Child Welfare Funding Opportunities: Title IV-E and Medicaid

Federal funds partially offset state and local funding for child welfare. These child welfare investments have long been plagued by a diminishing share of federal government funding. Federally funded child welfare programs include the Title IV-B block grant, the Social Services Block Grant, Temporary Assistance for Needy Families (TANF) for the first year of foster care and other emergency services, Supplemental Security Income for room and board for disabled children, and the open ended Title IV-E (IV-E) entitlement program for children from low-income families requiring foster care or subsidized adoptions. Since 1980, IV-E has reimbursed states for a portion of the cost to keep eligible children in out-of-home care. Over the course of the program, IV-E foster care eligibility has dropped from about 70 percent in the mid-1980s to less than 50 percent today, largely due to ridged eligibility requirements. For example, the IV-E family income requirement is still based on the federal poverty level from 1995.

Despite these limitations, IV-E is the major federal source of funding for child welfare services, supporting about one-third to one-quarter of the total cost of state programs. In addition, a number of states have used Medicaid to support their child welfare program. IV-E and Medicaid are federal entitlement programs, meaning the federal government guarantees states it will provide its share of the cost of allowable services for eligible children, regardless of spending levels by the state. This paper will focus on how these two federal programs, when managed creatively, can increase federal support for comprehensive and flexible child welfare programs.

Title IV-E

IV-E is an open-ended entitlement program providing federal reimbursement for state foster care placements meeting certain eligibility requirements. State placements are eligible if the child is:

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(1) Removed from a home eligible for assistance under the Aid to Families With Dependent Children (AFDC), a program that ended in 1995, but its family income standard remains the income eligibility criteria to this day;

(2) Placed through either a voluntary placement agreement or a court order, which says that continuation in the home would be contrary to the welfare of the child and reasonable efforts have been made to avoid removal; and,

(3) Placed in an eligible state-licensed or approved foster care setting.

States must also agree to provide certain procedural safeguards, designed to prevent extended stays in foster care and to assure that foster care continues to be in the child's best interest. These include case reviews at least every six months and court hearings no later than 18 months after placement.

IV-E partially reimburses states for subsidized adoption, and for some of a child's foster care costs including room, board, supervision, day care, and certain supplemental expenses like school supplies and clothing. It does not reimburse for counseling, therapy, medical, or education costs. The allowable costs are reimbursed with federal IV-E funding at the Medicaid service rate, which varies from 50 percent for the wealthiest states, to 80 percent for the poorest states.

IV-E also reimburses for administrative and case management expenses, exclusive of investigation and counseling activities, at a federal financial participation rate (FFP) of 50 percent. It also reimburses staff training at a FFP of 75 percent. The proportion of the administrative/case management and training costs IV-E will partially support is determined by the percentage of IV-E eligibility; the foster care eligibility rate is applied to foster care-related expenses and the IV-E adoption subsidy eligibility rate is applied to adoption-related expenses. Thus, a higher IV-E eligibility rate increases the federal share of program costs for both foster care and administrative/case management and training.

The scope of the administrative/case management and training activities IV-E participates in was greatly expanded under a Missouri Grant Appeals Board Decision in the mid-1980s that found that states were entitled to federal IV-E funding for activity on behalf of children at risk of foster care, absent the provision of preventive services. With such a finding placed in a child's case plan, IV-E reimburses states for administrative/case management and training costs associated with preventive services, which include protective services, exclusive of investigation, and foster care aftercare services.

A number of states have opened IV-E claiming for both foster care, administrative/case management, and training to sister public agencies through interagency agreements. Such agreements have been developed with community mental health, public health, juvenile justice, juvenile probation, and juvenile court programs for persons in need of supervision (PINS) or families in need of supervision (FINS).

