically, leaders expressed that, traditionally, tribal children in child welfare have been "funded at levels lower than non-tribal children." While funding appears to have been somewhat equalized in recent years, additional research is needed to fully develop a set of recommendations related to the provision equitable child welfare funding for Native families and children. Tribal leaders provided the following input related to the need for additional services in their communities :

- Tribal families face barriers related to poverty, housing availability, and employment. Frequently, supportive services, concrete goods, or economic supports would serve to minimize or overcome these factors. Financial resources are often not available to these families unless they are involved in the formal child welfare system.
- A prevention pathway tailored to Tribal needs should be implemented in their communities. This pathway should be staffed by culturally representative individuals who have received specific training regarding available services, interventions, and programs, how those programs work, and how to access them.
- Prevention programming should include culturally appropriate interventions selected to meet the specific needs of each tribal community.

- A statutory change to Nebraska law is required to allow families to enter into Tribal Customary Adoptions and still receive a state adoption subsidy for the family who are adopting a state ward.
- Tribes require assistance establishing title IV-E eligibility for children entering out-of-home care.
- Tribes require assistance recruiting and retaining licensed foster parents. Foster parents in tribal communities need designated support workers, respite care, and culturally specific training and support. The Nebraska Indian Child Welfare Coalition reports there are currently no tribal title IV-E eligible foster homes.
- Court and legal services are underfunded. There is a need for quality legal representation of children and families involved in the child welfare system. NICWC reports the desire to establish a legal advocacy program similar to that available in Hennepin County, Minnesota. NICWC further reported they have applied for grant funding to support a Tribal Liaison program to represent Tribes in ICWA cases when they are too far or lack the resources to be fully involved in their cases. As the program is implemented CFS should partner with NICWC to determine how additional state or title IV-E funding may be used to support program expansion and sustainability beyond the grant funding period.

Recommendation

> *Collaborate with NICWC to ensure child welfare funding to tribal entitles is equitable, tribal families children have culturally relevant access to concrete and economic supports, a tribal pathway to prevention services is developed, quality legal representation is available to families, and Title IV-E is accurately established for tribal children.*

In October 2023, Nebraska Department of Health and Human Services (DHHS) Division of Children and Family Services (CFS) with the support of the Nebraska Court Improvement Project, the Winnebago Tribe of Nebraska, the Omaha Nation, and the Ponca Tribe of Nebraska was awarded a $2.5 million grant to support efforts to reduce the number of indigenous children involved in the child welfare system.

The grant will help develop and implement a plan to strengthen best practices in Indian child welfare services to preserve families of federally recognized American Indian and Alaska Native Tribes; protect children, and ensure that children remain connected to their families, communities, and culture. The project was developed with the intent of :

- Improving compliance with the Federal and State Indian Child Welfare Act (ICWA)

- Increasing tribal capacity to meet community needs around prevention, safety, permanency, and well-being
- Enhancing relationships between state and tribal partners

The Work Group recommends DHHS leverage this unique opportunity and ,integrate the development of culturally-based prevention services, analysis of Tribal funding, and development of tribal foster parent capacity into the collaborative grant planning efforts.

PERFORMANCE-BASED CONTRACTING

State and local governments have paid private, voluntary agencies to provide child welfare services since the early 1800s. Until the mid-1990s, public child welfare agencies used noncompetitive, quasi-grant arrangements to purchase services from private, typically nonprofit, agencies. In 1997, the federal government passed the Adoption and Safe Families Act (ASFA), and then, implemented Federal Child and Family Service Reviews (CFSRs). Together, these federal reforms require states to achieve improved performance on child and family outcomes including child safety, timely permanence and well-being. The new federal mandates came at the same time that states were seeing escalating costs for out-of-home care driven by increases in the numbers served, the length of stay and the unit costs of care. State child welfare budgets were increasing but still not keeping up with demand. National surveys found that during the 1990s, most states increased their reliance on contracted social services to cope with new constraints on public resources .

Recommendation

> *Integrate meaningful, achievable performance-based outcome measures into provider contracts and provide financial incentives for providers able to achieve performance targets.*

As private agencies have assumed a larger role in many states, public administrators realized that private agencies needed to be held accountable for more than just delivering services. To hold private agencies more accountable, public agencies needed to give them greater decision-making authority. Contracts were then re-structured in ways that would align fiscal and programmatic goals and stimulate better results for children and families. In return for increased case-level decision-making authority, private agencies for the first time entered into performance- or risk-sharing contracts and were held accountable for specified outcomes and system improvements. Since that time, practice, policy, and fiscal considerations have set the stage for an increase in these new types of contractual relationships; these new contracts in

over half the states include performance targets and fiscal incentives or disincentives tied to performance standards .

