Department of Social Services

Recommendations for Implementing A Four Tiered Foster Care System

Dougherty Management Associates, Inc.

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Executive Summary

Dougherty Management Associates, Inc., DMA, Inc. has undertaken this study to assist the Department of Social Services in the review of the current methods for reimbursing foster parents of children with special needs, known as Parents and Children Together (PACT), and in the development of a foster care system with tiers reflecting children's special needs. DSS' current PACT system is based on a list of the hours per week for specified tasks foster parents must undertake in order to care for children with certain special needs. Parents receive $7.50 per hour for the number of hours authorized per week. Such reimbursement must be reauthorized at least every 6 months.

DMA, Inc. and DSS developed criteria which a new tiered system must meet, and conducted analyses to evaluate the current system and recommend changes which would better meet the requirements of the legislature and these criteria. Our analyses included: a review of data from the DSS payment authorization system; analysis of Area office procedures for authorizing PACT payments; a survey of a high need (20 or more hours per week) and low need (less than 20 hours per week) children; and a review of the systems used by 11 other states, including all New England states, to reimburse foster parents caring for children with special needs.

These analyses showed that the current PACT system's strengths are its flexibility, responsiveness to a child's changing needs, and cost containment. Area offices carefully scrutinize requests for PACT services, allocate hours conservatively for very significant needs, and carefully reconsider and adjust for changing needs at the 6 month reauthorization.

However, the system has some significant weaknesses. Most importantly, the basic payments designed to reimburse foster parents for the costs of caring for foster children are not adequate and as a result do not provide a strong foundation for the foster care system. Compared to United States Department of Agriculture estimates of the cost of raising a child in the urban Northeast, it is likely to cost foster parents between $25 and $229 more per child, per month than DSS reimburses.

We found significant differences in utilization of PACT services between Area offices, probably caused by Areas' differing PACT administrative procedures and differences in foster parent awareness about the PACT program. These variations suggest that children with similar special needs but located in different parts of the state are likely to receive different PACT amounts. The procedures for authorizing PACT services are not always well integrated into the assessment and service planning process, they require an extraordinary number of staff approvals which can result in delays in approval, and some Area offices require considerable documentation from outside systems both at approval and reauthorization.

In order to meet the requirements of the legislature and to better meet the criteria for a fair and cost effective reimbursement system, we recommend that DSS establish a foster care system with the following four tiers:

Tier 1: for children needing a standard level of daily care in a family setting

Tier 2: for children with a behavioral, emotional, and/or physical need requiring an enhanced level of daily care in a family setting
Tier 3: for children with a chronic and/or acute medical condition requiring an exceptional level of daily care in a family setting
Tier 4: for children with acute/chronic medical and/or behavioral needs requiring an intense level of supervision and care including stabilization in a Therapeutic or specialized foster care home supported by an OFC licensed foster care agency.

Our further recommendations address the implementation of the first three Tiers, since the Fourth Tier, while fitting into a tiered foster care continuum, is separately administered through contracts for which the procurement is already underway.

- Establish the First Tier so that the total of the standard rate, clothing allowance, and holiday/birthday allowance meet the USDA low income estimates. We endorse DSS' wish to set these rates for three age groups to better differentiate the costs associated with early childhood, school age children, and adolescents. We estimate that this will cost just over $5 million annually.
- Establish a Second Tier for children with emotional/behavioral needs which specifies several levels of intensity and establish a supplement to the First Tier rate consistent with the effort needed to meet those needs. Establish procedures such that every child is evaluated for such needs during the assessment process.
- Establish a Third Tier for medically fragile children. This will allow DSS to better identify and collect data on the needs of these children and to enable better use of DSS resources in managing the care of these children. We estimate that there may be up to 460 such children.
- Conduct further research to implement tiered reimbursements, making use of instruments developed by other states. Research must include clinically appropriate definitions of medically fragile and emotional and behavioral needs, case review with respect to those definitions, development of foster parent training and competencies corresponding to Tiers, and pilot testing of the definitions.
- Seek stakeholder input and support in developing need, foster parent competency, and reimbursement standards. States which have implemented system changes emphasize the value of such involvement in promoting acceptance of the methods selected.
- Develop and implement new authorization and review procedures that are incorporated into the current process for assessment, placement and service planning and that include certain centralized functions such as regular training and case review to maintain consistency in the application of the procedures and standards over time.
- Strengthen case management and family support services for families where children are in crisis or are not making progress, and define supplemental reimbursement for Tiers 2 and 3 as temporary rather than permanent for most children.

