Foster Care Rate Methodology

As Required by

2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 32)

Texas Health and Human Services Commission

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1. Executive Summary

The *Foster Care Rate Methodology Report* is submitted pursuant to the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 32). The full text of Special Provision 32 is in Appendix A.

Pursuant to Special Provision 32, HHSC contracted with a third-party vendor, Public Consulting Group, Inc. (PCG), to conduct an evaluation of the foster care rate methodology in collaboration with the Department of Family Protective Services (DFPS). PCG's full report, *The Texas Health and Human Services Foster Care Rate Methodology Study is in Appendix B.*

The Foster Care Rate Methodology Report contains information developed by HHSC and DFPS to provide context and considerations regarding PCG's key findings and recommendations. More specifically, the report provides considerations for implementation and anticipated fiscal impacts of implementation of the recommendations made by PCG.

2. Background

House Bill 5, 84th Legislature, Regular Session, 2017, codified at Section 40.058, Human Resources Code, requires the DFPS and HHSC to "enter into contracts for the provision of shared administrative services, including…rate setting." On May 4, 2018, HHSC and DFPS agreed in a memorandum of understanding that the HHSC Provider Finance Department (Provider Finance) would on an ongoing basis "identify and recommend appropriate rate changes, if applicable, and send a notification to DFPS staff of the recommendations." Pursuant to the memorandum, Provider Finance calculates recommended reimbursement rates for DFPS' 24-hour Residential Child Care (24-hour RCC) program and submits those recommendations to DFPS for their consideration as requested.

DFPS currently reimburses providers through two payment models: the legacy system and Community-Based Care (CBC). Under the legacy system, DFPS pays 24-hour RCC providers a payment rate for each day of care provided. The rate depends on the placement setting type and the child's assessed service level. HHSC uses provider cost reports to calculate rates for Child Placing Agencies (including a foster family passthrough); General Residential Operations/Residential Treatment Centers (GRO/RTCs); and Emergency Shelters (ES). For each setting, HHSC calculates a weighted mean/median rate. For CPAs and GRO/RTCs, HHSC applies a a service level index that adjusts the rates based on the child's service level. Rates for ES do not vary by service level. All calculated rates are adjusted upward by 7 percent to approximate the 60th percentile, consistent with other facility-based program rates. This results in the methodological rates. The final rates are set by the Legislature and are limited to available appropriations.

CBC pays blended rates intended to approximate what the state would have paid under the legacy system. HHSC calculates a statewide average blended rate using the current legacy rates and forecasted placement days. DFPS provides HHSC with projected days of care by Service Level, Placement Type, and Strata (based on age at entry and duration of care) for Legacy catchments. HHSC then develops average rates for each stratum based on the projected Legacy days while maintaining the overall statewide average. HHSC uses the statewide average rate for each stratum and projected number of placement days by strata for each CBC catchment area to develop a blended daily rate for each catchment area. Exceptional care days and payments are "carved out" of the blended rate and provide relief for some very high-cost cases.

The 86th Legislature directed HHSC, in consultation with DFPS, to evaluate the methodology for establishing foster care rates pursuant to the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 32).

Special Provision 32 required HHSC (in collaboration with DFPS) to determine whether there is an alternative rate methodology that would increase provider capacity capable of delivering appropriate and evidence-based services, incentivize quality improvements, and maximize the use of federal funds. HHSC was also directed to evaluate cost-reporting requirements to identify opportunities to streamline reporting and ensure necessary information is included to support any alternative foster care rate methodology. The provisions required that stakeholders have an opportunity to provide input on the alternative rate methodology. Finally, the provisions allowed HHSC to contract for the evaluation with a third party with demonstrated capacity to develop residential child care rates and risk-based contracting in child welfare settings.

HHSC pursued a Request for Proposal (RFP) to enter into a contract to evaluate the foster care rate methodology. HHSC posted the RFP solicitation on June 26, 2020. It was open for bidders for 21 days. During that time, bidders could post questions to HHSC. All questions and answers were posted online for each bidder to review. Once the solicitation period closed, HHSC went through an evaluation process to score all potential bidders. HHSC prepared and awarded the contract after selecting PCG as the vendor, and the solicitation moved into the contract management phase.

During PCG's evaluation, the vendor met with HHSC and DFPS weekly (at the minimum) and held industry stakeholder engagement sessions. PCG's report, *The Texas Health and Human Services Foster Care Rate Methodology Study*, contains the information shared and considered during their evaluation, along with their key findings and recommendations. This report is attached as Appendix B.

HHSC recommends that the reader familiarize themselves with PCG's report, *The Texas Health and Human Services Foster Care Rate Methodology Study, before reading HHSC's report, the Foster Care Rate Methodology Report.*

3. Public Consulting Group's Key Findings

PCG's report, *The Texas Health and Human Services Foster Care Rate Methodology Study,* includes key findings based on their evaluation, pursuant to Special Provision 32. The Appendix B page number of each PCG's key finding is listed in parenthesis for reference.

Below is a summarized list of PCG's key findings and information developed by HHSC and DFPS to provide additional context.

Key Finding #1: The current rates do not clearly align to cost of care.

HHSC Response: In the legacy system, services are provided and costs are generally incurred according to a specific setting type: a foster home, GRO/RTC or an ES. While payment rates vary based on setting costs, rates are established according to a child's service level so that providers are compensated at a higher rate for children with higher behavioral or medical complex needs.

Calculating payment rates based on service levels is a challenging process for several reasons. First, the state pays the same rate for GROs and RTCs, and HHSC is currently unable to differentiate the costs of GROs and RTCs or for facilities providing multiple specialties to children under their care. Second, HHSC calculates the service level rates by applying a service level index adjustment to the per diem setting costs. This calculation relies on decade-old staff time study data that may no longer realistically reflect staff time and effort associated with providing care to a child according to his or her service level.

Key Finding #2: The current rate level system, whereby rates can fluctuate for children based on assessed service level, creates fiscal challenges.

HHSC Response: Payment rates that vary based on service levels tied to a child's needs can create fiscal challenges for service providers. Payment rates are highest for children with the highest needs, and rates are lowered as children are "stabilized" and their conditions improve. This system can create a rate structure that does not incentivize/reward providers to improve children's outcomes. However, the service level system attempts to ensure providers are compensated appropriately for the cost of care for children with the most complex needs.

Key Finding #3: The rate development process is primarily retrospective.

HHSC Response: HHSC collects DFPS' 24-hour RCC cost reports on an annual basis from contracted providers. For instance, the 2020 cost reports are due April 2021. HHSC Provider Finance staff conduct a financial examination of each of the cost reports received. Once the financial examinations are complete, the costs are trended from the reporting period to the anticipated rate period. Since actual reported provider costs are the basis for HHSC's rate calculations, rate development tends to be retrospective. HHSC updates rate calculations for inflation and modifies rates for known economic or program changes. This process is similar to HHSC's process for collecting Medicaid cost reports; however, HHSC collects Medicaid costs reports biennially.

Key Finding #4: The rate calculations mix retrospective costs with forecasted payments.

HHSC/DFPS Response: This finding only applies to how CBC rates are calculated. CBC pays blended rates intended to approximate what the state would have paid under the Legacy system. A statewide average blended rate is calculated using the current Legacy rates and forecasted placement days. DFPS provides HHSC with projected days of care by Service Level, Placement Type, and Strata (based on age at entry and duration of care) for Legacy catchments. HHSC uses the statewide average rate for each stratum and projected number of placement days by strata for each catchment area to develop a blended daily rate for each catchment area. Exceptional care days and payments are "carved out" of the blended rate and provide relief for some very high-cost cases.

Key Finding #5: There is an overreliance on fundraising to support contract requirements.

HHSC Response: Title 1 of the Texas Administrative Code (1 TAC) §355.103(b)(18) establishes requirements associated with grants, gifts, and income from endowments and operating revenue. These requirements include which types of revenue should be included or offset prior to completing the cost reports. Providers can provide itemized offsets in their allocation summary or trial balances as supporting documentation with their cost reports.

Further analysis would be required to identify the amount of fundraising revenues providers offset before completing their cost reports. This analysis may warrant modifications to the cost report template to allow for more itemized reporting. This modification would enable HHSC to analyze the impact fundraising has on the recommended rates.

Key Finding #6: There is a lack of financial incentives and accountability in the rates.

HHSC Response: The payment rates are calculated to support a minimum level of care that is both economic and efficient. The current rates do not include financial incentives or additional accountability requirements. HHSC would require additional appropriations to develop a rate methodology for rates that include both financial incentives and accountability requirements. The fiscal impact of this possible update is unknown at the time of this report and will be dependent on the determination of the specific financial incentives and accountability requirements.

4. Public Consulting Group's Recommendations

PCG's report, *The Texas Health and Human Services Foster Care Rate Methodology Study,* includes recommendations to address the specific requirements of Special Provision 32. These recommendations include the evaluation of alternative rate methodology(ies) "…that would increase provider capacity capable delivering appropriate and evidence-based services, incentivize quality improvements, and maximize the use of federal funds" and cost reporting requirements "….to identify opportunities to streamline reporting and ensure necessary information is included to support any alternative foster care rate methodology."

HHSC outlined PCGs recommendations below. In collaboration with DFPS, HHSC provided contextual information for each recommendation to include potential implementation requirements and when a fiscal impact is anticipated. The Appendix B page number for each recommendation is listed in parenthesis for reference.

HHSC also recognizes the complexity of implementing these recommendations, in whole or in part. An estimated timeline for implementation is outlined in the Conclusion section of this report. Implementation would require, but is not limited to:

- DFPS, in collaboration with state partners, identifying the defined foster care program models to implement;
- DFPS, developing an appropriate assessment tool to be used for the proposed program models;
- HHSC, in collaboration with DFPS, developing assumptions and requirements for pro forma modeling of rates until cost report templates can be updated and data collected;
- DFPS amending or developing new contract requirements;
- DFPS updating or amending current billing infrastructure or practices;
- stakeholder involvement throughout the process; and
- appropriations sufficient to support the implementation of the recommendations and the rates developed based on the recommended program models.

In addition, the recommendations related to Federal Funds section may require additional analysis and/or feasibility studies.

Special Provision 32 states, "If an alternative is identified, HHSC and DFPS may implement the revised methodology if doing so would not increase General Revenue expenditures for foster care payments in Strategy B.1.9, Foster Care Payments." Additional analysis is required to determine if HHSC will be able to implement any of PCG's recommendations with budget neutrality. However, fiscal impacts are anticipated to support new rates, potential infrastructure creations/modifications, feasibility study(ies), and staff resources.

Alternative Rate Methodologies

PCGs alternative rate methodologies recommendations were:

"PCG recommends continuing to reimburse the legacy foster care providers with daily per diem rates and continuing to pay the SSCCs a blended daily rate in Community Based Care. However, we recommend significant modifications to the current processes for developing those rates to better align rates to the cost of care.

Given the forthcoming transition to statewide community-based care, an overhaul of the legacy system is not recommended at this time. However, PCG recommends that DFPS/HHSC move away from tying rates to children's assessed service level toward a system with defined foster care program models and corresponding rates. In the current system, and with the current data, it is not possible to understand the true cost of caring for children assessed as specialized versus moderate for example. Moving to a system that aligns programs to needs, and aligns rates to costs, will allow DFPS/HHSC to better track the cost of caring for children with different needs. In this system, assessment tools can be utilized to inform placement decisions, monitor placement decisions, and track the costs of children based on assessment scores. While incorporating these changes, PCG recommends the state consider incorporating new performance-based payments into the model.

Similarly, for the CBC model, PCG recommends retaining the current daily rate model but updating it to better reflect the cost of care. This is necessary to realize the intent of the blended rate which should place a reasonable amount of risk on the Single Source Continuum Contracts (SSCCs) (to incentivize efficient care) while also providing opportunity for reward (such as flexibility)…."

In addition to these recommendations, PCG provided further detailed recommendations in alignment with the Special Provision 32 requirements.

Individualized Needs of Children

Recommendation # 1: Align the rates to specific, clearly defined, program models.

DFPS Response: At a high level, DFPS implementation would require the following:

- Identifying a core set of service packages that would meet the various needs of children across the state and for which the state would procure.
- Developing a more robust assessment tool and process for evaluating children in care that aligns with the service models included in the foster care placement continuum.
- Collaborating with HHSC and stakeholders to define the costs and develop methodology for the payment structure that will be used for each of the service packages identified.
- Drafting and finalization of procurements and resulting contracts consistent with the defined service packages.
- Amending existing contracts (both SSCC and legacy) to allow for transition between current and newly designed services/methodology requirements. (This may require operating two systems during a time to allow for appropriate transition).
- Modifying existing financial IT payment components in IMPACT and other relevant systems.
- Modifying existing DFPS placement and contracting policies to align with new service delivery system.

Recommendation #2: Price the elements of the program models using cost report data and market analysis.

HHSC Response: HHSC would work with DFPS to model the costs of each proposed program based on defined service specifications and requirements, once determined through the scope of recommendation 1. The scope of pricing elements will depend on which discrete program(s) may replace the current service level system. HHSC, in consultation with DFPS, would need to develop a crosswalk to determine the extent to which current cost report data could be utilized to determine the costs of any proposed program or service changes. HHSC intends to leverage current cost report data to support cost estimates for each proposed new program model. If the proposed program models differ significantly from current systems such that HHSC is unable to develop a crosswalk using current data, HHSC would cost out each program model through a proforma modeling approach. HHSC would use reputable external data sources (such as salary data) provided by the Bureau of Labor Statistics to approximate reasonable anticipated costs for the proposed program changes.

It is not possible to estimate the fiscal impact of these changes until DFPS defines each program or service model. If directed, HHSC would develop two economic models:

- One model would seek to provide our best estimates of true program costs based on the established methodology.
- The other version would model the proposed program to achieve budget neutrality with the current foster care system.

HHSC may require additional full-time equivalents (FTEs) depending on the scope of the program model(s) and to provide adequate support in the evaluation, implementation, and monitoring phases. These full time equivalents will include a *Program Specialist VI – Rate Analyst and a Data Analyst III. The Program Specialist VI – Rate Analyst* would serve as a subject matter expert on DFPS rate setting and act as the lead staff member for HHSC to implement a new rate methodology for the 24-hour RCC program. The Data Analyst III would support project implementation by developing economic models, recommended rates, associated fiscal estimates, and an appropriate financing method for the proposed program changes. The estimated fiscal impact for state fiscal years 2022-23 is $379,632 all funds.

Recommendation #3: Review the rate calculations with stakeholders to refine the models and price.

HHSC Response: HHSC recognizes the importance of stakeholder involvement in our processes. We anticipate this involvement would be two-fold. First, stakeholders that represent families, child-placing agencies, and residential programs would be engaged as DFPS develops program models. Secondly, in collaboration with DFPS, HHSC would engage stakeholders during HHSC's biennial fee review schedule to incorporate a continued and systemic review of the program models.

One method for incorporating stakeholder engagement could be through the establishment of a DFPS lead-stakeholder workgroup/forum focused on the 24-hour RCC proposed program models. HHSC would utilize the FTEs required in response to the prior recommendation to support this recommendation. The designated staff, the Program Specialist VI and Data Analyst III, would serve as a resource to the stakeholder group. This process would ensure that stakeholders are involved in both the design of programs and services and are consulted on any assumptions used in economic models associated with producing fiscal estimates.

Recommendation #4: For facility-based programs, pay the rates that align to the placement setting in which a child resides, for as long as the child resides there. For foster family rates, maintain the same rate for some period after a child is assessed as ready for a lower placement level to allow the family to sustain the progress that has been made. In other states, this time period ranges from 30 days to much longer.

HHSC Response: HHSC could propose appropriate rates based on estimated costs that would remain constant for each child in that specific program unless directed to consider other factors such as behavioral needs or acuity into the rates. If a decision was made to continue to add an assessment of a child's level of need into the foster family rates, HHSC would explore whether changes to the methodology for the current foster family passthrough rates are appropriate.

Recommendation #5: Use CANS assessments (and other tools) to inform placement and service decisions and track progress.

DFPS Response: DFPS will continue to use the CANS to inform the child's plan of service.

Recommendation #6: Recalculate the rate every three (3) years and in between when there are significant program changes.

HHSC Response: HHSC can recalculate and recommend rates to DFPS on any schedule that is requested. However, HHSC would recommend that rate recalculations align with each biennium's general appropriations act and any associated legislative direction.

Regional Variation in Costs

At this time, PCG does not recommend geographic modifiers to rates based on CANS. PCG recommends continuing to track regional differences in CANS scores and costs to determine if trends emerge.

HHSC Response: The HHSC 24-hour RCC cost report collects the entity's location/contact information. This location could identify the contracted provider's legal headquarters and not necessarily the location where the services are provided. In order to track regional differences in costs, HHSC, in consultation with DFPS, would need to identify how to accurately designate geographic regions on the HHSC 24-hour RCC cost reports. More information regarding the proposed cost report amendments are located in the Cost Report recommendation section below.

Locally Competitive Wages

At this time, PCG does not recommend a geographic modifier for rates. PCG recommends that DFPS/HHSC consider the types of personnel and credentials that are desired for programs and factor commensurate and competitive salaries into the model budget legacy rate development process across the state.

HHSC Response: As referenced in PCG's report, this recommendation will be complex and will have a fiscal impact. If the Legislature directed DFPS to implement specific programs, HHSC would use appropriate salary information that reflected competitive wages into any cost estimates produced. HHSC typically relies on Texas-specific salary data provided from the US Bureau of Labor Statistics to conduct salary or wage comparisons between staff costs reported on the provider cost reports and other similar, competitive industries. HHSC, in consultation with DFPS, would identify industries to use for comparisons with different staff types employed by 24-hour RCC providers. As part of the wage comparison, HHSC would develop fiscal estimates based on the cost of increasing staff wages to the level of competitive industries. As HHSC currently cannot identify the geographic area where services are provided from the cost reports, the analysis would be on a statewide basis; but, in time, could be expanded to different geographic regions around the state.

The Legislature has directed HHSC to provide wage supports for Medicaid direct care or personal attendant staff in the form of a minimum base wage and the voluntary Attendant Compensation Rate Enhancement Program. HHSC can calculate the cost of paying an appropriate minimum wage for direct care staff in the 24-hour RCC program and evaluate how supplemental programs that support direct care wages could be expanded to residential child care. Both efforts would have a fiscal impact and would require additional appropriations. Expanding Rate Enhancement Program to 24-hour RCC direct care staff may increase the administrative burden on providers due to compliance requirements. It might also necessitate additional staff resources for HHSC to ensure that providers are properly trained in program requirements and reports are analyzed in a timely manner to meet established deadlines. An anticipated fiscal impact for additional wage supports for direct care staff is not available at this time.

Least Restrictive Environments and High-Quality Services

Recommendation #1: For foster family homes, when a child is assessed as eligible for a lower level of placement, keep the rate constant for some period of time to allow the child/youth to continue to receive needed services to sustain the progress that has been made.

HHSC Response: HHSC anticipates a fiscal impact if higher rates are maintained for a longer period than anticipated in the current rate structure. HHSC would need DFPS to determine the specific timeframe that rates would be held constant after the child's service level changed before a fiscal impact can be determined.

Recommendation #2: Develop incentive payments for CPAs and residential programs for desired outcomes such as timely permanency, recruiting and retaining foster homes, successful moves to lower levels of care, clinical improvements, etc.

DFPS Response: DFPS implemented cost neutral incentives and remedies as a result of Senate Bill 11, passed in the 85th legislature.

HHSC Response: If DFPS establishes additional quantifiable measures that correspond to specific programmatic/quality goals in response to PCGs recommendation, HHSC may need additional staff resources to support these efforts by calculating appropriate incentives and remedies. These staff resources cannot be estimated at this time, since the scope of the implementation of this recommendation has not been established. HHSC anticipates a fiscal impact that cannot be estimated at this time.

Recommendation #3: Incorporate more foster family recruitment and retention support into the CPA retainage rate.

HHSC Response: Foster Family recruitment and retention support costs are currently included as part of the CPA retainage rate. HHSC, in consultation with DFPS, can coordinate with stakeholders to identify and ensure all foster family recruitment costs are being accurately reported and collected on the cost reports. This effort will ensure all appropriate costs are captured for the recommended rates. HHSC can also calculate the fiscal impact if CPA rates were increased to cover the full cost of foster family recruitment and retention supports as reported on the current cost reports. This would allow for a potential rate increase that was targeted to support these particular cost areas. There is an anticipated fiscal impact that cannot be determined at this time.

Recommendation #4: Incorporate more family work, family engagement, and aftercare into the residential rates.

HHSC Response: Not all current rates include costs for family work, family engagement and aftercare. HHSC could modify the cost reports to collect these types of costs. DFPS would need to define each of these cost areas. Once these cost areas were defined, HHSC could use a proforma modelling approach to calculate fiscal estimates to support funding for these specific cost areas.

HHSC anticipates a fiscal impact if these costs areas are included in the residential rates; however, a fiscal estimate cannot be determined at this time.

Sustainable CBC Model

Recommendation #1: Calculate the daily blended rates based on the new legacy rates and CBC regional utilization data.

HHSC Response: Currently the CBC blended rates are meant to approximate what the state would have paid under the Legacy system. A statewide average blended rate is calculated using the current Legacy rates and forecasted placement days. PCG's recommendation would result in a change to the rationale behind the CBC methodology. The current strata model can result in rates that may not be sufficient to support SSCC costs when the actual regional case-mix deviates from the statewide Legacy forecast used in rate calculations.

Recommendation #2: Adjust the rate for known prospective changes (program changes, price increases, etc) specific to the CBC regions.

HHSC Response: Currently HHSC uses a new CBC forecast when recalculating the CBC rates. The forecast is developed and provided by DFPS. This forecast includes adjustments for known prospective changes.

Recommendation #3: Utilize CANS data to validate the CBC placement trends and track changes in case mix by region.

DFPS Response: DFPS will continue to partner with the SSCCs to secure CANS for children in conservatorship.

Recommendation #4: Reforecast the daily blended rates annually.

HHSC and DFPS Response: HHSC and DFPS agree that an annual update of the daily blended rate is appropriate.

Risk Mitigation Strategies

Recommendation #1: Continue the exceptional care "carve out".

DFPS Response: This recommendation can be continued with no additional cost.

Recommendation #2: Implement a risk reserve.

DFPS Response: This recommendation would require additional funding**.**

Sound Rate Development Principles

Recommendation #1: Recalculate the legacy rates to tie to specific placement settings and programs.

HHSC Response: Please see DFPS's response to Individualized Needs of Children Recommendation #1.

Recommendation #2: Utilize current CBC placement data to project the daily blended rate annually.

HHSC Response: Please see HHSC's response to Sustainable CBC Model Recommendation #1.

Recommendation #3: Consider adjusting the rates annually for inflation and continue adjustments as needed for significant program or policy changes.

HHSC Response: HHSC includes the 24-hour RCC rates in its biennial fee review schedule, which provides for systematic reviews of the rates. Currently, HHSC does not automatically increase recommended rates for inflation. If annual inflation adjustments were incorporated into the evaluation and calculation of recommended rates, a fiscal impact is anticipated if those recommended rates were implemented. HHSC cannot determine the fiscal impact at this time.

Federal Funds

Recommendation #1: Maximize use of Medicaid waivers for youth with high behavioral health needs.

HHSC Response: Children and youth access YES waiver services through the Medicaid fee-for-service delivery system, and most non-waiver services can be accessed through the managed care organization (MCO) in which the child is enrolled. This means YES waiver providers do not enroll with MCOs to provide YES waiver services. All providers enroll with the Texas Medicaid & Healthcare Partnership (TMHP) to be able to provide Medicaid services. If a provider is providing a service covered by a MCO, they are credentialed through the MCO. HHSC is in the process of implementing a new Provider Enrollment Management System (PEMS), which is intended to streamline the Medicaid provider enrollment process. Because of this initiative, the recommendation to simplify the Medicaid provider enrollment process can be implemented without additional resources.

The Institutions of Mental Disease (IMD) payment exclusion includes exceptions for persons over the age of 65 and under the age of 21. Texas Medicaid provides inpatient psychiatric services to beneficiaries under age 21 if they meet medical necessity requirements and services are provided in certain federally allowable settings[1]. However, Medicaid does not cover services for children and youth who reside in IMDs if they do not meet the CMS criteria for inpatient psychiatric services for individuals under the age of 21[2]. As noted in PCG's report: "CMS defines Psychiatric Residential Treatment Facilities (PRTFs) as a non-hospital facility that has a provider agreement with a state Medicaid agency to provide inpatient service benefits to individuals 20 years and younger. Texas does not have a mechanism for certifying PRTFs. A certification process and clinical coverage criteria would need to be established to recognize PRTFs and ensure that the level of service and facility structure meet state and federal standards for the state to be eligible for federal Medicaid matching funds." More research is needed to determine the feasibility and the policy and fiscal impacts of seeking an 1115 waiver to achieve the goal of this recommendation. Additionally, it is unclear if an 1115 waiver would address the identified need and if the solution could be targeted to only children in foster care.

Recommendation #2: Encourage STAR Health, Local Mental Health Authorities and providers to maximize use of S.B. 1177 In-Lieu-Of Services.

HHSC Response: This recommendation can be implemented without additional resources or research. Federal regulations stipulate that MCOs have discretion in whether to offer in-lieu-of services, thus HHSC can encourage, but not require, that the MCOs offer these services.

[1] Per 42 CFR §441.151, inpatient psychiatric services for individuals under age 21 may only be provided in the following settings, and at the state's discretion: a Medicare or Medicaid-certified psychiatric hospital, a general hospital with an inpatient psychiatric program accredited by a national accreditation organization whose hospital accreditation program has been approved by CMS, or a PRTF that is certified by a State Medicaid Agency. Note that facilities with fewer than 16 beds (for children and youth) are not IMDs.

[2] Note that facilities with fewer than 16 beds (for children and youth) are not IMDs.

Recommendation #3: Increase use of TCM and MH Rehab Service within current MCO model.

HHSC Response: This recommendation would require a full-scale study and additional funding/resources would be needed to conduct the study and could require engaging a contractor or hiring HHSC staff.

Recommendation #4: Follow-up on S.B. 58 Integration of Behavioral Health and TCM Services into Managed Care Model.