Research findings indicate that the transition to performance-based or other risk-sharing contracts has not been without challenges for both public purchasers and their contractors. There are mixed findings in terms of the effectiveness in meeting fiscal and programmatic goals. The quality of the contracts has also been an issue. In some cases, contracts combined vague service obligations, poorly defined outcomes and performance measures, and poorly specified roles and responsibilities of public and private agency workers. The result in many initiatives was that an inexperienced purchasing agent did not attain the expected results, which in turn, placed the provider agencies at some level of financial risk due to their poor performance .In addition, private agencies lamented the fact that contracts were too often designed "in a silo" by the public agency with little understanding of what it would take for the private agencies to succeed; contract negotiations, if they happened at all, failed to engage both sides in a dialogue about how the contracts would actually be implemented and how inevitable challenges would be handled. In short, it is not only difficult to consistently attain new performance measures and client-level outcomes and manage risk; it has also not been easy to shift the "business as usual mindset" and embark on a whole new process of "partnering" to achieve shared accountability for results.

To support efforts required to implement performance based contracts, several published studies recommend similar strategies to establishing a tiered, performance based contracting environment capable of driving outcome improvements:

#1: Establish a Culture of Collaboration, Trust and Cooperation. In the early stages of planning for the use of performance-based contracting (PBC), it is important for leadership to model trust in collaborative partners and build upon existing frameworks for collaboration. That is, the mission-driven solution for child welfare should be a theme evident throughout the system of care, not just part of the contract negotiation approach. The establishment of a shared vision and shared commitment to common goals attenuates the inevitable challenges of partnership. The culture of collaboration should include an underlying recognition of the fact that implementing and achieving system change isn't easy and that collaboration and cooperation doesn't mean that those involved will always agree. The use of a neutral third-party facilitator may be helpful in developing a framework for partnership, a shared vision and, as discussed later, in changing the culture of contracting.

#2: Convene the Right Parties. PBC planning and negotiation should be an inclusive process, including not only executive leadership, but also the staff responsible for providing and supervising services and those charged with quality assurance/improvement. Service providers

should be involved in planning/developing PBC performance measures in order to generate adequate "buy-in" on the part of those most directly responsible for implementing the change in practices.

#3: Change the Culture of Contracting / Equalize the Power Differential. The traditional "culture of contracting" typically involves an unbalanced power structure in which the contractor delineates performance objectives/outcomes and sub-contracted providers simply "comply". With PBC, although the state-mandated performance measures are non-negotiable, the additional PBC incentive measures are negotiable (prior to implementing the contract) and ideally are developed in a collaborative manner. For equitable negotiation processes to occur, all parties must be open to coming to the table as partners, with the contractor giving up the power position while still maintaining authority. Strategies to support a more equitable balance of power and sense of "fairness" in the negotiation process include the use of a third-party facilitator and transparent /open administration procedures.[35]

#4: Engage in Active Project Management. Project management is essential even in the planning/development phase of PBC. Leadership must consider timing and assess the readiness of the collaborative partners –those involved need to recognize or accept the idea that change is needed[36]. When the timing is right, leadership should begin with a clear program design/project description so that collaborative partners are able to quickly and clearly see "the big picture" of what the group wants to achieve and how. A clear theory of change makes the case for the intended changes in the organization [37].

 # 5: Clearly Define Performance Measures / Assessment / Incentives Emphasizing Practices that Staff Directly Control. When establishing performance measures, there should be a clear connection between an individual's behavior/practices and outcomes/incentives; without this connection, the motivation for the change in practice may be lost and the effectiveness of the PBC will be compromised. Accordingly, performance measures may actually be "outcome drivers" (the practices that lead to the outcomes). Performance measures must be clearly defined in a manner that can be understood not only by those involved in the development process, but also those who will be responsible for the implementation (front-line staff). Similarly, assessment of attainment of PBC measures should be clear, defining not only what will "count" as meeting the expectation, but also the data collection methods and reporting

[35] Straus & Layton, 2002; Susskind & Cruikshank, 2006.
[36] Petersilia, 1990
[37] Rogers, Wellins, & Conner, 2002

requirements. In terms of tiered or incentive payments, everyone involved should have a basic understanding of what is incentivized and how incentives will paid.

#6: Develop and Implement a Coherent Communication Strategy. Communication is critical to keep all partners "in the know" and needs to be actively addressed across all staff levels. A comprehensive approach to communication is important during all phases of PBC, but perhaps most critical post-implementation since questions tend to arise after implementation.

 # 7: Provide Training and Technical Assistance. Training and technical assistance for the implementation of PBC needs to begin prior to the start date and continue throughout the duration of the contract period, being mindful of staff turnover. The contractor should take primary responsibility for training prior to and during the launch of PBC, with subcontractors becoming increasingly engaged/responsible for training across the duration of the contract year(s). Initial training should be designed to 1) increase understanding the intent of the PBC performance measures, 2) breakdown performance measures into specific practices, 3) address assessment and reporting requirements/issues, and 4) clarify the incentive structure, emphasizing how it builds on existing contract dollars and specifying how much subcontractors can earn through meeting performance measures. Ongoing training should be organized around PBC measures so that the relevance of the material is apparent[38].

#8: Engage in subcontractor-driven Project Management. While the contracting agency is responsible for the overall management of the PBC process, certain aspects of project management remain the responsibility of (or are best handled by) subcontractor leadership. For example, since subcontract agency leadership are closely attuned to the specific needs, abilities, and attitudes of their staff, they are in a better position to determine if incremental goal setting for meeting performance objectives is necessary or identify training required to meet PBC outcomes.