Management of the IV-E program requires vigilant oversight from the highest levels of the states' child welfare programs. Without effective management, the complex IV-E eligibility rules cannot be properly applied, and the percentage of children eligible for the program will slip. Without effective management properly plugged into agency management, decisions unrelated to the management of the IV-E program may inadvertently undermine the claiming process. Without adequate staffing, agreements with sister agencies will not be established, and IV-E claims from sister agencies will not be adequately monitored, increasing the risk of audit exceptions.

Several opportunity areas will be briefly discussed. Prior to this discussion, areas that a IV-E manager should be monitoring on a regular basis will be reviewed.

Until the 1995 AFDC family income standards, which are now part of the IV-E eligibility process, are adjusted, state eligibility rates will remain at around 50 percent. If a state's eligibility rate is significantly below this level, there is a need to review eligibility policy and procedures. If a state is not able to claim IV-E maintenance payments for all IV-E-eligible children in foster care, there is a need to look at home licensing requirements. As TANF funds diminish, there may be a need to create licensure standards for kinship homes that meet basic safety standards, but might not meet room requirements. If a IV-E administrative claim is slipping, there may be a need to review the administrative cost pool construction to make certain that all eligible costs are present, that costs associated with all children in protective services are included in the cost pool, and that staff participating in the random moment time study are familiar with the codes and the importance of this process. Often just the act of training on the time study can increase the percentage of IV-E-eligible hits. These are steps to take in the day-to-day management of the IV-E program.

The opportunity areas that are briefly discussed below include agreements with other public agencies, training, and IV-E waivers.

IV-E Agreements with Other Public Agencies

In order to maximize federal IV-E funding, state and local governmental functions serving children in foster care (out-of-home) placement, or at risk of entering foster care, that are funded with state, local, or federal block grant funds that could be used in another area need to be identified. Departments of juvenile justice or mental health often provide family foster care, or residential or group residential care. As long as these facilities are

properly licensed and not locked detention facilities, public facilities with more than 25 beds, or institutions for mental diseases, IV-E funding could reimburse these agencies for children found to be IV-E-eligible. The court order removing the child from home would meet the IV-E removal requirements in the juvenile justice program, and the voluntary placement option available for the first 180 days would meet IV-E requirements for many children in the mental health program. Administrative claiming would be available for the case management services provided for children in foster care, and for children determined at risk of entering foster care, absent the provision of preventive services.

In addition to children in the juvenile justice and mental health programs, children receiving probation or community correction services, and children in PINS and FINS programs often operated by the juvenile courts would be eligible for IV-E-supported case management and training. Fiscal viability for any of these programs would depend on whether or not they are currently providing an eligible foster care program, and whether or not the children receiving case management services could be determined to be at risk of out-of-home placement, absent the provision of preventive services. The resulting IV-E percentage would be unique for the public agency, and would be applied to their administrative/case management and training costs.

If the answer is "yes" to the fiscal viability question, agencies would enter into an interagency agreement with the child welfare agency, assuring that all procedural safeguards required by IV-E would be met. The child welfare agency would amend its IV-E State Plan to include the sister agency. The child welfare agency would also amend the IV-E Training Plan found as part of the Title IV-B State Plan to include the sister agency. And the child welfare agency would provide IV-E eligibility functions for the sister agency, and the sister agency would assure child welfare their policies and procedures meet state and federal requirements, establish an administrative cost pool, and design and implement a time study for sister agency staff. It would also establish claiming protocols and monitoring requirements. For example, if the percentage of children in the foster care found to be IV-E eligible was 10 or 15 percent, you probably would not go forward with the project.

If a sister agency requests to go forward with IV-E, this would require substantial input from the child welfare agency initially, but over time would involve little cost for the child welfare agency other than the ongoing eligibility determination and monitoring functions. The sister agency would provide the required federal matching funds. All federal revenue would be passed along to the sister agency, and the sister agency would assume responsibility for any audit disallowances due to its mistakes. Typically, the most likely partners have been juvenile justice and juvenile probation agencies that operate with little federal funding, and the special initiatives of the juvenile court (i.e. PINS or FINS). The judicial function performed by the judge, court staff related to the judiciary function, and related programs like court-appointed special advocates (CASAs) appointed by the judge, and responsible to the judge, are not IV-E reimbursable as administrative costs.

