The Family First Prevention Services Act (FFPSA) and the Unintended Impact on California's Foster Youth in Short Term Residential Therapeutic Programs: Issues and Potential Solutions

Background:[1]

The federal Family First Prevention Services Act (FFPSA) was passed by Congress in 2018 and goes into effect in California on October 1, 2021. This is the latest date that states have been given to comply with the FFPSA. Not complying with the law puts California's federal Title IVE funding in jeopardy.

There are four parts to FFPSA, two of which are critical to services providers as they impact how services are delivered and reimbursed. Part I covers prevention services that can be provided to "candidates" for foster care, and give families the mental health, substance use or parenting services they need to remain together. Part IV, the focus of this document, requires that residential childcaring facilities receiving Title IVE dollars meet the federal requirements for a Qualified Residential Treatment Facility[2].

California, in a significant reform effort known as the Continuum of Care Reform (CCR) that began implementation in 2017, created Short Term Residential Therapeutic Programs (STRTPs). The vision for CCR is to ensure that children and youth are only in congregate care for trauma-informed treatment designed to prepare them for family-based care, to address their behavioral health needs, and to reduce the lengths of stay in group care. This legislation, AB403 (Stone), passed in 2015, required that these facilities be licensed by the California Department of Social Services (through Community Care Licensing, CCL), have their Mental Health program approved by the Department of Healthcare Services (or local county Mental Health Plan), and obtain a MediCal (Medicaid) certification for their mental health program enabling them to contract for mental health services from a County Behavioral Health Department. The structure of both the financing and programming of the STRTP model requires an integration of Title IVE funded and MediCal funded services. Additionally, children and youth placed in an STRTP must obtain approval through their Interagency Placement Committee requiring this level of care due to "serious emotional disturbance." AB403 also limited the length of stay in a STRTP to six months, unless the county has made progress or is actively working toward implementing the case plan that identifies the services or supports necessary to transition the child to a family setting, or other documented extending circumstances are identified.

It is important to note that while many states are just beginning to take steps towards reducing the number of foster youth in congregate care, California has been a leader in this effort. Between 2006 and 2016, California reduced placements in congregate care by 45%.[3] Between 2016 and today, that has been reduced by an additional 62%, going from 5,682 to 2,193 youth in April 2021. With 60,045 children in California's foster care system, the youth in STRTPs are less than 4% of the foster care population today.

[1] Some background information was provided by CWDA from their document, QRTP and IMD Issues and Options.

[2] What is a QRTP? National Association of Children's Behavioral Health. https://www.nacbh.org/assets/docs/PPC/What%20is%20a%20QRTP_07.01.20.pdf

[3] Webster, D., et al. (2016). CCWIP reports. (Data includes all children in foster care 0-21, including probation-supervised foster youth. Congregate care totals include any child or youth residing in a group or shelter setting. As of January 1, 2016, 5,682 youth resided in a congregate care setting compared to 10,330 youth on January 1, 2006.)

Foster and Probation Youth Placed in STRTPs

Youth placed in STRTPs have endured neglect, physical, sexual, and emotional abuse at the hands of adults; have suffered traumatic separations from parents and caregivers; and have faced reenactments of these tumultuous growing up experiences through multiple changes in caregivers, placements, and helping professionals. The experience of multiple traumas inevitably shapes youths' views of themselves, their strategies for fulfilling unmet needs, their expectations about personal relationships, and their world. As a result, it is difficult, if not impossible, to describe youth served in STRTPs without discussing complex trauma. Their behavioral presentations include serious patterns of attempts to harm themselves and others (in some cases violent assaults on peers and adults), severe and unmanaged mental health symptoms, multiple psychiatric hospitalizations, and substantial impairments in their abilities to function across life domains (e.g., challenges to complete daily self-care, regulate emotions, build and maintain relationships with peers and adults, access education, and remain safe in the community without institutional care supports).[4] ***When youth needed to be returned from out of state facilities within 45 days in late 2020, nearly half of these youth were placed in STRTPs.***

According to the 2019 California Child Welfare Indicators Project (CCWIP) data, African American and/or Black children and youth make up 21.5% of the foster system but are only 5.6% of the general California population and are 2.8 times more likely to be reported in child welfare allegations than white children. Also, per CCWIP in 2019, Hispanic and/or Latino children and youth entered foster care at a rate of 3.6 per 1,000 children, and Native American children and youth at a rate of 8.6 per 1,000 children[5]. Youth placed in STRTPs are the most vulnerable, having the most significant behavioral and mental health needs. Black youth are also overrepresented in STRTPs and will be among the most affected by the systemic changes created by FFPSA.