#9: Consider Data Management Issues. The consideration of data management issues is not necessarily limited to the evaluation phase (e.g., potential problems should be considered early on when determining measurement of a PBC outcome). Issues to consider include trust in the data source(s), data availability and ease of access, and potential problems with data entry and reporting schedules (e.g., accuracy, consistency, and timing) [39].

#10: Use Data to Inform and Strengthen Quality Improvement Efforts. Data collected to monitor performance measures can be used to strengthen the quality assurance and

[38] Joyce & Showers, 2002
[39] Pindus, Zielewski, McCullough, & Lee, 2008

improvement systems within the Lead Agency and service providers. PBC enhances current state/federal reporting requirements by integrating collaboratively developed, organization-specific measures. Monthly reporting tied to disbursement can encourage the timely use of performance and accountability data to proactively guide practice improvement (e.g., discussions about strategies and desired practice changes in order to meet performance expectations in the following month). Quality management (QM) processes should evaluate not only performance, but also staff understanding of the PBC design and key measures.

#11: Integrate Data Sharing into Project Management and Communication Strategies. Data sharing should not just be an isolated evaluation or QA process; it should also be integrated in project management and communication strategies. That is, leadership can share PBC data to document/communicate progress toward performance expectations, acknowledge successes, and inspire continued work towards targets that have yet to be attained. To be most effective, data should be shared in a timely manner with the right people, giving ample time to process/synthesize the information presented and to engage in meaningful discussions about progress barriers and next steps.

No Eject / No Reject Contract Clause

As the department and provider community pursue the development and implementation of performance-based contracts, implementing some iteration of a *No Eject / No Reject* contract clause may be considered. Several states, including Iowa, Texas, Colorado, and Texas have implemented similar standards for specific residential facility types or specially contracted beds. Some of these agreement include guaranteed payments whether the contracted beds are filled or not. These contract clauses serve to increase placement availability, allow children to be placed close to home, promote the continuity of treatment and services, and ensure a guaranteed revenue stream for the provider.

Complete an Enhanced Review of Placements in Tier 4 and Higher Levels of Foster Care

CFS program and financial management staff recommend implementing a process to complete an enhanced review placements of youth in Tier 4 and higher levels of care. Youth are frequently placed in these higher tier placements when options at lower levels of are not readily available, providers resist taking the child at a lower level of care, or children stay in higher levels beyond that which is programmatically necessary. CFS should establish a process to review and objectively determine whether placement at higher cost placements are programmatically necessary, in the best interest of the child, and if continued placement at these levels supports permanency efforts.

TECHNOLOGY ENHANCEMENTS TO SUPPORT MONITORING AND REPORTING OF PROVIDER OUTCOMES

Title IV-E agencies increasingly need information on the availability, effectiveness, and cost of services that reduce risk, strengthen families, and prevent the need for out-of-home placement. High quality data supports the delivery of effective, economical, and effective services, which support improved outcomes for clients.

CFS staff and leadership both indicate that, by-and-large, data and reports available through N-Focus are inaccurate and not readily able to provide meaningful data in a timely manner. As previously stated, investment should be made in a CCWIS capable of collecting and reporting program, service authorization, and expenditure data at an aggregate and client-specific level. Federal law mandates that the CCWIS maintain all federal data required to support the efficient, effective, and economical administration of the programs under Titles IV-B and IV-E of the Act. This includes data required for:

- Ongoing federal child welfare reports (AFCARS, NYTD data elements),
- Case Management (client interactions, case plans, recommended services, placement information, foster care provider licensing information, abuse and neglect reports, case plans, and placement histories),
- Title IV-E eligibility determinations (factors used to demonstrate the child would qualify for AFDC under the 1996 plan, placement licensing and background check information, and court findings),
- Authorizations of services and other expenditures that may be claimed for reimbursement under Titles IV-B and IV-E including documentation of services authorized, records that the services were delivered, payments processed, and payment status, including whether the payment will be allocated to one or more federal, state, or tribal programs for reimbursement, and the payment amount allocated. It is important to note that financial information may be maintained in a financial system exchanging data with CCWIS.
- Support of state or tribal laws, regulations, policies, practices, reporting requirements, audits, program evaluations, and reviews.

As Nebraska pursues the implementation of a modern, modular CCWIS, attention should be given to the fact that the system reporting should include the capability to capture data necessary to generate provider-specific reports, in real time. By collecting and maintaining service provider information in a CCWIS, the title IV-E agency can evaluate options and make informed decisions when creating a case plan and/or assessing systemic service needs.

Funding the Expansion of Prevention Services in Nebraska

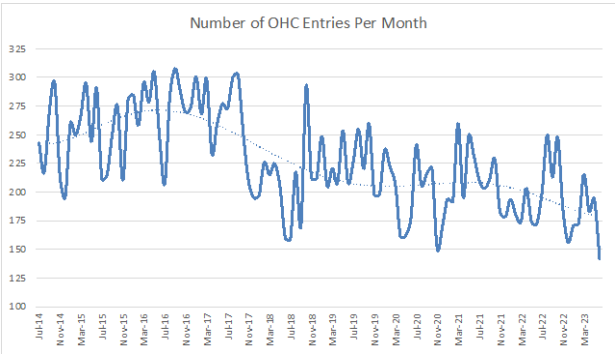
Funding for the vast majority of the recommendations included Practice Model and Financial Framework may be derived from a combination of reductions to out-of-home care and increased federal claiming under title IV-E (traditional and FFPSA), leveraging the reduction of out-of-home care expenditures, and innovative use of Medicaid Waivers. While these strategies are described above, the following provides additional information related to some of these opportunities.