IV-E Training

IV-E, from its inception, has provided a 75 percent FFP for training, discounted by the percentage of children IV-E-eligible in foster care for training related to foster care, or discounted by the percentage of children IV-E eligible receiving adoption assistance for training related to adoption. There are two types of training: short-term and long-term. Short-term training includes training of employees of the state IV-E agency, foster parents, adoptive parents, and, more recently, members of the staff of licensed or approved child care institutions providing care to foster or adoptive children. Long-term training leading to a baccalaureate or graduate degree in social work can be supported by IV-E for persons employed by, or preparing for employment by, the public state or local child welfare agencies. A 50 percent FFP is available for the remainder of expenditures necessary for the proper and efficient administration of a state's IV-E plan. Federal regulations from the U.S. Department of Health and Human Services at 45 CFR 1356.60 specify what is considered a training cost and what is considered an administrative expense, and further require that all IV-E training be described in the state's child welfare training plan, a part of the state's Title IV-B plan.

States have quickly found that such training provided under agreement with the public state universities could be largely supported with federal reimbursement and contributions by the university, requiring little or no funding by the state child welfare agency. Federal IV-E reimbursement sufficient to meet all, or nearly all, the out-of-pocket training costs became possible because the cost of training was increased by the university's federally approved indirect rate at about 50 percent of cost and the value of professors contributing time for the development of training, the provision of training, and the assessment of the training. If the university contribution was not sufficient to generate enough IV-E reimbursement to cover the actual out-of-pocket cost of training, the difference was made up by cash from the child welfare agency or by other public agencies, allowing the cost associated with their staff participation in the training to be used to generate additional IV-E reimbursement.

Effective in October of 2008 with the passage of federal Fostering Connections to Success and Increasing Adoptions Act (P.L. 110-351), the scope of short-term training by Title IV-E was greatly expanded in recognition that child welfare could not be successful without the support of well-trained partners. Partners include relative guardians if the state opted to offer guardianship assistance, members of licensed or approved child welfare agencies, staff of abuse and neglect courts, agency attorneys, attorneys representing children or parents, guardians ad litem, or other CASAs representing children or parents in child welfare proceedings in ways that increase their ability to provide support and assistance to IV-E-eligible children. This language allows IV-E support for the training of CASA volunteers. This language also allows IV-E support for training mental health, public health, school social workers, and private family service staff if their organizations are declared

by the state to be approved child welfare agencies for purposes of IV-E training. This law allows the training of parents as parent advocates if they are affiliated with a state-approved child welfare agency. There is no federal definition of an approved child welfare agency. This expanded array of personnel that can now be trained with the support of IV-E funding at a FFP of 65 percent, and as of October 2012 a 70 percent FFP, will be available.

Public universities and community colleges, in partnership with these child welfare partners, can now use investment in their current training programs to leverage new IV-E training reimbursement. The reimbursements can be used to expand training to promote a system of care approach where all participants are trained to perform more effectively, while understanding the role and limitations placed upon their system partners.

IV-E Waivers

Title IV-E waivers are once again available. Some states have chosen to use the waiver to create more flexible funding (e.g., using IV-E funds for family preservation and family support functions) as a way of reducing the use of out-of-home care in exchange for accepting a cap on federal IV-E funds. The waiver strategy requires added data collection, service monitoring, and administrative time with little benefit if flexible funding could be obtained through the use of Medicaid Rehabilitative Services. Use of Medicaid would mean you do not have to cap your federal IV-E entitlement program. The waiver strategy might be viable for a focused population, like status offenders experiencing extended lengths of stay in residential treatment facilities with a goal of family reunification. In this case, the use of flexible funding to purchase wrap-around services would enable many of these youth to shorten their length of stay, resulting in a cost savings that could be used to fund the wrap-around services. Because it is very hard to predict whether or not the foster care population will experience increased placements over time, any waiver funding formula that caps IV-E entitlement funding should be structured to be renegotiated periodically if placements increase.

