Learning Forum Questions and Answers:

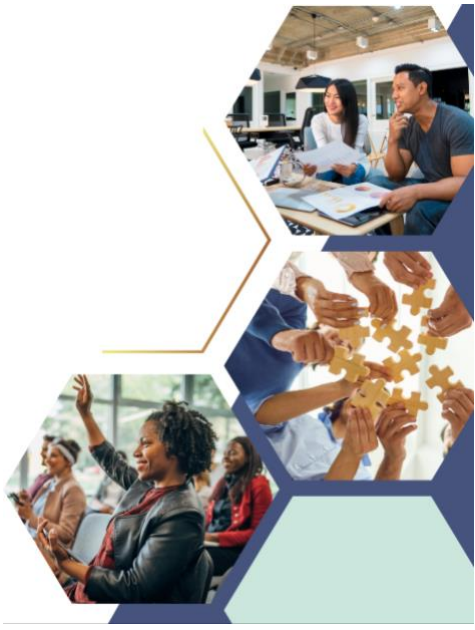
Fiscal, Candidacy & EBPs

August 2022

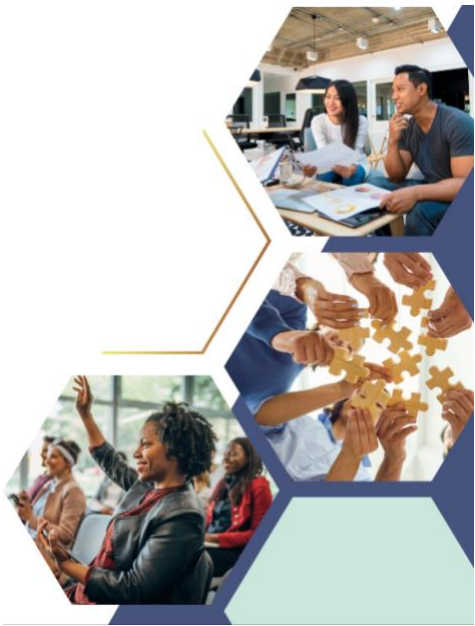
This document is a compilation of questions and answers from the Comprehensive Prevention Plan Learning Forums and Q&A Sessions. These questions were submitted in writing or asked live by the participants and were answered by the presenters.

Recordings of the Learning Forums and Q&A sessions can be found on the Comprehensive Prevention Planning Learning Series website: [Comprehensive Prevention Planning Support Learning Series | (caltrin.org)]

Thank you to our community of esteemed presenters for sharing their expertise and insight. We appreciate your time and commitment to this important work in support of California's children, families, and communities.



TOPICS

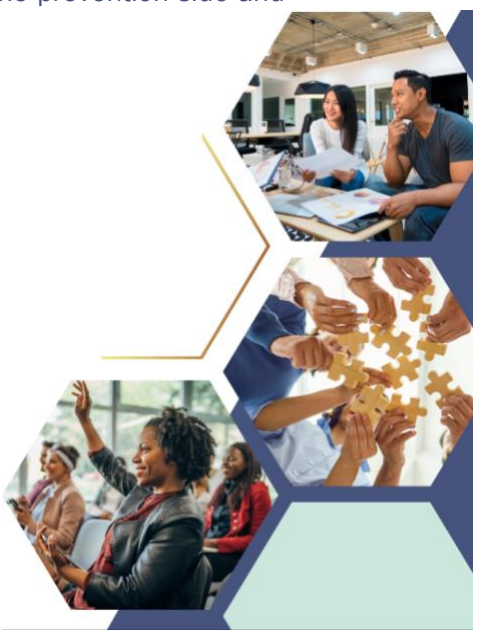


General Fiscal

- What is an FMAP rate?
  - Federal Medical Assistance Program (FMAP) percentage is a formula in federal law based on per capita income. FMAP rate is inversely related to state per capita income. If a state per capita income is less than the U.S. per capita income, then it would get a higher FMAP rate. If a state per capita income is higher than U.S., it gets a lower rate. If a state per capita income is exactly the same as the U.S. per capita income, then FMAP is 55% federal 45% state. However, federal law also sets out a minimum FMAP rate of 50% and a maximum of 83%. Currently there is an additional 6.2 percentage points because of the public health emergency. Normally, California has a 50% FMAP rate but during the public health emergency it is 56.2%. California's per capita income is higher than the U.S. per capita income. Therefore, its federal match rate is lower, but can't go below the 50% floor.

- What is the expectation for IV-E/FFPSA funding for clients who are receiving Regional Center services?
  - Generally, you would have a cost allocation plan for the administrative funds that would dictate which programs benefit from the existence of that Regional Center, and then you would allocate out the administrative costs among those programs. With FFPSA, you amend the cost allocation plan to account for the extent to which those activities benefit Title IV-E prevention services and then allocate that portion of the cost. There are some other ways that it could work and when you get into the details of cost allocation, it can get a lot more complicated, but that's the basic concept.