I. Introduction

Dougherty Management Associates, Inc. (DMA, Inc.) has been retained by the Department of Social Services to assist in developing a foster care reimbursement system with tiers related to children's needs and with different levels of reimbursement for foster parents reflecting the level of services they provide. The legislature has mandated that such a system be developed and has provided an additional annualized $8,000,000 to fund it. Dougherty Management previously assisted the Department to review its Adoption subsidy system which includes a special needs subsidy similar to that provided for foster parents.

Development of tiered reimbursement includes or relates to a number of initiatives DSS is undertaking to strengthen the foster care system. These include:

- an in-depth foster home needs assessment which included home visits to and interviews with every foster home in the Commonwealth;
- plans for requiring licensure of foster parents which include training requirements and levels of foster parent competency;
- standardizing the services provided by the highest Tier of foster care, that provided by contracted specialized foster care providers; and
- establishing Bridge Homes to provide a short-term intensive therapeutic setting for stabilization before placing the child in a family setting.

In addition to meeting the requirements of the legislature, the Department of Social Services set further objectives for the tiered foster care system. First, it must result in consistent payments for children with similar needs. Second, the tiers must create an appropriate continuum between foster care, therapeutic foster care and Bridge Homes. Finally, the tiers should also be consistent with licensing levels which the Department is planning.

To further guide our analysis of possible models for a tiered system, we met with Senior DSS managers to identify criteria which a reimbursement system for foster care tiers should meet. These criteria are listed and defined below.

- ***Adequacy Of Rate:*** Reimbursements should fairly cover the costs of raising the child and be sufficient to attract families with the right skills and talents
- ***Consistency And Fairness***: Reimbursement systems should clearly identify needs and reimbursement levels for foster children and should be administered consistently
- ***Appropriateness:*** The child should be placed in the best setting for him or her. This requires a continuum of care reflective of the needs of the children and identification of levels of foster parent competency
- ***Flexibility:*** Any reimbursement system should have the ability to respond upward and downward to a child's changing needs on a timely basis.
- ***Encouragement Of Progress In Treatment***: Reimbursements should not provide dis-incentives to foster parents when the child makes progress.

- ***Administrative Efficiency***: Any system must be simple and cost effective to administer.
- ***Total Costs Are Within Budget***: New reimbursement systems must not result in unanticipated budgetary increases.

We will further discuss these criteria in the discussion and recommendations section of this paper.

II. Methods

To collect the data necessary to make our recommendations, Dougherty Management Associates, Inc. analyzed reimbursement and other data extracted from DSS authorization files for foster care. Such reimbursements include the basic daily board rate reimbursed for every foster child, and the reimbursements made under the Parent and Children Together program (PACT). DSS' current PACT system is based on a list of the hours per week for specified tasks foster parents must undertake in order to care for children with certain special needs. Parents are reimbursed $7.50 per hour for the number of hours authorized per week. Such reimbursements must be reauthorized at least every 6 months.

In addition, DMA, Inc. and DSS collected data from case records on 260 children receiving PACT services. This represents a random sample of 100 of the 221 high intensity children receiving 20 or more hours per week of PACT services, and a random sample of 160 children from the balance (1504) of those PACT cases receiving less than 20 hours per week of PACT services.

We also reviewed systems used by 11 other states, including the New England states, to provide and reimburse for extra foster parent services for special needs children. We requested documentation of those systems which appeared to be most promising, including descriptions of criteria for placing children at each level, rate structure and foster parent training requirements.

Finally, we met extensively with DSS foster care staff. A group of Central Office staff who are experienced with the foster care reimbursement system reviewed our draft PACT case record survey and were trained to collect the survey data. They also discussed what they had learned in conducting the survey and reviewed several models, instruments and policies of other states. We conducted two focus groups with the Foster Care Planning Team, composed of Area, Regional and Central office staff. The first meeting addressed the processes Area offices follow to authorize and reauthorize PACT services, and identified problems with the system. Supplementary phone interviews were conducted with these and other DSS staff as needed to better understand processes. The second meeting reviewed our flow chart of PACT approval processes and reviewed models used by other states. We also met with DSS senior staff to present preliminary conclusions and to review reports and recommendations.

