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Adam M. Meier
Secretary

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Senator Mitch McConnell
317 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator McConnell:

The Family First Prevention Service Act of 2018 (FFPSA or Act) signed into law on February 9, 2018, as part of the Bipartisan Budget Act of 2018, Pub. Law 115-123, provides a groundbreaking opportunity for states to invest in prevention services for families prior to a child's entry into foster care. As a condition of the new funding flexibility, the Act requires enhanced oversight of foster children placed in congregate care settings due to clinical need, including provision of services during their transition to a family-like setting.

All states must comply with this law by October 2021, but states have the option to implement as early as October 2019. States, like Kentucky, that intend to be early implementers of the Act on October 1, 2019, need the ability and support to exercise this early option. Several barriers hinder implementation; however, relatively simple solutions exist and will maintain congruency with the intent and vision of FFPSA. On behalf of Kentucky and its Cabinet for Health and Family Services, I respectfully seek your assistance in resolving these barriers. Early implementer states have less than 100 days until the "go live" date, making time of the greatest essence.

Title IV-E Prevention Services Clearinghouse

The Act required that the U.S. Department of Health and Human Services (HHS) issue a "pre-approved list of services and programs that satisfy [its] requirements" (Section 471 (e)(4)(D) of the Social Security Act). The U.S. Children's Bureau (CB) has provided guidance indicating that these prevention programs and services will be part of the newly developed Title IV-E Prevention Services Clearinghouse (Clearinghouse).

States are only permitted to receive prevention reimbursement for Evidence Based Practices (EBPs) in categories of substance abuse, mental health, parenting skills, and kinship navigator services that are approved by the Clearinghouse and meet certain levels of effectiveness. Those levels are "promising," "supported," and "well-supported." According to FFPSA, at least 50% of a state's expenditures for prevention services must fall into the "well-supported" category. The application of clinical trials is necessary to meet the evidence-based thresholds, which is complicated by the highly vulnerable population served in child welfare and the need for human protections in research design and application.

The delay in the deployment of the Clearinghouse and ranking of programs is a significant impediment for states implementing in October 2019. The statute required that the list of approved prevention services in the Clearinghouse be provided by October 1, 2018. On November 30, 2018, CB released ACYF-CB-PI-18-09 indicating that a list of the first 12 prevention programs was being reviewed and expected to be released in May 2019. On June 20, 2019, the first rating for ten programs and services was released. Five programs and services rated as well-supported, two programs and services were rated as promising or supported, and three programs and services did not meet criteria for a rating. As a result, states were left with a total of seven EBPs from which to select for implementation and only five options meeting the well-supported prevention expenditures requirement.

Considering the delay in review and the current limited number of EBPs available for utilization by states implementing on October 1, 2019, alternative considerations are warranted at this time. **Allowing states to utilize a wider array of rated EBPs currently in the California Evidence Based Clearinghouse (CEBC) and/or waiving the required 50% threshold on expenditures for well-supported EBPs will eliminate significant barriers to implementation until a more robust Title IV-E Prevention Services Clearinghouse is available for use.** Many programs and services were created through states' Title IV-E waiver demonstration projects and are showing positive outcomes for children and families. Allowing a waiver of the 50% well-supported requirement until 2026, in particular, will permit states more time to develop the research base for prevention programs they want to use and foster innovative practices unique to the child welfare population. **Should the waiver request for the 50% threshold requirements be denied, it is requested that any expenditures for well-supported prevention services funded by Medicaid be counted towards the 50% threshold.**

Qualified Residential Treatment Program (QRTP)

The Act allows Title IV-E foster care maintenance payments for foster children who are placed either in a family setting or in a specific alternative setting, including a Qualified Residential Treatment Program (QRTP). According to recent guidance from the Centers for Medicare and Medicaid Services (CMS) provided to Kentucky, QRTPs, as defined in FFPSA, are defined as Institutions for Mental Diseases (IMDs) if the facility is over 16 beds. When QRTP services are provided in facilities that have more than 16

beds but are not Psychiatric Residential Treatment Facilities (PRTFs), these facilities cannot be an IMD in order to access Medicaid funding. Prohibiting states from accessing Medicaid funding for the care of children in residential settings would directly impact decisions to establish QRTP requirements for a congregate care setting used for caring for foster children; thus, this clarification impedes the ability to achieve the goal of FFPSA regarding the quality of care for this population. It essentially incentivizes states to maintain status quo care by either identifying all foster children as at-risk for human trafficking - an excluded population from the QRTP requirements - or foregoing Title IV-E foster care maintenance payments for foster children in congregate care settings.

The IMD exclusion is intended to prevent the institutionalization of adults and children who have mental/behavioral health diagnoses. The intention of FFPSA is the same in that children should be placed in family-like settings to the greatest possible extent, and when short-term intensive treatment is needed, residential beds with a high level of treatment are available at QRTP settings.

To assure that the funding is available to support treatment in QRTP settings, either a) Congress should specify in law that QRTP settings are an exception to the IMD exclusion so that Medicaid funding is available to support treatment provided by QRTPs; or b) HHS should define QRTP as an exception to the IMD exclusion in regulation or policy as soon as possible. With either option, the intention to prevent the institutionalization of children is preserved by the requirements within FFPSA: children are placed in QRTP as the result of an assessment indicating that residential treatment is necessary, and children remain in the QRTP only as long as the specific treatment provided by the QRTP is needed to meet the child's clinical needs.

On behalf of the Cabinet for Health and Family Services and the vulnerable citizenry it serves, I appreciate your consideration of these requests and your support to ensure a seamless transition for states during implementation of the Family First Prevention Services Act. Incredible, positive potentials await, further bolstering Kentucky's efforts to be a nationally recognized child welfare system.

If you have any questions concerning these requests, please do not hesitate to contact me.

Sincerely,

Adam Meier

Adam M. Meier
Secretary