HHSC Response: This recommendation can be implemented without additional resources or research. HHSC is currently reviewing the Behavioral Health Integration Advisory Committee (BHIAC) recommendations in order to update the current Behavioral Health Advisory Committee (BHAC) on the status. HHSC will outline how the recommendations were addressed and how HHSC plans to continue addressing them.

Recommendation #5: Conduct a feasibility study to determine costs and implications of bundling TCM and Medicaid Mental Health Rehab into the provider payment structure.

HHSC Response: This recommendation would require additional funding/resources to implement as it would require significant effort.

An important aspect of this study would be to analyze the impacts on monitoring, compliance, and potential impact on the MCO's ability to coordinate care.

Recommendation #6: Streamline the Medicaid credentialing process.

HHSC Response: Medicaid providers enroll with TMHP and providers contracted with a MCO credential with the MCO.

HHSC is in the process of implementing a new Provider Enrollment Management System (PEMS), which is intended to streamline the Medicaid provider enrollment process. Because of this existing initiative, this recommendation can be implemented without additional resources or research.

Recommendation #7: Review Opportunities to increase the Title IV-E eligibility rate.

DFPS Response: DFPS will build on existing quality assurance activities to explore any opportunity to increase the IV-E eligibility rate.

Recommendation #8: Increase kinship licensing.

DFPS Response: DFPS encourages all kinship placements to become licensed if the family wishes to pursue this option.

Recommendation #9: Develop Title IV-E Administrative Claiming strategies for GRO/RTC placements.

HHSC response: HHSC can work with DFPS to ensure that administrative cost categories are identified appropriately on the cost reports to capture and claim these IV-E eligible costs.

Recommendation #10: Develop a method to claim costs associated with child specific contracts.

DFPS Response: DFPS will continue to evaluate if federal claiming requirements can be met for these unique settings.

Cost Reports

Special Provision 32, required the evaluation of the cost reports to include:

> "…eliminating reporting requirements that are not required by state or federal law and are not currently being used by HHSC or DFPS to set rates; adding detail where needed to align rates paid with the quality and intensity of services across levels of care; and including additional or modified reporting requirements necessary to support implementation of any alternative rate methodology."

HHSC outlined PCG's recommendations and provided contextual information to include potential implementation requirements. To serve as a reference to the reader, the Appendix B page number of each PCG's recommendations is listed in parenthesis.

While some of the recommendations may be aligned with the proposed recommended program models, some of PCG's recommendations may be implemented independently. It is anticipated that if any PCG's recommendations are implemented independently from the proposed recommended program models, further modifications may be made once/if the proposed recommended program models are determined and implemented.

While it is anticipated some of the recommendations may be implemented within current resources, it is not known if the summation of the cost report revisions will result in a fiscal impact.

HHSC collects 24-hour RCC cost reports on an annual basis, historically from February through April. For example, the 2020 cost reports, which will be collected in February through April 2021. Once the cost reports are collected, they are examined by HHSC PFD Cost Report Review Unit. This financial examination ensures the data is acceptable and reasonable before utilization in rate calculations.

The earliest time some of the requested recommendations could be implemented would be for the 2021 cost reports, which will be collected in 2022. Some factors may impact the implementation of some of the recommendations. HHSC will want to engage stakeholers to ensure the proposed modifications do not burden the providers inadvertently. In addition, TAC rules provide guidance on cost report requirements. HHSC would need to evaluate if any proposed changes conflict with the TAC rules, and then determine if TAC amendments are appropriate. It can take approximately eight to twelve months to implement TAC Rule changes.

Unnecessary Cost Report Requirements

PCG's recommendation includes:

> "…after analyzing the TAC guidelines along with the data utilized in the rate setting models and comparing the data elements to the cost reporting information required, there are areas where some financial detail may be eliminated. A great deal of financial detail information is currently required in the cost reporting process. The TAC 40 RULE §700.1753 provides guidelines for broad categories of cost, primarily broken out between direct services and administration/all other non-direct expense."

HHSC response: HHSC will continue to work with DFPS to streamline the cost report so that only necessary items used in rate calculations are included on the 24-hour RCC cost reports.

Cost Report Additions

Recommendations #1:Geographic location of the Provider's program facility where services are delivered.

HHSC Response: HHSC can add a geographic location to cost reports for facility-based providers such as GROs and RTCs. HHSC would need to work with DFPS to determine if a geographic location makes sense for CPAs given where services can be performed. HHSC does not anticipate an additional cost for this proposed change to the cost reports.

Recommendations #2: Discrete Reporting by Service.

HHSC Response: HHSC can modify the cost reports to ensure each proposed program model costs are reported separately. HHSC would work with DFPS to identify which providers should be classified in terms of each program or service (for example, GROs vs RTCs). The State of Texas Automated Information Reporting System (STAIRS) which HHSC uses to collect cost reports is setup so there is a separate report for each facility type. If the current framework were maintained, HHSC would create separate reports for GROs and RTCs. HHSC believes that this change would allow us to calculate appropriate rates for GROs and RTCs separately based on different services provided.

HHSC estimates there may be a fiscal impact, depending on the number, complexity and scope of the new proposed program models. While a specific fiscal impact cannot be determined since the scope of aniticpated changes is unknown, it can cost up to $125,000 All Funds for a new report to be designed, developed, tested and implemented. In addition, an annual costs of $25,000 - $50,0000 is required in subsequent years to maintain and operate a new cost report, which may also require capital authority.

Recommendations #3: Report Revenues to Providers from DFPS.

HHSC Response: HHSC can add reporting fields on the cost report for DFPS revenue. HHSC would need to work with DFPS to ensure that reported revenue can be evaluated during the financial examinations process. HHSC does not anticipate an additional cost associated with this proposed change to the cost report.

Recommendations #4: Specify Fundraising in Non-DFPS Revenue.

HHSC Response: HHSC can add fields so that 24-hour RCC providers can report fundraising associated with program expenses. Prior to the 2015 cost reporting year, HHSC required providers to submit a Schedule D, which enabled them to report itemized unrestricted grants, gifts, and income from endowments from private sources or other revenues used to offset allowable costs. This requirement was removed to reduce provider burden. HHSC can work with DFPS and stakeholders to enable fundraising revenues to be reported in a way that limits provider burden as much as possible. HHSC can also begin to analyze the types of revenue and associated dollar amounts currently used to offset allowable costs and present that information to DFPS and the Legislature to inform any rate or funding decisions. HHSC does not anticipate a cost associated with this proposed change to the cost report.

Recommendations #5: One Agency Cost Report to include all Programs.

HHSC Response: The STAIRS system is setup to collect a different cost report for each facility or provider type. For example, if a contracted entity has two CPAs and a GRO. HHSC would collect separate reports for each CPA and an additional report for the GRO. The system is designed this way to attempt to ensure that costs from each type of provider can be easily identified and separated based on different contract requirements. Maintaining separate reporting requirements would ensure that adding a provider's geographic location to the cost report is relatively straightforward.

HHSC would need to evaluate the cost and feasibility of creating one report for each contracted entity. While moving to one report per entity would certainly reduce the number of required reports, it wouldn't reduce the amount or type of information providers would need to report. HHSC would work to ensure that any change to the cost reporting process maintains or improves HHSC's ability to collect and analyze costs for each program and provider type serving children in a 24-hour RCC program.

Recommendations #6: Update Cost Report to Isolate Qualified Residential Treatment Program (QRTP) Costs.

HHSC Response: HHSC can collaborate with DFPS to ensure that QRTP costs are appropriately reported on the costs reports in a way that minimizes provider burden and enables HHSC to calculate appropriate rates. HHSC does not anticipate an additional cost for this proposed change to the cost reports.

5. Conclusion

Special Provision 32, "If an alternative is identified, HHSC and DFPS may implement the revised methodology if doing so would not increase General Revenue expenditures for foster care payments in Strategy B.1.9, Foster Care Payments." While HHSC will evaluate budget neutrality, it will be dependent on the proposed program models that are designed, if implemented.

Implementation of Recommendations and Analysis

HHSC, in collaboration with DFPS, did identify some recommendations or considerations that may be implemented prior to the analysis, development, and implementation of any recommended program models. This primary includes cost report modifications.

In addition, HHSC and DFPS identified some areas where further analysis can be conducted independently of the recommended program models. This analysis will require DFPS to provide HHSC with certain crosswalks, definitions and/or assumptions. It is anticipated the below analyses could be completed within six months.

- Foster Family Payment – evaluation and potential pro forma modeling to estimate a proposed adjustment including research regarding alternative methodologies used in other state foster care programs;
- CPA Retainage – evaluation of costs associated with foster family recruitment and development to determine if a targeted adjustment is warranted; and
- GRO Direct Care staff – evaluate house parent/direct care worker salaries to model increases and submit recommendations as appropriate.

Timeline

HHSC, in collaboration with DFPS, developed the proposed timeline of key functions/tasks to implement PCG's proposed recommendations in whole or in part. If known, an estimated timeframe for the program development is included for each stage of the timeline. Some of these implementation activities may be concurrent, while some must be scheduled sequentially. Actual timeframes may vary based on external and internal factors, such as receiving necessary approvals, the complexity of the new program models, and any necessary procurement, contracting and monitoring changes.

Initial Development of Program Models (Unknown)

- Establish a DFPS-led stakeholder workgroup/forum to focus on the design of proposed program models.
- DFPS, in conjunction with the stakeholder workgroup/forum, defines and develops proposed program models.
- DFPS proposes/develops assessments that align with the proposed program models.

Development of Economic Models/Fiscal Estimates (Six to Nine Months)

HHSC, in collaboration with DFPS and stakeholders, develops assumptions that will underpin the economic models of the proposed program models.

HHSC will develop economic models and fiscal estimates to recommend to DFPS and stakeholder groups. (revenue-neutral and/or fully funded).

HHSC will work with DFPS and stakeholders to adjust and finalize the economic models, and fiscal estimates based on feedback received.

HHSC and DFPS will identify implementation requirements for their respective agencies. This will include fiscal estimates, and if capital authority is needed.

Approval of Recommended Rates (Unknown)

If needed, seek Legislative approval and sufficient appropriation to support implementation and new proposed program rates.

Implementation Considerations (Eight to Twelve Months)

HHSC, in collaboration with DFPS, develops rate methodology TAC rules. DFPS develops programmatic TAC rules.

HHSC formally recommends rates to DFPS. DFPS would implement rates based on approval (from DFPS EC) and appropriation level.

DFPS would procure new service packages as needed, update existing contracts when appropriate, implement any system changes, that are warranted, implementation of assessments, and other implementation needs related tasks.

HHSC to update appropriate cost report template to ensure data is collected to support the newly defined program models and implemented rate methodology.

Evaluation after Implementation (Ongoing)

HHSC will evaluate the rate methodologies during the biennial fee review.

List of Acronyms

Acronym	Full Name
1 TAC	Texas Administrative Code
BHAC	Behavioral Health Advisory Committee
BHIAC	Behavioral Health Integration Advisory Committee
CBC	Community-Based Care
CPAs	Child Placing Agencies
DFPS	Department of Family Protective Services
ES	Emergency Shelters
FTEs	Full-Time Equivalents
GRO	General Residential Operations
HHSC	Health and Human Services Commission
IDD-BH	Intellectual or Developmental Disability - Behavioral Health
IMD	Institutes for Mental Disease
IT	Information Technology
MCS	Medicaid and CHIP Services
MCO	Managed Care Organization
PCG	Public Consulting Group

Acronym	Full Name
PEMS	Provider Enrollment Management System
QRTP	Qualified Residential Treatment Program
RCC	Residential Child Care
RFP	Request for Proposal
RTCs	Residential Treatment Centers
SSCCs	Single Source Continuum Contracts
STAIRS	State of Texas Automated Information Reporting System
STAR	State of Texas Access Reform
TMHP	Texas Medicaid & Healthcare Partnership
YES	Youth Empowerment Services

Appendix A. Full Text of Special Provisions 32

Sec. 32. Foster Care Rate Methodology

(a) **Evaluation.** Out of funds appropriated above to the Health and Human Services Commission (HHSC) in Strategy L.1.1, HHS System Supports, and in consultation with the Department of Family and Protective Services (DFPS), HHSC shall evaluate the methodology for establishing foster care rates to determine whether there is an alternative methodology that would increase provider capacity capable of delivering appropriate and evidence-based services, incentivize quality improvements, and maximize the use of federal funds. HHSC shall also evaluate cost reporting requirements to identify opportunities to streamline reporting and ensure necessary information is included to support any alternative foster care rate methodology. HHSC may contract for the evaluation with a third party who has demonstrated capacity to develop residential child care rates and risk-based contracting in child welfare settings. HHSC and DFPS shall allow stakeholders the opportunity to provide input on the alternative rate methodology. If an alternative is identified, HHSC and DFPS may implement the revised methodology if doing so would not increase General Revenue expenditures for foster care payments in Strategy B.1.9, Foster Care Payments.

(b) Rate Methodology. It is the intent of the legislature that HHSC consider the following in evaluating a new rate methodology as outlined in subsection (a):

(1) Accounting for differences in the individualized needs of children as determined by a best practice needs assessment tool capable of predicting foster care costs reliable enough to inform rate setting, such as the Child and Adolescent Needs and Strengths (CANS) Assessments;

(2) Accounting for regional variation in costs, including differences in the individualized needs of children served in different regions and locally competitive wages to recruit and maintain qualified staff;

(3) Incentivizing placing children in the least restrictive environment that can best meet their needs;

(4) Maximizing the use of high-quality intensive home and community-based services;

(5) Maximizing the efficient and effective use of federal funds to improve capacity and address gaps in care, including:

(A) Increasing access to current Medicaid benefits such as mental health rehabilitation and targeted case management services;

(B) Identifying Medicaid benefits offered in other states for foster youth that decrease hospitalization and lower costs; and

(C) Improving reporting and tracking of data to maximize Title IV-E Reimbursements;

(6) Incorporating a viable and sustainable methodology for Community-based Care (CBC) rates, based on best practices and the experiences of other states;

(7) Providing opportunities, at least semi-annually, to adjust the rates based on demonstrated fluctuations across CBC regions and population needs;

(8) Including risk mitigation strategies that balance the risk to the state with the need to attract and maintain viable Single Source Continuum Contractors for each CBC region, such as time limited risk corridors; and

(9) Being consistent with actuarially sound rate development principles to the fullest extent possible.

(c) Cost Reports. It is the intent of the legislature that HHSC consider the following in evaluating the cost reports as outlined in subsection (a):

(1) Eliminating reporting requirements that are not required by state or federal law and are not currently being used by HHSC or DFPS to set rates;

(2) Adding detail where needed to align rates paid with the quality and intensity of services across levels of care; and

(3) Including additional or modified reporting requirements necessary to support implementation of any alternative rate methodology.

(d) Not later than September 1, 2020, HHSC and DFPS shall report on the evaluation of the methodology and cost-reporting requirements to the Governor, Lieutenant Governor, Speaker of the House, Chair of the Senate Finance Committee, Chair of the House Appropriations Committee, permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services, and the Legislative Budget Board.Public Consulting Group (PCG) Report.

Appendix B. Public Consulting Group (PCG) Report

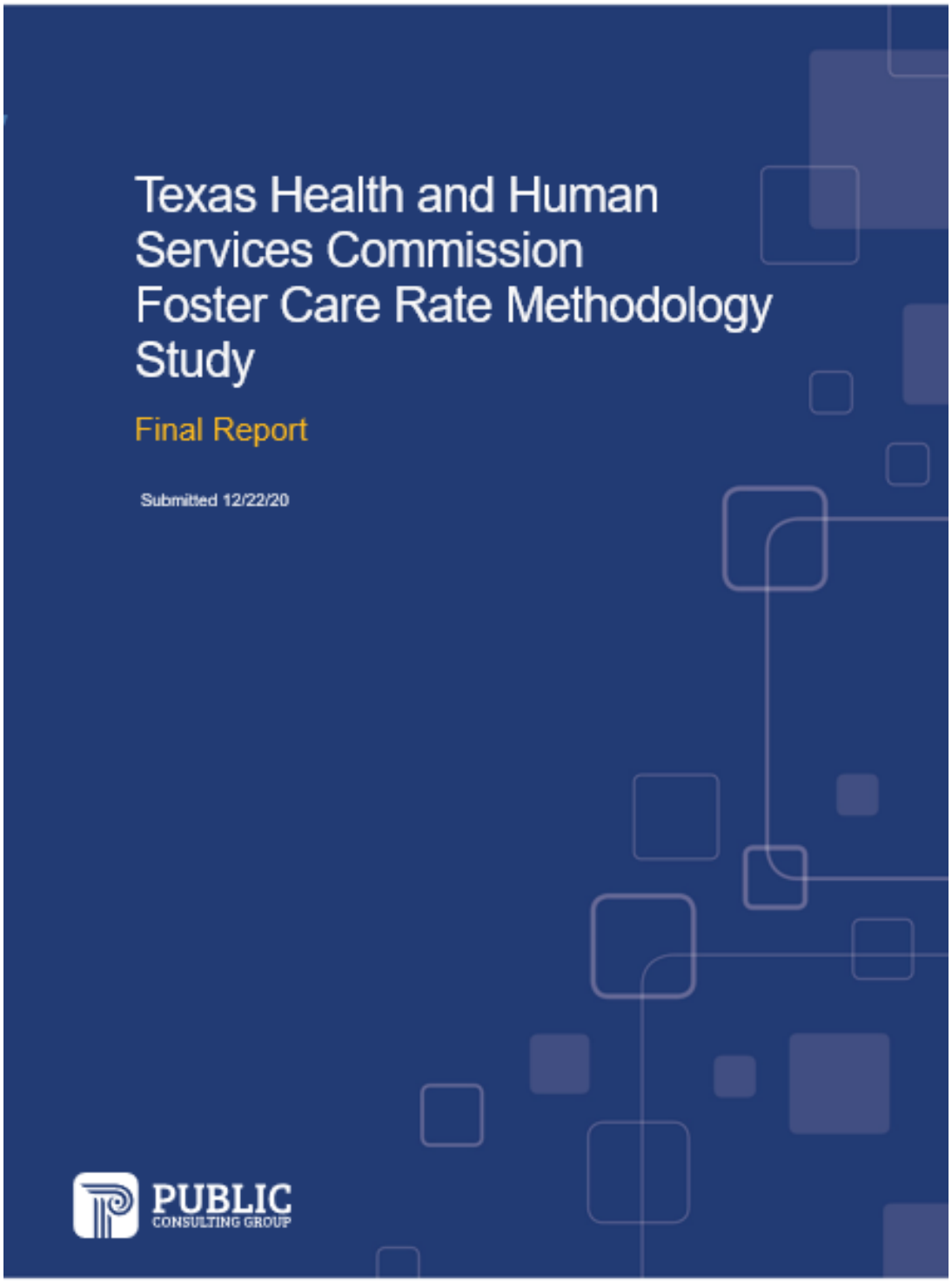


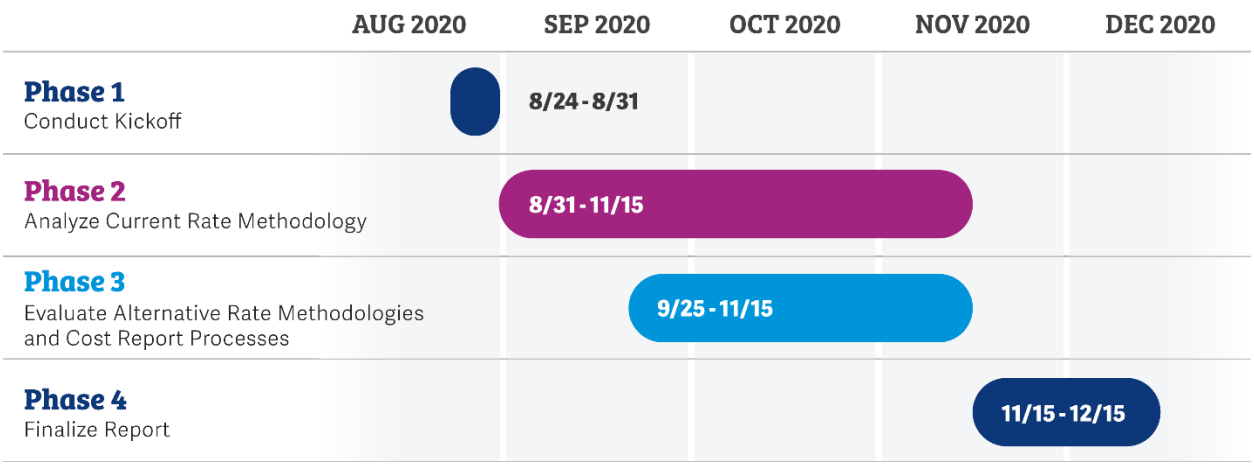
Table of Contents

1. Executive Summary

Background and Methodology

The Health and Human Services Commission (HHSC), in consultation with the Department of Family and Protective Services (DFPS), contracted with Public Consulting Group, Inc. (PCG), to evaluate the methodology for establishing foster care rates, pursuant to Special Provision 32 of the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission). This report summarizes PCG's methodology, findings and recommendations in accordance with Special Provision 32 rider requirements.

Figure 1: Project Tasks and Timeline



The figure above illustrates the tasks and timeline of PCG's review[3]. PCG reviewed provider cost report data, contracts, policies and procedures, and other supporting documentation from DFPS and HHSC. PCG conducted 32 meetings with providers and other stakeholders. A dedicated email account was created to offer all providers an opportunity to share information outside of the stakeholder sessions.

[3] The December 15, 2020 submission date was agreed upon at the beginning of the project. PCG submitted the final report on December 22, 2020 based on subsequent feedback and discussions with HHSC and DFPS.

PCG's review was undertaken with the understanding that the state aims to shift to the CBC model by 2028-2029 statewide. Our recommendations aim to support this goal by putting steps in place to better define placement models and services and ultimately better understand the cost of their care. While not recommending a complete overhaul of the rate methodologies, the recommendations herein will require significant effort and resources to accomplish.

Key Findings

Rates are developed based on historical service utilization data and informed by actual costs reported on the cost reports. However, the PCG team noted the following areas for improvement.

- The current rates do not clearly align to cost of care.
- The current rate level system, whereby rates can fluctuate for children based on assessed service level, creates fiscal challenges.
- The rate development process is primarily retrospective.
- The rate calculations mix retrospective costs with forecasted placements.
- There is overreliance on fundraising to support contract requirements.
- There is a lack of financial incentives and accountability in the rates.

Summary of Recommendations

Alternative Rate Methodologies

PCG recommends continuing to reimburse the legacy foster care providers with daily per diem rates and continuing to pay the SSCCs a blended daily rate in Community Based Care. However, we recommend significant modifications to the current processes for developing those rates to better align rates to the cost of care.

Given the forthcoming transition to statewide community-based care, an overhaul of the legacy system is not recommended at this time. However, PCG recommends that DFPS/HHSC move away from tying rates to children's assessed service level toward a system with defined foster care program models and corresponding rates. In the current system, and with the current data, it is not possible to understand the true cost of caring for children assessed as specialized versus moderate for example. Moving to a system that aligns programs to needs, and aligns rates to costs, will allow DFPS/HHSC to better track the cost of caring for children with different needs. In this system, assessment tools can be utilized to inform placement decisions, monitor placement decisions, and track the costs of children based on assessment scores. While incorporating these changes, PCG recommends the state consider incorporating new performance-based payments into the model.

Similarly, for the CBC model, PCG recommends retaining the current daily rate model but updating it to better reflect the cost of care. This is necessary to realize the intent of the blended rate which should place a reasonable amount of risk on the Single Source Continuum Contracts (SSCCs) (to incentivize efficient care) while also providing opportunity for reward (such as flexibility). More details of our recommendations are provided below.

Individualized Needs of Children (Legacy Rate System)

Legacy Rate Recommendations

1. Align the legacy rates to specific, clearly defined, placement/program models. Move away from tying rates to both placement setting and service level, and tie to placement settings/programs only.
    a. Consider the types of personnel and credentials that are desired for programs and factor commensurate and competitive salaries into the models.
2. Price the elements of the program models using cost report data and market analysis.
3. Review the rate calculations with stakeholders to refine the models and price.
4. For facility-based programs, pay the rates that align to the placement setting in which a child resides, for as long as the child resides there.
    a. For family-based settings, when a child is assessed as eligible for a lower level of placement, keep the rate constant for some period of time.
5. Use CANS assessments (and other tools) to inform placement and service decisions and track progress.

6. Recalculate the rates every three (3) years and in between when there are significant program changes. Adjustments for inflation should occur annually, if possible.

Regional Variation in Costs and Locally Competitive Wages (Legacy Rate System)

At this time, PCG does not recommend geographic modifiers to rates based on CANS. PCG recommends continuing to track regional differences in CANS scores and costs to determine if trends emerge. Instead of any geographic modifier to the rates, PCG recommends that DFPS/HHSC consider the types of personnel and credentials that are desired for programs and factor commensurate and competitive salaries into the model budget legacy rate development process across the state. This step alone (although not simple or cost neutral) may minimize the geographic issues and would be an important first step toward normalizing the salaries and rates.

Least Restrictive Environments and High-Quality Services (Legacy Rate System)

The daily blended CBC rate is already structured to incentivize placing children in the least restrictive setting that can best meet their needs, because the SSCCs will benefit financially from shifting to lower levels of care. Given that the state is transitioning to the CBC model, we recommend a few adjustments to the current legacy rate system to better financially incentivize less restrictive placements and high-quality intensive home and community-based services:

- For foster family homes, when a child is assessed as eligible for a lower level of placement, keep the rate constant for some period of time to allow the child/youth to continue to receive needed services to sustain the progress that has been made.
- Develop incentive payments for CPAs and residential programs for desired outcomes.
- Incorporate more foster family recruitment and retention support into the CPA retainage rate.
- Incorporate more family work, family engagement, and aftercare into the residential rates.