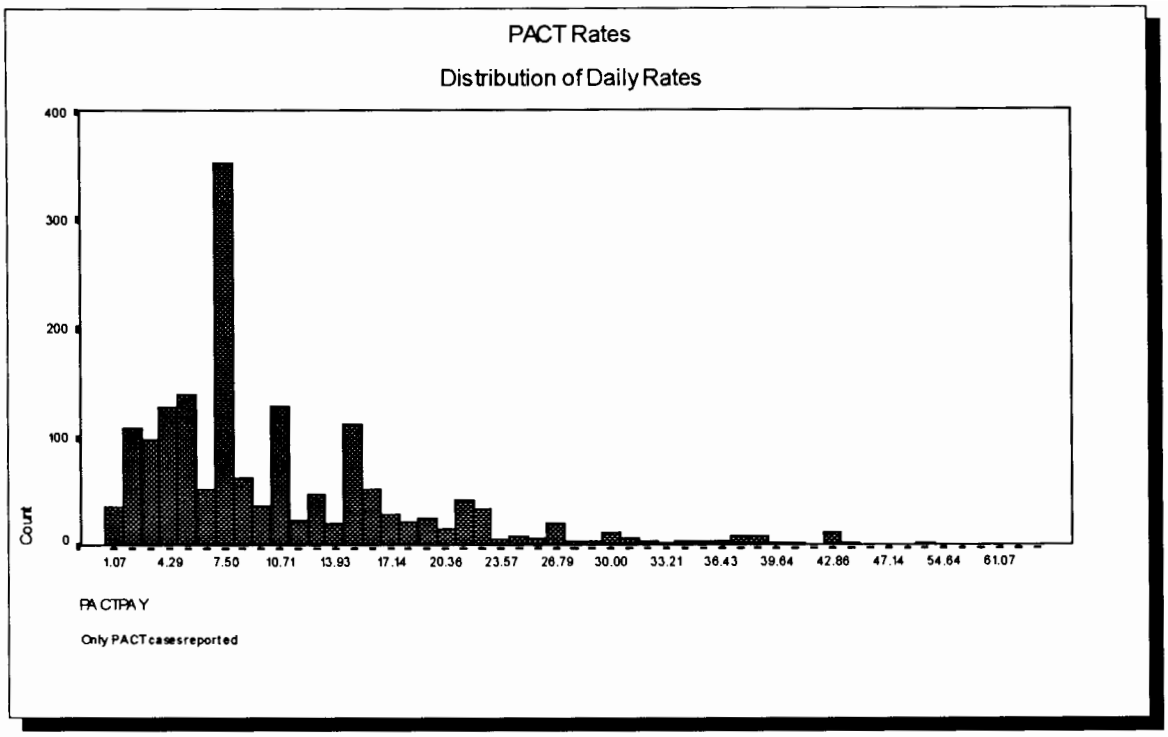
III. Analysis of MA Foster Care System

A. Analysis of Basic and PACT Payments

For the initial analysis of authorization data, DSS prepared an extract from ASSIST, their current MIS system used to authorize and document foster care reimbursements. This extract was a snapshot picture of all foster children in active placements on June 14, 1996. The extract contained some demographic data on the children, name and address of the foster family, authorizations for basic and special reimbursement, and indicators of the responsible area office. In reviewing this data and extrapolating from it to overall DSS expenditures for foster care, it should be remembered that this is an extract of the authorizations on file at a single point in time. The annual foster care expenditures will vary according to any variation throughout the year in the total number or type of authorizations.

The ASSIST extract had the following key findings:

- 10,044 children were authorized for foster care, of which, 49% were male and 51 % were female. Seventeen percent, 1725 children, were authorized for some level of PACT hours per week to reimburse the foster parent for additional time needed to perform specified tasks for children with special needs. (Only 1 case missing data in this field).
- Children identified as "white" represent almost half of foster children. Those identified black or Hispanic each represent about 20% of the total.
- 7450 children were authorized for a base rate of $13.65 per day (indicating children of 12 years and under) and 2583 at $16.20 per day (children over 12). 11 children were missing data in this field.
- The file showed a total of 5017 foster families serving these 10,044 children, averaging 2 children per family. Almost 25%, or 1191, foster families provide PACT services.
- The average number of PACT service hours authorized per child per week is 10.44. This results in an average monthly PACT reimbursement of $340. However, there are many more low PACT service authorizations than high. The median number of hours per week is 7 hours, resulting in a monthly reimbursement of $227.50. Seventy-five percent of children with PACT services are receiving $455 or less.
- The overall distribution of PACT services authorizations (daily rates) is shown in the figure below and then shown in ranges in the table that follows. Note the high number of cases at $7.50 per day (7 hours of PACT services per week):