Medicaid (Title XIX of the Social Security Act)

There are several reasons why child welfare programs should carefully consider the use of Medicaid. First, Medicaid can support counseling and therapy for children in foster care and for children living at home, yet at risk of entering foster care. In contrast, IV-E does not cover treatment services essential to a comprehensive child welfare program. Second, nearly all children in foster care are Medicaid-eligible while only about one-half of the children in foster care are IV-E-eligible. Third, Medicaid reimburses the state at the service rate of reimbursement-- the FFP ranges from a low of 50 percent to a high of 80 percent depending on a state's level of poverty-- when a state opts to use Targeted Case Management (TCM), while IV-E reimburses the state for TCM at the administrative 50 percent FFP.

States, however, are reluctant to use Medicaid in their child welfare program because the program requires a focus on the individual child rather than the family. For example, all service documentation must tie back to the child for whom the case was opened. This is not the case when claiming case management under IV-E. Second, there is a fear that the program could lose control of the number of providers and the program's costs. Third, there is concern on the part of the child welfare and provider communities that the rates may not be adequate to cover costs. Finally, there is a fear that child welfare, a minor Medicaid player, will have a hard time gaining administrative support from the Medicaid staff focused on controlling the costs of managed care, nursing homes, hospital emergency rooms, and services for chronically ill adults.

A number of states have overcome these problems through the training of case workers on how to document Medicaid services in the individual case record, and the development of state plan amendments that place limits on how services are authorized and who can provide the services. An additional cost control strategy has coupled Early Periodic Screening Diagnostic and Treatment (EPSDT) provisions of the Medicaid program, which limits services to children under age 21, with the Medicaid provisions governing claims submitted through the Title V Maternal and Child Health (MCH) program. Medicaid provisions allow the state's MCH program, usually found in the Health Department, and its grantees, which could be another public entity like child welfare, to select providers and submit claims based on provisions described in an interagency agreement with Medicaid and in the MCH State Plan. Further, these services can be claimed for Medicaid reimbursement for Medicaid-eligible children when similar services are being provided to other children without cost. Child welfare programs making use of these provisions within the Medicaid program include Tennessee, Kentucky, Georgia and Alabama. Many other states make use of Medicaid for their child welfare program using the more traditional plan amendment strategy.

There are two Medicaid programs that are of particular interest to child welfare: TCM and Rehabilitative Services.

Targeted Case Management

Medicaid case management services are defined as services that assist individuals eligible under the State Medicaid Plan to gain access to needed medical, social, educational, and other services. The functions of Medicaid TCM are assessment, development of a care plan, referral and monitoring, and follow-up. Once a case has been opened, much of the activity of the public child welfare worker can be described as case management. For this case management to become TCM, the State Medicaid Plan must identify the target group and describe the services. Child welfare agencies using TCM target children receiving foster care services, and may also include children receiving protective services. The services must be authorized by a child welfare worker and

recorded in the child's service plan. Such authorization does not require special professional credentialing. The worker must record at least one TCM contact with the child, or on behalf of the child, monthly. Such a contact can be face-to-face or by phone, depending upon the state's policy and procedural requirements.

The rate of TCM is generally cost-based, using a monthly unit of service. The rate is typically set annually, based on the costs identified as case management by the random moment time study and the associated cost pool. The modification of the time study to identify TCM activity requires a cost allocation plan amendment and staff trained on what constitutes TCM as opposed to other child welfare activity that may be IV-E eligible, and how to document TCM activity in the child's case record. TCM does not include payments for medical, educational, or social direct services. For example, activities performed by the foster care worker that relate directly to the provision of foster care services (e.g., home investigations, recruiting or interviewing potential foster care parents, assessing adoptive placements, serving legal papers, making placement arrangements, or providing transportation) cannot be claimed as TCM.