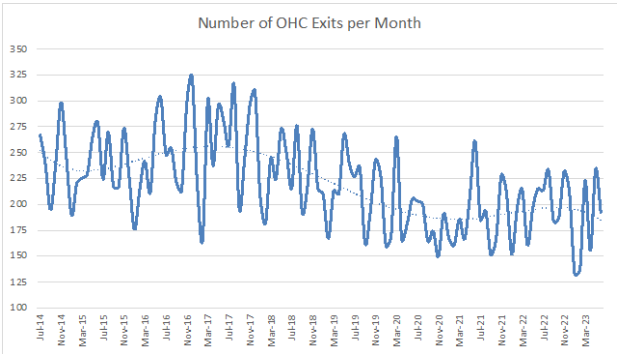
Increased Title IV-E Administrative Claiming

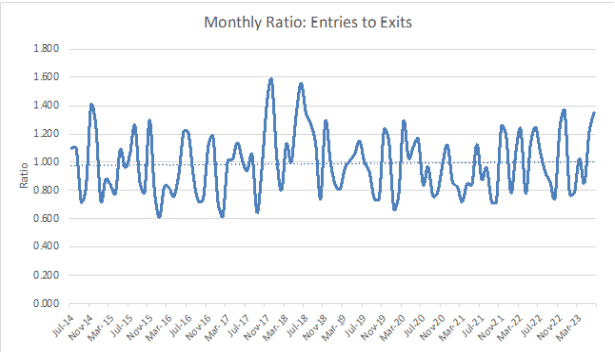
As previously described, CFS has not fully accessed available administrative title IV-E funding reimbursement for traditional candidacy services. Though a significant portion of these administrative costs are likely to shift between traditional candidacy and FFPSA candidacy under title IV-E, it is estimated the reimbursement for these administrative costs are likely to average $2,000,000 per quarter. As these expenses are largely covered by state funds, we estimate continuing these claims will lead to the availability of approximately $8,000,000 annually to invest in the provision of prevention services to children and families in the state. Additional opportunities exist related to expanded claiming for FFPSA related activities and administrative costs.

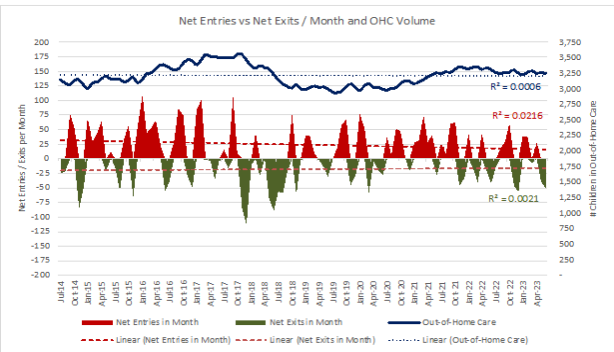
Out-of-Home Care Expenditures

As described in the LB 1173 Practice Model report, over the past ten years, the number of child removals has reduced by 25% annually. Unfortunately, because exits from out-of-home care have reduced at a similar rate, there has not been an overall reduction to the number of children served in out-of-home care during this period. The following graphs depict the net impact of the reduction of both entries and exits from foster care.









A concerted effort to move children from out-of-home care to permanency is necessary and will result in a significant reduction to state costs. The chart, below, provides an estimate of funds available for reinvestment in prevention services if there is a reduction to the number of children in out-of-home care. The estimate is based on the following assumptions:

- Total Reduction of 1,200 youth in OHC,
- Reductions are straight-lined over 60-months,
- Reductions occur from foster and relative placements,
- There will always a core set of children needing more intensive placement options,
- Based on total average claims,
- Estimated cost reduction per 20 children: $53,682,
- 20% Penetration Rate
- Estimated federal share of claimed expenses: 45%,
- Assumes no changes to penetration rate or other efforts to maximize title IV-E reimbursement for out-of-home care.

Month	OHC Reduction	# Children in OHC	Monthly OHC Cost Reduction	Cumulative OHC Cost Reduction	Estimated OHC Cost Reduction to Reinvest
12	240	2,947	$644,184	$4,187,197	$3.81m - $3.89m
24	480	2,707	$1,288,368	$16,104,602	$14.6m - $14.9m
36	720	2,467	$1,932,552	$35,752,217	$32.5m - $33.2m
48	960	2,227	$2,576,736	$63,130,040	$57.4m - $58.7m
60	1,200	1,987	$3,220,920	$98,238,072	$89.3m - $91.3m

Over the five year period, the projected reduction to out-of-home care costs should total approximately $98 million. Of this, it is estimated that approximately $90 million will be available for investment in prevention services. Should this reduction to out-of-home care be

sustained, the state will have approximately $33-$36 million dollars in funding available for ongoing investment annually.