The Current Issue Facing STRTPs, Counties and the State:

As noted above, FFPSA narrowed the settings under which Title IVE funds can be used for foster youth requiring a congregate level of care effective no later than October 1, 2021. Title IVE funding is permitted upon determination by a Qualified Individual that a foster youth requires placement in a Qualified Residential Treatment Program (QRTP), which is equivalent to California's Short-Term Residential Therapeutic Programs (STRTPs). Based on the definition of QRTP in the FFPSA law, Federal CMS has opined that some QRTPs may meet the definition of an Institution for Mental Disease (IMD) and would, therefore, fall under the IMD exclusion. The result is that foster youth placed into such facilities will lose all federal Medicaid (MediCal) funding, and not have access to critical behavioral health, medical and dental services.

The IMD exclusion refers to Medicaid law [Section 1905(a)(B) of the Social Security Act] which prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases" except for "inpatient psychiatric hospital services for individuals under age 21." The law goes on to define "institutions for mental diseases" (IMDs) as any "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.[6]" The IMD exclusion was intended to ensure that states, rather than the federal government, would have principal responsibility for funding inpatient psychiatric services. In the State Medicaid Manual, the federal Department of Health and Human Services (HHS) interprets the IMD exclusion to include "any institution that, by its overall character is a facility established and maintained primarily for the care and treatment

[4] STRTP Policy and Practice Recommendations: Recommendations to Improve a Critical Component of Care for Foster Youth, CA Alliance STRTP Mental Health Taskforce, February 2021.

[5] California's Five-Year State Prevention Plan: Implementing the Title IV-E Prevention Program Established By the Family First Prevention Services Act. https://cdss.ca.gov/Portals/9/CCR/FFPSA/CA-FiveYear-State-Prevention-Plan-Draft.pdf

[6] Note that a facility may qualify as an IMD even if the facility has 16 beds or less, but shares a building or campus with another facility providing treatment to persons with a mental illness. Facilities may be deemed as IMDs if other factors/criteria are present, pursuant to an assessment tool recently issued by DHCS to facilities.

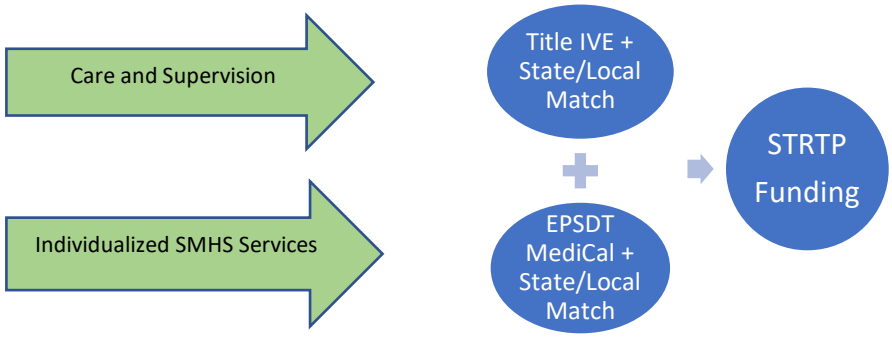
of individuals with mental diseases." Additional information on the determination of an IMD facility can be found in an overview document by the Legal Action Center.[7]

The Centers for Medicare and Medicaid Services (CMS) issued guidance September 2019[8] that was reinforced again in joint ACF and CMS policy guidance to states on October 5, 2020[9] discussing the IMD exclusion. CMS also identified certain exceptions in regulation: "Medicaid payment is permitted for inpatient psychiatric hospital services for individuals under age 21, sometimes referred to as the "psych under 21" benefit, furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable Conditions of Participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a "Psychiatric Residential Treatment Facility."[10][11]

The guidance was followed by correspondence between California DHCS and CMS, which ultimately reinforced the point that some STRTPs may fall under the IMD exclusion and that a review/assessment for each facility would be necessary. DHCS has agreed to the review of each facility and that review is due for completion by December 31, 2021. Additional information of the implications of the IMD exclusion can be found on the National Association for Children's Behavioral Health website.[12]

How Current Funding Works

STRTPs are financially structured as childcare facilities that provide Specialty Mental Health Services and programming based on a youth's individualized treatment needs.