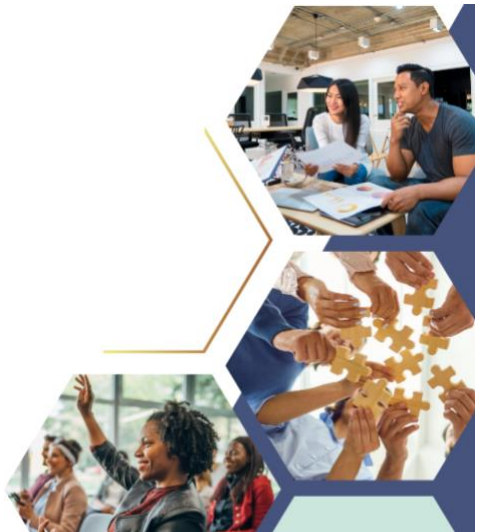
- What is the federal sharing ratio and does the FosterCare discount rate apply? Is the federal share open ended?
  - For FFPSA, the federal matching rate is 50% for services, 50% for administration and training, not subject to the discount rate. Under traditional IV-E foster care, a financial eligibility test is applied to each family removal based on the 1996 AFDC needs standard. The discount rate is essentially the percentage of families with a child in a licensed IV-E home/facility that meet the AFDC needs standard divided by the total number of children in foster care. The discount rate is applied to administrative costs and generally determined every four years. It is called a discount rate because it reduces that 50% reimbursement.
  - The AFDC Financial Eligibility standard does not apply to Family First. Once a child is determined to be a candidate or is a pregnant/parenting foster youth, and is receiving an approved EBP, the 50% federal matching rate applies. Therefore, over the long-term Family First incentivizes prevention services and increasing the number of families served on the prevention side and anticipates not just an expansion in that space, but also a reduction of the number of children in foster care.
    - Family First candidates are not included in the discount rate, which applies only to children in placement. Therefore, Family First does not impact a County's discount rate for children in placement.
  - Counties will have a mix of families with the discount rate and without in their cost allocation plans. Therefore, the Counties will want to define two different cost pools in their cost allocation plans -- one for Family First with a full 50% sharing ratio and another which will be subject to the discount rate.



- Are the Feds considering de-linking foster care from 1996 AFDC requirement as they did with adoptions?
  - For Adoptions, the Feds laid out a multi-year plan based on the age of the child to delink eligibility for IV-E Adoption Assistance from the 1996 AFDC requirements. And while there are certainly a lot of people who would like to see that same concept apply to foster care, the problem is cost. The Congressional Budget Office has repeatedly stated that de-linking would be incredibly expensive. However, that is one of the reasons why Family First is so historic. Congress has essentially de-linked FFPSA funding from the prevention component of IV-E by not applying the discount rate. In other words, 100% of children receiving prevention services are eligible once they've been determined a candidate and have an EBP in their individual prevention plan.

- How to blend funding to provide the prevention services a child and/or family needs?
  - Bring community service providers to the table to discuss blending funds – they already do this for families. Of course, put in the protections needed so the providers are not later disqualified from RFPs or other solicitations. Providers currently use one funding stream for a piece of the work and another funding stream for a different piece, especially providers like Family Resource Centers.
  - An example: if a parent has substance abuse needs and they qualify for MediCal, then MediCal pays for the service. However, if the MediCal-funded service providers are at capacity for substance abuse then you can bring in FFPSA IV-E to provide substance abuse services using an EBP from the Clearinghouse. Or if the substance abuse provider is not MediCal certified or the family doesn't meet the criteria for medical necessity, then it is possible to use IV-E funds as long as the EBP services are provided with fidelity and a trauma-informed method.
  - FFPSA however cannot address the issue of rate adequacy. That is, if providers are unhappy with the current rate they receive for certain services, FFPSA cannot address or help with that issue.

- Question about decision making around blended funding at the client level example: A Spanish-speaking parent needs mental health services. The waiting list is three to six months for Spanish speaking mental health services. Could the social worker document the situation and work with behavioral health and then determine to utilize Family First funding for Functional Family Therapy? And will the social worker's efforts be reimbursed at the 50% rate?
  - If there is a waitlist, IV-E can pay for the services if all FFPSA criteria are met, until MediCal services become available. In other words, FFPSA funds can be a bridge for services. This could also be a strategy to prevent re-entries for families who have recently reunified or have a guardianship/adoption arrangement but have a long waiting list for services. In this scenario, a social worker would be reimbursed at 50/50/00/00. CFL 21-22-110 (June 1, 2022) - Claiming Instructions For The County Opt-In Family First Prevention Services (FFPS) Program: https://cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/CFLs/2022/21-22-110.pdf?ver=2022-06-06-160421-720

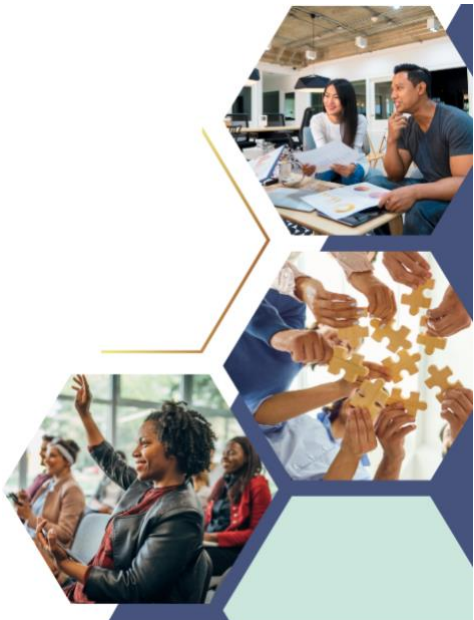


Maintenance of Effort (MOE)

- What do most counties use for the federal match?
  - The basic requirement is that the match must be non-federal funds. It can be state funds, it can be local funds, it can be realignment funds. Also, the funds must be under the control of the public agency and these funds cannot be funds that are used to match a different federal program. There are some exceptions for tribes.