Sustainable CBC Model

The overall methodology of the daily blended rate should accomplish the desired goal of additional local flexibility. But because the rate has not been sufficient to cover costs, the state has had to provide additional assistance, the SSCCs have had to fundraise, and the benefits of shared risk and reward have been minimized. To address this, the rate must be calculated to more closely align to cost of care and the state must also have a way to validate placement decisions made by the CBCs. PCG recommends the following:

CBC Rate Recommendations

1. Calculate the daily blended rates based on the new legacy rates and CBC regional utilization data.
2. Adjust the rate for known prospective changes (program changes, price increases, etc.) specific to the CBC regions.
3. Utilize CANS data to validate the CBC placement trends and track changes in case mix by region.
4. Reforecast the daily blended rates annually.

Risk Mitigation Strategies

For risk mitigation strategies, PCG recommends:

1. Continuing the exceptional care "carve out"
2. Implementing a risk reserve, including the development of a process for CBCs to petition the state for additional funds from the reserve under specified circumstances.

Sound Rate Development Principles

In alignment with the recommendations described throughout this report, PCG recommends the following changes to how rates are calculated to address rider requirements for actuarially sound principles of achieving reasonable, appropriate, and attainable costs.

- Recalculate the legacy rates to tie to specific placement settings and programs.
- Utilize current CBC placement data to project the daily blended rate annually.
- Consider adjusting the rates annually for inflation and continue adjustments as needed for significant program or policy changes.

Federal Funds

PCG recommends the following to maximize the efficient and effective use of federal funds to improve capacity and address gaps in care:

Recommendations

- Maximize the use of Medicaid waivers for youth with high behavioral health needs.
- Encourage STAR Health, Local Mental Helath Authorities and providers to maximize use of S.B. 1177 In-Lieu-Of-Services.
- Increase the use of Targeted Case Management (TCM) and Mental Health (MH) Rehab Service within current Managed Care Organization (MCO) model.
- Follow-up on S.B. 58's Behavioral Health Integration Advisory Committee (BHIAC) Integration of Behavioral Helath and TCM Services into Managed Care Model findings to determine which recommendations were implemented4.
- Conduct a feasibility study to determine costs and implications of bundling TCM and Medicaid Mental Health Rehab into the provider payment structure.
- Streamline the Medicaid credentialing processes to improve how providers become credentialed provider through a Managed Care Organization (MCO).
- Review opportunities to increase the Title IV-E eligibility rate.
- Increase kinship licensing.
- Develop Title IV-E administrative claiming strategies for GRO/RTC placements.
- Develop a method to claim costs associated with child specific contracts.

Cost Reports

PCG analyzed cost report data and reviewed the cost reports against Texas Administrative Code requirements and best practices in cost reporting. We recommend changes to streamline four (4) sections of the cost report outlined in Section j1. We also recommend the following additions to the cost report to support the development of the alternative rate methodology.

Recommendations

- Add geographic location to provider cost reports to better capture program locations and service areas.
- Require discrete reporting by service (i.e., do not comingle GRO and RTC revenue, expense and service date).
- Require DFPS revenue to allow cost report data to furnish solvency analysis without tying in state data sets (which should be used for quality assurance.)
- Add a fundraising line for non-DFPS revenue so that HHSC and DFPS can understand provider reliance on fundraising.
- Require only one (1) cost report from each agency (with program detail delineated within one submission).
- Update the cost report to isolate Qualified Residential Treatment Program (QRTP) costs.

2. Background and Methodology

Background

In accordance with the General Appropriations Act, House Bill 1, 86th R.S. at Article II, Special Provision 32, the Health and Human Services Commission (HHSC), in consultation with the Department of Family and Protective Services (DFPS), must evaluate the methodology for establishing foster care rates to determine whether there is an alternative methodology that would increase provider capacity capable of delivering appropriate and evidence-based services, incentivize quality improvements, and maximize the use of federal funds. HHSC must also evaluate cost reporting requirements to identify opportunities to streamline reporting and ensure necessary information is included to support any alternative foster care rate methodology.

PCG was contracted to:

1. Analyze the current rate methodology for both the Legacy System and Community-Based Care (CBC) models.
2. Determine whether there is an alternative rate methodology that HHSC can utilize to recommend residential foster care rates to DFPS for the 24-Hour Residential Child Care (RCC) Program in increase provider capacity of delivering appropriate and evidence-based services, incentivize quality improvements, and maximize to use of federal funds.
3. Evaluate existing cost reporting requirement to identify opportunities to streamline reporting; eliminate reporting requirements that are not required by state or federal law and are not currently being utilized by HHSC or DFPS to set rates; add detail where needed to align rates paid with the quality and intensity of services across levels of care; and include additional or modified reporting requirements necessary to support implementation of any alternative rate methodology.

PCG's review was undertaken with the understanding that the state aims to shift to the CBC model by 2028-2029 statewide. Our recommendations aim to support this goal by putting steps in place to better define placement models and services and ultimately better understand the cost of their care. While not recommending a complete overhaul of the rate methodologies, the recommendations herein will require significant effort and resources to accomplish.

Current Rates

DFPS currently reimburses providers in two (2) ways:

1. **The legacy system and Community-Based Care (CBC).** Under the legacy system of reimbursement, DFPS pays out-of-home care providers a per diem payment for each day of care provided. The per diem rate depends on the placement setting type and the child's assessed service level. For the current legacy rate development process, weighted mean/median rates are first calculated for each separate setting type and then adjusted using service level indices to calculate rates for each service level. The median/mean daily rate is adjusted upward by 7% to approximate the 60th percentile. The final rates are determined by the legislature based on available funding.
2. **CBC is a community-based model** where DFPS purchases (through a staged implementation) substitute care, case management and family reunification services from a Single Source Continuum Contractor (SSCC) to meet the individual and unique needs of children, youth and families in Texas. The CBC model is intended to "give local communities the flexibility to draw on local strengths and resources and find innovative ways to meet the unique and individual needs of children and their families[4]." Community-Based Care is currently active in four (4) service areas: Catchment Area 1, Catchment Area 2, Catchment Area 3b, and Catchment Area 8a with full state implementation expected by 2028-2029. An SSCC in each catchment area creates a network of services and placement settings for the children in that area and they are paid a daily blended rate intended to cover the full range of placement costs and settings.
   CBC blended rates start with the statewide average weighted rate (total expenses divided by total days of care in the legacy system). DFPS projects

[4] https://www.dfps.state.tx.us/Child_Protection/Foster_Care/Community-Based_Care/default.asp

days of care by strata (based on age at entry and duration of care) and develops rates for each stratum while maintaining the overall statewide average. The statewide average rate for each stratum and projected number of placement days by strata for each catchment area are then forecasted to develop a blended daily rate for each catchment area. Exceptional care days and payments are "carved out" of the blended rate and provide relief for some very high-cost cases.

Table 1: Basic Service Level: 24-Hour Residential Child Care Payment Rates Effective September 1, 2019

Service	Payment Rate Per Day
Child Placing Agency*	$49.54
Foster Family	$27.07
General Residential Operations / Residential Treatment Center (GRO/RTC)	$45.19

Table 2: Moderate Service Level: 24-Hour Residential Child Care Payment Rates Effective September 1, 2019

Service	Payment Rate Per Day
Child Placing Agency*	$87.36
Foster Family	$47.37
General Residential Operations / Residential Treatment Center (GRO/RTC)	$108.18

Table 3: Specialized Service Level: 24-Hour Residential Child Care Payment Rates Effective September 1, 2019

Service	Payment Rate Per Day
Child Placing Agency*	$110.10
Foster Family	$57.86
General Residential Operations / Residential Treatment Center (GRO/RTC)	$197.69

Table 4: Intense Service Level: 24-Hour Residential Child Care Payment Rates Effective September 1, 2019

Service	Payment Rate Per Day
Child Placing Agency*	$186.42
Foster Family	$92.43
General Residential Operations / Residential Treatment Center (GRO/RTC)	$277.37

Table 5: Intense Plus Service Level: 24-Hour Residential Child Care Payment Rates Effective September 1, 2019

Service	Payment Rate Per Day
General Residential Operations / Residential Treatment Center (GRO/RTC)	$400.72

Table 6: Other Service Level: 24-Hour Residential Child Care Payment Rates Effective September 1, 2019**

Service	Payment Rate Per Day
General Residential Operation/Emergency Care Services (GRO/ECS)	$137.30
Intensive Psychiatric Transition Program (IPTP)	$374.33
Treatment Foster Family Care	$277.37
Temporary Emergency Placement	$400.72

*Includes the minimum daily amount to be reimbursed to a foster family of $27.07, $47.37, $57.86, $92.43 for basic, moderate, specialized and intense service levels, respectively.

**There are also eight (8) Supervised Independent Living (SIL) daily rates ranging from $35.21 for host home settings (adult only) to $57.25 for apartment or shared housing settings (young adult plus child).

Table 7: CBC Foster Care Blended Rates

Catchment Area	Rate
Catchment Area 1	$83.05/day
Catchment Area 2	$85.72/day
Catchment Area 3b	$88.04/day
Catchment Area 8a (Bexar County)	$87.64/day
Exceptional Care Ceiling	$458.92/day

Methodology

Data and Materials Review

PCG reviewed provider cost report data, contracts, policy and procedures and other supporting documentation from DFPS and HHSC. A complete list of documents PCG reviewed is located Appendix a1.

Stakeholder Engagement

PCG conducted 32 meetings with providers and other stakeholders. A dedicated email account was created to offer all providers an opportunity to share information outside of the stakeholder sessions. A table detailing the stakeholder engagement sessions along with stakeholder feedback is located in Appendix a2. Stakeholder feedback is incorporated throughout this report.

Data Analysis

Cost report data, placement data, CANS data, and state Medicaid data were analyzed to inform the rate recommendations. PCG analyzed DFPS placement, CANS, and expenditure data to identify factors that may be predictive of cost. HHSC/DFPS provided PCG with placement and removal history data from FY2016 to FY2020 for analysis.

3. Key Findings

The PCG team noted the following areas for improvement:

- **The current rates do not clearly align to cost of care.** Rates align to children's assessed service levels, rather than specific program models and costs. The rates for various service levels are determined by service level indices that aren't tied to current placement costs or associated staff time and effort at each service level. Further the cost reports do not isolate costs by service level, so it is not possible to determine how well the current rates cover actual costs.
- **The current rate level system, whereby rates can fluctuate for children based on assessed service level, creates fiscal challenges.**
  - Children's assessed levels may change (and the corresponding rate), but their placement and services may not. For example, residential programs may care for children assessed as intense and specialized, but the services provided for those children is the same while they are in a program, regardless of their assessed service level. Thus, the rates do not directly align to cost of care and depending on the mix of children in their programs, they may experience losses.
  - It is difficult for providers to budget for their overall program costs because the rates are dependent on the child's assessed service level rather than their specific program offerings.
- **The rate development process is primarily retrospective,** based on historical data, and no (or limited) adjustments made for program changes, case mix changes, or increases in cost beyond inflation.
- **The rate calculations mix retrospective costs with forecasted placements.** This could skew the rate calculations because half of the equation (the denominator) no longer aligns directly with costs. For a methodology that uses retrospective costs, retrospective placements should also be used (and then adjusted for inflation and updated to account for service utilization changes).
- **There is overreliance on fundraising to support contract requirements.** Ideally, fundraising should support program innovations or enhancements. Final rates are determined by the legislature based on available funding, and they are usually set below HHSC's calculated rates.

- **There is a lack of financial incentives and accountability in the rates.** Legacy foster care providers could be held more financially accountable for performance, through incentive and penalty payments for timely permanency, successful program exits, and clinical progress expanding on the requirements of S.B. 11. Because the daily rate for the CBC system has not been sufficient to cover costs, the state has stepped in to cover costs above and beyond the daily rate, while the SSCCs have fundraised. This has been necessary to keep the system viable, but negates the effectiveness of a blended rate, which ideally offers some risk (to incentivize efficient care) while also providing some reward (such as flexibility).

4. Recommendations

Alternative Rate Methodologies

Special Provision 32 (a): HHSC shall evaluate the methodology for establishing foster care rates to determine whether there is an alternative methodology that would increase provider capacity capable of delivering appropriate and evidence-based services, incentivize quality improvements, and maximize the use of federal funds.

Given that the state is transitioning to the CBC model statewide, a major overhaul to the legacy system is not recommended at this time. However, PCG recommends significant modifications to the current rate calculation processes to better align rates to the cost of care.

Specifically, PCG recommends that DFPS/HHSC move away from tying rates to children's assessed service level toward a system with defined foster care program models and corresponding rates. In the current system, and with the current data, it is not possible to understand the true cost of caring for children assessed as specialized versus moderate for example. Moving to a system that aligns programs to needs, and aligns rates to costs, will allow DFPS/HHSC to better track the cost of caring for children with different needs. Additionally, it allows DFPS/HHSC to drive the program models as the buyer, incorporating the state's priorities into the models, and clarifying the expected programs inputs and elements. Assessment tools can be incorporated into processes to inform placement decisions, monitor placement decisions, and track the costs of children based on assessment scores. While incorporating these changes, PCG recommends the state consider incorporating performance-based payments into the model.

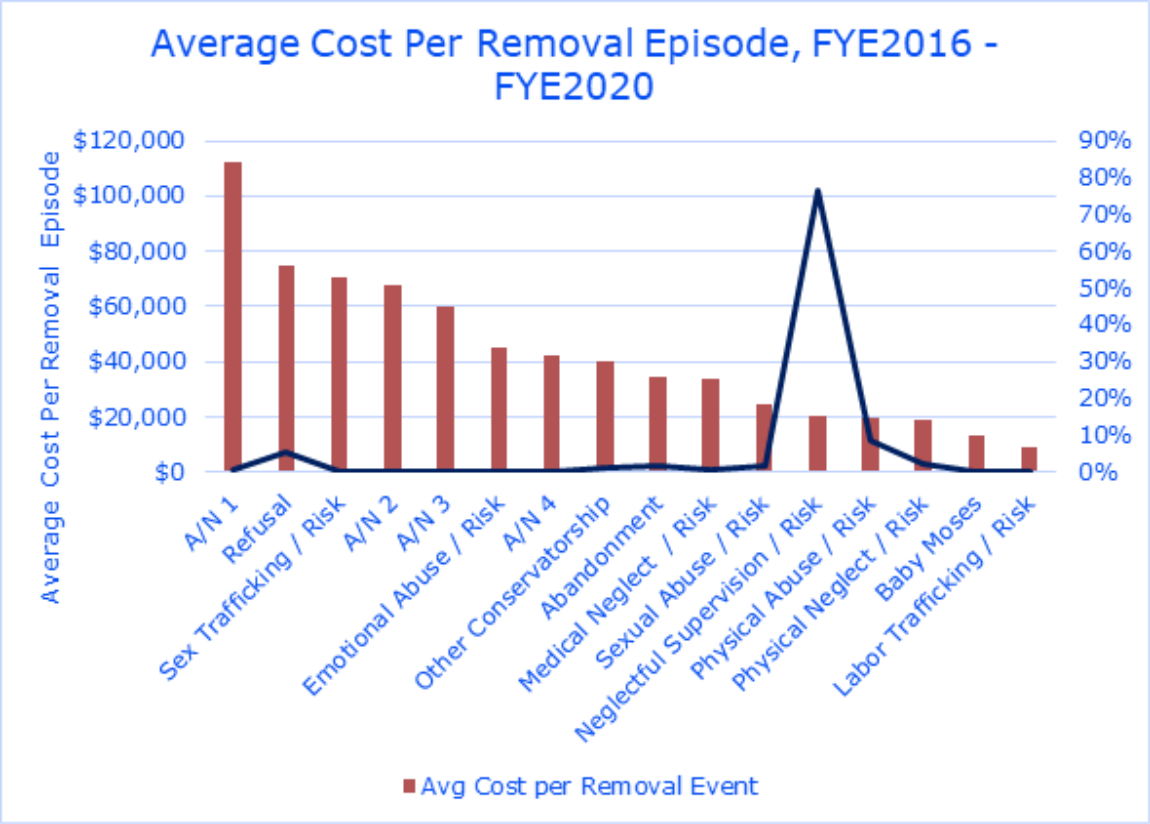
Similarly, for the CBC model, PCG recommends retaining the current daily rate model but updating it to better reflect the cost of care. This is necessary to realize the intent of the blended rate which should place a reasonable amount of risk on the SSCCs (to incentivize efficient care) while also providing opportunity for reward (such as flexibility). More details of our recommendations are provided below.

Individualized Needs of Children

Special Provision 32 (b) (1): Accounting for differences in the individualized needs of children as determined by a best practice needs assessment tool capable of predicting foster care costs reliable enough to inform rate setting, such as the Child and Adolescent Needs (CANS) Assessment.

As a starting point, to understand the associations between child characteristics and needs, PCG analyzed IMPACT data. The figure below illustrates the average cost per child by removal reason. During the four-year period of fiscal years ending 2016 to 2020, the vast majority of removals were due to neglectful supervision. Removal reasons associated with high costs generally only applied to a small percentage of cases. Additionally, there were often multiple removal reasons selected for placement episodes. Thus, removal reasons are only somewhat helpful for understanding costs.

Figure 2: Average Cost per Child by Removal Reasons, FY2016-FY2020

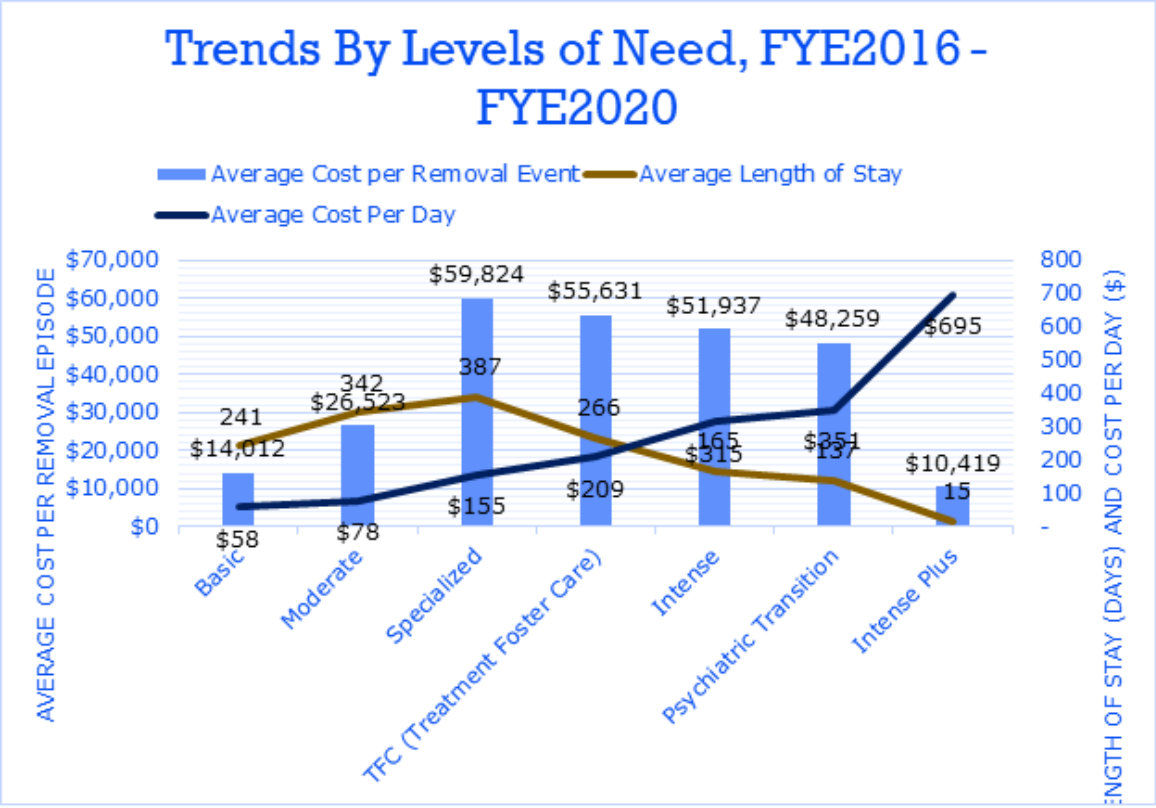


- **A/N 1** – A/N risk: Primary caregiver relinquishes custody of this child solely to obtain mental health services for the child.
- **A/N 2** – A/N risk: ack of Juvenile Justice services.
- **Refusal** – Refusal to Assume Parental Responsibility.
- **A/N 3** – A/N risk: Lack of mental health or intellectual disability services.
- **A/N 4** – A/N risk: Lack of physical/medical services.
- **Baby Moses** – Abandonment: Infant left with a Designated Emergency Infant Care provider (Baby Moses).

Dataset includes children removed between FY16 and FY20 that are no longer in placement. Children with no removal reason are not included in this figure. Children with multiple removal reasons are excluded. This report's methodology and population may not necessarily match DFPS' method of reporting on removals or placements.

Looking at service level, the specialized service level tends to be the most expensive service level overall, with an average cost per removal episode of $59,824 (see figure below). This is due in large part to average length of stay of 1.06 years at that level. Children tend to spend significantly less time in more intensive service levels. This is helpful for understanding that costs overall are a function of both service level and time in care.

Figure 3: Trends by Service Level, FY2016-FY2020



This report's methodology and population may not necessarily match DFPS' method of reporting on removals or placements. Underlying data: placements open between FY2016 and FY2020 that had a foster care payment made for services for children who were removed between FY2016 and FY2020. Duplicate Placement IDs were removed. Children with current placements (Placement End Date equals blank) were removed. "Cost" is based on placement costs only. To calculate the average cost per removal, the total payment costs were divided by the total number of unique Removal Event IDs. To calculate the average length of stay, total number of placement days were divided by the total number of unique Removal Event IDs. To calculate the average cost per day, we divided the total payment cost by the total number of placement days.

DFPS/HHSC sought to understand whether an assessment tool, such as the CANS could be utilized as a reliable predictor of foster care costs to inform rate setting. The CANS is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services[5]. It is widely used in child welfare, juvenile justice, and children's mental health systems. The CANS was developed as a communication tool to facilitate linkages between the assessment process and the design of individualized service plans. It can be used as part of the service planning process, such as in California where it is part of the Child and Family Team meetings or it can be used as a decision support tool that includes the development of algorithms for levels of care.

The table below provides examples of how states utilize the CANS for determining placement levels and impacting rates. Decision support algorithms, such as those below, take years to implement.

Summary of CANS Use

Indiana[6]

When the Indiana Department of Child Services (DCS) places a child in an out-of-home placement, the per diem rates are based on the child's age and category of supervision, largely influenced by the results of the CANS Assessment. DCS supervision categories include:

Table 8: Indiana Example of CANS Use in Determining Placement Levels and Impacting Payments

CANS Placement Recommendation	Foster Care Category of Supervision
1-Foster Care	Foster Care
2-Foster Care with Services	Foster Care with Services
3-Therapeutic	Therapeutic Foster Care

[5] https://praedfoundation.org/tools/the-child-and-adolescent-needs-and-strengths-cans/

CANS Placement Recommendation	Foster Care Category of Supervision
4-Group Home (15 and older)	Therapeutic Plus
5-Treatment Foster Care Plus (ages 12 and younger)	Therapeutic Plus
6-Group Home/Treatment Group Home (youth ages 12 to 14)	Therapeutic Plus
7-Residential Treatment Center	Therapeutic Plus

DCS family case managers (FCM) complete the CANS Assessment prior to placement or within five (5) days of placement and reassess the child every 180 days. DCS utilizes the CANS placement recommendation to determine the appropriate placement category, which are listed in the above table. When a CANS reassessment is completed, and the recommendation is to increase the level of care, the rate will increase on the date of the assessment. If the recommended level of care decreases, the rate will remain the same until two consecutive reassessments completed six (6) months apart recommend a lower placement level.

Wisconsin[7]

DCF caseworkers complete the CANS assessments and share the results with the child's team and incorporate the results into case planning for the child, family, and caregivers. The CANS must be completed within the following timelines:

- Within 30 days of a child's placement in a foster home
- Within 30 days of a new placement, but prior to a new placement in a higher level of care if the child is not already in a Group Home or Residential Care Center
- Every six months thereafter when the child has been placed with the same provider

The CANS use algorithms to provide three (3) different results:

- A mental health screen, to determine whether a child has mental health needs,
- A Level of Need, to recommend a level of placement for a child based on the identified needs and strengths, and
- A supplemental rate to be included in the foster care reimbursement

New Jersey[8]

New Jersey has utilized the CANS to support implementation of their children's system of care since the early 2000s. The CANS was initially used to support planning through the child and family teams and the Care Management Organizations. Algorithms were developed to support decision making about the use of out of community placements with specific youth. The use of the CANS, along with other system reforms, has allowed NJ to significantly increase the number of children served in their own communities.

CANS Data Analysis

To identify associations between CANS scores and foster care costs, IMPACT placement data was linked to CANS data. CANS assessments are completed by STAR Health certified clinicians. For children in the legacy system CANS assessments are completed upon entry to care and once per year thereafter. For children in the CBC system, CANS assessments are completed every 90 days for children at a therapeutic level of care. For this analysis, placement records were matched to CANS assessments that were completed within one (1) year prior to the start of the placement. If no CANS assessment matched to placement, the placement data was excluded, resulting in analysis of 21% of the placement data. If more than one (1) CANS assessment occurred within the year prior to the placement episode, then the most recent assessment was utilized.

CANS provides for a structured assessment of the youth along a set of dimensions relevant to recovery and/or service planning[6]. The Texas CANS is divided into core domains, with some variation in the domains depending on the age of the child. Needs are rated on a scale of 0-3 with a 0 indicating no evidence of need/no action required and a 3 indicating that the need is dangerous or disabling and immediate

[6] Texas Child and Adolescent Needs and Strengths, Comprehensive Assessment Manual, TX CANS 2.0

action/intensive action is needed. For strengths, again a scale of 0-3 is utilized, with 0 indicating the item as a centerpiece strength central to planning and 3 indicating no identified strength in that domain, with strength identification/creation possibly indicated. Scores in core domains may trigger the need to complete additional modules that delve more specifically into particular areas of risk.

In our model, we analyzed:

- Associations between the average domain scores and placement costs.
- Associations between the total number of items marked as risk (2 or 3) within a domain, and placement costs.

A Simple Linear Regression (SLR) was utilized to analyze the data. This statistical approach uses a straight line to quantify the relationship between an independent variable (in this case CANS scores) and a dependent variable (in this case cost per day). It finds the line of best fit through the data by searching for the value of the regression coefficient(s) that minimizes the total error of the model.