Potential Programmatic and Funding Impact

California Department of Social Services (CDSS) data indicates that as of June 28, 2021 there were 2,174 foster youth placed by Child Welfare Services (CWS) or Probation in provisionally licensed and permanently licensed STRTPs. ***STRTPs subject to the IMD exclusion – somewhere between 42-86 organizations will lose federal financial participation (FFP) for all Medicaid-related expenditures on behalf of these foster youth beginning January 1, 2022.*** This includes Specialty Mental Health Services (SMHS) and other medically necessary services including physical health, dental health, and substance use services.

[7] https://www.lac.org/assets/files/IMD_exclusion_fact_sheet.pdf
[8] https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf
[9] https://www.medicaid.gov/federal-policy-guidance/downloads/cib100520.pdf
[10] 42 C.F.R. § 440.160.
[11] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/WhatisaPRTF.pdf for description of PRTFs.
[12] https://nacbh.memberclicks.net/assets/docs/EBPC/Family%20First%20QRTP-IMD%20Fact%20Sheet%20and%20FAQ.pdf

Programmatically, CWS and probation agencies already struggle with finding appropriate care and treatment for foster youth in need of a congregate level of care. Facility closures because of the FFPSA law will have a devastating impact on child welfare outcomes, undermines CCR's progress, and will leave hundreds of foster youth without adequate care and services. ***Based on a CA Alliance member survey the loss of FFP for MediCal services will be between $55 and 77 million annually. These dollars fund critical behavioral health services now received by children and youth in STRTPs.*** Moreover, STRTP closures could also disrupt treatment services and care for youth referred/placed by California's educational agencies, private health care systems, and regional centers. For youth in the juvenile justice system, this could increase the likelihood that they will languish in juvenile halls and have less opportunities for treatment and rehabilitation, which could result in greater criminalization of these youth.

Across all STRTPs, as many as 1,188 youth could be displaced between now and December 31, 2021, as organizations try to reduce their risk of being identified as IMDs. These numbers could increase to 1,666 if some organizations decide to close all their available foster youth placements. These are our most vulnerable and at-risk youth, and they deserve stability regardless of federal and state policy shifts.

Equity in Access to Services

California's foster youth deserve to have a full continuum of care that meets their social, emotional, health and behavioral healthcare needs. STRTPs currently serving, or capable of serving youth needing residential care through commercial insurance, educational placements, or the Office of Refuge Resettlement, are likely to shift their residential resources to these populations thus reducing or eliminating the number of available beds for foster youth.

As compared to youth who access treatment services via commercial insurance, youth in the Medicaid public insurance system have higher rates of exposure to adverse childhood experiences, are disproportionately Black, Indigenous, People of Color (BIPOC), and have fewer relational resources in terms of involved family and other permanent, natural supports. The looming loss of available beds for foster youth reflects a further eroding of critical resources for our most vulnerable youth, ironically at a time when the glaring disparity of access to essential mental health treatment for BIPOC youth is being highlighted nationally as a social justice issue.

There are a range of potential remedies to the current situation facing the foster care system, but time is of the essence in addressing these remedies and taking statewide action***. The remedies must be put in place between now and October 1.***

POTENTIAL REMEDIES AT THE FEDERAL LEVEL:

1. ***Federal law change to Medicaid law to exempt QRTPs from the IMD rule.***
   While there has been discussion with lawmakers at the federal level to provide an exemption to QRTPs from the Medicaid IMD exclusion law, no specific legislation has been introduced to date. While this could still take place between now and October 1, California providers, counties and state departments cannot assume that this will take place. Simultaneously, as STRTPS begin to re-evaluate their business models, quality programs and needed beds for treatment will continue to decline. If a congressional action takes place too late in the process, hundreds of people will have lost jobs or left the field and youth will have been displaced, potentially mid-treatment, disrupting healing relationships for youth that are in placement, many as the result of unhealthy or dysfunctional relationships. The State and STRTPs waiting for congressional action would not be prudent, though we must continue to push it.