- Does MOE include county dollars that exceed the required match?
  - It would depend. The MOE is a very simple concept, but calculating it is not so simple. First, if you're talking about the IV-E program and state match for IV-E program, then those funds do not count toward the match. However, if you are talking about state funding, above and beyond the IV-E program, it would depend. The federal law allows expenditures for foster care prevention services and activities under any state program that is not TANF, IVB or SSBG. But to be counted toward MOE it would have to meet all the criteria for prevention services. Therefore, the question is: in 2014, was there a state program and did it serve families that were at imminent risk according to the criteria and were those services evidence-based and trauma-informed? You would have to apply all of those filters to determine whether or not it was countable towards the MOE. Many jurisdictions when they apply all those filters find that the MOE is less than they thought it was going to be. Local expenditures on state programs that meet all those criteria could potentially be part of the MOE calculation.

- What are the implications of MOE requirements on the ability to identify sustainable funding for primary prevention activities?
  - First, what is the purpose of the MOE? Congress established this requirement because it wanted states not just to expand prevention services and supports rather than just shift prevention funding.
  - Also, MOE is limited in several ways as it only applies to:
    - specific funding sources: IVB, SSSB, TANF, or a state funded program that may be applicable and
    - federal fiscal year 2014 and
    - prevention services that meet all the criteria in the Family First law -- evidence based services that are listed in the Clearinghouse at the time that the state submits its prevention plan, delivered with fidelity and trauma informed
  - MOE is a one-time calculation made at the time when the state and federal government reach agreement on the state's Family First plan and it gets locked in at that point. It never changes. It never increases. In terms of sustainability, essentially there is no need to worry about it.
  - Another consideration for sustainability beyond MOE is the idea of prevention services to prevent entry into foster care. Therefore, if prevention services are going to be sustainable, they must successfully keep children out of foster care. In other words, if you provide prevention services and prevent entries into foster care, that is going to be sustainable. And if you don't reduce entries to care, then you may have resource issues that you need to deal with. Basically, the sustainability issue is whether you are effectively providing services that prevent entry into foster care where that can be accomplished safely.



FFPSA – Allowable Activities and Claiming

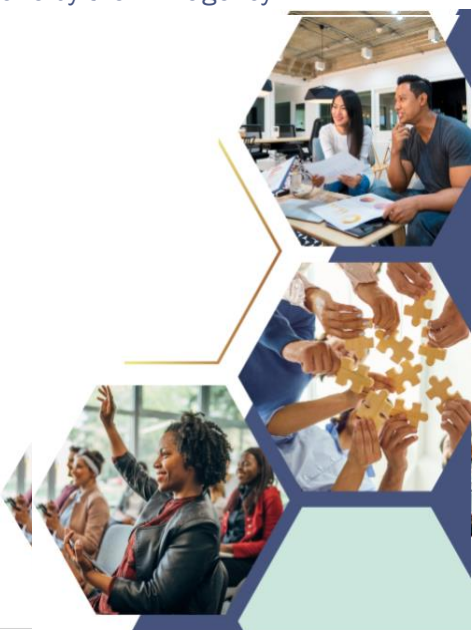
- Can you provide more details regarding family stabilization funding and concrete support pilots?
  - There is a growing body of science around the provision of economic and concrete supports and its associated relationship with reducing child maltreatment and involvement with child welfare. Many states are starting to think about how-to stand-up pilots to provide direct cash transfers or stipends to families and are working through benefit issues so that families don't lose other benefits if a stipend or cash transfer is provided. Many states are starting to think about economic and concrete supports far differently than they have historically in child welfare, such as EITC and childcare. For example, New Mexico created universal childcare for a year for families earning less than $100,000. We've often concerned ourselves with child welfare policies, and not with macro-economic and social safety net policies that have seemed outside of our wheelhouse. But the evidence suggests quite the opposite.

- Is FFPSA funding open-ended?
  - FFPSA IV-E funding for prevention services, administration and training is an open-ended, uncapped federal entitlement.

- Can FFPSA funds be used for housing?
  - Family First prevention services are statutorily defined in three categories: mental health prevention and treatment, substance abuse prevention and treatment, and in-home parenting skills building. Only programs in these categories are being reviewed to determine if they meet the evidence-based practice criteria and then placed in the Prevention Services Clearinghouse. Currently, there are no housing specific interventions in the Clearinghouse. And Counties can only use Family First funding to pay for interventions that are in the Clearinghouse.
  - There are researchers working to build the evidence around housing as a strategy to prevent mental health problems as well as prevent or treat substance abuse issues. However presently there is not a straight line to pay for housing. Counties could think about contracting for evidence-based practices, like Motivational Interviewing or Functional Family Therapy, with providers that also offer housing support. In that way the County is paying for the EBP but in a context that might involve housing.

- Can case management of Family First be a contracted service?
  - Yes, there is specific guidance in the federal policy manual about contracting for all facets of case management including developing and monitoring the prevention plan. The only work that cannot be contracted is the determination of candidacy which must be done by the IV-E agency. Other than candidacy determination, it is up to the County how best to provide case management services.