Looking at the independent values together, the following is noted:

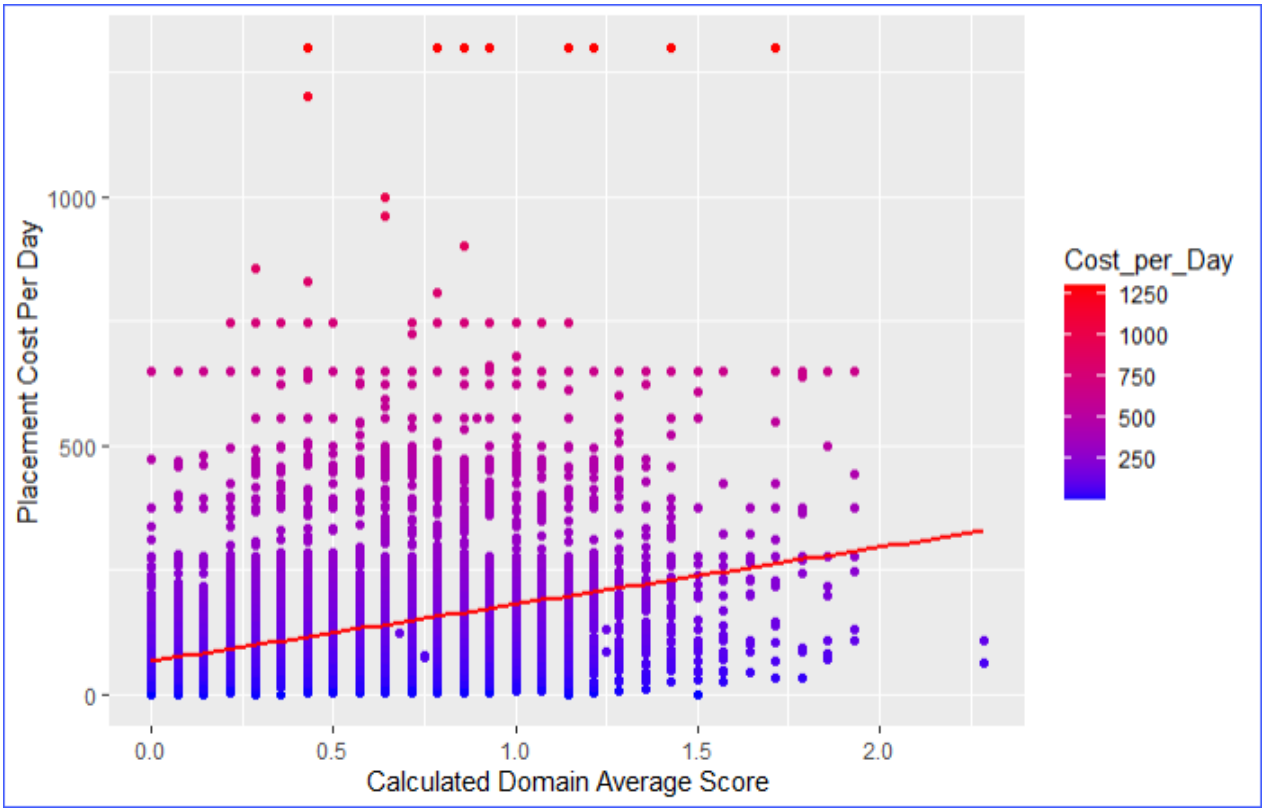
- Scores in 14 of the 15 domains are predictive of cost.
- For 9 of the 15 domains average score AND the total number of items marked as risk were predictive of cost.
- 5 of the 15 domains showed that average domain score is a better predictor of placement cost per day than the total number of items noted as risks.
- Only one (1) domain showed that level of risk (average and risk score) was not predictive of placement cost per day (Infant and Young Children Risk Factors).

Table 9: Domains Predictive of Cost

Domain (Reviewed Independently as Single Regressions)	Average Score Predictive of cost?	Total Risk Items Predictive of Cost?
Acculturation	Yes	
Behavioral and Emotional Health Needs	Yes	
Child Traumatic Experiences	Yes	Yes
Infants and Young Children Behavioral and Emotional Needs	Yes	
Infants and Young Children Functioning/Development	Yes	Yes
Infants and Young Children Risk Behaviors	Yes	
Infants and Young Children Risk Factors		
Life Functioning	Yes	
Child Risk Behaviors	Yes	Yes
Strengths	Yes	Yes
Suicide Risk	Yes	Yes
Traumatic Stress	Yes	Yes
Psychiatric Crisis History[7]	Yes	Yes
Psychiatric Hospitalizations History[8]	Yes	Yes
Child Involvement in Child Protection[9]	Yes	Yes

As examples, figure 4 illustrates this relationship for the Behavioral and Emotional Needs Domain. The average score for the Behavioral and Emotional Needs Domain ranges from 0 to 3 and as that average score increases the cost per day increases. For every domain average score increase of 0.1 the placement cost increases by $11.45/day. Figure 5 also indicates a positive relationship between the placement cost per day and the total number of items marked as risk (2 or 3) within the Behavioral and Emotional Needs Domain. The number of risk items ranges from 0 to 14 and as the number increases the cost per day increases. For every additional domain risk item, the placement cost per day increases by $19.03/day.

Figure 4: Behavioral and Emotional Needs Scores and Cost

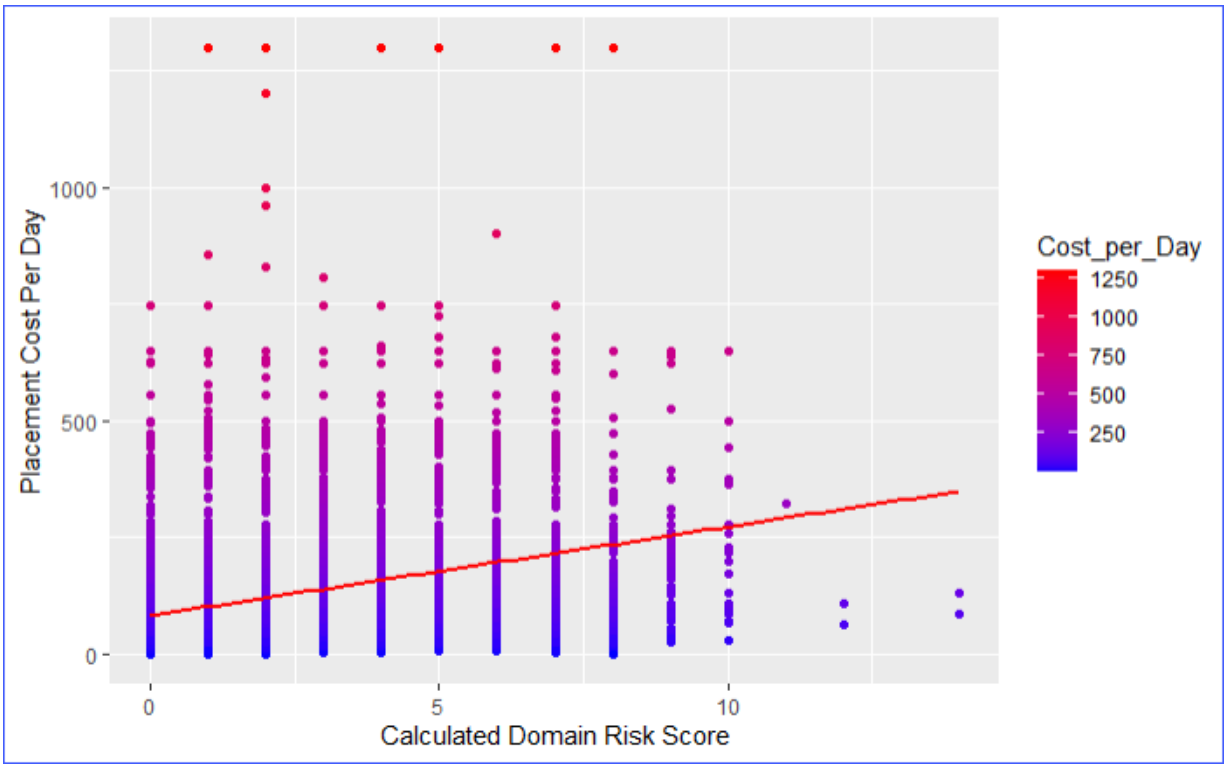


[7] This domain does not measure current needs; it includes historical service utilization information.

[8] This domain does not measure current needs; it includes historical service utilization information.

[9] This domain does not measure current needs; it includes historical service utilization information.

Figure 5: Number of Items Marked as Risk in the Behavioral and Emotional Needs Domain and Costs



While this initial analysis indicated that CANS scores are predictive of foster care costs, there are significant limitations to the analysis. First, many placement episodes were not matched to CANS scores for various reasons (not all children receive CANS assessments, missing data, etc.). Additionally, this was a single variate analysis, which means that the cumulative effect of multiple risk factors is not presented or understood. It should not be assumed that multiple risk factors have a direct, cumulative effect on cost. Experience in other states indicates that the CANS is a useful tool in determining level of care; however, it can take years to develop algorithms that tie scores to placement and service recommendations. More work needs to be done to understand the link the between CANS scores and costs and to ensure that the CANS is being delivered to fidelity.

The following steps are recommended to better align the rates to individualized needs of children:

Align the rates to specific, clearly defined, program models.

Define placement settings/services that align to children's needs with rates that tie to those specific settings and services. Clarify the program expectations for each setting, such as staffing requirements, supervisory expectations, training, and other support/operating assumptions. DFPS needs to define target populations for residential treatment centers versus cottage homes, for example, and define program specifications to meet those needs. CANS data could be utilized to better understand the needs of children in the system, so that programs can be designed or modified to meet their needs. Below we provide an example of the placement settings/services purchased in Colorado compared to Texas.

Table 9: Basic Service and Rate Options Comparison Between Texas and Colorado

Service (Texas)	Rate Type (Colorado)
Child Placing Agency	Child Placement Agency
General Residential Operations / Residential Treatment Center (GRO/RTC)	Group Home

Table 10: Moderate Service and Rate Options Comparison Between Texas and Colorado

Service (Texas)	Rate Type (Colorado)
Child Placing Agency	Group Center Care
General Residential Operations / Residential Treatment Center (GRO/RTC)	Residential Child Care Facility

Table 11: Specialized Service and Rate Options Comparison Between Texas and Colorado

Service (Texas)	Rate Type (Colorado)
Child Placing Agency	
General Residential Operations / Residential Treatment Center (GRO/RTC)	

Table 12: Intense Service and Rate Options Comparison Between Texas and Colorado

Service (Texas)	Rate Type (Colorado)
Child Placing Agency	
General Residential Operations	

Table 13: Intense Plus Service and Rate Options Comparison Between Texas and Colorado

Service (Texas)	Rate Type (Colorado)
General Residential Operations / Residential Treatment Center (GRO/RTC)	

Table 14: Other Service and Rate Options Comparison Between Texas and Colorado

Service (Texas)	Rate Type (Colorado)
General Residential Operation/Emergency Care Services (GRO/ECS)	
Intensive Psychiatric Transition Program (IPTP)	
Temporary Emergency Placement	

Price the elements of the program models

Price the elements of the program models such as direct care staff ratios, supervisor ratios, clinical staff requirements, training requirements, vehicles/mileage, etc. and price the elements of the program using cost report data and market analysis (see Table 15 below for an example). The model typically starts with assumptions about program capacity, direct care staff ratios, and first line supervisor ratios, with supporting costs built around them. This allows DFPS/HHSC to define what they want to buy, clarifies program expectations for programs, and results in a daily rate that reflects the cost of caring for children and youth in different settings. The budget can be easily modified to account for program changes and allows DFPS/HHSC to consider how children who have historically been harder to place, or who have been served through child-specific contracts, could be better served through models developed to meet their needs[13]. The supplemental payments to programs to support the 24-hour awake supervision requirements can be built into the models, eliminating the need for the supplemental payment.

Table 15: Personnel Cost Calculation Example

Personnel	Salary	FTE	Expense
Position 1 (occupation, credentials, etc.)	$$,$$$	#.##	$$,$$$
Position 2 etc. (type, credentials, etc.)	$$,$$$	#.##	$$,$$$
Total Program Staff Costs			$$$,$$$
Tax and Fringe Benefits		%.%%	$$,$$$
Total Personnel Costs			$$$,$$$

Table 16: Operating Cost Calculation Example

Operating Costs	Operating Amount/Unit	Operating Unit	Expense
Occupancy	$ Per Unit	#,###	$$,$$$
Other Program Expenses	$ Per Unit	#,###	$$,$$$
Total Operating Costs			$$$,$$$

Table 17: Indirect Expenses Calculation Example

Indirect Expenses	%.%%	$$,$$$
Model Budget Subtotal		$$$,$$$
Subtotal with Inflation Factor	%.%%	$$$,$$$
Subtotal with Utilization Factor (for GRO and GRO-ES only)	%.%%	$$$,$$$
Total Other Costs		$$$,$$$

Review with stakeholders to refine the models and price.

While the models should be driven by HHSC and DFPS, based on the needs of children in care, some engagement with families and representatives from child placing agencies and residential programs is important for capturing program costs. Engaging providers through a transparent process will ultimately result in more accurate, sustainable rates.

For facility-based programs, pay the rates that align to the placement setting in which a child resides, for as long as the child resides there.

For foster family rates, maintain the same rate for some period after a child is assessed as ready for a lower placement level to allow the family to sustain the progress that has been made. In other states, this time period ranges from 30 days to much longer.

Use CANS assessments (and other tools) to inform placement and service decisions and track progress.

1. Increase the frequency of CANS assessments. Jurisdictions outside of Texas, such as Indiana, Kentucky, New Jersey, and Wisconsin that utilize CANS assessments to inform service and placement decisions are completing them at least every six (6) months, more in certain circumstances. This would require investment in additional assessments as well as supporting infrastructure such as better technology to support the use of CANS data.
2. Monitor fidelity of completion of the CANS.
3. Use CANS results to better understand the needs of children in placement and refine the placement models.
4. Use CANS scores to track child progress and identify what services are working well and/or where adjustments, training, or technical assistance are needed.

Recalculate the rate every three (3) years and in between when there are significant program changes.

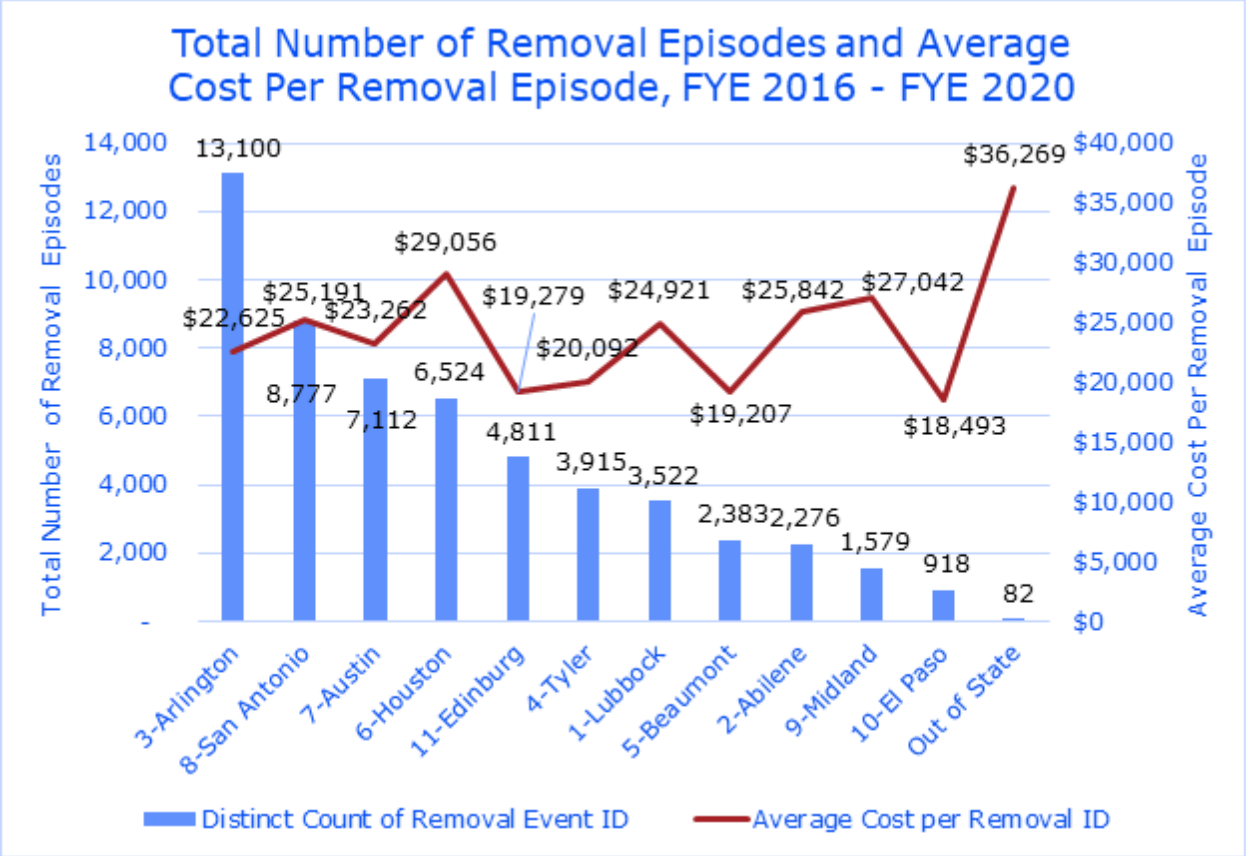
Revising the legacy system in this manner will also provide a foundation for better aligning the CBC rates to the individualized needs of children. More details will be provided in the section of this report titled "f. Sustainable CBC Model.

Regional Variation in Costs

Special Provision 32 (b) (2): Accounting for regional variation in costs, including differences in the individualized needs of children served in different regions and locally competitive wages to recruit and maintain qualified staff

The cost reports have limited utility for geographic analyses because the contact location included on the cost reports, in some instances, reflects the corporate headquarter location, and therefore may not represent the location where the service(s) were provided. However, we can view differences across regions by using the IMPACT data provided. There is significant variation in the average cost per removal episode by region. Region 10 (El Paso) had the lowest average cost per removal episode at $18,493, with Region 6 (Houston) at the highest average cost per removal at $29,056 (excluding Out of State).

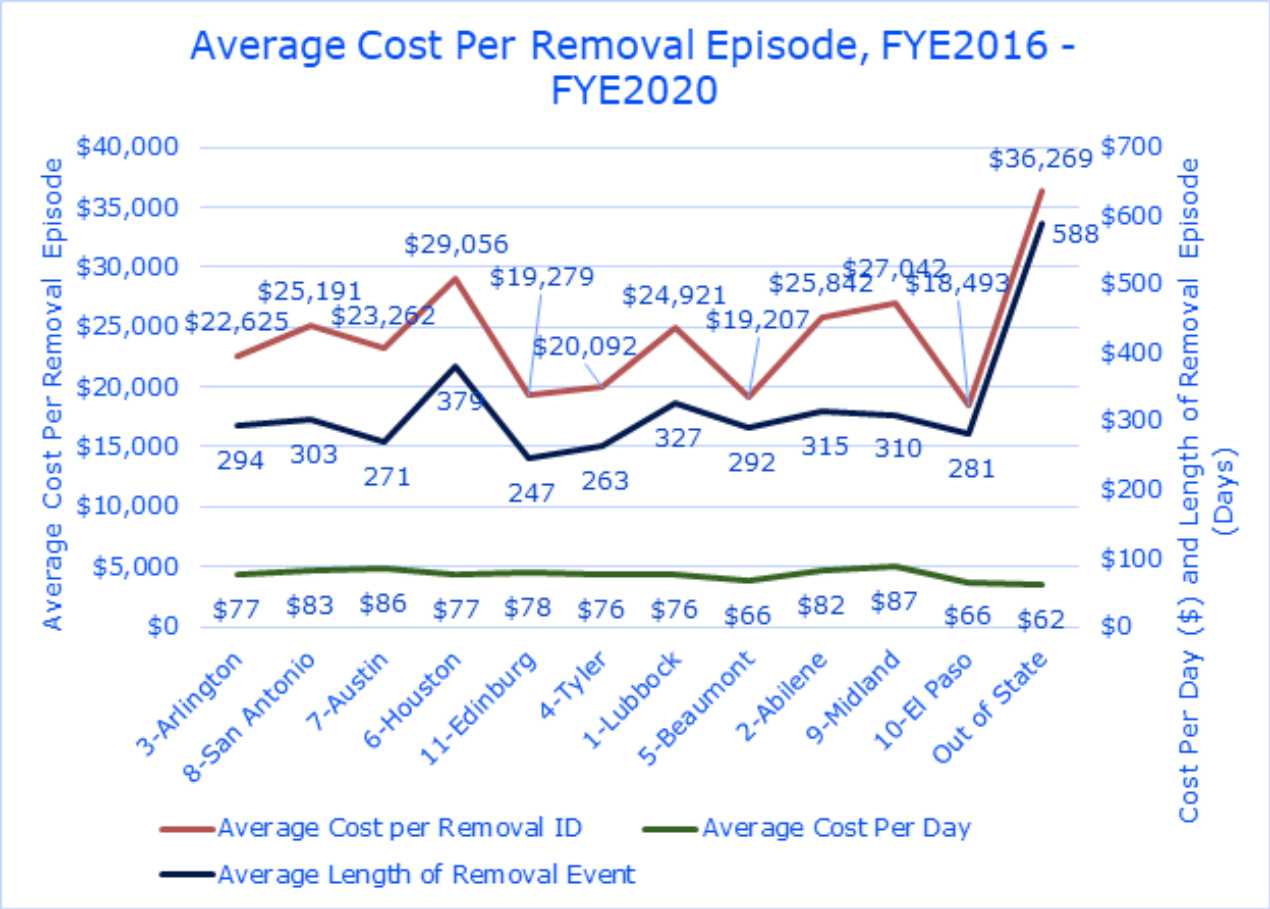
Figure 6: Total Number of Removals and Average Cost per Removal, FY2016 - FY2020



This report's methodology and population may not necessarily match DFPS' method of reporting on removals or placements. Underlying data: placements open between FY2016 and FY 2020 that had a foster care payment made for services for children who were removed between FY2016 and FY2020. Duplicate Placement IDs were removed. Children with current placements (Placement End Date = blank) were removed. Region is the child's legal region. "Cost" is based on placement costs only. Graph excludes regions labeled "Blank." To calculate the average cost per removal episode, we divided the total payment cost by the total number of unique Removal Event IDs.

The variations in cost per removal episode by region are largely due to variations in length of stay. Regions with longer average lengths of stay generally experience higher costs per removal episode with the Houston region having the longest length of stay (379 days) and Edinburg having the shortest (247 days). There are also variations in average cost per day with an average cost per child per day of $66 in El Paso and $87 in Midland, although cost per day was less of a driver for overall cost than length of stay.

Figure 7: Average Cost per Removal, FY2016-FY2020



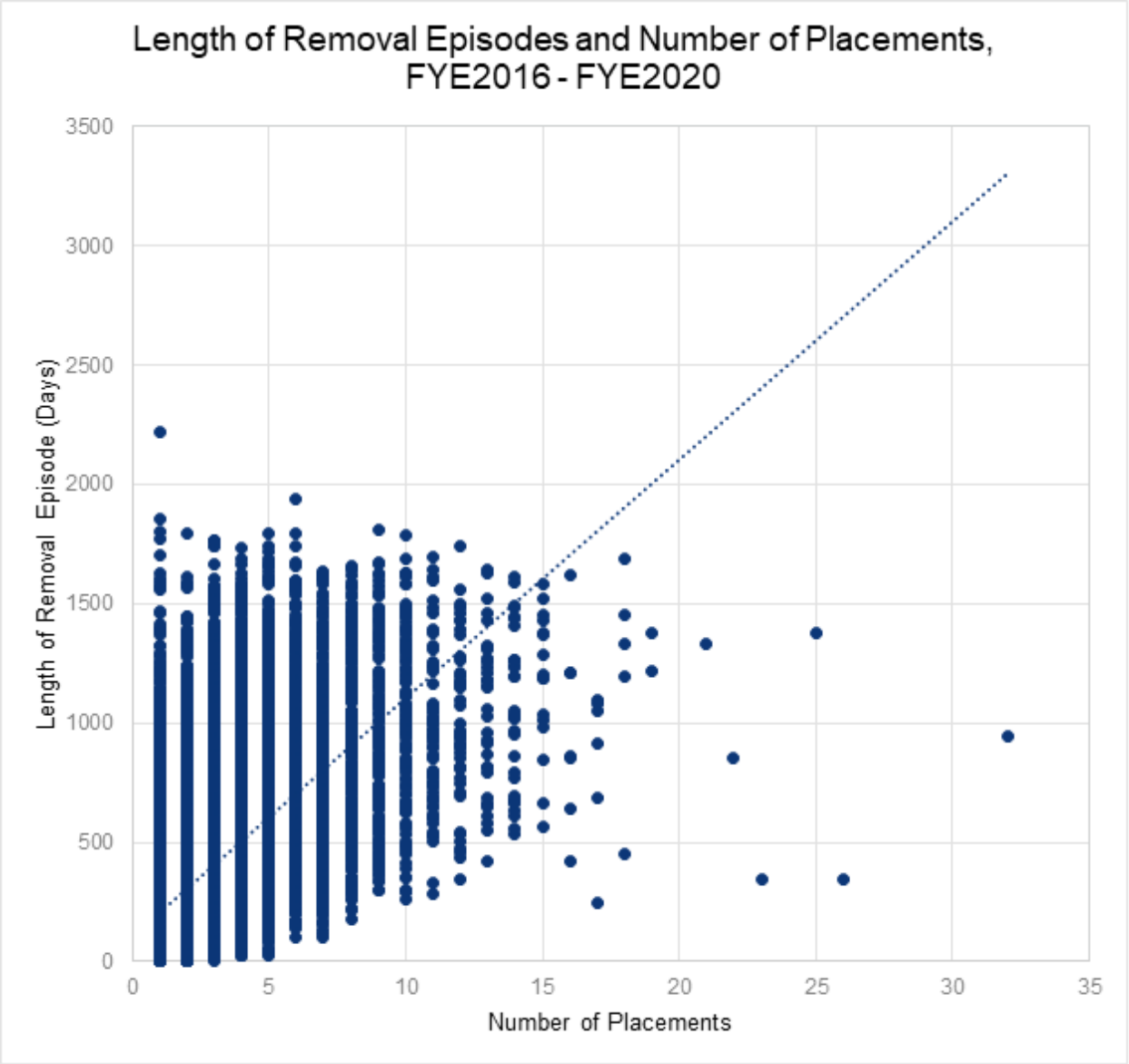
Note: This report's methodology and population may not necessarily match DFPS' method of reporting on removals or placements. Underlying data: placements open between FY2016 and FY 2020 that had a foster care payment made for services for children who were removed between FY2016 and FY2020. Duplicate Placement IDs were removed. Current placements (Placement End Date = blank) were removed. Region is the child's legal region. "Cost" is based on placement costs only. The graph excludes regions labeled "Blank." To calculate the average cost per removal episode, we divided the total payment cost by the total number of unique Removal Event IDs. To calculate the average length of removal episode, we divided the total number of placement days by the total number of unique Removal Event IDs. To calculate the average cost per day, we divided the total payment cost by the total number of placement days.