There are several issues that lead child welfare agencies to forgo the use of TCM. Many of those concerns are addressed below, including that providers cannot be limited to the public agency, the freedom of a client to choose their service provider, duplicative services, rate adjustment, non-federal matching,

Public agency limits. The concern that providers cannot be limited to the public agency (i.e., that any social worker could gather a group of children in foster care and submit claims for reimbursement) has not happened. The primary inhibitor has been the description of the worker placed in Medicaid and child welfare policy manuals limiting qualified case managers to workers authorized to provide protective services. The Title V arrangement, mentioned previously, is also an excellent vehicle for limiting the service vendor to the public child welfare agency.

Service provider choice. Issues surrounding the freedom of a client to choose their own service provider do not occur in the case of foster care where the agency is the surrogate parent. But if it does surface for a child in a protective caseload, the child can be offered a choice of providers from other public child welfare workers.

Duplicative services. The child welfare agency must assure the Medicaid agency that they will make every effort to avoid duplicative services, and not submit a claim for TCM when another agency is providing the same service for the same period. This could occur if mental health and/or juvenile services served the child for a partial month and submitted a TCM claim for the child along with child welfare. Only one agency can claim TCM for that child for the month. If two agencies were to serve the child during the month, only one would be reimbursed. The common solution to this problem is a policy and practice statement that such case

management, when it occurs, will be coordinated and that the first agency to submit a claim receives payment, while claims from other agencies for a similar service for the same period are denied. Other more equitable solutions have been considered, but because of system and/or time limitations, they have not been implemented.

Rate adjustment. Once the initial rate is set for TCM, the Medicaid agency is reluctant to adjust the rate based upon new cost data provided by the child welfare agency. Such an adjustment requires Medicaid staff time. When setting up the program, the rate adjustment process should be clearly spelled out and made as automated as possible so that staff time by the Medicaid agency is minimized.

Non-federal matching. The child welfare agency must provide the non-federal match or the Medicaid agency will be reluctant to move forward with the project. This payment can be made quarterly, annually, or through the appropriation process where the match funding goes directly to the Medicaid agency to meet the non-federal matching cost of the program. The child welfare agency should retain the appropriated match funds needed for the Medicaid draw down and forward these funds to Medicaid on either a quarterly or annual basis. When this is not done, the child welfare agency loses control of these funds and will find it difficult or impossible to reclaim them if, in the future, the TCM program ends.

Finally, a state adopting TCM must be able to match the unit of service rendered with a child's Medicaid eligibility to generate a Medicaid claim, just as it is now done to generate a IV-E claim for foster care services.

If a state were to adopt TCM for its foster care program, its federal return for the TCM activity identified would more than double the federal reimbursement received today under IV-E, while IV-E would continue to reimburse the non-TCM portion of the case management activity. States have found about 50 percent of their case management activity is TCM eligible. If $100,000 is expended on IV-E eligible foster care case management, IV-E would generate $25,000 in federal reimbursement (if 100 percent of the activity is IV-E eligible and 50 percent of the children are IV-E eligible at a 50 percent FFP). Under a combined TCM/IV-E strategy, $42,500 in federal reimbursement would be generated, a 70 percent increase over an IV-E option (if 50 percent of the activity was TCM-eligible, and 100 percent of the children eligible at a 60 FFP + 50 percent of costs IV-E eligible x 50 percent of children IV-E eligible at 50 percent FFP).