Fully Utilize Available SAMHSA Block Grant Funding

Between FY 2019 and FY 2023, DBH provided a total of $435,435 million in SAMHSA Block Grant and state general fund dollars for Regional Behavioral Health Authorities (RBHAs) services. Of these funds, only $351,591 million was expended. Eligibility for available services appears to be limited as a result of current state Financial Income Guidelines for RBHA services. We recommend that DHHS/DBH consider developing a method that balances currently appropriated RBHA funding with new and revised Financial Income Guidelines that are more flexible in managing over or under budget expenditures throughout the Fiscal Year. Over a four-year period, 2019 to 2023, $83 million was left unspent and returned to DBH by the RBHAs.

Attachments

ATTACHMENT 1: NURSE FAMILY PARTNERSHIP BLENDED FUNDING EXAMPLE

NFP® COSTS:	Salary	FTE	Wages	Benefits/ Taxes	Operating*	Indirect	Total
Medical Director	$ 300,000	0.01	$ 1,500	$ 405	$ 286	$ 219	$ 2,410
Licensed Clinical Nurse Manager	$ 100,000	0.13	$ 12,500	$ 3,375	$ 2,381	$ 1,826	$ 20,082
NFP® Registered Nurse: BSN or MSN)	**$ 80,000**	**1.00**	**$ 80,000**	**$ 21,600**	**$ 15,240**	**$ 11,684**	**$ 128,524**
Intake/referral coordinator	$ 40,000	0.10	$ 4,000	$ 1,080	$ 762	$ 584	$ 6,426
Admin/Data Entry Clerk (data collection req.)*	$ 36,000	0.13	$ 4,500	$ 1,215	$ 857	$ 657	$ 7,229
QA/Compliance	$ 46,000	0.10	$ 4,600	$ 1,242	$ 876	$ 672	$ 7,390
*Reuires position to fulfill data collection and reporting requirements (1 per 8 RNs)							$ 172,062

UNIT COST ESTIMATE	Hours	
Direct Service Hours (per Direct Service FTE)	1640	
Total Direct service Hours (per Program)	1640	
UNIT COST (DIRECT SERVICE HOUR)	**$ 104.92**	Cost divided by direct service FTE hours (bolded positions only)
UNIT COST (PER FCU SESSION)	$ 372.43	Cost / # sessions (including Everyday Parenting)

Medicaid Service (Code) Rate	Rate
Targeted Case Management T1017	$ 48.00
Family Training/Counseling	$ 64.00

Caseload assumption		
	21	Caseload per direct service FTE (ave caseload * unitlization rate)
Utlization rate:	85%	Based on caseload turnover expectations
Ave caseload:	25	Mid Point of model EBP (unique clients)
Episode of care	33	Mid Point of model EBP (months)
Sessions	22	Mid Point of model EBP (Sessions)
Session Duration:	75	Mid Point of model EBP (Minutes)
Families served/year	21	Total served
Estimated cost per family	$ 8,193	Per family per episode of care

Session Model Rate: FCU® Florida			
Costs	$ 172,062	Family Care Specialist(S), plus supervision and management of program	
Total sessions	462	# sessions * # families served	
Session Rate:	$ 372.43		
Full rate (if reimursable by one source only)	$ 372.43		
Blended rate (Medicaid eligible):			
Medicaid	$ 80.07	21.5%	
Other fund sources (4E or CSC)	$ 292.36	78.5%	
	$ 372.43	100.0%	
Blended rate (Non-Medicaid eligible):			
4E	$ 186.21	50.0%	
Other fund sources (SAMH or CSC)	$ 186.21	50.0%	
	$ 372.43	100.0%	

TRAINING/FIDELITY/CREDENTIALING	Online/On Site	Assumes 2 Train the Trainers
UNIT 1: Orientation - self study		*40 hours(nurses) and 50 hours (supervisors)*
UNIT 2: Training on practice model		*25 hours over 3. 75 days in Denver (nurses); 33 hours over 4.75 days (supervisors)*
UNIT 3: Distance education and training		*10 hours (nurses)*
UNIT 3: Supervisory training/annual refersher		*20 hours over 3 days in Denver (supervisors) - annual event*
Ongoing consultation with NFP consultant		
Range (depending on modality)	$ -	*Recommendation: Cost reimbursement*

ROI Calculation		
Success rate	75%	Remain stable in home/community
Cost avoidance DCF/CBC	$ 19,000	Based on $19,000/year case mgmt, non-room and board costs
	$ 19,000	
Adjusted cost avoidance	$ 14,250	Assumes % success
Cost of intervention	$ 8,193	1 episode of care
ROI	$ 1.74	for every $1 invested
		https://www.wsipp.wa.gov/BenefitCost?AreaSelection=BC&SearchQueries%5B0%5D.paramType=KEYWORD_ANY&SearchQueries%5B0%5D.paramJoin=AND&SearchQueries%5B0%5D.valueString=
ROI Documented	$ 1.37	
ROI documented (by developer)	**$5.70**	for every $1 dollar invested
	https://www.nursefamilypartnership.org/wp-content/uploads/2020/08/NFP-Benefits-and-Costs.pdf	