There are likely a multitude of reasons why some regions experience longer lengths of stay than others, but a positive relationship was noted between the length of removal and the number of times a child changed placements. Changing placements more often is associated with longer removal periods.

Figure 8 plots 55,023 unique entries to compare the relationship between number of placements and length of removal (in days). The vast majority of the entries are clustered at the bottom left, such that they appear to be solid lines: the median number of placements was 1, and the average number of placements was 1.9; the median number of days removed was 229, and the average number of days removed was 299. However, the average number of placements per region only ranged between 1.7 to 2.1, meaning there is little variation across the state and low numbers of placement changes on average[10].

[10] This data excludes current open placement episodes. It looks at the unique number of placements per removal episode, then the total number of days in care for that removal episode.

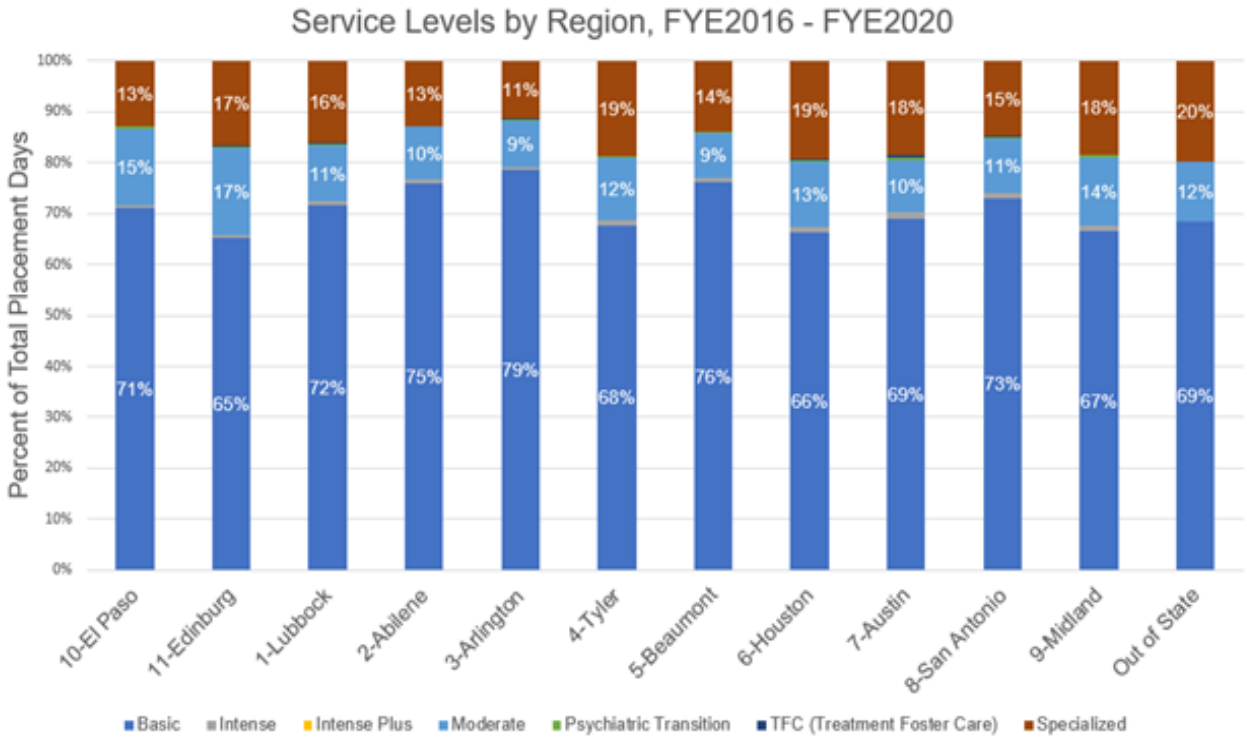
Figure 8: Length of Removal and Number of Placements, FY2016-FY2020



Note: This report's methodology and population may not necessarily match DFPS' method of reporting on removals or placements. Underlying data: placements open between FY2016 and FY 2020 that had a foster care payment made for services for children who were removed between FY2016 and FY2020. Duplicate Placement IDs were removed. Children with current placements (Placement End Date = blank) were removed.

Across all regions, most children are placed in the basic placement level (based on the child's legal region as noted in DFPS data).

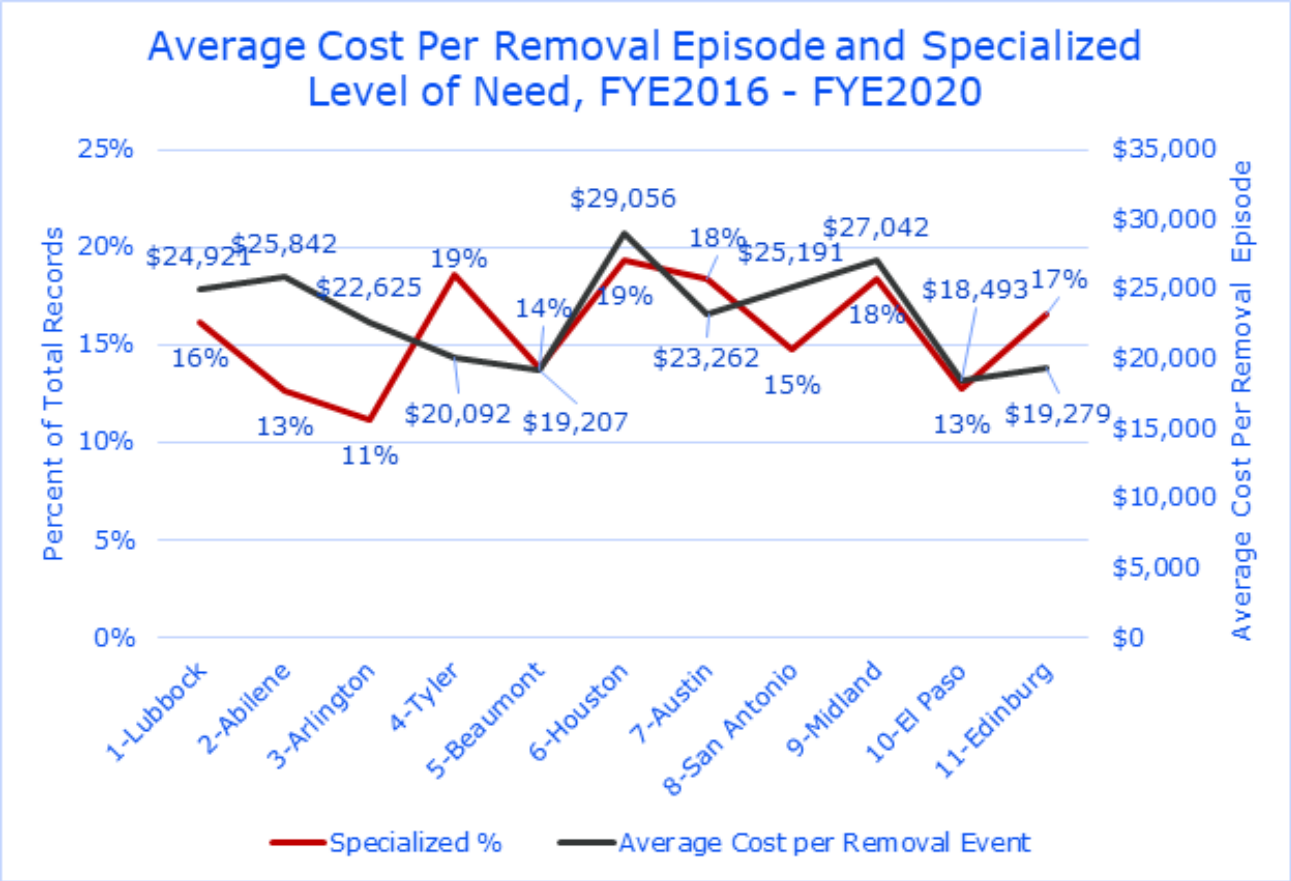
Figure 9: Service Levels by Region, FY2016-FY2020



Note: This report's methodology and population may not necessarily match DFPS' method of reporting on removals or placements. Underlying data: placements open between FY2016 and FY 2020 that had a foster care payment made for services for children who were removed between FY2016 and FY2020. Duplicate Placement IDs were removed. Children with current placements (Placement End Date = blank) were removed. Region is the child's legal region. All CBC service levels are added as "Basic." The graph excludes regions labeled "Blank."

The following figures indicates that regions with higher percentages of children in the Specialized placement level have a slight tendency to see higher overall costs of care per child. This aligns with expectations, as Specialized care is costlier than Basic and Moderate care, and as noted above, children tend to stay in specialized service levels longer than other service levels.

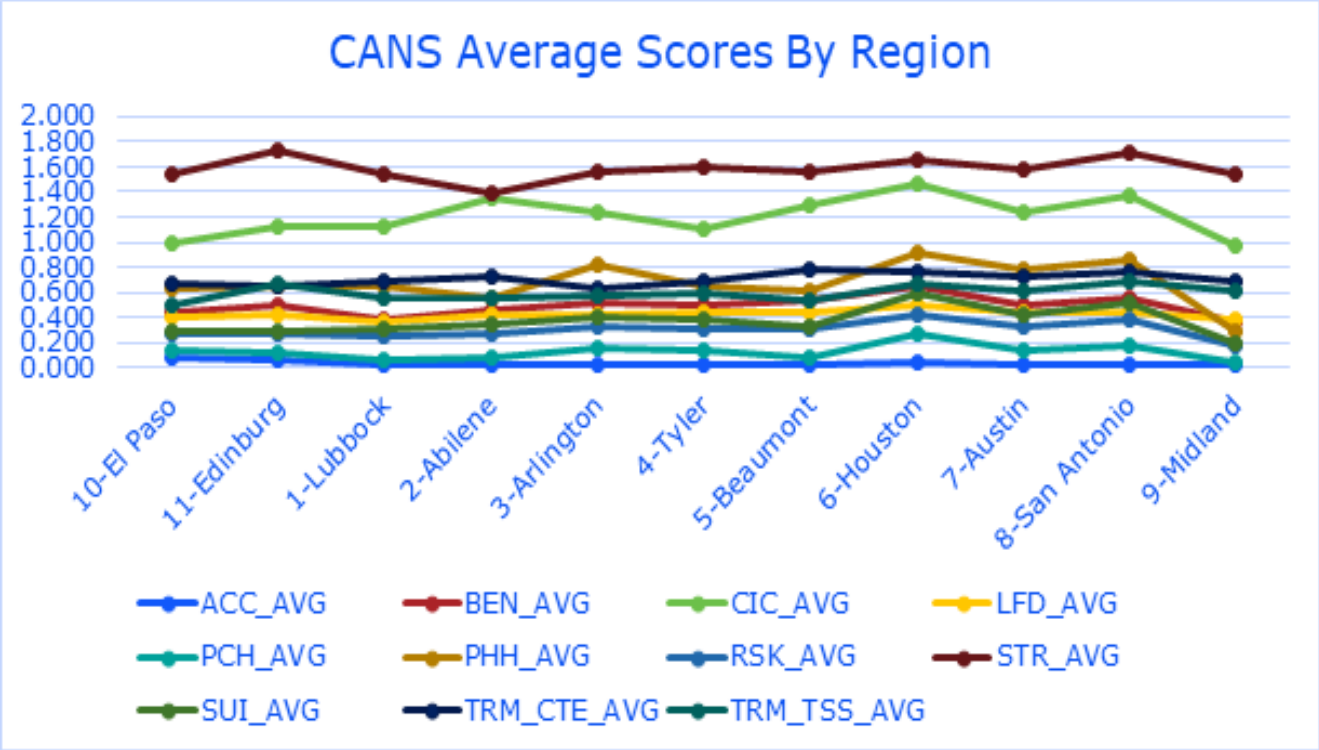
Figure 10: Average Cost per Child and Specialized Service Levels, FY2016-FY2020



Note: This report's methodology and population may not necessarily match DFPS' method of reporting on removals or placements. Underlying data: placements open between FY2016 and FY 2020 that had a foster care payment made for services for children who were removed between FY2016 and FY2020. Duplicate Placement IDs were removed. Children with current placements (Placement End Date = blank) were removed. Region is the child's legal region. "Cost" is based on placement costs only. The graph excludes regions labeled "Blank" or "Out of State." To calculate the average cost per removal episode, we divided the total payment cost by the total number of unique Removal Event IDs.

Regional cost variations are largely driven by length of stay and service levels. This may be due to differences in case mix across the regions, as well as differences in the capacities of regions to meet those needs. Looking at CANS scores, there is some regional variation, with Houston and Arlington generally showing higher average CANS domain scores than the other regions[11].

Figure 11: CANS Average Scores by Region



[11] The infant and young children domains were excluded from this data as they were not generally found to be associated with increased placement costs.

In summary, while this analysis does not consider every possible driver of geographic differences in cost, length of stay and the use of specialized levels of care were found to be significant drivers, with considerable regional variation in those measures. The regions with the highest cost per child were Midland, Houston, and Abilene. These regions also had relatively long lengths of stay. Houston and Midland also had proportionally high numbers of children and youth in specialized levels of care. But average CANS scores across most domains tended to be higher in Houston and San Antonio. This may explain why Houston's costs are higher than other regions, but there was not a clear association between regional CANS scores and regional costs in other cases.

At this time, PCG does not recommend geographic modifiers to rates based on CANS. PCG recommends continuing to track regional differences in CANS scores and costs to determine if trends emerge.

Locally Competitive Wages

Special Provision 32 (b) (2): Accounting for regional variation in costs, including differences in the individualized needs of children served in different regions and locally competitive wages to recruit and maintain qualified staff

A common theme in the stakeholder sessions was the need for programs to pay staff more competitive wages. This theme was heard statewide, although there are wage differences across the state that were also noted. Cost report wages were compared to FY2020 regional wage data collected by the Texas Workforce Commission[12]. Findings suggested that facilities paid an average of 93% of locally competitive wages for direct care positions (see table below).

[12] Corresponding locally competitive wage positions were within the following industries: Nursing and Residential Care Facilities, Social Assistance, Individual and Family Services, Administrative and Support Services, Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities, Nursing Care Facilities (Skilled Nursing Facilities), Community Food and Housing, and Emergency and Other Relief Services, Vocational Rehabilitation Services, Office Administrative Services, Facilities Support Services, Other Residential Care Facilities, Education and Health Services, Health Care and Social Assistance, Educational Support Services. Texas Workforce Commission, https://texaslmi.com/LMIbyCategory/Wages

Table 18: Direct Care Positions

Cost Report Position	Corresponding Locally Competitive Wage Position
Case Management	Community and Social Service Occupations
Counselors, Therapists, and Social Workers	Community and Social Service Occupations
Program Directors and Program Coordinators	Management Occupations
Treatment Coordinators And Directors	Community and Social Service Occupations
Psychological Services Staff	Healthcare Practitioners and Technical Positions
Psychiatrists And Physicians	Healthcare Practitioners and Technical Positions
Registered Nurse/Licensed Vocational Nurse	Healthcare Practitioners and Technical Positions
Medical/Health Care Technician/Nurse's Aide	Healthcare Support Positions
Intake And Evaluation Staff	Healthcare Support Positions
Houseparents / Child Care Staff	Community and Social Service Occupations
Foster Family Recruiting and Retention Staff	Community and Social Service Occupations

The locally competitive wages utilized in this analysis are calculated based on an average of relevant occupations from 2020, by region, published by the Texas Workforce Commission. These averages are weighted by the hours for corresponding occupations in the FY2018 cost reports[13]. To appropriately compare the FY2018 cost reports with the locally competitive wages from SFY2020, SFY2019 and SFY2020 cost-of-living adjustments were applied to the SFY2018 cost report wages.

This analysis is imperfect because there is not an exact match between the location provided on the cost reports and the actual locations where work takes place.

Table 19: Comparison of Facility Wages and Locally Competitive Wages

Region	Average Facility Wage (Adjusted to FY2020)	Percent of Local Wage	Average Local Wage (Relevant Occupations, 2020)
1-Lubbock	$43,476	100%	$43,314
2-Abilene	$45,372	109%	$41,690
3-Arlington	$41,029	81%	$50,765
4-Tyler	$39,226	87%	$44,940
5-Beaumont	$40,848	102%	$39,874
6-Houston	$44,721	88%	$50,767
7-Austin	$41,866	92%	$45,397
8-San Antonio	$41,509	91%	$45,557
9-Midland	$42,355	87%	$48,638
10-El Paso	$43,892	97%	$45,452
11-Edinburg	$40,760	90%	$45,433

To address regional variations in costs, the rate methodology could apply a modifier per region. For example, Region 6 (Houston) has a locally competitive wage that is 110% of the statewide average. The rate methodology could apply a 10% increase to the base rate[14]. Note that this would require an additional step in the rate setting process, as the locally competitive wages would need to be re-calculated every rate-setting year and this would be challenging for CPA agencies, which may provide services across a range of locales.

At this time, PCG does not recommend a geographic modifier for rates. PCG recommends that DFPS/HHSC consider the types of personnel and credentials that are desired for programs and factor commensurate and competitive salaries into the model budget legacy rate development process across the state. This step alone (although not simple or cost neutral) may minimize the geographic issues and would be an important first step toward normalizing the salaries and rates.

Least Restrictive Environments and High-Quality Services

Special Provision 32 (b) (3): Incentivizing placing children in the least restrictive environment that can best meet their needs

Special Provision 32 (b) (4): Maximizing the use of high-quality intensive home and community-based services

The daily blended CBC rate is already structured to incentivize placing children in the least restrictive setting that can best meet their needs, because the SSCCs will benefit financially from shifting to lower levels of care. Given that the state is transitioning to the CBC model, we recommend a few adjustments to the current

[13] Not all occupations are equally represented in the cost reports. For example, there are significantly more hours (and therefore costs) spent on case management than psychiatrists and physicians. To make meaningful comparisons to Texas wage data, our team weighted the salaries reported by the Workforce Commission to mirror the cost report wages. We calculated the percent of hours reported for "Community and Social Service Occupations," "Management Occupations," "Healthcare Practitioners and Social Service Occupations," and "Healthcare Support Positions" in the 24-hour RCC cost reports. We then multiplied locally competitive wages by each of those percentages before adding them to calculate the weighted average for the locally competitive wage. We did this for each region.

[14] PCG would not recommend applying a negative modifier to programs in regions with wages that are lower than the statewide average as compensation is already lower than local averages across most program regions.

legacy rate system to better financially incentivize less restrictive placements and high-quality intensive home and community-based services:

- **For foster family homes, when a child is assessed as eligible for a lower level of placement, keep the rate constant** for some period of time to allow the child/youth to continue to receive needed services to sustain the progress that has been made.
- **Develop incentive payments for CPAs and residential programs for desired outcomes** such as timely permanency, recruiting and retaining foster homes, successful moves to lower levels of care, clinical improvements, etc.
- **Incorporate more foster family recruitment and retention support into the CPA retainage rate.**
- **Incorporate more family work, family engagement, and aftercare into the residential rates.** Studies have demonstrated that involving families and providing parent education and support lead to better outcomes for adolescents, such as greater post-discharge stability, and increased probability of discharge to less restrictive environments, or successful family reunification[15]. To promote family and youth participation, it is essential to involve youth and families in meaningful roles and to value their input as increased family involvement, stability, and support in the post-residential environment are crucial to success[16].

Sustainable CBC Model

Special Provision 32 (b) (6): Incorporating a viable and sustainable methodology for Community-based care (CBC) rates, based on best practices and the experiences of other states

Special Provision 32 (b) (7): Providing opportunities, at least semi-annually, to adjust the rates based on demonstrated fluctuations across CBC regions and population needs

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[15] Interagency Working Group on Youth Programs, Impact of Family Engagement: https://youth.gov/youth-topics/impact-family-engagement; Transitioning Youth from Residential Treatment to the Community: A Preliminary Investigation, Nickerson, Amanda et. al., Child Youth Care Forum (2007) 36:73–86 (which was based on interviews with residential treatment staff, youth and their families): https://link.springer.com/article/10.1007/s10566-007-9032-4

[16] http://dhss.alaska.gov/dbh/Documents/residentialcare/Files/promoting-youth-engagement-providers.pdf

The CBC daily blended rate is similar to other blended funding models in child welfare, particularly models utilized in Missouri and Nebraska.

The Nebraska Department of Health and Human Services (DHHS) contracts with a lead agency in the Omaha area and pays a case rate in two (2) parts per month. At the beginning of the month, the lead agency receives an "administrative" payment which has been agreed upon as a flat amount each month to administer the program. The service component of the case rate is paid at the end of the month based on population served reported each month. If the lead agency is able to serve children in lower levels of care, then the lead agency may be paid more than their actual expenses.

The Missouri Department of Social Services (DSS) contracts with consortiums throughout the state to manage foster care cases. DSS pays the consortiums a monthly rate for a pre-determined number of cases. The base caseload and percentage of children expected to move to permanency in 12 months are used to calculate the total number of additional referrals the consortium receives throughout the contract. Agencies that move more children to permanency than expected therefore receive a financial reward, while those that take longer than expected to permanency incur financial penalty.

The overall methodology of the daily blended rate should accomplish the desired goal of additional local flexibility. But because the rate has not been sufficient to cover costs, the state has had to provide additional assistance, the SSCC has had to fundraise, and the benefits of shared risk and reward have been minimized. To address this, the rate must be calculated to more closely align to cost of care and the state must also have a way to validate placement decisions made by the CBCs. PCG recommends the following:

1. **Calculate the daily blended rates based on the new legacy rates and CBC regional utilization data.**
    a. The CBC rate has always been based on the legacy rates. As proposed herein, the new legacy rates will better align to cost of care and will make a better foundation for the CBC rates. PCG recommends moving away from the current CBC modeling which involves projections around age and length of time in care, to the following calculation method: CBC caseload by placement type multiplied by new legacy placement rates equals total projected expenses divided by total projected days of care equals daily blended rate. This methodology may require HHSC/DFPS to collect utilization data from the CBCs and match it to the legacy placement system, where their systems differ slightly.
2. **Adjust the rate for known prospective changes** (program changes, price increases, etc.) **specific to the CBC regions**.
3. **Utilize CANS data to validate the CBC placement trends and track changes in case mix by region**.
    a. This will require that the CANS be completed by an individual unaffiliated with the CBCs.
4. **Reforecast the daily blended rates annually**.
    a. Reforecast the rate for each catchment area annually with current service utilization data and legacy rates.
    b. Adjust the rates for significant program/policy changes specific to the CBC regions.
    c. Utilize CANS data to validate the CBC placement trends.
    d. Over time, develop an algorithm to tie changes in CANS scores to changes in the daily blended rate.

Risk Mitigation Strategies

Special Provision 32 (b) (8): Including risk mitigation strategies that balance the risk to the state with the need to attract and maintain viable Single Source Continuum Contractors for each CBC region, such as time-limited risk corridors

Currently, there is no formal risk reserve for the CBCs. The current exceptional care "carveout" does provide some risk mitigation[17]. At the end of each year, the CBCs report how much they spent in exceptional care payments and the state shares 50% of the exceptional care costs.

Other states that have implemented community-based care models like TX have implemented corresponding risk mitigation strategies. For example:

- In Florida, the state implemented a shared risk pool. Because Florida operates as a capped allocation, the CBCs may seek additional funding where there is increased service utilization or if the cost of care increases due to changes in law or policy that affect service delivery, or if there is a significant change in service needs. The Department determines if the increases are a function of the Department, external events, or the Lead agency's managed service performance. If it is determined that the costs are due to the Department or external factors, then additional funds may be sought through the legislature or the shared risk pool.
- In Missouri, when it is expected that service costs will exceed $100K in the contract year for a child, the state may provide additional funding to the agency, if the agency submits sufficient documentation such as the Family Support Team Recommendations and documentation of efforts to find suitable placement at a lower cost[18].
- In Kent County, Michigan, the state recently funded a risk reserve for the West Michigan Partnership for Children which may be tapped if the number of foster care entries increases significantly under the new capped allocation funding model.

[17] Based on PCG's October 13, 2020 discussion with HHSC and DFPS, exceptional care "carve out" payments are defined as rates that occur when the SSCC determines that the child needs exceptional care. A care request is submitted to the director of placement for the state to evaluate whether they need exceptional care. When the exceptional placement gets approved, DFPS pays an exceptional care "carve out" rate based on the projected average cost per day. This rate is paid to the SSCC for that placement, and then at the end of the placement, it is reconciled to the actual cost, splitting it 50/50 between DFPS and the SSCC.

[18] This information is from 2008 contracts found online.

PCG recommends the following:

1. Continue the exceptional care "carve out."
2. Implement a risk reserve.
    a. Determine the circumstances for when the risk reserve can be accessed, such as for unforeseen policy changes or significant changes in case mix which cause the daily cost of care to exceed the daily blended rate by 5% or more. Identify what will not be covered, such as deficiencies caused by rate increases enacted by the SSCC that are above and beyond what the state pays for similar services.
    b. Develop a process for the CBCs to petition the state for additional funds from the reserve under the circumstances above, including the documentation that would need to be provided.