Rehabilitative Services

Rehabilitative Services under Medicaid are optional treatment services a state can choose to provide. Most states have included them in their State Medicaid Plan, and if they have not been included, they can be provided using the EPSDT provisions of Medicaid. Most states use Rehabilitative Services for their community

mental health program to obtain Medicaid reimbursement for treatment services authorized by a licensed practitioner of the healing arts. These services, not limited to the clinic setting, can also be provided in schools, homes or other community-based settings. Staff must document the services provided in the individual treatment plan. Community mental health has traditionally not focused their services on the child welfare population. The primary clients of the community mental health program are adults receiving services within the clinic setting. The smaller investment in children's services rarely specialize in child welfare services because the cost of providing services to the child welfare population generally exceeds the reimbursement offered by Medicaid. Thus, to obtain mental health services, child welfare programs often set up a parallel, and largely separate, system of treatment services for children in foster care, and children at risk of entering foster care, without the benefit of federal Medicaid funding.

A number of states have developed a Rehabilitative Services program for their child welfare program using the provisions of EPSDT and Title V MCH program, discussed previously, allowing child welfare agencies to claim federal Medicaid reimbursement for treatment portions of their program. Such Rehabilitative Services can be provided to Medicaid-eligible children diagnosed as emotionally disturbed, or at risk of emotional disturbance, who meet the medical necessity criteria for admission to the program. Such diagnosis and medical necessity must be determined by a licensed practitioner of the healing arts, generally a licensed social worker, and provided directly by the public child welfare agency or by private vendors under agreement with the child welfare agency using unique cost-based rates. These services include intake and assessment, development of the Individual Care Plan, service coordination, living skills development, counseling, therapy, crisis intervention, and consultation. These wrap-around services are provided in non-medical residential and group care settings, therapeutic foster care, and for children living at home, yet at risk of foster care. The therapeutic foster care and treatment services provided for children in group and residential care settings are commonly reimbursed by Medicaid using a bundled cost-based per diem rate determined through the use of a time study/cost report. Some states, at the urging of federal Centers for Medicare & Medicaid (CMS) officials, are unbundling these services and submitting claims for each specific service provided.

Use of Medicaid would more than double federal participation in the cost of residential and group home programs. These expensive programs are generally funded on a per diem basis through a combination of state and federal IV-E funding. About 70 percent of the total cost can be claimed for IV-E reimbursement. If 45 percent of the children receiving these services are IV-E eligible (children in family foster care have on average a 10 percent higher rate of IV-E eligibility), federal IV-E reimbursement generates for the state about 19 percent of the cost (70 percent proportion of IV-E cost $\times$ 45 percent IV-E eligibility $\times$ 60 percent FFP = 19 percent). The remaining 81 percent of this program is met with state funding. If Medicaid is used to cover treatment and related service coordination, about 50 percent of the program would be Medicaid-eligible activity

and 45 percent of the remaining cost could be supported by IV-E, resulting in 42 percent of program cost supported with federal funds and a 110 percent increase in federal funding. This reduces the state share from 81 percent to 58 percent (Medicaid 50 percent of cost × 100 percent eligibility × 60 percent FFP + 45 percent IV-E activity × 45 percent IV-E eligibility × 60 percent FFP = 42 percent). The cost of education has not been included in this example.

Thus, the use of Medicaid can significantly reduce the proportion of state funds required to support residential and group home programs. Similar savings can be realized when Medicaid is claimed for therapeutic foster care and wrap-around services provided for children known to child welfare and living at home.

Concerns states have expressed about establishing a Medicaid-supported child welfare Rehabilitative Services program include cost shifting from mental health to child welfare for services that should be provided by mental health, limiting exposure to unintended claims/providers, cost-based rates in a free service environment, bundled rates, introduction of a clinical program within a non-clinical child welfare program, documentation, and avoidance of duplicate claims and service overlap. Each of these concerns is addressed below.