2. ***Submit 1115 Waiver to permit use of STRTPs (as IMDs) for facilities greater than 16 beds.***
   In its September 2019 guidance to states on the QRTP/IMD issue, CMS has indicated that one option for states to consider is to include QRTPs in their Section 1115 Demonstration Waivers. However, 1115 waivers must meet cost neutrality requirements and CMS has indicated in its guidance that statewide average lengths of stay in IMDs must be under 30 days. Current STRTP stays are limited to 6 months, but there are cases in which a youth's length of stay may

go beyond that through approvals of exceptions by CWS and Probation. Reducing lengths of stay in these programs to an average of 30 days would result in youth being bounced from one program to another, with no real opportunity to stabilize and do the critical permanency and family work needed to transition them to family-based care. This is not a viable option.

3. ***Request administrative and/or regulatory relief through federal Health and Human Services for an alternative interpretation, possibly connected to the COVID-19 Public Health Emergency.***
   It is unclear whether there would be a willingness to do this administratively on HHS' part. It could take time to accomplish especially if it involves regulatory change that will likely go beyond the October 1, 2021 and December 31, 2021 deadlines.

POTENTIAL REMEDIES AT THE STATE LEVEL:

The current funding available for STRTPs does not meet the treatment needs of the youth referred and placed in them. CA Alliance's STRTP Policy and Practice Recommendations white paper outlines the current resources and regulatory relief needed to stabilize these programs and support their efforts to serve foster and probation youth's treatment needs. These resources will not solve the looming IMD issue, but to ensure a robust continuum of care for these youth, this gap must be addressed.

1. ***Forgo Medicaid (MediCal) match for STRTPS (QRTPs) that are considered an IMD and backfill those service costs with State dollars on an ongoing basis.***
   This option permits existing providers to continue with services; minimal disruption to services for children/youth. It may be expensive on an ongoing basis, since both mental health costs as well as all other Medicaid related services (i.e., health care) would have to be backfilled. If this option were seen as viable by the State, it would be important to remove the administrative/documentation requirements connected to MediCal billing and claiming to reduce the burden on providers when it is not required.

2. ***Convert some or all STRTPs that meet IMD rules into PRTFs.***
   This was identified in the CMS guidance as a viable option and will allow states to claim Medicaid reimbursement. There is no PRTF designation currently in California statute. PRTFs are a Medicaid funded designation, and therefore would result in MediCal paying for the full amount of the placement, compared to the current funding structure of Title IVE used to pay for care and supervision, and MediCal EPSDT used to pay for the Specialty Mental Health Services and other medical services that a youth may need.

   The CA Alliance is currently sponsoring legislation (AB226 - Ramos) that will create a PRTF designation for purposes of Children's Crisis Residential Programs (CCRP). Assuming that this bill is passed into law in September 2021, and takes effect in January 2022, DHCS could expand the use of PRTFs to include those STRTPs that are able to convert to a PRTF. Several issues exist with this option, however: 1) PRTFs would be limited to those youth who qualify for MediCal. It is unclear if a probation youth once identified for placement in foster care would qualify for a PRTF in the same way they do for an STRTP, which could limit available placements for youth placed by probation, 2) it will take at least 6-12 months in order for regulations and licensing standards to be developed for these facilities, and the deadline for IMD determination is December 2021, creating a funding gap for those STRTPs that want to convert.

3. ***Require all STRTPs in the state to have 16 beds or less.***
   This option cannot be realistically achieved by the December 2021 deadline. There would be hundreds of youth displaced in the process of reducing beds, and many providers would simply decide to close their facilities completely.

Some STRTPs may still meet the IMD requirement even if they are under 16 beds (i.e. if the facility shares a building or campus with another facility, or if the character of the facility appears to provide IMD-level of services). Other states have worked to reduce bed capacity in facilities but the process takes time (upwards of 3 years) and has been described as a difficult process for providers. This option certainly cannot be achieved in the six months between now and January 2022. Additionally, this change would require a significant increase in the STRTP rate – over and above the rate boost needed to correct the original STRTP cost and revenue assumptions – because the economies of scale that exist in larger programs will not be available to smaller facilities.