Sound Rate Development Principles

Special Provision 32 (b) (9): Being consistent with actuarially sound rate development principles to the fullest extent possible.

Actuarial soundness is a term that has historically been utilized in the insurance industry, but it is becoming more commonly utilized in child welfare, as more systems implement risk sharing payment strategies. Section 1903(m) of the Social Security Act and 42 CFR §438.4 require that Medicaid managed care capitation rates be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract[19].

Utilizing this definition as a starting point, actuarial soundness as it applies to this study can be defined as:

[19] https://www.medicaid.gov/Medicaid/downloads/2019-2020-medicaid-rate-guide.pdf

- Rates should be sufficient to cover the services required under the terms of contracts.
- Utilization and cost data should be derived from the applicable population, or if not, are adjusted to make them comparable to the anticipated population.
- Adjustments should be made to account for such factors as trend/inflation, incomplete data, provider-specific data, etc.
- The rates should be developed in accordance with generally accepted actuarial principles and practices.

Based on this definition, PCG recommends the following changes to how rates are calculated:

- **Recalculate the legacy rates to tie to specific placement settings and programs.** This should result in models that are clearly understood by providers and rates that are clearly aligned to contract requirements and state priorities. Additionally, the aim is to reduce reliance on fundraising for contract requirements, and divert fundraising dollars to support enhancements, capacity building, and innovation.
- **Utilize current CBC placement data to project the daily blended rate annually.** Shift away from the current CBC rate development process which utilizes strata based on age and length of time in care to CBC placement data. This will result in rates that are more closely aligned to the needs of the catchment areas. CANS can be used to monitor the placement decisions of the SSCCs and track changes in case mix to justify rate increases if needed.
- **Consider adjusting the rates annually for inflation and continue adjustments as needed for significant program or policy changes.** If annual inflation adjustments are too costly, the cost reports could be monitored to track whether rate adjustments are warranted based on any large swings in cost data.

The changes above will result in rates that are more closely aligned to the cost of care for children in Texas, However, it should be noted that the rates recommended by HHSC are generally not fully funded, as a result of insufficient state funds. Funding shortfalls may continue to be a barrier to full rate implementation.

Additionally, the SSCC's identified concerns about the Stage II funding methodology, noting that the methodology needs to be better aligned with the functions required under Stage II and the size of the population being served. However, since the scope of this study was focused on foster care, this was not examined.

Federal Funds

Special Provision 32 (b) (5): Maximizing the efficient and effective use of federal funds to improve capacity and address gaps in care, including:

1. Increasing access to current Medicaid bendfits such as mental health rehabilitation and targeted case management services;
2. Identifying Medicaid benfits offered in other states for foster youth that decrease hospitalization and lower costs; and
3. Improving reprting and tracking of data to maximize Title IV-E Reimursements.

Analysis of Texas STAR Health Medicaid services to the Foster Care Population

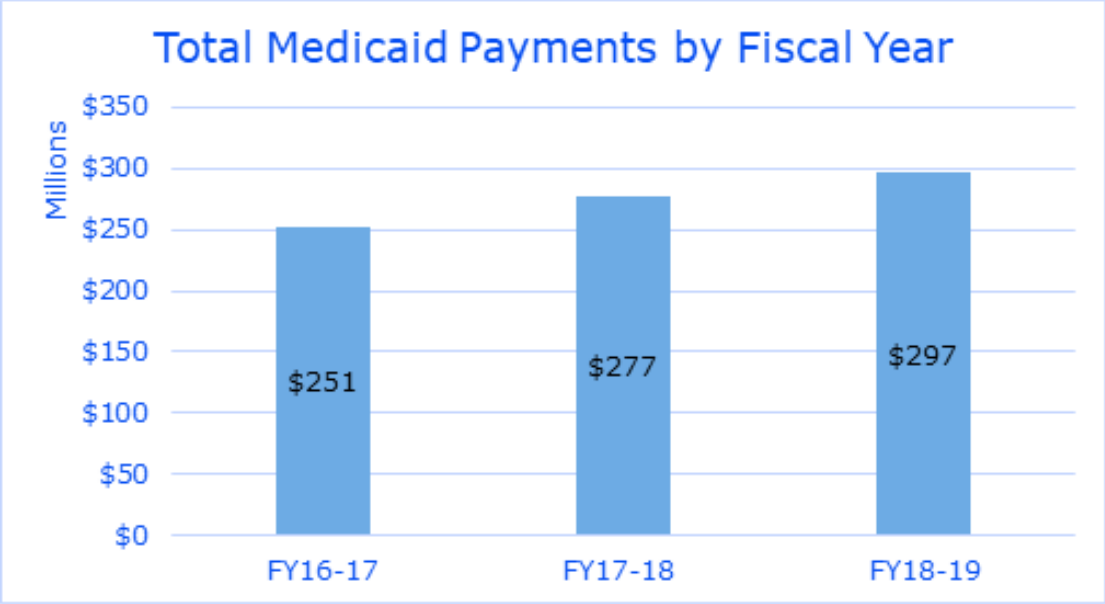
STAR Health, administered by Superior HealthPlan, is the first comprehensive health and medical network for children and young adults who are, or were formerly, in the Texas foster care system. STAR Health provides the following services to its enrollees:

- Medical Services that include primary and specialty physical care services, prescription drugs and medical supplies, medical checkups, including Texas Health Steps, behavioral health services, hospital care, vision services, family planning services, and dental services (as well as long-term services and supports).
- Care Coordination that helps members and caregivers understand benefits and identify community-based resources.
- Training Programs that provide clinical expertise and program information for families, caregivers, caseworkers and child advocates.

Most services provided are capitated services and must be submitted to Superior HealthPlan. In order to determine the gaps in care and how to increase access to current Medicaid benefits, such as mental health rehabilitation and targeted case management services, PCG worked with HHSC to obtain STAR Health Medicaid data for the foster care population. Data files were obtained for FY16-17, FY17-18, and FY18-19.

The following graphs present the results of the data analysis. For the purposes of this report, PCG presents the highlights of the data analysis generated regarding overall Medicaid encounters and payments as well as certain specialty providers' utilization statistics. Appendix 2b-1 contains additional Medicaid utilization and payments analysis performed to supplement the information presented in this section.

Figure 12: Total Medicaid Payments by Fiscal Years Ending 2017, 2018 and 2019

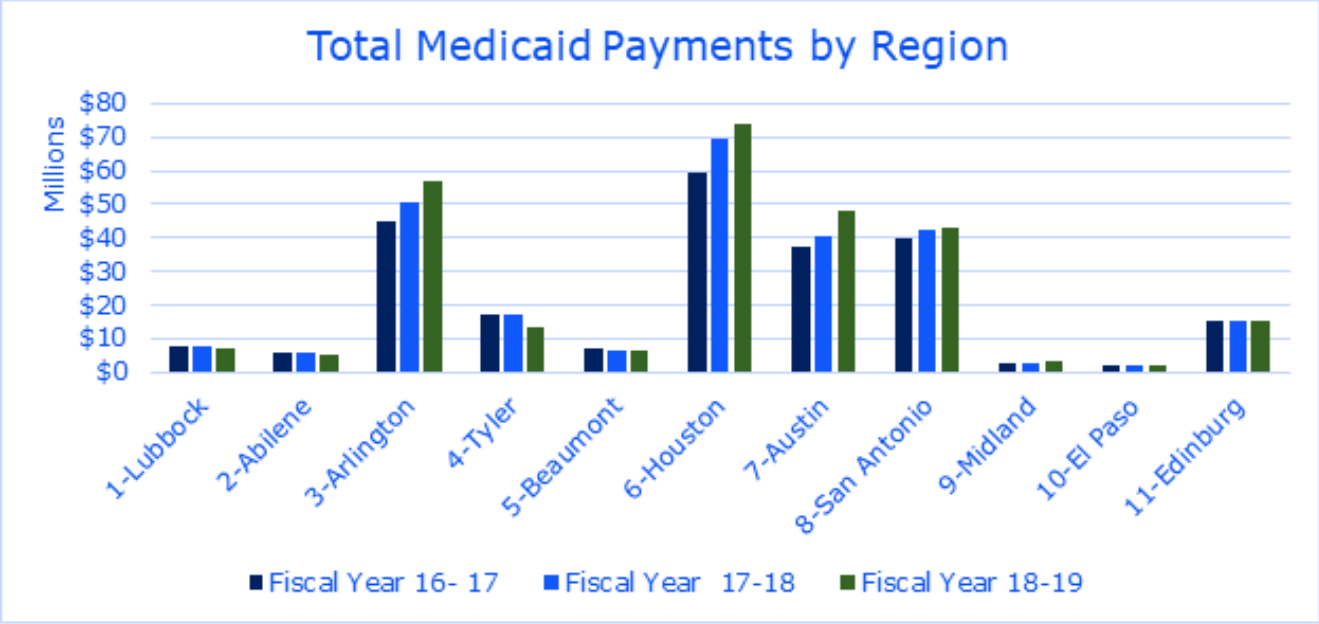


Total Medicaid payments made to providers who served the foster care population increased each year over the past three fiscal years (FY2017, FY2018 and FY2019). Medicaid payments increased by 10% from FY2017 to FY2018 and increased by 7% from FY2018 to FY2019. Likewise, total Medicaid service encounters increased each year as well. PCG was unable to determine how and why encounters and costs increased as part of this study.

Regional Outlook

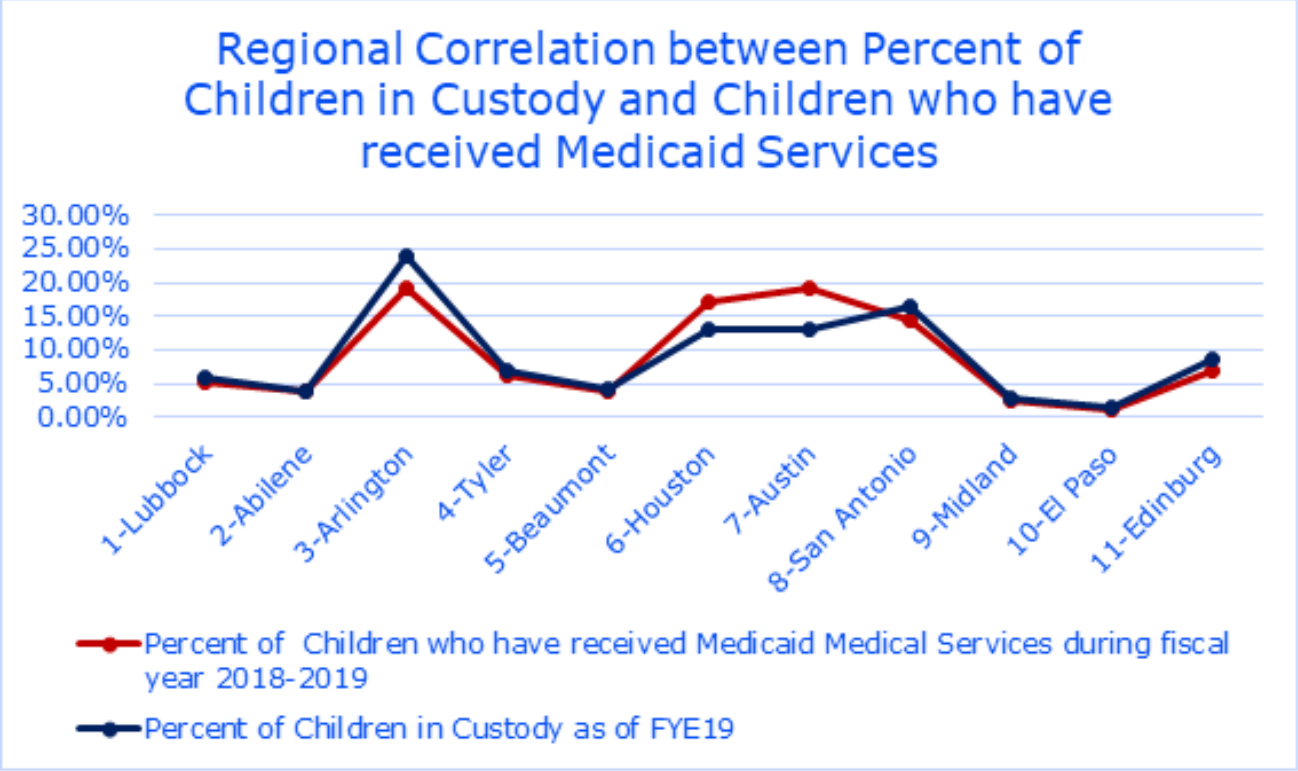
PCG analyzed Medicaid payments by Region for the fiscal years ending 2017 through 2019. The top four (4) Regions with the greatest payments across all three time periods were Houston, Arlington, Austin, and San Antonio. The Regional Medicaid service encounter data shows similar trends. PCG performed analysis by Region to derive the top 15 service type providers' categories for service encounters and payments amounts. The results showed increases in the behavioral health services categories for several Regions; however, there were no significant changes noted other than the Houston Region. The regions of Abilene and Edinburg did show medical case management included in their top fifteen service encounters for FY2019.

Figure 13: Medicaid payments by Region



PCG analyzed the child placement data along with the Medicaid services data to determine if there is a correlation between the Region's percentage of children in custody as of 2019 fiscal year end and percentage of children who received Medicaid services during the 2018 – 2019 fiscal year. Generally, there is close correlation between the percent of children in custody and the percent of children who received Medicaid services. The percent of children receiving Medicaid services were slightly higher for the Houston and Austin Regions; and were slightly lower for the Arlington Region. It would be interesting to explore Houston's and Austin's program practices regarding access and referral to Medicaid services and share any innovative ideas with the other Regions.

Figure 14: Regional Correlation Between Percent of Children in Custody and Children who have Received Medicaid Services



Specialty Service Type Providers Encounters, by Region

PCG analyzed Medicaid data for selected specialty providers of behavior health services. Service encounters utilization and cost analysis by Regions were performed for:

- Case Management (which may include Targeted Case Management)
- Chemical Dependency Treatment
- Mental Health Rehabilitation Services
- Rehabilitation Centers
- Hospital – Psychiatric Services
- Licensed Professional Counselor
- Licensed Clinical Social Worker
- Psychologist
- Psychology Group

The results of our analysis showed wide variation across the Regions in accessing and referring children to behavioral health services. For example, Edinburg revealed the greatest number of Case Management encounters, while Austin and Houston showed the greatest number of Psychology Group and Psychologist encounters, respectively. The Houston area experienced over 700% increase from 2018 to 2019 regarding mental health rehabilitation services and costs. Houston also experienced the largest growth in service encounters and costs for Psychiatric hospitalizations, which rose over the three-year period to $11,707,484 in 2019. It would be worthwhile to interview the Houston Region to determine why there was such an increase in the behavioral health services. Further research in Medicaid utilization for behavioral health services across the regions may help to identify differences in program practices. This research would lend to understanding regional differences and where focused efforts are needed to enhance the use of Medicaid behavioral health services; that in turn, may improve the outcomes of children in foster care. Note that it is unknown whether this would increase overall Medicaid costs. There is potential for offsets if this shifts toward a better use of outpatient treatment services (e.g. TCM, rehab, and psychotherapy) to prevent or reduce inpatient stays and emergency services.

The following figures present the results for Mental Health and Other Rehabilitation Centers based on specialty provider data furnished by HHSC.

Figure 15: Medicaid Mental Health Rehab Encounters, FY 2017 - FY 2019 (from Provider Type Code 12)

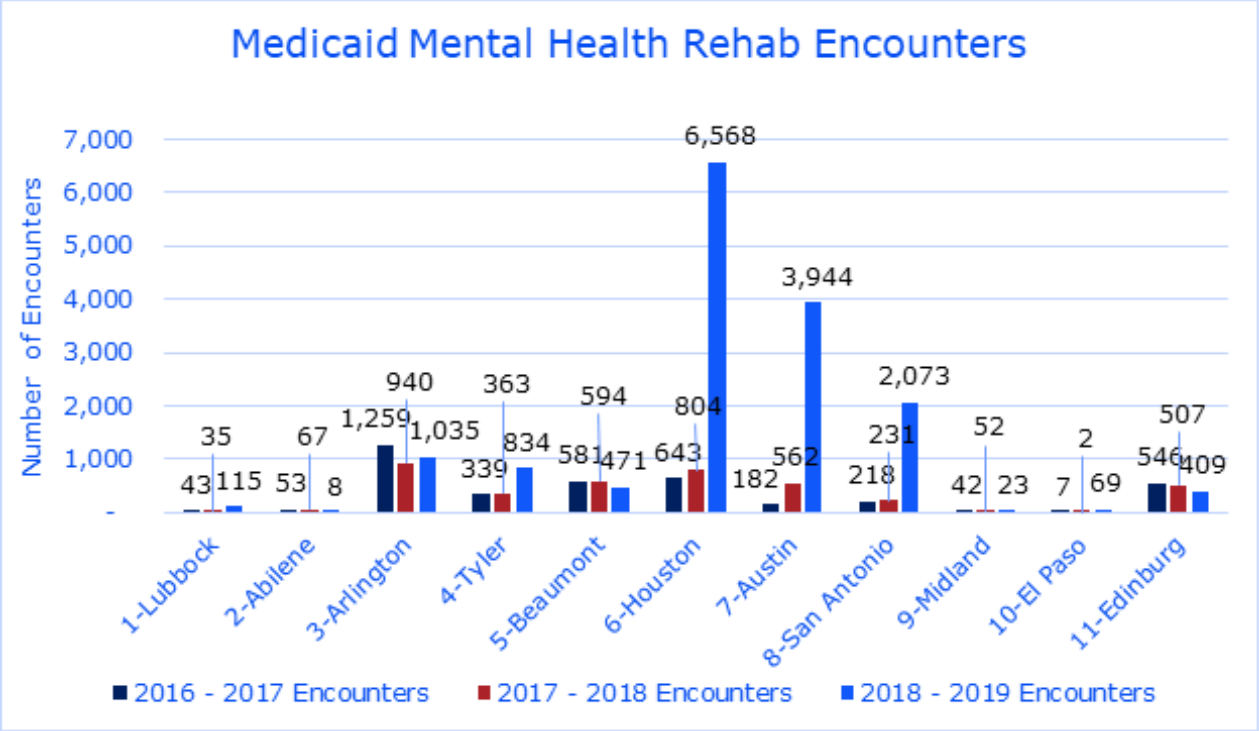
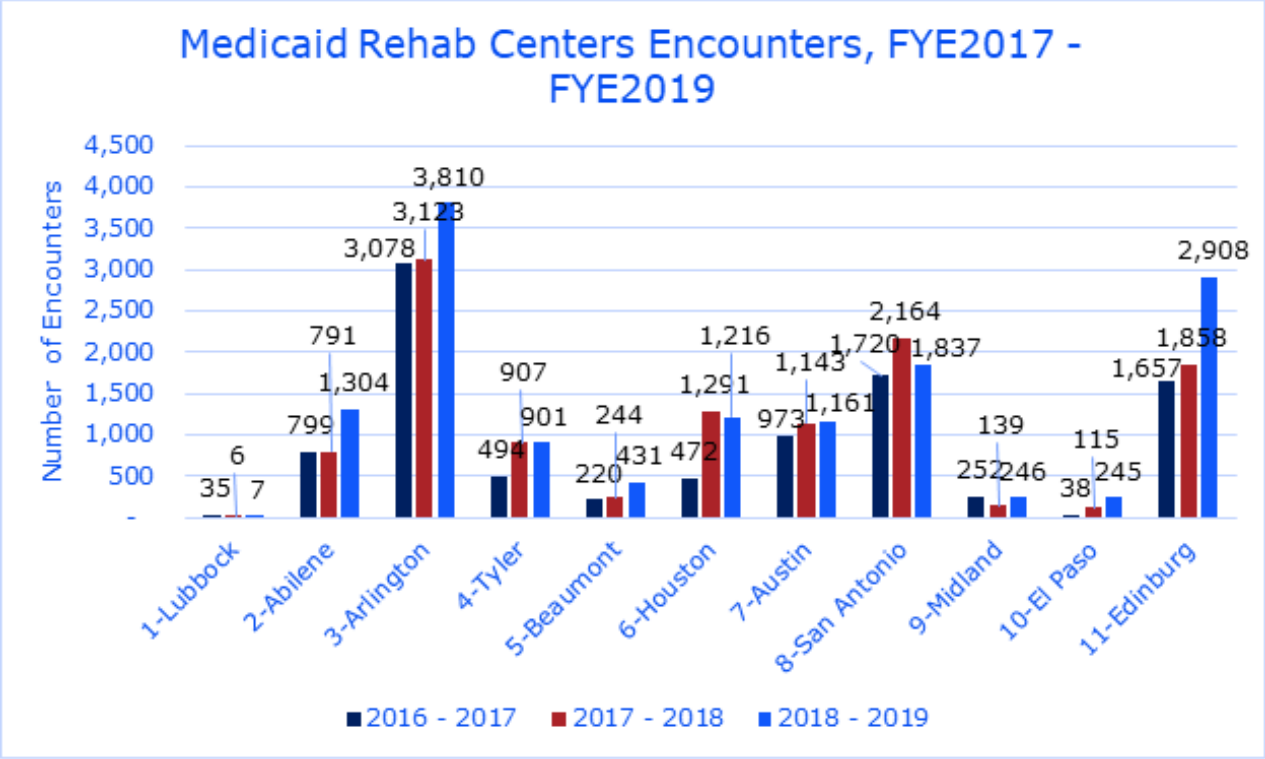


Figure 16: Medicaid Rehabilitative Centers Encounters, FY2017 – FY2019 (from Provider Type Code 65)



Specific to the foster care population (which is the focus of this study), STAR Health members are eligible for Mental Health Targeted Case Management (TCM) when the individual has a single diagnosis of chronic mental illness or a combination of chronic mental illnesses and who has been determined via a uniform assessment process to need these services. Mental Health (MH) Rehabilitative Services provide assistance in maintaining or improving functioning and may be considered rehabilitative when necessary to help a person achieve a rehabilitation goals defined in the treatment plan. For this population, types of services included are medication training and support services and skills training and development. Functioning is determined by the CANS for children and youth under 17 and on reassessment at least every 90 days – people over 18 are reassessed every 180 days[20]. (Note that CANS used for these services is not the same as CANS used for foster care placement purposes.)

[20] Texas Health and Human Services Commission. STAR Health Contract Terms

PCG analyzed the STAR Health Medicaid data to determine the utilization of Targeted Case Management services among the foster care population. Targeted Case Management services were processed under the Medicaid program. Targeted Case Management encounters for the three-year period examined are shown in the following table:

Table 20: Targeted Case Management Units and Hours in Fiscal Years Ending 2017, 2018 and 2019

Fiscal Year	HCPC Procedure Code	Description	Units of Service (15-Minute)	Hours of Service
FY 2017	T1017	Targeted Case Management	5,557	1,389
FY 2018	T1017	Targeted Case Management	7,688	1,922
FY 2019	T1017	Targeted Case Management	11,768	2,942

In 2019, the Texas Legislative Budget Board Staff authored a report that identified the following concerns about how Texas is utilizing TCM and rehabilitation services:

1. Approximately 80% of Texas Medicaid program clients that have a mental health-related diagnosis indicative of a serious mental health illness did not receive TCM or rehabilitative services during fiscal year 2017.
2. The process to authorize TCM and rehabilitative services results in unnecessary administrative costs for MCOs and providers due to the duplication of efforts, which results in greater expenses for the state
3. State oversight of the delivery of these services does not include a review of activities related to these services; therefore, it is uncertain whether there is adequate access to these services[21].

[21] 4740_Medicaid_Behavioral_Health.pdf (state.tx.us)

Review of Title IV-E Use in Texas

HHSC determines the way in which Title IV-E maintenance costs are claimed for each provider type as described below.

1. **Child Placing Agencies (CPA), Residential Treatment Centers (RTC), and Emergency Shelters (ES).** HHSC utilizes a cost reporting process for CPAs, 24 RCC and Emergency Shelter providers to gather financial and statistical information for HHSC to use in developing reimbursement rates. The cost centers identified in the cost report are determined as either Title IV-E FMAP (maintenance), Title IV-E administration, or unallowable costs using a comparison and analysis of Title IV-E requirements and cost principles. Converted time study results are used to determine the levels. Annually, providers are required to submit their most recently completed, audited cost report to HHSC with which HHSC calculates the weighted mean or median cost per day of service for each of the identified cost centers.
2. **Foster Family Pass-Through.** All costs are Title IV-E allowable and claimed at 100% Title IV-E.
3. **Supervised Independent Living (SIL) and Intensive Psychiatric Transition Program (IPTP).** HHSC determines which costs are maintenance costs, administrative costs, or unallowable based on federal regulations. HHSC then calculates the SIL and IPTP individual total rates and categorizes costs as maintenance, administrative, or unallowable.
4. **Community-Based Care Blended Rates.** CBC blended rates are calculated by weighting the average number of days of service provided by the CPA, RTC, ES, and IPTP. Then, HHSC calculates costs as maintenance, administrative, or unallowable.

Federal Funding Recommendations

The Federal funding recommendations align with Special Provision 32 (b) (5) (A): Increase access to current Medicaid benefits (such as mental health rehabilitation and TCM). There are costs to review and implement each of these recommendations.

Maximize use of Medicaid waivers for youth with high behavioral health needs.

Medicaid waivers allow states to waive certain Medicaid funding requirements.