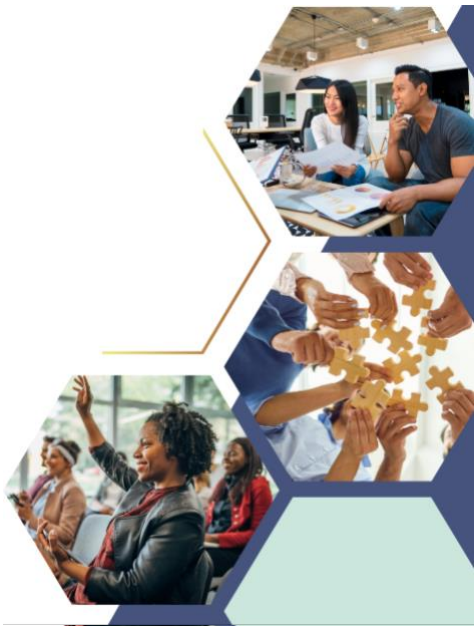
- Does FFPSA pay for IV-E staff training?
  - There is an admin and training reimbursement component of IV-E for standing up and delivering Family First Prevention Services.
    - If IV-E agency staff is going to deliver an EBP, then training, supervising and monitoring those staff to provide the EBP qualifies to draw down FFPSA training and admin dollars.



        - Even when the IV-E agency is not providing the intervention, the agency workforce needs training on which EBPs are available, how to select an appropriate EBP and how to refer families. Also, there is considerable literature regarding the difficulty of keeping families engaged in EBPs. Training the workforce on how to assist families to stay engaged with EBPs should be part of workforce training, and therefore qualifies for FFPSA training and admin funding.
    - You can also look at administration in two broad subcategories: Child specific administration such as case management, assessment and developing individual prevention plan; and non-child specific administration which includes training, policy development, and building CQI. Child specific administration can be reimbursed from the first day of the month in which the child is identified in a prevention plan. Non-child specific activities can be reimbursed from the first day of the quarter in which the State submits an approvable Family First Prevention plan.
    - See CFL 21-22-110 (June 1, 2022) - Claiming Instructions For The County Opt-In Family First Prevention Services (FFPS) Program: County Fiscal Letter 21/22-112https://cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/CFLs/2022/21-22-110.pdf?ver=2022-06-06-160421-720

- Does FFPSA pay for training providers, especially with respect to model fidelity?
    - Yes, providing EBPs with model fidelity is core to Family First, and so training the workforce on fidelity is essential. Counties should be thinking about integrating such training into provider contracts.
    - There are additional considerations for building your cost modeling – for well-supported interventions there is a CQI process, and for supported and promising interventions there is an evaluation process.

- Are there training dollars for child welfare, partner agencies and community organizations, maybe even an integrated training program, for the hands-on workforce?
    - State Block Grant funds can be used for training and it does not have to be specific to EBPs. There are also the admin dollars for IV-E that can be used for training as well.
    - See CFL 21-22-110. County Fiscal Letter 21/22-112https://cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/CFLs/2022/21-22-110.pdf?ver=2022-06-06-160421-720
    - There are two kinds of training: (1) training to deliver services both evidence-based and non-evidence based; (2) training to do casework. They are connected but distinct. To the degree that we can figure out how to have those trainings simultaneously that's going to be a cost savings. Also, if Counties elect to implement the community pathway, then community-based providers will need training in the same processes as County workers, such as assessments and [recommendations for] candidacy (ultimately candidacy *determination* is the role of the IV-E agency]. Joint training would be a good idea in this situation as well.
    - There is a way to separate out claiming as there are distinct training funds for different workforce populations. However, there are ways to break that out and allow for joint training. If you have questions, reach out to CDSS Fiscal Policy at fiscal.systems@dss.ca.gov
    - Additionally, the State is planning to provide (and cover the costs of) training for the foundational elements of FFPSA such as candidacy assessment, case management and individual prevention plans.



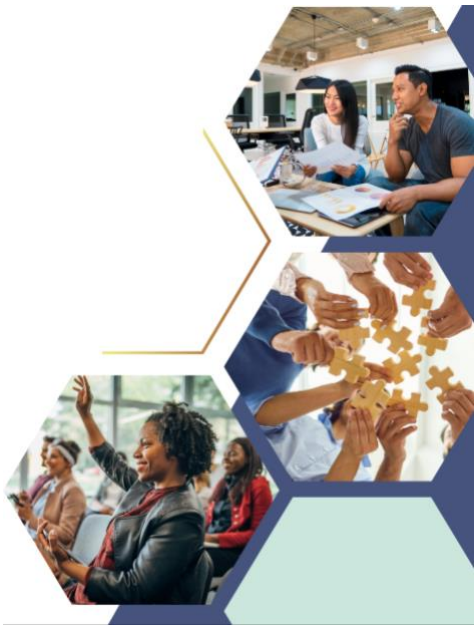
- Is case management for FFPSA eligible clients claimable under FFPSA, or is it only when overseeing the eligible EBP?
  - If a child is a candidate with an EBP in their individual prevention plan, then case management is claimable.

- How do you access and claim Family First IV-E?
  - It is very similar to how you access your claim IV-E for foster care, adoption assistance or guardianship assistance. There is a reporting system that state accesses to claim funds and when your Family First Prevention Plan is approved, then it unlocks a portion that the state can access and claim those funds.