Distribution of PACT Services by Hours Per Week

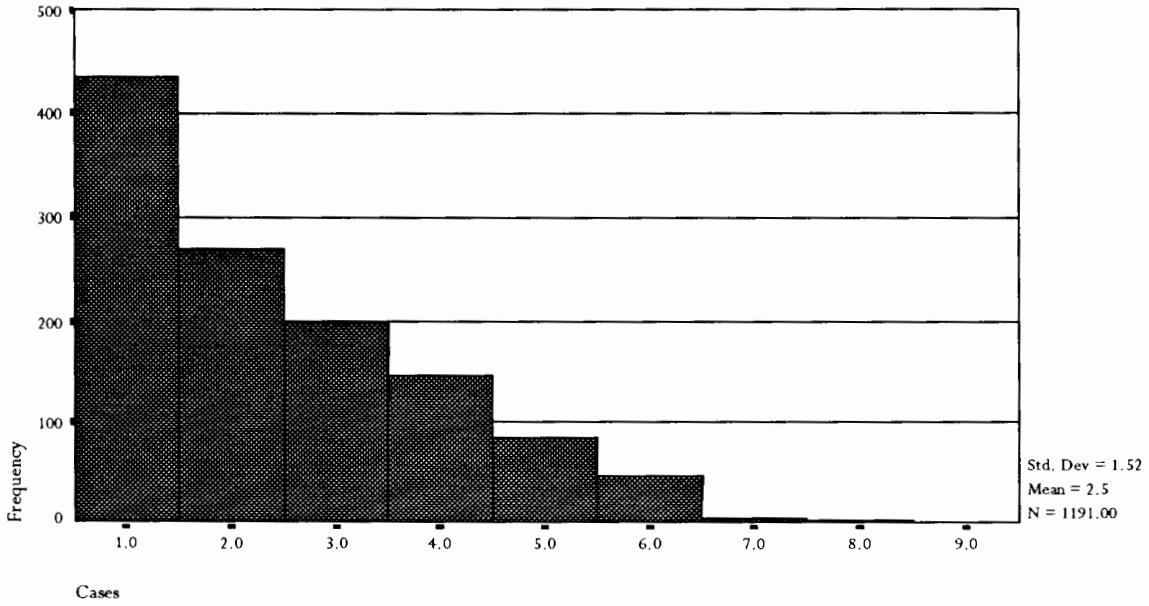
Hours per Week	Number of Children	Percentage of Children with PACT	Total Hours Authorized	Percentage of Auth. Hours
No Pact	8,318			
1-3 Hours	245	14.2%	552	3.1%
4-6 Hours	321	18.6%	1,531	8.5%
7 Hours	352	20.4%	2,464	13.7%
8-9 Hours	102	5.9%	854	4.7%
10-19 Hours	484	28.1%	6,434	35.7%
20-39 Hours	149	8.6%	3,405	18.9%
30-39 Hours	46	2.7%	1,579	8.8%
40-80 Hours	26	1.5%	1,186	6.6%

Source: ASSIST Data as of July 1, 1996

- Since foster families may have more than one child, the analysis by child does not necessarily reflect the average PACT service reimbursement received per foster family. The average PACT service authorization per foster family was 15.1 hours per week resulting in an average monthly PACT reimbursement of $491. Only 1.2% of foster parents were authorized for more than 40 hours per week of PACT service.
- The chart below shows the distribution of the number of children in placement with foster families providing PACT services to at least one foster child. This indicates all children placed in these families, some of whom are not authorized for PACT services. The vast majority of such cases are in placements with 4 children or less. Slightly more than 100 families providing some PACT services care for 5 or 6 children, and less than 10 families care for 7, 8 or 9 children.