- Continue 1915(c) YES Waiver: The YES waiver is a 1915(c) Medicaid program that helps children and youth with serious mental, emotional and behavioral difficulties[22]. It provides intensive services delivered within a strengths-based team planning process called Wraparound. As a preventative service, HHSC and DFPS should continue to promote this service in an effort to prevent out-of-home placements. HHSC should also work with STAR Health and local mental health authorities to simplify the credentialing process to increase the number of YES providers. Specifically, this refers to streamlining the processes for both provider enrollment with the Texas Medicaid & Healthcare Partnership (TMHP) and credentialing with MCOs.
- Apply for 1115(a) Waiver for IMD Payment Exclusion: Texas does not utilize psychiatric residential treatment facilities (PRTFs) to fund inpatient psychiatric services[23]. Currently, Medicaid provides inpatient psychiatric services to beneficiaries under age 21 if they meet medical necessity requirements, but there are a subset of children and youth in DFPS custody, who require high cost services and placements, who don't meet medical necessity criteria and/or may be placed in settings that are designated as Institutes for Mental Disease (IMDs.) Medicaid does not cover services for children and youth in IMDs[24]. One option for Medicaid support for these youth may be to apply for a demonstration project waiver under Section 1115(a) of the Social Security Act. Four (4) states have approved 1115(a) waivers for IMD payment exclusion, and three (3) have pending waivers[25]. While these waivers eliminate some requirements, they add others. For example, 1115(a) waivers are required to be budget neutral and must be renewed every five years. Texas would also need to contract with independent evaluators to

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[22] HHSC Youth Empowerment Services Waiver: https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/youth-empowerment-services-waiver-providers

[23] CMS defines PRTFs as a non-hospital facility that has a provider agreement with a state Medicaid agency to provide inpatient service benefits to individuals 20 years and younger. Texas does not have a mechanism for certifying PRTFs. A certification process and clinical coverage criteria would need to be established to recognize PRTFs and ensure that the level of service and facility structure meet state and federal standards for the state to be eligible for federal Medicaid matching funds.

[24] Note that facilities with fewer than 16 beds (for children and youth) are not IMDs.

[25] Idaho, Indiana, Vermont and Washington State have approved waivers. Massachusetts, Oklahoma and Utah have pending waivers (all as of December 3, 2020), according to the Kaiser Family Foundation: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#

conduct periodic evaluations of waiver outcomes. In short, this waiver would eliminate some requirements while adding others, so the costs and implications should be considered in determining whether this waiver would be in the best interest of children in the Texas foster care system.

Encourage STAR Health, Local Mental Health Authorities and providers to maximize use of S.B. 1177 In-Lieu-Of Services.

In 2019, Texas S.B. 1177 was passed, which states that HHSC will allow MCOs to have more flexibility in offering medically appropriate, cost-effective, evidence-based behavioral health services in lieu of covered Medicaid State Plan services. This two-stage process consists in-lieu-of inpatient services to be implemented in March 2021 and in-lieu-of outpatient services to be implemented by September 2022.

- The following are being considered for inclusion in Phase 1 in-lieu-of inpatient services:
  - Coordinated specialty care
  - Crisis respite
  - Crisis stabilization
  - Extended observation units
  - Partial hospitalization
  - Intensive outpatient program
- The following are being considered for inclusion in Phase 2 in-lieu-of outpatient services:
  - Cognitive rehabilitation
  - Multisystemic therapy
  - Functional family therapy

Increase use of TCM and MH Rehab Service within current MCO model.

Texas Medicaid reimburses TCM services; however, despite positive trends in recent years with increased encounters, utilization of these services indicates limitation (for the FY2019, TCM encounters represented less than one (1) percent (.44%) of the total medical services encounters). HHSC and DFPS should investigate the reasons for this limitation. Questions can be asked at the state, MCO, LMHA and provider levels. Addressing and improving this type of systemic issue would require insight from all involved parties. Feedback from stakeholders involved in Medicaid service provision would provide HHSC and DFPS with a strategy to increase the use of Medicaid TCM and MH Rehab in Texas without disrupting the MCO system and other populations outside of foster care that rely on it. Stakeholder questions could include the following, which stem from provider feedback given to PCG:

- **Number of Providers:** Do the regions lack a sufficient number of providers to render these services?
- **Credentialing Barriers:** What factors prevent providers from enrolling in TMHP or getting credentialed with the MCO to provide services directly?
- **TCM In Residential Care:** Are TCM services not readily accessible to children placed in residential settings? What are the obstacles?
- **TCM Overlap in Case Plans:** How do the residential care agencies or SSCCs incorporate the use of TCM services into their case plans?
- **Non-Covered Therapeutic Services:** Are there non-covered therapeutic services that should be covered MH Rehab services? Note that expanding the scope of what is covered in MH Rehab would have broader impacts beyond the STAR Health program.
- **Medicaid Rate Sufficiency:** What costs are not covered in the current Medicaid rates?
- **Necessary Family Services:** Are there necessary services for the family that are not covered?
- **Regulatory Changes:** What regulatory changes would make it easier for providers to offer and/or access more TCM and MH Rehab services?

The Federal funding recommendations align with Special Provision 32 (b) (5) (B): Identify Medicaid benefits offered in other states for foster youth that decrease hospitalization and lower costs. There are costs to review and implement each of these recommendations.

Follow-up on S.B. 58 Integration of Behavioral Health and TCM Services into Managed Care Model.

Texas S.B. 58 states that to the extent possible, behavioral health services, including TCM and psychiatric rehabilitation services and physical health services are to be integrated into the Medicaid managed care program. The MCO must develop a network of public and private providers of behavioral health services and ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services[26]. HHSC should revisit the S.B. 58 Behavioral Health Integration Advisory Committee (BHIAC) recommendations for integrating care[27]. HHSC can then determine which recommendations were implemented and address recommendations that were not implemented. S.B. 58 also required HHSC to implement a health home pilot program. Pilot sites implemented an integrated care model where providers collaborate and coordinate care for Medicaid members with complex health conditions and established value-based alternative payment models (APMs) with Medicaid MCOs. Developing alternative payment models was identified as a challenge for pilot sites and MCOs. Barriers include:

- Integrated care practices are still maturing,
- Standard reimbursement models do not adequately fit the integrated care model, and
- Few alternative payment models exist for integrated care, and development of these models takes time.

Results of this pilot study suggest it is worth continuing to identify methods to utilize APMs in an integrated behavioral health setting.

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[26] 83(R) SB 58 - Enrolled version (texas.gov)

[27] Senate Bill 58 Behavioral Health Integration Advisory Committee Second Report HHSC: https://hhs.texas.gov/sites/default/files/documents/about-hhs/leadership/advisory-committees/bhiac/BHIAC-Phase-II-recommendations.pdf

Conduct a feasibility study to determine costs and implications of bundling TCM and Medicaid Mental Health Rehab into the provider payment structure.

A bundled provider payment structure would incorporate costs associated with TCM and Medicaid mental health services directly into DFPS's payment rates. Providers would then be required to offer or contract for a standard level of these services for every child they serve, which could improve access to services and reduce the provider burden to bill Medicaid. Significant effort would need to be expended to make this happen and the MCO model in Texas cannot be changed without affecting numerous stakeholders and STAR Health enrollees that are not involved in the DFPS foster care system. Therefore, PCG recommends a feasibility study as a first step at objectively weighing the pros and cons of a shift to statewide Medicaid services bundled into existing or modified provider payment structures. Specifically, HHSC should review the following in a feasibility study:

- State fiscal impact: State net revenue or costs of incorporating TCM and MH Rehab services into provider payment rates (outside of the MCO model)
- Member and provider fiscal impact: Net revenue and cost impacts to members and providers
- Quality of care assessment: The impact the bundled payment model would have on the frequency, duration and quality of services that children in foster care could receive.
- Impact on operations: The operational impact on the system that integrating TCM and MH Rehab would have. This may include the impact to HHSC in data reporting and monitoring as well as the latent impact to non-foster care populations. This could also affect the Medicaid program more broadly (beyond STAR Health) depending on current Medicaid State Plan requirements.

States that include Medicaid-eligible services directly in payments to providers assume responsibility for monitoring and compliance. Providers expressed an interest in this model during PCG's stakeholder engagement sessions. Providers should be included in this process as key stakeholders.

Streamline the Medicaid credentialing process.

SSCCs noted the administrative and cost difficulties associated with the Medicaid credentialing process (with the Medicaid agency's contractor, the Texas Medicaid Healthcare Partnership (TMHP)). Legacy providers noted that the process is supposed to take 30 days but actually takes several months or even a year. While many of these requirements stem from federal requirements that HHSC must comply with, HHSC should review the federal requirements against its own, and identify areas that can be improved to make it easier for providers to become credentialed.

The Federal funding recommendations align with Special Provision 32 (b) (5) (C): Determine how to improve the reporting and tracking of data to maximize Title IV-E reimbursements. There are costs to review and implement these recommendations.

Review Opportunities to increase the Title IV-E eligibility rate:

Title IV-E is the largest federal funding source for Texas child welfare agencies[28]. The eligibility rate is the ratio of children who are Title IV-E eligible to the total population of children in out-of-home placement. Currently 47 percent of children in paid foster care in Texas are Title IV-E eligible. The outdated income test from 1996 AFDC standards is the most common reason that children are ineligible. However, while the eligibility rate in Texas is in line with many other states, PCG recommends that DFPS review additional opportunities to increase the eligibility rate. PCG did not complete a full eligibility review as part of this study, but other states have identified the following opportunities:

- Completion of prior quarter adjustments of previously pending cases that moved to a determined status;
- Utilization of multiple eligibility rates for administrative claiming (overall eligibility rate, CPA rate, foster family rate, congregate care rate);
- Improved understanding of removal home determination (which may not necessarily be the home the children were physically removed from); and
- Improved understanding of allowable income deduction determination (for children that are students).

Increase kinship licensing.

[28] Texas_SFY2016-CWFS_12.13.2018.pdf (childtrends.org)

DFPS confirmed that kinship caregivers do not always want to meet licensure requirements, particularly if they only plan to care for children for a short time. However, licensing foster homes, and paying them the full licensed foster care rate, may ultimately reduce the number of children placed in higher cost settings. While DFPS costs would increase, they could recoup some of that cost in Title IV-E reimbursement and may offset additional costs through improved outcomes for children who are able to remain in kinship placements (and therefore avoid GRO, RTC and other high-cost non-kinship placements).

Develop Title IV-E Administrative Claiming strategies for GRO/RTC placements.

DFPS/HHSC are factoring the reasonable costs of administering residential programs into the Title IV-E care and maintenance rate, which is appropriate. However, there may also be an opportunity to claim for Title IV-E administrative costs rendered by residential programs, such as case management, family engagement and transition planning, and aftercare activities. A significant portion of GRO/RTC costs are currently offset by Title IV-E care and maintenance reimbursement, however those dollars will not be available after October 2021 for programs that don't meet QRTP requirements. DFPS could offset some revenue loss, by capturing and claiming allowable Title IV-E administrative activities provided in these programs. Programs do not have to meet QRTP requirements for DFPS to claim Title IV-E administrative costs for eligible children in those programs.

Develop a method to claim costs associated with child specific contracts.

DFPS does not claim IV-E on behalf of child-specific contracts. While we understand that each contract is unique and that the rates are not part of the formal Title IV-E claiming percentage calculation process, we think there is an opportunity for DFPS to claim some of the payments they are making.

Cost Reports

Unnecessary Cost Report Requirements

Special Provision 32 (c)(1): Eliminating reporting requirements that are not required by state or federal law and are not currently being used by HHSC or DFPS to set rates;

PCG's approach to determine what cost reporting requirements may be considered for elimination was to evaluate the following information:

1. 24-hour RCC cost Reporting Requirements
2. 24-hour RCC Cost Reporting Process
3. Utilization of Cost Reporting Data in the Rate Setting Methodology Process

Below is a summary of our evaluation, with more detail included in Appendix 2c-1.

The cost reporting requirements for contracted providers of 24-hour Residential Child Care programs generally align with TAC regulatory guidance. However, after analyzing the TAC guidelines along with the data utilized in the rate setting models and comparing the data elements to the cost reporting information required, there are areas where some financial detail may be eliminated. A great deal of financial detail information is currently required in the cost reporting process. The TAC 40 RULE §700.1753 provides guidelines for broad categories of cost, primarily broken out between direct services and administration/all other non-direct expense.

While it may be nice to have a more granular level of expense detail for various types of cost analysis, there is also a tradeoff of that benefit relating to staff time and administrative burden for both the provider and for the HHSC cost reporting support staff and financial examiners. Reducing some of the administrative burden would result in a more streamlined and efficient process. It also would help improve cost reporting accuracy.

The following table provides a summary of expense information that may be considered for modification or removal from the cost reporting process:

Table 21: STAIRS Modification Considerations

STAIRS Screen Section	Description of Items that May be Modified or Eliminated
General reporting of revenue and expense	General recommendation is to have providers report all revenue, including DFPS payments, and all expenses in the cost report. Providers' expressed expenses that support the program but are covered by other non-DFPS funding sources are not recorded on the DFPS cost reports.

STAIRS Screen Section	Description of Items that May be Modified or Eliminated
5.d. Revenue Offsets	Line items to reduce expenses may be added after a subtotal for: Non-reimbursable cost Allow actual expenses to be reported without max limits. Revenue offsets could reduce expenses prior to determining grand total of allowable costs for DFPS purposes.
6.d. Non-Administrative and Operational Personnel	Evaluate positions listed to determine if job positions could be rolled up. This roll up should still allow for a comparison against locally competitive wages, but DFPS should nonetheless review alignment between these categories and whatever market wage resource it uses to ensure salary and rate adequacy (e.g., Texas Workforce Commission, Bureau of Labor Statistics, public job postings etc.). The core categories listed in TAC 40 RULE §700.1753 are: Case management Treatment coordination Direct care Direct care administration; and Medical
6.e. Administrative and Operations Personnel	Evaluate positions listed to determine if job positions could be rolled up into a few core administrative categories, such as: Administrator/COO/CFO Contract Management Staff Central Office Staff All Other Administrative Staff

8.f. Non-Related-Party Facility, Operations, Administrative and Other Direct Care Costs – Entry (sections broken out by related and non-related parties)	Create a unique section for Direct Care (non-labor) Costs Administrative/Operating Expense Section: Reduce the number of expense line items and consolidate categories The following provides an example of how this expense reporting category may be modified: Direct Care (Non-labor) Costs Transportation - Staff Transportation – Client Program related training Medical and Drugs Direct service equipment and supplies Information Technology/Telecommunications Costs assigned to Program(s) Other Direct Client Specific Assistance Dietary Supplies Housekeeping and Laundry Supplies Other direct service program expenses Administrative/Operating (Non-labor Costs) Building & Equipment Operations and Maintenance (includes utilities) Building Depreciation Vehicle Depreciation All Other Depreciation & Amortization Vehicle Rent

STAIRS Screen Section	Description of Items that May be Modified or Eliminated
	All Other Lease / Rent Information Technology/Telecommunication Costs (Not Assigned to Direct Services) Office Supplies and Equipment All other administrative and operating expenses Non-Reimbursable Expenses Fundraising and Development Activities Other non-reimbursable expenses

Cost Report Additions

Special Provision 32 (c) (2): Adding detail where needed to align rates paid with the quality and intensity of services across levels of care; and

Special Provision 32 (c) (3): Including additional or modified reporting requirements necessary to support implementation of any alternative rate methodology

Currently, the cost reports capture costs by placement type, but not service level. The GRO costs are submitted at the aggregate GRO level, rather than by specific GRO program (GRO Basic, RTC). Based on the cost reports, the following average costs per day were noted for each setting type.

Table 22: Expenses - Average Calculated Cost per Placement Day

Placement Type	Total Cost	Total Days of Care	Calculated Cost Per Day
CPA[29]	$94,286,054	4,102,177	$22.98
ES	$39,904,695	272,904	$146.22
GRO	$134,365,389	937,500	$143.32
Total	$268,556,138	5,312,581	

Because of the submission limitations, the cost reports do not provide a means to understand the cost per day of operating specific GRO programs such as an RTC, nor the cost differences associated with youth at the basic, moderate, or specialized levels for example.

[29] Foster parent pass through expenses are excluded from CPA totals here.

As indicated above, PCG recommends that DFPS align rates with quality and intensity through a standardized rate structure that delineates the program, staff and price expectations for each placement setting and program. From a practical standpoint, the immediate changes in the legacy system include a shift from payments based on setting and assessed service level to payments based solely on setting/program model.

The cost-reporting process will need to be modified to gather information from providers that will support the development of the alternative rate methodology. Some of the additional information recommended will include the following:

1. **Geographic Location:** Geographic location of the Provider's program facility where services are delivered. Currently, the data submitted in the cost report lists the location of the program's agency headquarters versus the location where services are rendered. Reporting the programs location of service will allow for analysis of costs based on geographic regions. If providers would not find it unduly burdensome, then it is recommended that the specific Region and Catchment Area is added to the general agency section of the cost report. This may not be feasible for CPAs – but could be explored.
2. **Discrete Reporting by Service:** An agency's program offerings should be reported uniquely for each service. For example, an agency that provides GRO and RTC programs should report their revenue, expenses, and client statistics for each program separately. This is already done for placement days.
3. **DFPS Revenue Reporting:** DFPS revenue should be included in the cost reports. Other revenue is captured in section 5a of the cost report. However, including DFPS revenue as well would allow each cost report to have all information necessary to understand solvency in one place. HHSC can also use the provider-reported revenue in its cost report reviews to ensure accuracy in reporting.
4. **Specify Fundraising in Non-DFPS Revenue:** In addition to DFPS revenue, fundraising revenue should be specified in section 5a of the cost report. This will allow HHSC and DFPS to understand how much fundraising providers must do to remain solvent. With expenses already captured and DFPS revenue and fundraising revenue added, HHSC and DFPS will be able to use the cost report data alone to assess provider solvency and the need for fundraising. In short, all revenue and expenses should be reported. HHSC can still use state data to verify DFPS revenue.

5. **One Agency Cost Report to include all Programs:** Currently, the providers create a unique cost report in the STAIRS system for each program service. During the stakeholder meetings, the providers expressed frustration with the creation of multiple cost reports. The providers shared the current process is burdensome, inefficient, lends to inaccuracy due to user error, there are difficulties with cost allocation entries and reconciling the recorded data to their agency's accounting reports. The providers should be able to create one cost report with each program's data entered in uniquely. This would allow for more accuracy of the data reported while streamlining the process and making it more efficient.
6. **Update Cost Report to Isolate QRTP Costs:** DFPS is currently piloting and reviewing QRTP requirements. With Family First implementation required in less than a year, HHSC and DFPS should update the cost report to isolate QRTP expenses. This will ensure that DFPS can properly allocate QRTP eligible for claiming purposes. Specifically, costs associated with nursing and clinical staff 24/7 coverage should be captured in the cost report (as personnel or contracted personnel). Expenses associated with adhering to a trauma-informed treatment model should also be captured. Similarly, family engagement, accreditation and aftercare costs should have their own lines in the cost report.

Appendix C. Background and Methodology

Data Materials Review

Table 23: Cost Report, Placement, CANS and Medicaid Datasets Analyzed

Document Name	Type of Document
2020-10-07 Authorized Level of Care for Children in Paid Foster Care	Aggregated placement data from FY16-FY20
2020-10-07 Children in Paid Foster Care Placements FY16-FY20	Aggregated placement data from FY16-FY20
2020-10-07 Children in Paid Foster Care Placements FY16-FY20	Aggregated placement data from FY16-FY20
2020-10-07_EV_ Children in Paid Foster Care Placements FY16-FY20	Aggregated placement data from FY16-FY20
2020-10-07_EV_Single_Reason_ Children in Paid Foster Care Placements FY16-FY20	Aggregated placement data from FY16-FY20
2020-10-07_HHSC CANS Report	Aggregated CANS data from FY16-FY20
24RCC-2017-SDF.Adjusted	Aggregated 2017 24/7RCC provider cost report data.
2018-24RCC-ADJUSTED	Aggregated 2018 24/7RCC provider cost report data.
2020-10-15-20_specialprovisions32_dataextract_dtl_17_19	Aggregated Medicaid data
2020-10-15-20_specialprovisions32_dataextract_hdr_17_19	Aggregated Medicaid data

Document Name	Type of Document
2020-10-15-20_specialprovisions32_DataExtractDictonary_Final	Medicaid data dictionary

Table 24: Other Files Reviewed

Document Name	Type of Document
Links to Contracts	Links to contracts database search, the 24 RCC residential contract requirements, and CBC contracts
Links to Medicaid Manual	Links to STAR health contract terms and Texas Medicaid and CSHCN Services Program provider manuals
2018 Cost Report Instructions_24RCC	Step-by-step instruction guide for completing a cost report for 24RCC using STAIRS (TX's automated system)
ZZZ RAD 24RCC-CPA 2018 CR	2018 cost report: Child Placing Agencies
ZZZ RAD 24RCC-ES 2018 CR	2018 cost report: Emergency Shelters
ZZZ RAD 24RCC-GRO-RTC 2018 CR	2018 cost report: General Residential Operation - Residential Treatment Center
ZZZ RAD 24RCC-GRO-RTC-IPTP 2018 CR	2018 cost report: General Residential Operation - Residential Treatment Center - Intensive Psychiatric Transition Program
ZZZ RAD 24RCC-SSCC 2018 CR	2018 cost report: Single Source Continuum Contractor

Document Name	Type of Document
24RCC-2017-SDF.Adjusted_Definitions	Definitions of column headings in 24RCC-2017-SDF.Adjusted
2018-24RCC-ADJUSTED_Definitions	Definitions of column headings in 2018-24RCC-ADJUSTED
All paid foster care placements and associated authorized level of care information	Definitions of collected info for all paid foster placements, associated authorized level of care and CANS
SpecialProvisions32_DataExtractDictionary_v1	Header definitions
Texas_Service_Levels_Resource_Guide	2019 definitions of service levels (basic, moderate, specialized, intense, intense-plus), standards for foster caregivers
FC Redesign_SSCC_Combined_202007_v	Foster care statistics: Rates, Days, Clients, Copays, Paid FTEs
PFC KPFC Combined_202007_v	History statistics: Rates, Clients, Copays, FTEs
SIL_History 202007_v	SIL statistics: Rates, Days, Clients, Copays, Paid FTEs
TEP_202007_v	Temporary Emergency Placement statistics: Days, Cost, Rates, Copays, FTEs
2019-12-20_Community-Based_Care_Implementation_Plan	A high-level outline of the structures/processes to implement and oversee TX's Community-Based Care Plan

Document Name	Type of Document
CANSReview_Executive Summary_3Q2020_Final	Executive summary of CANS implementation process review for Q3 FY20
Clinical Populations in Paid Foster Care	Our Community Our Kids report identifying/describing clinically meaningful subgroups of children in paid foster care in Region 3b (North TX)
IV-E Methodology_	Rationale for IV-E allowable breakouts for provider types reimbursed under the 24 RCC program
SP 32 - Stakeholder Register Template	Contact info for stakeholders in foster care rate setting
star-health-contract	Updated 2020: terms for the managed care org to participate in the STAR Health Program (operated by HHSC)
TMPPM	TX Medicaid Provider Procedures Manual: inpatient and outpatient hospital services handbook (rules and regs for claiming, admission, types of care)
CANS_2-0_Manual	2017 Texas CANS reference guide
24 RCC Legacy Rate Model inc. TFFC_2018 to 2022-2023	2018-2022/23 Weighted/final rates and calculations, service level/CPA indices, inflators & forecasted totals
24RCC 2018 Rate Code	Rate setting coding syntax

Document Name	Type of Document
24RCC Intense Plus & TEP - 2022-2023	Options comparison with weighted median rates & rate models; 2016-2019
24RCC Rate Methodology Rules	TX Administration Code for residential child-care contracts, post-permanency services and reimbursement methodology for 25 hr. child care facilities
24RCC-2017-SDF.Adjusted	2017 Detailed description of combined entities (cost report group codes, contact, contract and program info)
2018-24RCC-ADJUSTED	2018 Detailed description of combined entities (cost report group codes, contact, contract and program info)
2019 Current 24RCC Rates	Payment rates per day by service for 24RCC (2019)
2020-21 SIL MOF Update	Current and enhanced SIL/MOF rates/calculations with fiscal impact summary (FY20 and FY21)
CBC Rate Model	Calculations of FY20 Blended Rates for 24RCC Community-based Care
Chapin Hall Rate Method Response 9.19	Texas Alliance for Child and Family Services compiled feedback on the Chapin Hall CBC rate methodology report
Chapin Hall Rate Study	March 2019 Chapin Hill report on TX's risk groups and average cost of paid foster care to generate the blended per diem rate

Document Name	Type of Document
LTSS-1.0003 DFPS Legacy Policy & Procedure	Current policy/procedure for calculating 24 RCC rates, incl. step-by-step instructions and definitions
LTSS-1.0005 DFPS IPTP Rate Model (working copy)	Workbook for IPTP rate, updated May 2020
New Indices for CPA rates in 24RCC Legacy Model	Adjusting CPA rates to better reflect true provider costs (methodology)
2019-01-16_Incremental_Cost_of_One-Percent_Rate_Change	Incremental cost of a 1% rate change, incremental cost to fully fund the rate
2020-10-07 Authorized Level of Care for Children in Paid Foster Care	Aggregated placement data from FY16-FY20
2020-10-07 Authorized Level of Care_shortnameforMSOffice	Aggregated placement data from FY16-FY20
2020-10-07 Children in Paid Foster Care Placements FY16-FY20	Aggregated placement data from FY16-FY20
2020-10-07 Children in Paid Foster Care Placements FY16-FY20	Aggregated placement data from FY16-FY20
2020-10-07_EV_ Children in Paid Foster Care Placements FY16-FY20	Aggregated placement data from FY16-FY20
2020-10-07_EV_Single_Reason_ Children in Paid Foster Care Placements FY16-FY20	Aggregated placement data from FY16-FY20
2020-10-07_HHSC CANS Report	Aggregated CANS data from FY16-FY20

Document Name	Type of Document
2020-10-15-20_specialprovisions32_dataextract_dtl_17_19	Aggregated Medicaid data
2020-10-15-20_specialprovisions32_dataextract_hdr_17_19	Aggregated Medicaid data
2020-10-15-20_specialprovisions32_DataExtractDictonary_Final	Medicaid data dictionary
FC Redesign_SSCC_Combined_202007_v	Rate cost allocation by federal funding source
PFC KPFC Combined_202007_v	Rate cost allocation by federal funding source
SIL_History 202007_v	Rate cost allocation by federal funding source
TEP_202007_v	Rate cost allocation by federal funding source
FY 19 FC Rates Color worksheets_21 FMAP	FY19 federal funding allocation
FY 19 FC Rates Color worksheets_21 FMAP_COVID_FMAP	FY19 federal funding allocation by with COVID updates
FY 20 FC Rates Color worksheets_21 FMAP	FY20 federal funding allocation
FY 20 FC Rates Color worksheets_21 FMAP_COVID_FMAP	FY20 federal funding allocation with COVID updates
FY 21 FC Rates Color worksheets_21 FMAP	FY21 federal funding allocation

Document Name	Type of Document
FY 21 FC Rates Color worksheets_21 FMAP_COVID_FMAP	FY19 federal funding with COVID updates
2022-23 Rate Table Recommendation	Draft memo listing 2022-23 24 RCC Rate Recommendations
Attachment 1- 2022-23 1% Change Rate table for DFPS_Draft	Draft fiscal impact of 2022-23 rate recommendations
Attachment 2 2022-23 24 RCC All Rates	Draft 2022-23 24 RCC Rate Recommendations
Attachment 3 2022-23 MOF	Draft 2022-23 Rate Recommendations Method of Finance
MMHPI Final Report_20190562	Meadows Mental Heath Policy Institute & Texas Center for Child and Family Studies, Foster Care Rate Analysis and Rate Setting Leading Practices- April 2019
OCOK Report 3-31-17 Draft V2	PCG's- Our Community Our Kids Rate Analysis and Recommendations Report March 2017
Parity Workgroup Requested Information	Inpatient and Residential MH Services in Texas Medicaid and CHIP Background and Policy information
Annual Report-Medicaid Managed Care in Lieu of Services-SB 1177	2019 Annual Report for the Medicaid Behavioral Health in Lieu of Services
20101201_Leg_Report	2010 Psychiatric Residential Treatment Facilities Report to the Texas Legislature

Stakeholder Engagement

Table 25: Stakeholder Engagement Schedule

Stakeholder Group	2020 Dates
General Residential Operations (GRO) Providers, 5 sessions open to all providers	October 27th – November 5th
Child Placing Agencies (CPA) Providers, 5 sessions open to all providers	October 27th – 30th
Single Source Continuum Contract (SSCC) Providers	October 7th, 16th, 22nd, 26th,
Single Source Continuum Contract (SSCC) Providers and Texas Alliance of Child and Family Services	October 6th, November 6th, and November 30th
Dr. John Lyons	November 3rd
HHSC/DFPS	August 24th – December 18th
Meadows Mental Health Policy Institute	November 6th
Youth for Tomorrow	October 22nd

Stakeholder feedback played a critical role in our analysis. PCG shared key takeaways with HHSC and DFPS during the project. We also incorporated feedback throughout the report.