- The CFL does not mention how counties can claim child specific case management costs. Does this fall under code 1012 as Admin costs? Please advise what SBG coding we should use to claim costs associated with the assessment, documentation, and determination/redetermination of a child's "candidacy" status in the following circumstances before the implementation of child specific claiming structures under CARES for:
  1. Candidacy assessment activities performed by DCFS or CPD staff;
  2. Candidacy assessment activities performed by other staff in other public agencies under "contract" with DCFS or CPD to perform those activities;
  3. Candidacy assessment activities performed by private agencies under contract with DCFS or CPD to perform those activities;
  4. Candidacy documentation activities performed by DCFS or CPD staff;
  5. Candidacy documentation activities performed by other staff in other public agencies under "contract" with DCFS or CPD to perform those activities;
  6. Candidacy documentation activities performed by private agencies under contract with DCFS or CPD to perform those activities;
  7. The determination/redetermination of candidacy status performed by DCFS or CPD staff.
  - Per CDSS, counties shall not claim child-specific case management codes to Program Code (PC) 1012. PC 1012 is funded by federal Title IV-E with a sharing ratio of 50/50/00/00. CWS-CARES has been selected by the State of California to be the automated state-wide system to collect and track child-specific outcomes per the federal regulations. Until CWS-CARES is available, a county will not be able to draw down Title IV-E for child-specific case management costs. When CWS-CARES becomes available CDSS will release new claiming guidelines.
  - Counties can claim child-specific case management costs to PC 1015 -FFPS STATE BLOCK GRANT PREVENTION ADMIN & TRAINING which has a sharing ratio of 00/100/00/00.
  - Counties may claim the candidacy activities listed above to PC 1015 - FFPS STATE BLOCK GRANT PREVENTION ADMIN & TRAINING.

State Block Grant

- Can the state Block Grant be used to assist in the development of the comprehensive prevention plan through a consultant contract?
  - Yes. The Block Grant can support any delivery of primary or secondary services that meet local needs as well as EBPs that are not included in California's FFPSA prevention plan. Additionally, Counties can use Block Grant funds to support development of the local Comprehensive Prevention Plan, which includes consulting services.



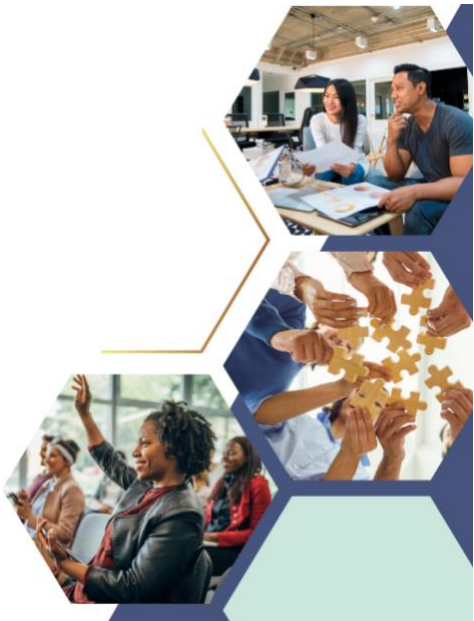
- What is the difference between the FFPSA transition grant allocation (FFTA) and the State Block Grant as to what funds can be used for?
  - There is a lot of overlap between FFTA and the State Block Grant so there is an opportunity to be strategic. FFTA funds can be used for needs assessments, gap analyses and service inventories. Also, FFTA can be used for determining funding sources and outcomes for existing services as well as building local capacity and infrastructures. There is overlap with the State Block Grant for establishing, continuing and/or expanding prevention and early intervention services. Both funding sources also can be used to evaluate evidence-based practices.
  - Only FFTA (not the SBG) can be used to fund transition activities for former waiver demonstration project counties.
  - The State Block Grant can only be used for prevention. In contrast, after dedicating at least 50% of the FFTA funding for prevention and early intervention activities, counties can then use FFTA funding for any activity to support all parts of FFPSA including Part IV residential services.

Payer of Last Resort

- Does the payer of last resort apply to local and state funding streams or only federal funding streams?
  - Payer of last resort primarily applies to federal funding and specifically MediCal. There have been questions about other funding this could apply to, but Congress's intent appears to focus on prevention services that, prior to Family First, were paid for by MediCal, and the extent to which those could be paid for by IV-E.

- How will it be determined which funding source (FFPSA vs. Medi-Cal) will pay for services if both are payers of last resort?
  - First, the term "payer of last resort" depends on context. Historically, MediCal has been the payer of last resort for health services covered by Medicare. For example, if someone has private health insurance coverage, and also MediCal, then MediCal pays after the private health insurance. In regards to FFPSA, Congress said for this specific purpose, if a service would have been paid for by MediCal before Family First, then it continues to be paid for by MediCal. Conversely, if a prevention service is payable by IV-E and would not have been paid for by MediCal or the family would not have been eligible for MediCal then it must be paid for by IV-E. Once you get past that simple framework, there are many scenarios at the margin. CDSS and DHCS are working on guidance on those issues.

- If Medicare pays for a prevention service, can you still claim IV-E for case management or other admin services?
  - Yes, the Children's Bureau has specifically addressed this issue and states that jurisdictions can claim IV-E admin for case management even if the prevention services are paid for by MediCal. Also, if MediCal funding would unduly delay the provision of service, then IV-E can pay for the service and seek reimbursement from MediCal. However, this is an issue that would require the child welfare and behavioral health agencies to work out the specific arrangements.



- To implement successful claiming, states have amended their cost allocation plans to set up clear cost pools and looked at RMS systems to ensure those are clearly defined. Once the cost pool is set up correctly and there is a way to identify the costs that are in those pools, then the claiming itself becomes fairly straightforward. Also, some states that participated in the IV-E Waiver had some advantage in that some of the things that they were doing under waivers were things that they then were able to sustain and continue under their Family First Prevention Plan.
- CDSS sent out County Fiscal Letter 21-22-110 in June. The CFL letter identifies codes that are available and indicates that the discount rate is not applied. The piece that remains outstanding is the service components since that is pending CARES. The CFL also states that the MOE statewide is $ 2.6 million. It is a difficult conversation because counties want to know their portion of MOE. It will be an after the fact determination whether counties met the MOE which we realize does make it a little bit challenging for some of the counties to build their plans.