Distribution of Number of PACT Providers

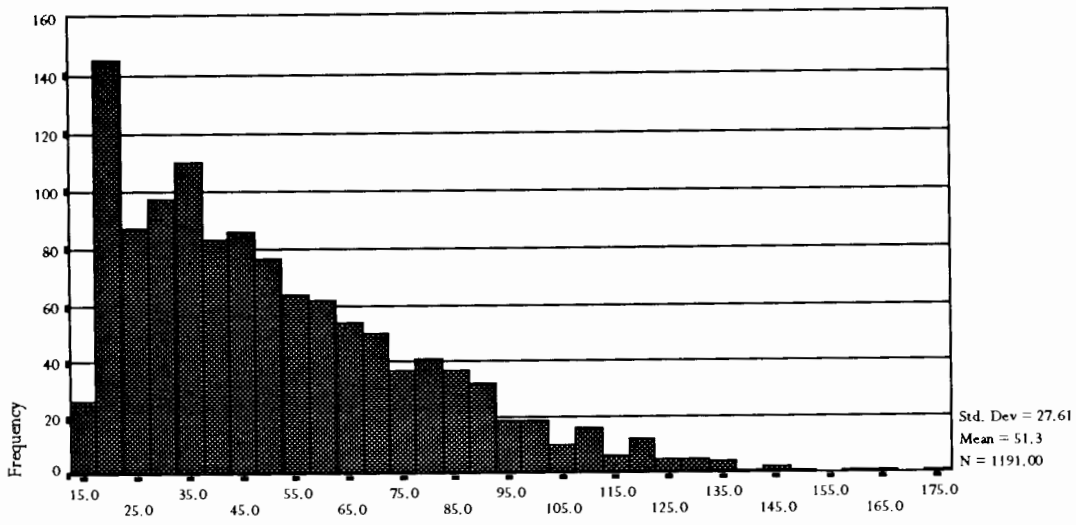
by Number of Cases in Placement



- The chart below indicates the total reimbursement per day received by foster families who provide PACT services. This includes the basic rate received for all children in care, plus any PACT reimbursement and any other extra care reimbursement. (Only 26 children have extra care.) The number of foster parents receiving PACT peak at a very low payment level of about $20 per day, of which $13 to $16 is the basic rate. They decline thereafter, with small numbers of families receiving quite high daily reimbursements, either for caring for a large number of children, or for very high need children.

Distribution of Total Payments

for PACT Providers



Note: Excludes clothing and birthday/holiday allowances.

- The regional distribution of foster children receiving PACT services was as follows:

	Areas	*Children with PACT*	*Total Foster Children*	*PACT Percentage of Total*
Region 1	**1,2,3,4,43,44**	**382**	**2,113**	**18.1%**
Region 2	**5,6,7,50**	**173**	**1,170**	**14.8%**
Region 3	**8,9,10,11,57**	**269**	**1,531**	**17.6%**
Region 4	**12,13,14,15,16,65,66**	**186**	**916**	**20.3%**
Region 5	**17,18,19,20,21,72**	**233**	**1,911**	**12.2%**
Region 6	**22,23,24,25,26,80,81**	**291**	**1,900**	**15.3%**
Region 9	**85,86,87,89**	**191**	**492**	**38.8%**
	Missing Data		**11**	
	Totals	**1,725**	**10,044**	**17.2%**

- The table in Attachment A shows data available on the area office utilization of PACT services for their foster children. Note that the utilization of PACT (% Children) as a percent of all children in foster care, varied significantly among area offices and the average number of PACT service hours also had a wide variation.[1] In order to

[1] Note that the regional office designation was taken from the first digits (1) and area office the second two digits (2-3) of the case worker number for the case. As a part of this analysis, you can see that quite a large number of cases were from area office codes with numbers 43 and

equalize these differences, we looked at PACT service hours as a function of all the children in foster care. This standardizes the potentially opposite influence of percentage of children with PACT services and average number of PACT service hours per PACT case in each of the areas. In this analysis, several Area offices stand out as being a good bit above average. These included Areas 1, 10, 11, 12, 13, 19, and 26. Foster children with Area Office numbers above 40 are from private agencies providing "partnership" services.

For the purpose of developing tiered reimbursement levels within the $8 million dollar allocation, we have estimated the current annual expenditures for foster care including basic reimbursement and PACT services. (These estimates do not include the costs of therapeutic foster care.) We estimate that basic foster care reimbursement at the daily rates of $13.65 and $16.20 result in expenditures of $52.4 million. PACT reimbursement are projected at $7.0 million and total expenditures, including other allowances and special reimbursements would be $64.8 million. Table 1, illustrating our method of calculation, appears in Attachment F.

B. Process for Authorizing and Re-authorizing PACT Services

We analyzed DSS's Supplemental Reimbursement Policy revised 2/24/92, and the forms and PACT standards referenced therein, to determine the policies governing authorization of PACT services and reimbursement. In addition, we met with a group of Area, Regional and Central office staff including PACT coordinators from the Brockton, Worcester, and Fitchburg area offices to determine the processes area offices use to implement these policies. This process is represented in the flow chart included in Attachment B. A summary of our conclusions follows.

- The process for administering PACT services provides careful scrutiny of the need for such support, both at the time of award and every 6 months thereafter; there is little doubt that the children authorized for PACT services have significant special needs and that reimbursements are adjusted to reflect both greater and reduced need for the services.
- The PACT authorization process is administratively demanding. It involves a large number of Area office staff and is not always well integrated into the service planning process. Collecting the large number of approvals required can cause lengthy processing time. In addition, some Areas require a considerable amount of documentation, not only on initial approval, but every 6 months thereafter. This is also somewhat time consuming and burdensome on foster families.
- Area office-based administration of PACT services has resulted in significant variation; Areas use different standards to authorize PACT services, some never authorize more than 40 hours per week, and some are more demanding of documentation of the child's needs than others.
- Area based budgeting contributes to such variation. Areas' PACT budgets are allocated based on their total foster care case load. Those Areas with a greater

up. There were also a number of Region 9 cases with area office designations for these cases as well (in the 80's). Note that there are 10 cases who have $1.00 per day as the foster care rate and $13.65 or $16.20 for the extra care amount.

proportion of special need foster children experience greater demands on their PACT allocation, and are likely to authorize smaller amounts of PACT than those Areas with a less needy caseload.