4. ***Create a pathway and funding for transition of STRTPs (QRTPs) that are IMDs through 2023 to make necessary changes and implement new state laws expanding service options for youth.***
This option would involve the state, counties and providers working together to determine options for those programs that are determined to be IMDs and would require that the state fund the gap in FFP through the transition period of 2023. Given the substantial systemic changes that must be made during the first few years of FFPSA implementation, it is essential that a planning and design process occur for every county and every provider throughout the state.

   Simultaneously, California is embarking on a Children and Youth Behavioral Health Initiative envisioned to significantly increase access to behavioral health services for all children and youth in California. The convergence of FFPSA implementation and the development of a robust behavioral health system can be a catalyst to create pathways for those organizations providing STRTP services to transition to serving children and youth's behavioral health needs more broadly. Assisting organizations in meeting new requirements under the federal FFPSA laws, as well as developing or expanding new services for foster and all California youth – Wraparound/Aftercare, individualized services for youth with complex care needs, prevention, substance use, LBGTQ+, crisis residential services – is a both vital and time urgent if we are to be successful at maintaining stability for children and youth.

   This option will ensure that organizations that have the skills and expertise in working with foster and probation youth with considerable emotional and behavioral health needs can maintain the qualified staff that are needed to grow the Children and Youth Behavioral Health Initiative. Additionally, a large percentage of staff in these programs are Black, Indigenous People of Color (BIPOC), and as we focus greater attention on equity in our child-serving systems, creating stability for these staff affirms the states and counties' commitment to diversity and inclusion and preserves a qualified workforce. The individuals laid off from STRTPs reducing beds carry with them both irreplaceable lived-experience and core competencies in working with our most vulnerable youth.

CA Alliance Recommendations:

Based on discussions with member organizations and state DHCS and CDSS representatives, the CA Alliance offers the following specific recommendations:

Short Term (July - December):

1. ***Federal legislative solution:*** Continue pursuing a legislative or administrative "fix" at the federal level to exempt QRTPs from the IMD exclusion concurrently with state-level solutions.

2. ***Expedite IMD decision and options process:***
   - Develop clear criteria and guidelines to assist STRTPs in making the determination regarding their status as an IMD.
   - Provide consultation on options for those determined to be IMD.
   - Expedite CCL processes that assist providers in converting STRTP facilities (reducing # of beds under facility licenses, converting to group home beds).

3. ***Statewide planning and systems change process:***

- Engage the state, counties and providers in a planning process that creates pathways for organizations that must make changes and ensures that there is as little disruption for foster and probation youth as possible.
- Identify programs and services (e.g., substance use programs, school based behavioral health) that are components of the C/Y BH Initiative that are realistic options for current STRTP providers to consider providing.
- Continue efforts to develop at least 75 individualized programs (individual STRTPs, enhanced ISFC) for youth with complex care needs.
- Develop plans to address special population needs such as commercially sexually exploited youth, sex offenders, etc.
- Support staff training and development opportunities necessary to assure the most competent and confident STRTP direct care workforce.

4. ***Funding stability:*** Ensure state-level funding for any loss of FFP of Medicaid funding due to placements into STRTPs which are considered IMDs, through 2023.

5. ***Expedite PRTF licensure:*** DHCS to develop PRTF licensing standards as quickly as possible once legislation is approved. Also consider expanding this licensure beyond crisis residential services.

6. ***Increase resources to support the development of ISFC families:*** ISFC families are a critical resource for youth with intensive behavioral health or other needs, and we must ensure that they have all the necessary supports in place if we are to have options for youth currently in STRTPs.

Longer-term activities (January – December 2023):

1. ***State provides for lost federal revenue (FFP match for all MediCal services) needed by youth in STRTPs that are deemed to be IMDs***.

2. ***Implement strategies identified in the planning process*** (#3 and 5 above). This will include, but not be limited to:
   - Implementing PRTF regulations and identifying those organizations that will convert to PRTF.
   - County child welfare, probation and behavioral health departments work with STRTPs that meet IMD criteria to identify potential pathways to transition services through identified services needs that result in contract changes or expansion.
   - CCL working with STRTPs to change licensure, populations served.

3. ***Extensive training and technical assistance for counties, school districts and providers*** on financing models for prevention services, school-based mental health, substance use services (for both youth and parents of youth at risk of foster care involvement), etc.

4. ***Implementation of Crisis Continuum Pilots*** that will address the shortage of available resources for foster youth experiencing behavioral health crises.

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