DIRECT CARE ACTIVITY (HOURS)	DIRECT SERVICE HOURS	TOTAL	MEDICAID	NON-MEDICAID	COMMENTS
Home Visits (NFP Curriculum)***	578	$ 60,641	$ 36,992	$ 23,649	# sessions * # families. Assumes an average of 2 sessions per month per family on caseload (session length: 60-90 min, average 75)
Additional Supervision required for fidelity	84	$ 8,813		$ 8,813	Traditional supervision monthly covered by Medicaid rate; NFP requires weekly case consultation and team supervision (2 hours/week), est. 7 additional hours per month
Care coordination/TCM	504	$ 52,877		$ 52,877	Estimated 2 hours per month per family on caseload (participation in CBC case staffings, collateral contacts, care coordination), including travel. Not TCM reimbursable: cap 20.
Community Advisory Board Participation	24	$ 2,518		$ 2,518	Estimated 1 hour to prepare for meeting and 1 hour per month to participate
Documentation (FSFN)	450	$ 47,212		$ 47,212	Estimated approx. 1.75 hours per month per family on caseload
****Difference between unit cost and rate reimb.*	**1640**	**$ 172,062**	**$ 36,992**	**$ 135,070**	
			21.5%	**78.5%**	

Functional Family Therapy® – In Lieu of Service

In lieu of: Inpatient or Residential Treatment

Procedure Code: TBD. Suggested option: H0400 (FACT), use a different modifier for each EBP.
Rate Recommendation: Negotiate a case rate: per diem, weekly or monthly. Per Diem minimum: $40.98 (*see rate calculation Table 1*)

Service Description: Functional Family Therapy (FFT®) is a short-term, family-focused, community-based treatment for youth who are either "at risk" for or who manifest antisocial behavioral problems such as conduct disorder, oppositional defiant disorder, and disruptive behavior disorder, violent acting-out and substance abuse disorders. Co-morbid behavioral or emotional problems, such as anxiety or depression, may also exist as well as family problems, such as communication and conflict issues. FFT has been applied to a wide range of families with at-risk, pre-adolescent and adolescent youth in various multi-ethnic, multicultural contexts. Interventions are conducted at home, in school, in outpatient settings, and at times of transition, from a residential placement.

Additional EBP requirements:

- CRISIS RESPONSE: as defined in the FFT® model
- EPISODE OF CARE: Duration of treatment is an average of 4 months with an expected range of 3 to 5 months
- CASELOAD: FFT caseloads range from a minimum of 5 active families to no more than 15 active families, with the average, considering travel time, collaterals, documentation, and assessments, of 10-12 families per therapist

Service Limits	Medical necessity applies
Service Type	Per Day
Prior Authorization	Prior Authorization is not required
Eligible Members	Members age 11 through 18 with maladaptive externalizing or internalizing behaviors.
Provider Type	Master's Level behavioral health practitioner under the supervision of a licensed behavioral health clinician. The practitioner must be an employee or contractor at an agency that has a certified FFT® team.

	Rendering practitioners must complete an initial training by an approved FFT® certified/competent trainer and then pass competency, or actively be participating in ongoing training, supervision, and coaching by competent FFT® experts to ensure fidelity.
Service Location	Member's home, provider office, or other community setting
Procedure Code	TBD or suggested option
Reimbursement and service limitations	Medicaid reimburses 1 unit per day for 365 or 366 days per state per fiscal year
Service Delivery Requirements	Provider is operating under a duly licensed/certified FFT® program in good standing and delivering care in accordance with all program and staffing requirements of FFT® Service delivery documentation requirements as defined in the Health Plan's EBP Services protocol handbook*

TABLE 1: Rate Calculation

	Salary	FTE	Salary Costs	Benefits/ Taxes	Operating Costs	Indirect	Total Costs
Medical Director	$ 300,000	0.01	$ 4,000	$ 1,080	$ 762	$ 672	$ 6,514
Clinical Director	$ 90,000	0.14	$ 12,857	$ 3,471	$ 2,449	$ 2,159	$ 20,937
Clinical Supervisor	$ 70,000	1.00	$ 70,000	$ 18,900	$ 13,335	$ 11,757	$ 113,992
Therapist	$ 55,000	4.00	$ 220,000	$ 59,400	$ 41,910	$ 36,951	$ 358,261
Intake and D/C Specialist	$ 46,000	0.29	$ 13,493	$ 3,643	$ 2,570	$ 2,266	$ 21,973
Administrative support/data analyst	$ 33,000	0.29	$ 9,680	$ 2,614	$ 1,844	$ 1,626	$ 15,763
Compliance/QA specialist	$ 46,000	0.29	$ 13,493	$ 3,643	$ 2,570	$ 2,266	$ 21,973
						COST OF 1 TEAM	**$ 559,414**

	FFT
Salary of Therapists	$ 55,000
Cost of model (1 therapist)*	$ 139,853
Traditional unit rate assumptions (41 weeks, 22 units/week)	$ 155.05
Ave Caseload (or as limited by EBP)	11
Utilization assumption	85%
Daily rate calculation (Available slot/day)	**$ 40.98**