- PACT services are not authorized for all children who meet criteria. Requests made toward the end of the fiscal year may be authorized at lower levels because of concerns that funds will run out. Some children are never assessed to determine whether they are eligible for PACT services. DSS staff estimate, based on anecdotal evidence, that approximately 25% of foster children have special needs requiring sufficient additional effort to warrant PACT services. Currently 17% participate.
- Many foster parents are not aware of the PACT program and do not request it, even though they may have foster children with special needs. Others are very aware of the PACT program and are aggressive in requesting it in order to accept a child with special needs.
- The Share the Homes system used by DSS to assure that homes not needed for children in the Area are made available to children from outside the Area is one mechanism by which sophisticated foster parents seek placements from Areas which are more generous in authorizing PACT services.
- Assessment for PACT services is not always a child-centered process. It is not integrated into the Service Planning process for every child (though it is incorporated into the Service Plan when authorized). PACT service requests arise more often from the family or the family resource worker. PACT coordinators, who play a key role in facilitating the approval process, are generally foster parents assigned to the family resource unit. They are well acquainted with the foster families, but they are not always aware of assessment and treatment summary documents available in the child's record and are often not familiar with the specific children involved.

C. Survey of Current PACT Cases

Introduction and Methodology

In order to better understand the needs of foster children using PACT services and the utilization of PACT by Areas and Regions, we developed a plan to collect information on the clinical needs of the children currently receiving PACT services. The information needed from current PACT cases was not available through the DSS ASSIST system, so a review of a random sample of existing case records was undertaken. Our interests were in better understanding the clinical needs of those individuals who were the highest utilizers of PACT services, as well as the general population of children receiving PACT services. As a result we surveyed a random sample of approximately 50% of those children receiving more than 20 hours of PACT services per week (high need) and a random sample of 160 children (approximately 11%) from the rest of the PACT children (low need).

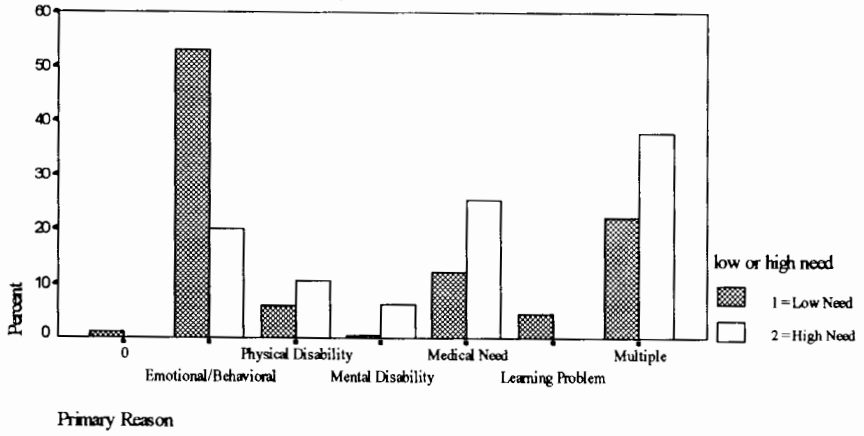
A survey was developed to collect information from the case files of the identified children. A team of Central office staff participated in the development of the survey instrument and was trained in its administration. These staff were assigned Area and Regional offices and during the

last two weeks of November, they visited each of the Areas and reviewed the case files of the sample. Completed surveys were collected, entered into the survey data base and analyzed using statistical software. The analysis consisted primarily of descriptive statistics, frequencies, crosstabulations and correlations.

Characteristics of Children Receiving PACT Services

- For the overall sample[2] of children receiving PACT services, 11% were placed in "restricted foster homes" (kinship and child specific homes, not available to other placements), 78% were in unrestricted homes and 11% were placed in other types of homes (pre-adoptive, etc.)
- Restricted homes tend to be predominantly used for children receiving PACT services to address behavioral and emotional needs, whereas a greater percentage of children receiving PACT services to address multiple needs were served in unrestricted homes. Children receiving PACT services in restricted homes also tended to have fewer previous placements than those receiving PACT services in unrestricted homes. Children receiving PACT services in unrestricted homes had a significantly wider range of the number of previous placements. Neither of these findings were surprising since most restricted homes are kinship homes.
- Twenty percent of the children in the low need sample had changed homes in the five to six months since the data extract had been drawn, while only 10% of the high need children had moved.
- As shown on the following chart, over 50% of the low need children (group 1) had emotional behavioral problems as the primary reasons for their PACT services. High need children, on the other hand, tend to have more multiple needs and medical needs as the primary reasons for their PACT service hours.