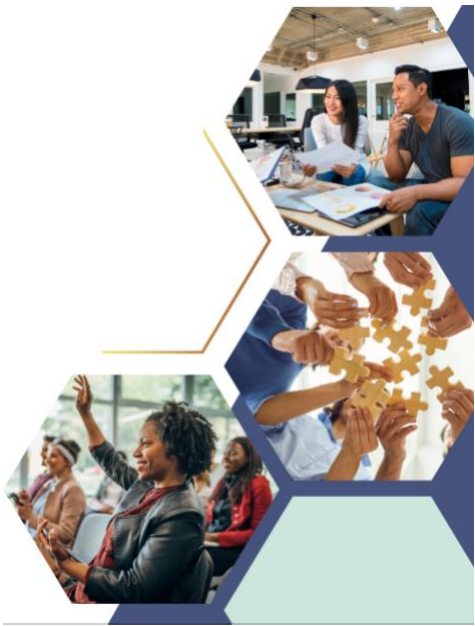
Candidacy

- Request for more clarity on the discussion about traditional candidacy versus FFPSA candidacy. And more specifically whether families need to meet both to qualify for IV-E reimbursement?
  - No, a child does not need to meet both traditional and FFPSA requirements for candidacy.
  - Here are a series of questions to ask for FFPSA candidacy:
    1. does the child meet the criteria for imminent risk according to the criteria that is in the State Family First Prevention Plan? If the answer to that is yes, then
    2. does the child's individual prevention plan include an evidence-based program that is listed on the Clearinghouse?
       - If the answer is yes to both of those questions, then the child is a candidate under Family First, meaning that the prevention service is eligible for 50% Federal reimbursement from IV-E, and that the administrative cost including case management is eligible for 50% reimbursement and not subject to the discount rate that normally applies.
       - If the answer to the EBP question is no, then the next question would be, does the child meet the imminent risk criteria of traditional candidacy that existed before Family First? And if the answer to that is yes, then the child is a candidate under traditional IV-E, meaning that you can't use IV-E for the cost of services, but that the administrative cost including case management is reimbursable at 50% multiplied by the foster care discount rate.
       - Therefore, you would first want to consider Family First candidacy and only go to traditional candidacy if criteria are not met.

- Will at risk families be able to access FFPSA supported prevention services prior to contact with a child welfare agency?
  - Along with a few other states, California has elected to put in its FFPSA plan an option for counties to create a “Community Pathway” where contact with the child welfare agency can be significantly minimized. In a community pathway option, the local community-based provider

can conduct an assessment and make a recommendation to the IV-E agency for candidacy, based on provided State-approved elements. While the IV-E agency must make the final determination of candidacy, the child does not have to have had contact with the child welfare agency, e.g., have child abuse report to be eligible for FFPSA services.

- Is it fair to say that someone in foster care cannot have access to FFPSA?
  - Yes, the issue is candidacy. An FFPSA candidate is a child who is at imminent risk of entering foster care. If a child is already in foster care, then by definition they cannot be candidates.
  - The only children in foster care who can qualify for FFPSA are pregnant and parenting youth. They are not considered a candidate, but they are eligible for prevention services. It is a separate category of eligibility. You don't have to worry about whether or not the child is a candidate because the pregnant/parenting youth is eligible for prevention services.
- Is a report to the child welfare agency a necessary (but not sufficient) requirement for candidacy?
  - A mere report would not be sufficient for Family First candidacy. There is a broader ability for the State through its prevention plan to propose a definition of imminent risk, and that can be broader than the traditional candidacy definition. And states have significant flexibility in how broadly they define imminent risk and therefore who can or can't be a candidate.
  - Federal guidance states the federal government will not further define candidacy or imminent risk. States are taking a variety of approaches to define candidates with some requiring that the family be known to child welfare and the traditional way that families become known to child welfare is through a hotline call. Some states are requiring that there be an investigation and some sort of substantiation while others are thinking more broadly. We have a couple of examples of states that have proposed families who are receiving Healthy Families America services to be categorically eligible to receive FFPSA so that they meet the risk criteria set forth in in a service process.
  - If you are going to say that every call to the hotline represents a candidate, or some subsection of families that are called into the hotline have candidate children, you will need further analysis, for instance, families where substance abuse is a concern or a need to prevent substance abuse. If you believe that substance abuse, mental health and/or parenting EBPs are going to anchor your prevention plan, you might look for families that that are called into the hotline that are the target populations for those EBPs so there are a number of different ways to approach it. Making the decision is the first step.
- Does "family settings" refer to parents, or parents and relatives? If a child is living with relatives, but not in foster care, could they be eligible for prevention services?
  - Yes. If the child is not under the placement and care of the IV-E agency, then they are not in foster care. The child could be living with a parent or relative and the definition of relative can include fictive kin.
- How does the new system track the candidacy of the child of an expectant and parenting youth when the youth is in the foster care system already?
  - Pregnant and parenting foster youth are categorically eligible for FFPSA prevention services. There is no need to determine candidacy for the child of the pregnant or parenting foster youth. The child of that foster youth is not categorically eligible for FFPSA candidacy. The data tracking is of the pregnant/parenting youth in foster care, rather than the foster youth's child.
  - This categorical eligibility for pregnant or parenting foster youth also applies to fathers.