EPISODE OF CARE	**4**	months
NUMBER OF CLIENTS SERVED ANNUALLY	**112**	
COST PER CLIENT EPISODE OF CARE	**$ 4,986**	

ASSUMPTIONS

300	Medical Director (1:____ clients)
4	Therapist to Supervisor ratio
7	Supervisor to Director ratio
150	Intake specialist (1:___ clients)
150	Admin/Data ratio (1:___ clients)
150	Compliance/QA Specailist (1: ____ clients)
11	Clients on caseload
85%	Utilization rate (ave)
27%	Benefits/Taxes (as a % of salary costs)
15%	Operating costs (occupancy, travel, training, data/comm) as a % of total personnel costs
12%	Indirect (as a % of all direct personnel and direct operating costs)

UNIT COST ASSUMPTIONS

2080	paid work hours in a year
-280	less 14 vacation, 12 holiday, 9 sick
-72	less training and professional development (6 hours/month)
-40	less lost producivity (no shows, missed appts), ave 3-4 hours/month
-24	less lost producivity (FMLA, turover, time to hire ave 2 hours per month per FTE position)
-24	less administrative agency requirements (Time and attendance, accreditation req.)
1640	Available direct service hours to client
41	Available work weeks
40	Hours per full work week
-5	Less Travel (1 hour/day)
-5	Less Documentation (1 hour/day)
-8	Less non billable activities (staffings, collateral contacts, additional assessments required by EBPs, on call, crisis de-escalation)
22	Available "billable hours" to funder

2021 Indiana DCS Residential Treatment Services Provider Rates

TYPE OF HOME		#	DAILY RATE						
License Type	Program Service Category	Count	Min	1st Quartile	Mean	Median	3rd Quartile	Max	StDev
Group Home	Emergency Shelter	10	$ 215.08	$ 242.47	$ 337.28	$ 276.26	$ 400.39	$ 719.23	$ 157.28
Group Home	Open Residential	16	$ 217.70	$ 249.49	$ 393.34	$ 312.24	$ 586.48	$ 586.48	$ 159.57
Group Home	Open Residential plus Emergency Shelter	7	$ 215.08	$ 248.12	$ 344.78	$ 274.61	$ 362.79	$ 701.95	$ 175.34
Group Home	Independent Living / Residential Step Down	1	$ 322.11	$ 322.11	$ 322.11	$ 322.11	$ 322.11	$ 322.11	
Group Home	Sexually Maladaptive Youth	9	$ 319.99	$ 364.27	$ 387.95	$ 364.27	$ 416.40	$ 459.60	$ 44.51
Group Home	Teen Mom and Baby	2	$ 295.92	$ 298.66	$ 301.41	$ 301.41	$ 304.15	$ 306.89	$ 7.76
Group Home	Developmental and Intellectual Disabilities	11	$ 207.22	$ 380.32	$ 415.07	$ 380.32	$ 474.89	$ 557.41	$ 94.17
Child Caring Institution	Emergency Shelter	21	$ 227.75	$ 305.67	$ 400.48	$ 382.51	$ 465.35	$ 731.48	$ 122.52
Child Caring Institution	Open Residential	7	$ 215.05	$ 254.46	$ 267.52	$ 266.00	$ 281.84	$ 318.97	$ 32.22
Child Caring Institution	Open Residential plus Emergency Shelter	7	$ 227.75	$ 288.55	$ 374.97	$ 328.21	$ 359.03	$ 773.71	$ 182.33
Child Caring Institution	Independent Living / Residential Step Down	2	$ 213.41	$ 235.70	$ 258.00	$ 258.00	$ 280.29	$ 302.58	$ 63.05
Child Caring Institution	Staff Secure / Intensive Residential	19	$ 306.98	$ 349.00	$ 403.71	$ 364.42	$ 424.10	$ 584.91	$ 88.76
Child Caring Institution	Sexually Maladaptive Youth	10	$ 326.81	$ 347.18	$ 379.81	$ 364.50	$ 420.39	$ 446.57	$ 43.59
Child Caring Institution	Drug and Alcohol	7	$ 330.63	$ 333.96	$ 367.11	$ 337.17	$ 401.88	$ 430.30	$ 43.88
Child Caring Institution	Teen Mom and Baby	3	$ 220.07	$ 257.24	$ 281.45	$ 294.40	$ 312.14	$ 329.88	$ 56.04
Child Caring Institution	Developmental and Intellectual Disabilities	10	$ 391.36	$ 426.30	$ 459.52	$ 477.66	$ 477.66	$ 507.17	$ 40.89
Child Caring Institution	Short-Term Diagnostic and Evaluation	6	$ 241.16	$ 363.83	$ 362.48	$ 379.97	$ 396.06	$ 413.91	$ 62.59
Child Caring Institution	Stabilization and Diagnostic Services	2	$ 497.51	$ 564.20	$ 630.89	$ 630.89	$ 697.58	$ 764.27	$ 188.63
Private Secure	Secure Treatment	26	$ 312.26	$ 375.81	$ 441.46	$ 416.36	$ 487.66	$ 702.30	$ 105.97
Private Secure	Drug and Alcohol	2	$ 323.95	$ 347.43	$ 370.91	$ 370.91	$ 394.39	$ 417.87	$ 66.41
Private Secure	Developmental and Intellectual Disabilities	10	$ 421.80	$ 471.20	$ 473.57	$ 471.20	$ 471.20	$ 560.48	$ 34.35
Private Secure	Sex Trafficking	1	$ 525.99	$ 525.99	$ 525.99	$ 525.99	$ 525.99	$ 525.99	
Private Secure	Short-Term Diagnostic and Evaluation	4	$ 348.80	$ 353.61	$ 366.32	$ 355.92	$ 368.63	$ 404.66	$ 25.78
Statewide	All Facility Types	193	$ 207.22	$ 319.52	$ 395.58	$ 380.32	$ 455.00	$ 773.71	$ 114.75