Sample Characteristics
Low and High Need Placements

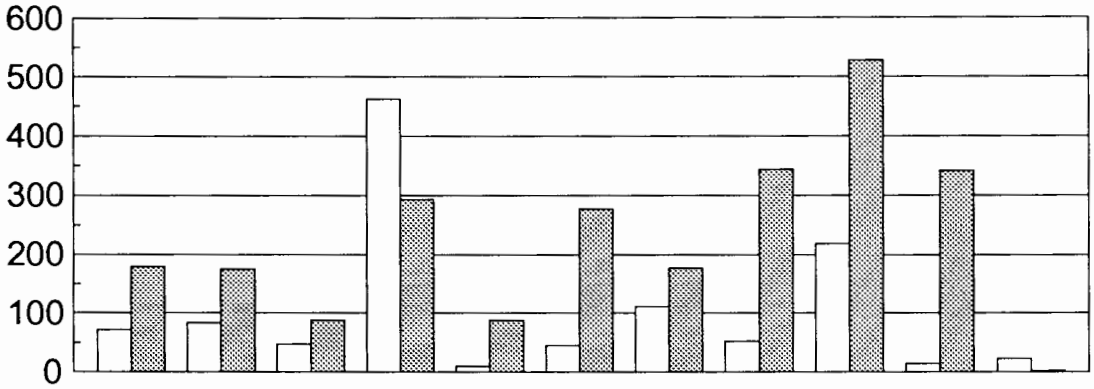


[2] References to the "overall" sample refer to results for both the high (20 or more hours) and low need children (under 20 hours)

- Similarly, the low need children had a greater likelihood of having changes in the hours of PACT services in the time period (5 to 6 months) between the date of the sample extract and the survey.
- Forty to 44% of the children reviewed in the samples had their hours of PACT service changed at some point in their care, showing evidence of the active management of PACT services and reimbursement.
- Similarly, the "low need sample" of PACT children tended to receive a majority of their PACT service hours for behavior management and therapy, while the high need children had PACT subsidies for therapy (physical, speech, etc.), total physical care, special feeding and behavior and medication management.

PACT Hours by Task

PACT Hours Authorized (total)



	Adv. & Cons.	ADL	Med. Adm.	Beh. Mgmt.	Eq. Care	Health Mon.	Other	Spec. Feed	Ther. Hrs.	Tot.Phys. Care	Transp.
Low Need	71.5	83.5	48.0	461.5	10.0	45.0	111.0	53.0	219.0	14.0	23.0
High Need	179.0	175.0	88.0	294.0	88.0	277.0	177.5	343.5	528.0	342.0	3.0

- High need children with multiple, mental disabilities and emotional/behavioral needs tend to be older than those with medical and physical disabilities, though the age differences between the low and high need samples were not significant.
- For high need children, the use of PACT services varied among the Regions based upon the primary reason for PACT. This may have been a result of the ratings of the different reviewers, though anecdotal evidence suggests that there are Regional differences in the way PACT services are used.
- Thirteen percent of the high need children and 9% of the low need children had been in residential placement previously.
- A slightly higher percentage of high need children compared to low need were in foster care from voluntary custody agreements (13% compared to 3%). For both samples, the vast majority of children were in care from Care and Protection petitions.

- The low need children had been in an average of 3.1 placements prior to the current placement, while the high need children had an average of 2.7 previous placements. On the other hand, the high need children tended to have been in placement longer (33% for five years or more) than the low need children (23%). Similarly, more of the high need children compared to the low need children had received PACT services for more than five years (16% vs. 1%).

IV. Massachusetts Foster Care Reimbursement in Relation to those of Other States.

We requested and reviewed policy descriptions of the foster care systems of 11 states, including all New England states. Most states had systems to address the following types of needs:

- Children in need of basic foster care
- Children needing foster care that can address emotional and behavioral needs, and
- Medically fragile children.

States set rates which correspond to the three types of needs, with a basic rate and some form of enhanced rates for children with emotional/behavioral and medical needs. In some cases, the enhanced rates were tied explicitly to required qualifications of the foster parents related to their capacity to meet the children's needs. Others did not address foster parent qualifications. States also differed in the degree to which they defined the levels of need that qualified children for placement at a particular level. The definitions varied from very vague to quite specific. We requested those definitions and have provided them all to the Department.