Cost shifting. In a perfect world, mental health programs would maintain sufficient funding to provide treatment services for children in foster care and children at risk of entering foster care. A number of states have assumed partial responsibility by establishing hospital step-down, Medicaid-supported residential treatment facilities serving referrals from child welfare, as well as others. Additionally, some states have included the child welfare population in their Medicaid managed care programs, but even when this occurs, the managed care organizations have had great difficulty mastering the complex child welfare system. To provide the treatment services their children require, child welfare programs continue to purchase such services for children they have placed in non-medical residential, group home, and therapeutic foster care settings and, on an exploratory basis, provide wrap-around services in place of out-of-home care for children able to live at home with such supports. It is unlikely mental health will pick up these costs. Thus, any federal reimbursement child welfare can receive for these services will relieve child welfare of costs that would otherwise be supported with state general funds.

Unintended claims/unintended providers. When child welfare systems take on the provision of Rehabilitative Services, they do not want to be paying claims from service providers that have not been authorized, nor do they want to pay claims for children they have not authorized for services. To overcome the provisions of Medicaid requiring service for any child found to have medical necessity for service, and from any willing and properly credentialed provider, the child welfare rehabilitation services program should be placed within EPSDT and made part of a state's Title V program. This limits services to children authorized for service by child

welfare, and providers are limited to providers selected, and under contract, with the child welfare program. All other children qualifying for service and qualified providers must obtain reimbursement for services from the Medicaid-supported mental health system.

Cost-based rates/pay in a free-service environment. Even when the rates paid by mental health or managed care are below cost as experienced by the providers within the child welfare Rehabilitative Services program, the program can base reimbursement on cost when it falls within the Title V MCH program. Another feature of the special status Title V MCH has within the Medicaid program is that Medicaid reimburses eligible services at cost, even when similar services are provided without cost to other children. This provision is not only important in the public health domain, but also becomes very important for child welfare.

Bundled rates. Child welfare programs have often adopted bundled rates because it simplifies the claiming process and provides predictable costs, a form of managed care. Under IV-E, billing is usually based on the IV-E proportion of the per diem rate linked to an eligible child. With the addition of Medicaid, the per diem rate is factored into the IV-E and Medicaid portions and linked to the respective eligibility to generate both a IV-E and a Medicaid claim. The bundled rate minimizes the need for each service provided to be documented by using a daily documentation requirement to establish that at least one of the services within the bundle was provided for the child each day. Federal Medicaid officials do not like bundled rates because they do not show how much, or what kind of, service the child is receiving. Further, CMS has established a set of service codes to standardize the measurement of service volume, make cross-state comparisons, and track service utilization over time. Bundled rates are unique state codes that disguise and blur service tabulation. When each service within the bundle must be documented and billed when provided, it can be determined whether or not the child is receiving the prescribed mix and amount of service in accordance with his or her individual service plan. The billing of individual units of service increases service accountability, but places increased service documentation burdens on the service providers and may result in increased cost because the number of units of service are no longer governed by the per diem based on historic cost. It is unclear at this time whether CMS will approve a bundled rate, but a state might offer a system for generating encounter data as is done in managed care that would meet CMS' goals while keeping costs under control.

Clinical programs within child welfare. Child welfare is complex enough without the addition of another funding stream with added rules and requirements, particularly when this medically driven program is being established within a child welfare/social service culture. To take on the Medicaid Rehabilitative Services program, the child welfare agency, as well as its private providers, will have to hire clinical staff.

There are two responses to this concern. First, most child welfare agencies have licensed social workers on staff, and have consultant clinicians (e.g., psychiatrists, psychologists, nurses and social workers) to assist, assess, and serve children with severe behavioral and developmental disabilities. Second, the Rehabilitative Services program requires licensed practitioners of the healing arts, such as licenses social workers, to assess each child, establish diagnoses, authorize service, and develop a service plan. If the public agency has clinical staff, they can control the size and cost of the program, directing the child to the program that best meets his or her service needs. If the program requires providers to assign its clinical staff for these functions, the requirements of the rehabilitation program are met, but the public agency transfers control of the program and perhaps cost factors to the private agency. Child welfare agencies operating a Rehabilitative Services program usually opt to retain control of the program by assigning clinical staff, usually licensed social workers, to the front end service authorization process.