2023 Indiana DCS Residential Treatment Services Provider Rates

TYPE OF HOME		#	DAILY RATE						
License Type	Program Service Category	Count	Min	1st Quartile	Mean	Median	3rd Quartile	Max	StDev
Group Home	Emergency Shelter	14	$ 237.00	$ 352.89	$ 714.66	$ 572.19	$ 814.95	$ 2,836.32	$ 648.10
Group Home	Open Residential	18	$ 268.43	$ 360.47	$ 508.23	$ 544.63	$ 661.82	$ 661.82	$ 150.38
Group Home	Open Residential plus Emergency Shelter	8	$ 237.00	$ 321.76	$ 696.51	$ 396.66	$ 490.74	$ 2,836.32	$ 872.70
Group Home	Independent Living / Residential Step Down	2	$ 548.62	$ 603.69	$ 658.75	$ 658.75	$ 713.82	$ 768.88	$ 155.75
Group Home	Sexually Maladaptive Youth	5	$ 432.40	$ 630.40	$ 715.92	$ 713.51	$ 759.81	$ 1,043.47	$ 221.88
Group Home	Teen Mom and Baby	1	$ 382.26	$ 382.26	$ 382.26	$ 382.26	$ 382.26	$ 382.26	
Group Home	Developmental and Intellectual Disabilities	10	$ 308.82	$ 537.35	$ 583.72	$ 537.35	$ 698.17	$ 722.62	$ 129.57
Child Caring Institution	Emergency Shelter	23	$ 307.08	$ 532.18	$ 748.14	$ 637.91	$ 792.02	$ 2,282.67	$ 463.83
Child Caring Institution	Open Residential	8	$ 244.94	$ 334.62	$ 408.69	$ 408.48	$ 504.61	$ 527.98	$ 106.81
Child Caring Institution	Open Residential plus Emergency Shelter	10	$ 341.67	$ 436.45	$ 700.97	$ 612.84	$ 652.55	$ 1,898.09	$ 452.40
Child Caring Institution	Independent Living / Residential Step Down	2	$ 328.16	$ 333.84	$ 339.52	$ 339.52	$ 345.20	$ 350.88	$ 16.07
Child Caring Institution	Staff Secure / Intensive Residential	15	$ 397.21	$ 493.39	$ 620.16	$ 568.67	$ 759.42	$ 993.33	$ 181.13
Child Caring Institution	Sexually Maladaptive Youth	9	$ 411.09	$ 454.54	$ 608.92	$ 591.14	$ 692.53	$ 900.49	$ 171.26
Child Caring Institution	Drug and Alcohol	9	$ 321.78	$ 511.96	$ 567.40	$ 575.98	$ 622.40	$ 841.91	$ 144.25
Child Caring Institution	Teen Mom and Baby	2	$ 331.65	$ 402.27	$ 472.90	$ 472.90	$ 543.52	$ 614.14	$ 199.75
Child Caring Institution	Developmental and Intellectual Disabilities	11	$ 438.30	$ 557.62	$ 591.08	$ 557.62	$ 651.55	$ 766.56	$ 91.71
Child Caring Institution	Short-Term Diagnostic and Evaluation	8	$ 417.93	$ 489.50	$ 642.18	$ 624.39	$ 793.95	$ 874.48	$ 181.43
Child Caring Institution	Stabilization and Diagnostic Services	2	$ 597.30	$ 600.64	$ 603.98	$ 603.98	$ 607.31	$ 610.65	$ 9.44
Private Secure	Secure Treatment	29	$ 395.88	$ 499.05	$ 617.25	$ 546.27	$ 739.65	$ 1,096.34	$ 182.85
Private Secure	Drug and Alcohol	1	$ 507.82	$ 507.82	$ 507.82	$ 507.82	$ 507.82	$ 507.82	
Private Secure	Developmental and Intellectual Disabilities	11	$ 437.00	$ 642.32	$ 778.50	$ 642.32	$ 724.91	$ 1,411.37	$ 323.78
Private Secure	Sex Trafficking	2	$ 820.97	$ 825.81	$ 830.66	$ 830.66	$ 835.50	$ 840.34	$ 13.70
Private Secure	Stabilization and Diagnostic Services	1	$ 739.65	$ 739.65	$ 739.65	$ 739.65	$ 739.65	$ 739.65	
Private Secure	Short-Term Diagnostic and Evaluation	5	$ 417.11	$ 426.35	$ 533.09	$ 445.69	$ 541.40	$ 834.92	$ 175.82
STATEWIDE	**ALL FACILITY TYPES**	**206**	**$ 237.00**	**$ 450.40**	$ 627.05	$ 575.98	**$ 687.27**	**$ 2,836.32**	**$ 333.81**