CANS Data Analysis

The table below represents the placement cost increase or decrease for every additional 0.01 increase in average CANS Score for each domain. Fourteen of the 15 domains show an increase in placement cost associated with increased scores.

Table 26: Domains Placement Cost Estimates (Average Scores)

Domain	Placement Cost Estimate	Interpreting the Estimate for Average Scores
Acculturation	$2.04	• There is a positive relationship between placement cost per day and the average CANS score for the Acculturation Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($2.04) as the Acculturation Average Score increases per 0.1 unit.
Behavioral and Emotional Health Needs	$11.45	• There is a positive relationship between placement cost per day and the average score for the Behavioral and Emotional Health Needs Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($11.45) as the Behavioral and Emotional Health Needs Average Score increases per 0.1 unit.
Child Involvement in Child Protection	$1.72	• There is a positive relationship between placement cost per day and the average score for the Child Involvement in Child Protection Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($1.72) as the Child Involvement in Child Protection Average Score increases per 0.1 unit.
Infants and Young Children Behavioral and Emotional Needs	$2.29	• There is a positive relationship between placement cost per day and the average score for the Infants and Young Children Behavioral and Emotional Needs Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($2.29) as the Infants and Young Children Behavioral and Emotional Needs Average Score increases per 0.1 unit.

Domain	Placement Cost Estimate	Interpreting the Estimate for Average Scores
Infants and Young Children Functioning/ Development	$1.43	• There is a positive relationship between placement cost per day and the average score for the Infants and Young Children Functioning/ Development Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($1.43) as the Infants and Young Children Functioning/ Development Average Score increases per 0.1 unit.
Infants and Young Children Risk Behaviors	$2.17	• The placement cost per day as explained by the domain average score, states that there is a positive relationship between placement cost per day and the average score for the Infants and Young Children Risk Behaviors Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($2.17) as the Infants and Young Children Risk Behaviors Average Score increases per 0.1 unit.
Infants and Young Children Risk Factors	$(0.16)	• There is a negative relationship between placement cost per day and the average score for the Infants and Young Children Risk Factors Domain. • Within this domain, the average placement cost per day will decrease by the coefficient ($0.16) as the Infants and Young Children Risk Factors Average Score increases per 0.1 unit.
Life Functioning	$11.94	• There is a positive relationship between placement cost per day and the average score for the Life Functioning Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($11.94) as the Life Functioning Average Score increases per 0.1 unit.

Domain	Placement Cost Estimate	Interpreting the Estimate for Average Scores
Psychiatric Crisis History	$6.09	• There is a positive relationship between placement cost per day and the average score for the Psychiatric Crisis History Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($6.09) as the Psychiatric Crisis History Average Score increases per 0.1 unit.
Psychiatric Hospitalizations History	$6.01	• There is a positive relationship between placement cost per day and the average score for the Psychiatric Hospitalizations History Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($6.01) as the Psychiatric Hospitalizations History Average Score increases per 0.1 unit.
Child Risk Behaviors	$12.01	• There is a positive relationship between placement cost per day and the average score for the Child Risk Behaviors Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($12.01) as the Child Risk Behaviors Average Score increases per 0.1 unit.
Strengths	$2.56	• There is a positive relationship between placement cost per day and the average score for the Strengths Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($2.56) as the Strengths Average Score increases per 0.1 unit.

Domain	Placement Cost Estimate	Interpreting the Estimate for Average Scores
Suicide Risk	$4.33	• There is a positive relationship between placement cost per day and the average score for the Suicide Risk Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($4.33) as the Suicide Risk Average Score increases per 0.1 unit.
Child Traumatic Experiences	$4.85	• There is a positive relationship between placement cost per day and the average score for the Child Traumatic Experiences Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($4.85) as the Child Traumatic Experiences Average Score increases per 0.1 unit.
Traumatic Stress	$4.98	• There is a positive relationship between placement cost per day and the average score for the Traumatic Stress Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($4.98) as the Traumatic Stress Average Score increases per 0.1 unit.

The table below represents the placement cost increase or decrease for every additional one (1) item scored as CANS Risk in each domain. Eleven of the 15 domains show an increase in placement cost. Exceptions included the domains for infants and young children, which is reasonable given that placement costs tend to be lower for very young children in general.

Table 27: Domains Placement Cost Estimate (Risk Scores)

Domain	Placement Cost Estimate	Interpreting the Estimate for Risk Scores
Acculturation	$7.91	• There is a positive relationship between placement cost per day and the risk score for the Acculturation Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($7.91) as the Acculturation Risk Score increases per 1 unit.
Behavioral and Emotional Health Needs	$19.03	• There is a positive relationship between placement cost per day and the risk score for the Behavioral and Emotional Health Needs Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($19.03) as the Behavioral and Emotional Health Needs Risk Score increases per 1 unit.
Child Involvement in Child Protection	$19.17	• There is a positive relationship between placement cost per day and the risk score for the Child Involvement in Child Protection Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($19.17) as the Child Involvement in Child Protection Risk Score increases per 1 unit.
Infants and Young Children Behavioral and Emotional Needs	$(11.07)	• There is a negative relationship between placement cost per day and the risk score for the Infants and Young Children Behavioral and Emotional Needs Domain. • Within this domain, the average placement cost per day will decrease by the coefficient ($11.07) as the Infants and Young Children Behavioral and Emotional Needs Average Score increases per 1 unit.

Domain	Placement Cost Estimate	Interpreting the Estimate for Risk Scores
Infants and Young Children Functioning/ Development	$(12.47)	• There is a negative relationship between placement cost per day and the risk score for the Infants and Young Children Functioning/ Development Domain. • Within this domain, the average placement cost per day will decrease by the coefficient ($12.47) as the Infants and Young Children Functioning/ Development Risk Score increases per 1 unit.
Infants and Young Children Risk Behaviors	$(13.85)	• There is a negative relationship between placement cost per day and the risk score for the Infants and Young Children Risk Behaviors Domain. • Within this domain, the average placement cost per day will decrease by the coefficient ($13.85) as the Infants and Young Children Risk Behaviors Average Score increases per 1 unit.
Infants and Young Children Risk Factors	$(24.93)	• There is a negative relationship between placement cost per day and the risk score for the Infants and Young Children Risk Factors Domain. • Within this domain, the average placement cost per day will decrease by the coefficient ($24.93) as the Infants and Young Children Risk Factors Average Score increases per 1 unit.
Life Functioning	$14.99	• There is a positive relationship between placement cost per day and the risk score for the Life Functioning Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($14.99) as the Life Functioning Average Score increases per 1 unit.

Domain	Placement Cost Estimate	Interpreting the Estimate for Risk Scores
Psychiatric Crisis History	$120.42	• There is a positive relationship between placement cost per day and the risk score for the Psychiatric Crisis History Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($120.42) as the Psychiatric Crisis History Average Score increases per 1 unit.
Psychiatric Hospitalizations History	$47.17	• There is a positive relationship between placement cost per day and the risk score for the Psychiatric Hospitalizations History Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($47.17) as the Psychiatric Hospitalizations History Average Score increases per 1 unit.
Child Risk Behaviors	$31.77	• There is a positive relationship between placement cost per day and the risk score for the Child Risk Behaviors Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($31.77) as the Child Risk Behaviors Average Score increases per 1 unit.
Strengths	$5.18	• There is a positive relationship between placement cost per day and the risk score for the Strengths Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($5.18) as the Strengths Average Score increases per 1 unit.

Domain	Placement Cost Estimate	Interpreting the Estimate for Risk Scores
Suicide Risk	$92.63	• There is a positive relationship between placement cost per day and the risk score for the Suicide Risk Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($92.63) as the Suicide Risk Average Score increases per 1 unit.
Child Traumatic Experiences	$6.98	• There is a positive relationship between placement cost per day and the risk score for the Child Traumatic Experiences Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($6.98) as the Child Traumatic Experiences Average Score increases per 1 unit.
Traumatic Stress	$13.74	• There is a positive relationship between placement cost per day and the risk score for the Traumatic Stress Domain. • Within this domain, the average placement cost per day will increase by the coefficient ($13.74) as the Traumatic Stress Average Score increases per 1 unit.

Appendix D. Unnecessary Cost Reporting Requirements

PCG's approach to determine what cost reporting requirements may be considered for elimination was to evaluate the following information:

1. 24-hour RCC cost Reporting Requirements
2. 24-hour RCC Cost Reporting Process
3. Stakeholder Forums Feedback Regarding 24-Hour RCC Cost Reporting
4. Utilization of Cost Reporting Data in the Rate Setting Methodology Process
5. Evaluation of Cost Reporting Requirements that may be Considered for Elimination

The following sections provide a summary of our evaluation.

24-Hour RCC Cost Reporting Requirements

The Texas Administrative Code (TAC) provides regulatory guidance pertaining to general principles of allowable and unallowable costs and reimbursement methodologies for services provided by 24-Hour Child Care Facilities. This guidance may be found in the following TAC sections:

- Title 1, Part 15, Chapter 355, Subchapter A, Rule §355.102: General Principles of Allowable and Unallowable Costs
- Title 40, Part 19, Chapter 700, Subchapter Q, Division 3, §700.1751: What is the Cost Determination Process?
- Title 40, Part 19, Chapter 700, Subchapter Q, Division 3, §700.1753: What is the Rate-Setting Methodology for 24-Hour Residential Child-Care Reimbursements?
- Title 40, Part 19, Chapter 700, Subchapter Q, Division 3, §700.1755: What is the Reimbursement Methodology for Supervised Independent Living?
- Title 40, Part 19, Chapter 700, Subchapter Q, Division 3, §700.1757: What is the Reimbursement Methodology for Sub-Acute Inpatient Treatment Programs?
- Title 40, Part 19, Chapter 700, Subchapter Q, Division 3, §700.1759: What is the Reimbursement Methodology for Residential Child Care Case Management and Family-Based Safety Services?

The TAC regulatory guidance requires DFPS contracted providers of child welfare services who provide 24-hour residential child-care services to submit financial and statistical information. Specifically, "Providers of 24-hour residential childcare services must report this information on cost-reporting forms approved by the HHSC, or electronically in HHSC-prescribed format where these systems are operational. The cost report must cover all of the provider's activities while delivering contracted services during the fiscal year specified by the cost report unless HHSC, at its sole discretion, requires a provider to submit a cost report covering selected activities or covering another time period[30]." In addition to the TAC regulatory guidance, the cost reports must be completed in accordance with federal regulations and guidelines as directed in the Code of Federal Regulations (CFR):

- **45 CFR 74:** Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals and Other Nonprofit Organizations and Commercial Organizations
- **48 CFR 31:** Contract Cost Principles and Procedures
- **2 CFR 200:** Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards

[30] TAC Rule §700.1753: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=19&ch=700&rl=1753

The following presents a summary of the 24-Hour RCC cost reporting requirements:

- Every 24-hour residential child-care provider that directly or indirectly receives payment from DFPS for services to children whom DFPS has placed with the provider (broadly, this includes all CPA, GRO, GRO-ES and SSCC provider types and subtypes within these)
- The provider must submit a separate cost report for each separately licensed facility that the provider operates
- If two (2) or more facilities share a license, but function as separate and distinct facilities, each of them must submit a cost report that covers its own revenues, expenses, and statistics; and
- A child-placing agency that holds multiple licenses that operates as one legal entity must submit one cost report for the entire legal entity[31]

Provider must submit a cost report for each contract unless they meet one or more of these conditions:

- Contract terminated or not renewed
- Provided only basic level services
- Total number of state placed days was 10% or less of the total days of service
- Total number of DFPS placed days was 10% or less of the total days of service
- Facilities providing emergency care services ONLY, occupancy rate was less than 30% or all other facility types expect CPA and those providing emergency services, the occupancy rate was less than 50% during cost reporting period

[31] TAC Rule §700.1751: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=19&ch=700&rl=1751

Other Cost Reporting Requirements[32]

HHSC may exclude from the database any cost report that is not completed according to the published methodology and the specific instructions for completion of the cost report. Reasons for exclusion of a cost report from the database include, but are not limited to[33]:

1. Receiving the cost report too late to be included in the database
2. Low occupancy
3. Auditor recommended exclusions
4. Days of service errors
5. Providers that do not participate in the level of care system
6. Providers with no public placements
7. Not reporting costs for a full year
8. Using cost estimates instead of actual costs
9. Not using the accrual method of accounting for reporting information on the cost report
10. Not reconciling between the cost report and the provider's general ledger
11. Not maintaining records that support the data reported on the cost report

24-Hour RCC Cost Reporting Process

The 24-hour Residential Child Care (24RCC) programs utilize the State of Texas Automated Information System (STAIRS) web-based system to complete the 24-Hour RCC cost report. The STAIRS cost reporting instructions state the purpose of completing the cost report "is to gather financial and statistical information for HHSC to use in developing reimbursement rates[34]." In addition, provider cost reports are generally used to gain an understanding of the cost of delivering contracted services and to provide accountability to the use of state and federal funds. In order for the cost report that is entered into the STAIRS web-based system to be acceptable it must pass several criteria outlined in TAC.

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[32] Id.

[33] TAC Rule §700.1753: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=19&ch=700&rl=1753

[34] Texas Health and Human Services 2018 Cost Report Instructions for 24RCC

Providers are required to maintain records to support the financial, statistical and legal information that is entered into the cost report. Further, the provider must allow access to all records necessary to verify information recorded on the cost report.

The provider enters agency general information that is displayed on the entity's dashboard. Upon signing into the system, the user would select "Cost Reporting" in order to begin entering data into the cost report. The user would proceed in completing the cost reporting system screens 1 through 14 (with some steps containing several additional steps noted in letters):

Stakeholder Forums Feedback Regarding 24-Hour RCC Cost Reporting

PCG facilitated stakeholder forums to solicit 24RCC provider community feedback regarding the current cost-reporting process. Our objective was to ensure we thoroughly understood the complexities of the cost-reporting process and that we included the 24RCC provider community feedback in our considerations to improve and streamline the cost reporting process.

The following bullets summarize the feedback we received from the 24RCC provider community as we discussed the effectiveness and issues with the current 24-Hour RCC cost reporting process.

- **Understated and Retrospective Expenses:** Providers noted that non-DFPS revenues and expenses are not recorded in the cost report, which may cause reduced payments. Similarly, providers reported that other funding streams are often required to cover DFPS-related expenses. Providers expressed concerns that using historical expenses from the cost reports does not take into consideration facility building repair costs, insurance costs, other capital projects, salary increases, necessary fundraising costs and forthcoming QRTP costs.
- **Lack of Transparency and Understanding on Rate Setting Process:** Providers expressed a lack an understanding about why DFPS eliminates some of the administrative costs that should be included. Providers noted a lack of understanding on the rate-setting process and calculations. Providers believe they are paid program service rates that are not based directly on the cost report data—specifically, that projections are not evaluated against the actual costs of service.
- **Desire for More Support and Less Burdensome Monitoring:** Similar to the transparency issues, providers expressed a desire to have more support from HHSC during the cost reporting process. Additional training, technical assistance from seasoned HHSC staff and a focus on the cost report content, not just the STAIRS functionalities, would go a long way in helping providers more easily adhere to the process requirements.
- **Complexity and Difficulty of Cost Reporting Process:** Most pervasively, providers reported frustrations with the complexity and difficulty of the cost reporting process. Providers noted that STAIRS does not align with provider accounting systems. Providers also reported difficulties with the STAIRS system functionality itself. According to providers, cost report instructions should be re-examined to better align with provider definitions of positions and cost pools. It was noted that providers with multiple programs have difficulties completing multiple submissions, and one cost report per provider with cost pools by program may alleviate that particular provider hardship.

Utilization of Cost Reporting Data in the Rate Setting Methodology Process

HHSC recommends payment rates for the 24-Hour Residential Child Care Program (24-Hour RCC) according to the rate methodologies in Title 40 of the Texas Administrative Code (40 TAC) RULE §700.1753, "What is the Rate Setting Methodology for 24-Hour Residential Child-Care Reimbursements?", and 1 TAC Section 355.101, Cost Determination Process. The Texas Administrative Code states a rate-setting model is applied to child placing agencies' and residential care facilities' cost report information included within the rate-setting population defined in the guidance. Three allocation methodologies are used in the rate-setting model to allocate allowable costs among the levels of care of children that are served.

Methodology 1

A staffing model that is supported by a time study and based on the number of direct care and treatment coordination staff assigned to children at different levels of care. The staffing model is used to allocate direct care costs among the levels of care. The cost reports provide information regarding the following expenses that are a component of Methodology 1:

- Direct Care Labor
- Total payroll taxes and workers compensation expense
- Direct care non-labor for supervision/recreation, direct services, and other direct care (not CPAs)

Methodology 2

Certain non-labor expenses are aggregated to determine a total cost that is divided by the total number of days of care to arrive at a cost per day of care. This per day amount is subsequently multiplied by the number of days in each level of care in order to allocate a proportionate share of these expenses to the various levels of care. The cost reports provide information regarding the following expenses that are a component of Methodology 2:

- Direct care non-labor for dietary/kitchen
- Building and equipment
- Transportation
- Tax expense
- Net educational and vocational service costs

Methodology 3

The results of Methodologies #1 and #2 (above) are totaled. Next, a percent of the total among each level of care is calculated. Lastly, the percentages for each level

of care are applied to Administrative expenses in order to allocate a proportionate share of these administrative costs to each level of care category. The cost reports provide information regarding the following expenses that are a component of Methodology 3:

- Administrative wages/benefits
- Administration (non-salary)
- Central office overhead
- Foster family development

The rate setting model outlined above is applicable to the child placing agencies (CPA) and residential care facilities is known as the "Legacy System" reimbursement for contracted foster care services rendered. A second system of reimbursement for contracted foster care services exist, known as Community-based Care (CBC) payment model.

The CBC model is the reimbursement mechanism for the Single Source Continuum Contractor (SSCC). The TAC 40 RULE §700.1753, (t) Community-based Care provides guidance regarding the CBC payment model and states "(1) Initial payment rates for a defined rate period for Single Source Continuum Contractors under Community-based Care are determined on a pro forma basis in accordance with §355.105(h) of this chapter using the official forecast of case mix for paid foster care for each specific catchment area for the rate period available at the time the payment rates are calculated." The CBC rate methodology model utilizes the cost reporting information that was outlined for the Legacy rate model, described above.

In addition to understanding the guidance as outlined in the Texas Administrative Code pertaining to the establishment of rate-setting methodologies for reimbursement to the 24RCC providers, PCG also analyzed the HHSC rate setting model workbooks. There are three (3) rate model workbooks that pertain to Legacy System reimbursement and one rate model workbook for the CBC reimbursement. The following rate model workbooks were analyzed:

- Legacy System - 24 RCC Legacy Rate Model
- Legacy System - 24RCC Intense Plus and Temporary Emergency Placement (TEP) Rate Model
- Legacy System - Intensive Psychiatric Transition Program (IPTP) Rate Model
- CBC - CBC Rate Model

All the above rate setting model workbooks are in Excel format and contain multiple tabs with financial and statistical information, compilations of data, computations, formulas, and data links. PCG's objective in analyzing these workbooks, under this scope of work, was to review cost reporting data elements that are instrumental in developing the reimbursement rates.

PCG determined that the cost reporting data elements utilized in the rate model workbooks either include expense categories outlined in the TAC 40, RULE §700.1753 or utilize the Legacy Rates as a basis for further rate modeling, such as the CBC blended rates.

Other Cost Reporting Requirements[35]

Training

- HHSC is responsible for providing all cost report training
- Cost report or accountability report preparer must complete the required state sponsored training
- Contracted preparer's fees to complete training are considered allowable expenses for cost reporting purposes. Preparers that participate in training may be assessed a convenience fee, which will be determined by HHSC. Convenience fees assessed for training are allowable costs.

Cost Report Due Date

Unless HHSC specifies otherwise, providers must submit cost reports to HHSC Rate Analysis no later than 90 days following the end of the provider entity's fiscal year or 90 days from the transmittal date of the cost-reporting forms, whichever due date is later.

Accounting Requirements

- **Use accrual method of accounting** - Each provider's treatment of financial and statistical data must reflect the application of generally accepted accounting principles (GAAP) approved by the American Institute of Certified Public Accountants (AICPA).
- **Allocation** - Direct costing method of allocation should be used whenever possible. If direct costing is not possible, a provider must use reasonable methods of allocation and must be consistent in the use of allocation methods across program areas and business entities to ensure that allowable costs are equitably allocated across business activities or business entities receiving the benefits of those allocated costs.
- **Function Basis Allocation Method** - When practical and the amounts are material, costs must be allocated on a functional basis. Some examples are listed as follows:
  - Costs of a central payroll operation could be allocated to all business components based on the number of checks issued

[35] TAC Rule §700.1753: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=19&ch=700&rl=1753

    - Costs of a central purchasing function could be allocated based on the dollar amount of purchases made or requisitions handled
    - Costs of utilities or rent could be allocated based upon square footage.
    - Payroll costs for an employee working across business components could be allocated based upon that employees' timesheets and/or a documented time study
    - Transportation equipment costs could be allocated based upon mileage logs
- **General management and administrative costs** – If these costs cannot be allocated on a functional basis should be allocated reasonably and consistently across all business components receiving the benefits of those allowable general management and administrative costs.
- **Cost allocation methods** - must be clearly and completely documented in the provider's workpapers, with details as to how specific allocations are made

Certification

A completed cost report must contain a signed, notarized, original certification page.

Review of Cost Reports

HHSC conducts a desk review or field audit of each cost report to ensure that the financial and statistical information presented in the report conforms to all applicable requirements

Limits

- For cost reporting purposes, costs incurred under less-than-arms-length (related-party) transactions are allowable only up to the cost to the related party as per OMB, CFR Title 2, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (reference Related Party Transactions).
- Limits on related-party administration salary costs. To ensure that the results of HHSC's cost analyses accurately reflect the costs that an economic and efficient provider must incur, HHSC sets upper limits for certain wages at the 90th percentile in the array of costs per unit of service or total annualized cost, as appropriate for specific cost categories, as reported by all contracted facilities, unless otherwise specified. The specific cost categories that are subject to the 90th percentile cap include:
  - Related-party facility administrator/director salary, wages, and benefits with the cap based on an array of nonrelated-party administrator/director salaries, wages, and benefits;
  - Related-party assistant administrator/director salary, wages, and benefits with the cap based on an array of nonrelated-party assistant administrator/director salaries, wages, and benefits;
  - Related-party facility owner, partner, or stockholder salaries, wages, and benefits (when the owner, partner, or stockholder is not the facility administrator/director or assistant administrator/director), with the cap based on an array of nonrelated-party administrator/director salaries, wages, and benefits.

24-Hour RCC Cost Reporting Process

In order for the cost report that is entered into the STAIRS web-based system to be acceptable it must:

- Be completed in accordance with the Cost Determination Process Rules, program-specific rules, cost report instructions, and policy clarifications
- Be completed for the correct cost reporting period
- Be completed using an accrual method of accounting (except for governmental entities required to operate on a cash basis
- Be submitted online as the Cost Report for the specified time period for the correct program through STAIRS
- Include any necessary supporting documentation, as required, uploaded into STAIRS

- Include signed, notarized, original certificate pages scanned and uploaded into STAIRS
- Calculate all allocation percentages to at least two decimal places
- If allocated costs are reported, include acceptable allocation summaries, uploaded into STAIRS
- Have uploaded in STAIRS a detailed asset listing/depreciation schedule if the summary method of reporting was used in Step 8.e.
- Have uploaded into STAIRS a workpaper supporting related party building rent/lease if the summary method of reporting was used in Step 8.e.

The provider enters agency general information that is displayed on the entity's dashboard. Upon signing into the system, the user would select "Cost Reporting" in order to begin entering data into the cost report. The user would proceed in completing the 32 cost reporting system screens (labeled in 14 steps with lettered variations).