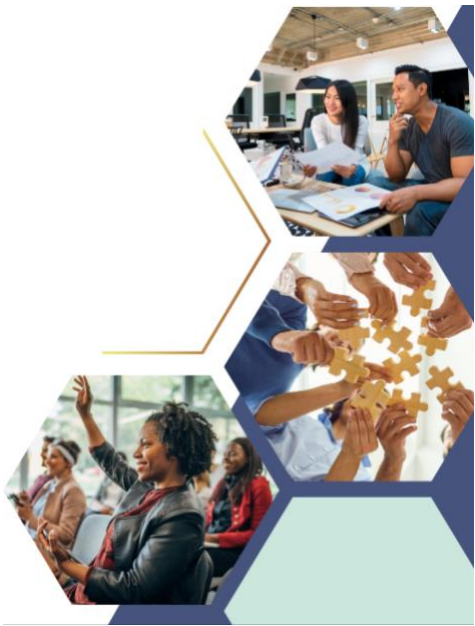
Evidence-Based Practices (EBPs)

- Can you discuss the intersection between utilizing an EBP in a family's prevention plan and being able to utilize Title IV-E?
  - Under Family First, evidence-based programs listed in the Clearinghouse are reimbursable by IV-E. This is a monumental change in IV-E funding. Since the creation of IV-E and even its predecessor program, funds could not pay for services. Family First now changes that so an evidence-based program listed in the Clearinghouse is IV-E reimbursable when provided to a "candidate" or a pregnant/parenting foster youth. There will be some restrictions in the future for EBPs that are determined to be promising or supported practices. However, at this point, California's plan includes only well-supported EBPs. Therefore, for the EBPs that are currently in California's plan there is a 50% Federal reimbursement for uncapped federal entitlements.

- If California's plan does not include promising or supported EBPs does that mean that there is no funding available to draw down for them?
  - Promising and Supported EBPs need to be in the State Plan in order for Counties to draw down Family First funding for those interventions.
  - The State Plan can be amended in the future, including adding new EBPs. And there is no limit on how often a state can amend its plan.
  - State Block Grant funds can be used for any EBPs, including those the Clearinghouse deems Promising and Supported, that are not in the State Prevention Plan. Those EBPs a county is planning to fund with the SBG will need to be described in the county's three-year Prevention Plan due in January of 2023.

- How is Motivational Interviewing (MI) used and claimed as a cross-cutting FFPSA service in other states?
  - There is no need to describe MI as a "cross-cutting service" in the prevention plan. States are being encouraged to define in their prevention plan who will be receiving the intervention and for what purpose. Although MI is in the Clearinghouse as a substance abuse intervention, MI is being approved to address substance abuse, mental health, and parenting skills in some state's prevention plans. Kentucky has submitted claims for MI, and they are using it for mental health, substance abuse and parenting and they have defined per child, per family, which way they are using it. DC has also successfully been reimbursed for use of MI in that way. Additionally, Motivational Interviewing can be used as a case management strategy by the IV-E workforce to help engage the family in the case planning process, assist family in completion of services, and provide additional support to services that are part of that child's prevention plan. Motivational Interviewing can also be used by providers as a standalone intervention.
  - In order to be claimed under FFPSA, all MI must be provided by trained and certified practitioners and be provided to the model fidelity standards set by a purveyor/training organization.

- When social work staff use Motivational Interviewing as part of case management, how does that impact the reimbursement rates?
  - There is no impact to the reimbursement rate. In this situation, MI is the standalone intervention or service that the workforce is delivering. Multiple states are embedding MI into caseworker visits and



identifying a rate for that visit. One key issue is that practicing MI "to fidelity" means that caseworker must audio/video record or have an observation for fidelity monitoring. A trained "coder" must observe or listen/view a segment (typically 15 minutes) of the caseworker visit and score the fidelity tool. Not every visit is scored; the gold standard is for caseworkers to receive coding feedback every 4-6 weeks for up to 6 work samples, then approximately every 6 months thereafter.

- <u>If a County is using the community pathway to reduce contact with the child welfare system, why would the County casework staff use Motivational Interviewing?</u>
  - If there is an open family maintenance or voluntary family maintenance case or a 602 determination, or expectant/parenting youth in foster care (in CA plan, these are eligible candidate populations) then County workers will use MI as a case management and visitation strategy to engage that family and keep the family involved in services.
  - In the case of the community pathway, family contact with a County agency is ideally minimized. However, if and when a safety or risk concern is raised by the service provider with the County agency, there could be an advantage to the County worker also using MI. In order to claim IV-E for the County worker's delivery of MI, the County Prevention Plan and individual prevention plans in that County would need include the possibility, need and/or purpose of having multiple workers using MI.

- <u>How does a County identify the payer of last resort as it relates to Motivational Interviewing (MI)</u>?
  - This would be the same process as any other EBP. If MediCal in California is currently paying for MI (conducted with model fidelity by certified practitioners), in any way, then MediCal would continue to pay for it. However, if there is no existing structure for drawing down MediCal for MI, then a County can look to IV-E as payer of last resort.

- <u>From a CQI perspective, who is monitoring Motivational Interviewing to adhere to fidelity</u>?
  - Nationally, there are a couple different models being used:
    - External coders observe the visit, or a videotape or audiotape interaction with families is submitted to an external coder to review and provide feedback.
    - Internal coders: Once trained and certified (e.g., through a contract with a university partner who trains and certifies the agency staff and providers on the fidelity tool), the agency may identify and use internal trainers, CQI staff, coaching staff, or maybe their practice model staff to be coders. There could be a fidelity tool that is asking supervisors to do the coding/scoring.
    - Note: not every engagement utilizing MI needs to be reviewed for fidelity. There are great sampling tools out there as a guide to jurisdictions on how to do a random sampling at a level that is appropriate based on the number of users.