Private providers offer Rehabilitative Services on a day-to-day basis. Clinical staff, usually social workers with graduate degrees, supervise paraprofessionals providing living skills development. In addition to program supervision, the clinical staff would be responsible for counseling, other clinical services and assessing the condition of the children receiving services. This is the method by which providers under contract with child welfare programs provide therapeutic foster care and group and residential care today. The most significant change is the requirement for service documentation, and perhaps a licensed social worker to initially authorize, and periodically reauthorize the service plan.

Documentation. The Achilles' heel of the Rehabilitative Services program is service documentation. For services to be evaluated as effective or in need of modification, the services must be properly documented, but this requirement has never been critical for maintaining IV-E funding given that IV-E supports room and board and basic care, not treatment services. And, state audits of child welfare programs rarely focused on this aspect of the program. Medicaid on the other hand, focuses on documentation in their audits, and this has resulted in significant paybacks. The cultural shift from IV-E funding to one involving both IV-E and Medicaid-- where documentation of service is required-- has been difficult to instill in private foster care providers. This difficulty is due in part to the way the program is structured, such that the state rather than the private provider shoulders responsibility for the payback, and rarely is this responsibility shifted to the private provider.

Avoidance of duplicate claims and overlapping services. Medicaid requires programs to take steps to avoid duplicate claims and overlapping services. This is particularly true in the area of Rehabilitative Services where Medicaid is funding two parallel systems, one in mental health and one in child welfare. Child welfare is apt to have a better array of step-down residential programs than mental health. Thus mental health, anxious to reduce length of stay and cost for children in psychiatric hospital settings, will often try to access a child

welfare residential option for children in its care that are not ready to return home, which is a cost shift to child welfare. On the other hand, child welfare must, from time-to-time, access psychiatric hospital level care for children in its care, shifting the cost for these children to mental health. And at the community level, child welfare provides in-home wrap-around services for children at risk of entering foster care, or for children in family foster care homes while a case remains open. However, once discharged, the child must be able to access community mental health services, and usually a new set of service providers, if he or she is to successfully remain in the community. It is essential that these two systems, mental health and child welfare, develop and maintain protocols that can assure continuity of care for children moving between the two systems. Before approving a child welfare Rehabilitative Services program, Medicaid may require both child welfare and mental health to describe how their services would be coordinated so that children do not lose services as they move from one system to another.

Another situation requiring attention arises when the private foster care providers under contract with child welfare supplement their child welfare per diem rates by accessing community mental health services for their children. If child welfare is going to build Medicaid-supported Rehabilitative Services into per diem foster care programs, such a payment should be considered full payment for treatment services, and procedures should be in place to prevent supplemental treatment services from community mental health. Medicaid, before approving the Rehabilitative Services program, would view this as a case of duplicate service and require child welfare to demonstrate how such a situation would be avoided.

Conclusion

For a child welfare system to take full advantage of the financing opportunities provided by IV-E and Medicaid, the State Budget Director and the Governor's Office must become partners in the revenue maximization effort. Without their support, it is unlikely that child welfare will have the staff necessary to maintain the complex IV-E program within the child welfare agency, while also having the capacity to extend the program and its associated federal funding to juvenile justice services, juvenile probation, juvenile courts, the public university system, and providers of foster care and family support services. Each of these entities can provide the match necessary to draw down additional IV-E funds for services the state is already providing for children in foster care, or at risk of entering foster care. Without their support, it is also unlikely that child welfare will receive the level of commitment required from public health, mental health, and the state Medicaid office to implement child welfare TCM and the child welfare Rehabilitative Services program, even though in doing so, they would each more than double the level of federal funding for these child welfare services.

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