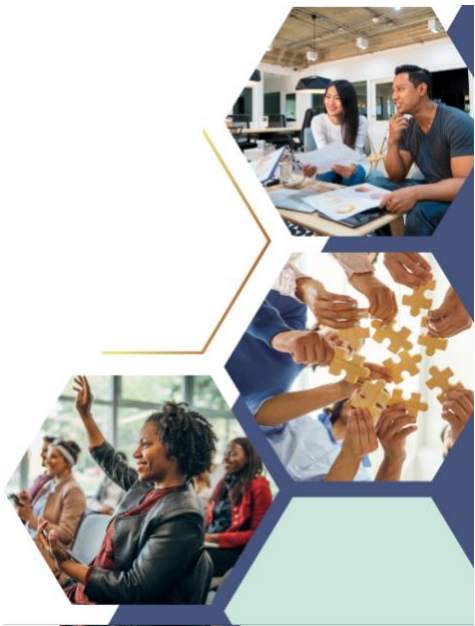
- <u>How do we break out FFPSA interventions for billing</u>?
  - Here is an example: A county has Family Checkup as one of its EBPs. Family Checkup uses some motivational interviewing in its model. Any one hour that a provider spends with a family can only be billed to one intervention. In this example, the provider would bill for Family Check-up and not MI because MI in this case is a part of the Family Checkup intervention.

- Another example: A caseworker uses MI during a casework visit and refers the family to Healthy Families America. Both, each HFA session delivered by the service provider is tracked/invoiced, and each casework visit when MI is used by the caseworker is tracked. The child-specific individual Prevention Plan must include both interventions in order for both to be submitted for Federal reimbursement.

- <u>One challenge is that our mental health providers and substance abuse providers bill for an hour of therapy, they usually don't bill for specific interventions. They could use four or five different modalities during an hour with a parent. How do we break out the FFPSA EBPs?</u>
  - The way in which providers invoice for Family First is going to have to be intervention specific. For example, PCIT was delivered to Child on July 13, 2022. That is the information that the state will need to aggregate for claiming. And if provider used MI during that PCIT intervention, they would only invoice for PCIT.
  - However, if the provider is meeting with the family to develop the plan and using MI to engage the family in these activities and discuss needs, then it is possible to bill/claim MI as an EBP for case management. As always, it is important to note that all EBPs need to be provided with fidelity by certified practitioners.
  - It is important to work with providers about explicitly distinguishing the use of MI as an intervention in and of itself, versus using MI techniques as part of another intervention.

- <u>Does CSU San Diego's Motivational Interviewing as listed in the California's Evidence-Based Practice for Child Welfare meet the criteria for an FFPSA intervention</u>?
  - MI is an interesting intervention compared to others in that there is no central purveyor. There is a professional organization of independent MI trainers called MINT providing standardized training for MI. Therefore, it is really about making sure that you have high quality training like MINT and a trainer who is familiar with CA's fidelity tool of choice to make sure that staff understand their roles and responsibilities for fidelity.

- <u>If a county chooses internal coding/scoring for MI, is there any additional oversight/CQI</u>?
  - Nationally, the practice is to have the audio/video recordings and a random sampling reviewed and coded/scored by a person or group. Typically, they look at only 15 minutes of that recorded session. If they don't find use of MI, often they will fast forward and look for another part of that submission that they can code as MI. Each worker's score will need to be tracked and uploaded into a system that aggregates the data for a broader look. Counties will want to have someone who can assess how well MI was implemented to fidelity by each worker and how often reviews should occur. For example, one university partner is planning to do some coding in the first eight weeks of 10% of their audio/video submissions and then to move to reviews every six months or maybe even every year, based on again, this person's ability to demonstrate the skills to fidelity. You don't have to look at that sampling in the same way over time.
  - At this point we do not know what CA will require for CQI or oversight or how much of that will be centralized at the State or decentralized at the County level. However, there is no national requirement for such oversight. That said, because the State is entering into a federal contract with the approval of the prevention plan, the Children's Bureau can audit for the appropriate use of the EBP. If they did not find evidence of fidelity monitoring, they could recoup/disallow funding. Fidelity monitoring is required by nature of entering this agreement



with the Administration for Children and Families (ACF) that a State is going to implement this EBP in the way that it was described in the approved State Plan.

- <u>The CPP requires a continuum of prevention services – primary, secondary and tertiary. There are currently 10 EBPs and more will be added. However, EBPs only seem to fit with tertiary prevention, and so counties also need to identify more primary and secondary services. Could those same EBPs fit within those primary and secondary prevention categories?</u>
  - This depends on whether the child meets the definition of candidacy. If a child meets FFPSA candidacy, the County can provide an EBP using FFPSA funds. If a child does not meet criteria for candidacy, the County can provide the same EBP using other funding sources, such as the State Block Grant. Also, counties do not need to deliver several EBPs to several populations. Only one EBP delivered to one population could be sufficient for the CPP.
  - Certain EBPs, particularly those in the home-visiting category, can be delivered in a primary, secondary or tertiary context. The context is dependent on the nature of the population or community receiving the EBPs and what stage of the prevention continuum at which a family finds itself. The context(s) in which an EBP is used must be stated in the CPP.