A. Base Rates

Every state had a basic rate, often referred to as a Board and Care rate. This may be supplemented by a separate clothing allowance, provided in larger amounts on a less frequent basis, and sometimes by other stipends designated for specific needs. In foster care, such reimbursement have been defined as reimbursement of the expenses a foster family incurs in raising the child. They are expressly not defined as "compensation" for the foster parent. This reimbursement provides the foundation and first tier of a foster care continuum.

In comparing basic foster care rates, we have computed them all on a monthly basis, and have added in additional stipends or allowances, pro-rated to a monthly basis. To adjust for differences in regional expenses, we compared these totals for each urban state in our sample, to the USDA regional estimates for low income families in an urban setting. The United States Department of Agriculture estimates the cost to a family at low, medium and high income levels to raise a child in urban settings in different regions, and in rural settings every year. These estimates are based on data from the Consumer Expenditure Survey administered by the Bureau of Labor Statistics, the most comprehensive source of information on household expenditures.[3] These data were collected in 1990-1992 and adjusted on a yearly basis. 1995 is the most recent year for which such estimates have been issued. (See Attachment E for the complete listing of the rates for the Urban Northeast). Table 1 in Attachment D presents these comparisons.

Massachusetts' reimbursement for children in basic foster care cover only 86% to 95% of the USDA low income estimates of the cost to raise a child in the urban Northeast in 1995. Of the 5 other primarily urban states on which we collected information, Massachusetts was lower than four other states. The rates for those four states came very close to or exceeded the USDA low

[3] Center for Nutrition Policy and Promotion, USDA Miscellaneous Publication Number 1528-1995, *Expenditures on Children by Families: 1995 Annual Report*

income cost for their region. Massachusetts rates were in a similar range to one state, Michigan, and were higher than one state, Rhode Island, whose rates are extremely low, meeting not quite 60% of the cost of raising a child.

Recently some states, notably Connecticut and Vermont, have set their base rates in reference to USDA standards for middle income families when establishing new reimbursement procedures. Connecticut, with by far the highest rates, currently sets their rates based on the USDA standard for middle class families (in an earlier period). Vermont - whose rates for 1st and 2nd year foster parents are now lower than MA, intends to raise their rate to meet USDA middle income standards for the Rural communities.

B. Enhanced Rate for Emotional/Behavioral Needs

States have a variety of models for meeting the needs of children with special behavioral and emotional needs. Many systems involve enhanced rates to foster parents which reimburse them for additional time and/or competencies needed to provide special care. Unlike the basic rate, this reimbursement is not intended to cover out-of-pocket expenses. It is more of a reimbursement for foster parent time, raising tax issues for foster parents that require further investigation and review. Frequently, states contract with providers who recruit, train, and support foster families to serve such children, as Massachusetts has done with the approximately 600 cases in specialized foster care. (Massachusetts is transitioning specialized foster care into a new model called Therapeutic Foster Care through a current procurement.) Other states administer specialized foster care themselves.

These systems vary tremendously in the amount of supplement provided, in the number of levels of reimbursement and in the degree to which extra reimbursement is set at fixed levels, or flexible within a maximum. See Table 2 in Attachment D. It is difficult to compare the rates provided by such varied systems. To do so, we compared the total monthly reimbursement which would be received by families caring for special needs children. Where such reimbursement consist of a base reimbursement plus a supplement, we added the two together to look at total reimbursement.[4] We compared Massachusetts 25th percentile PACT reimbursement to others states' first tier special need level. We excluded any level titled as Specialized Foster Care or Therapeutic Foster Care which required foster parents to meet training requirements. We found that Massachusetts' total reimbursement for families receiving 25th percentile PACT exceeded or was comparable to other states' reimbursement.

Total reimbursement to parents receiving Massachusetts' median PACT reimbursement was compared to other states' second tier special need level or the first tier of specialized or therapeutic foster care programs. Total reimbursement for families receiving Massachusetts median reimbursement fell in the middle of the range of total reimbursement for these programs, with 3 rates less than the median, 1 rate which was roughly comparable, and 5 rates which were higher. Total reimbursement for families receiving Massachusetts 75th percentile reimbursement was compared to the third tier special need level, or the second tier of specialized and therapeutic

[4] We did not have the specific amounts of certain types of reimbursement, such as additional clothing allowances, for certain states. This understates reimbursement for such states.

foster care levels. Total reimbursement for the 75th PACT percentile was higher than 4 rates, and lower than 2. Total reimbursement at Massachusetts' maximum rate was higher than total reimbursement for any other special need level in our sample.

We present these comparisons with the significant caveat that data were not available on the intensity of needs of foster children that are being reimbursed for at these rates in each state. Therefore, we may not have compared rates reimbursed for children with similar needs. The preliminary conclusion we draw from this analysis is that Massachusetts PACT reimbursement rates for caring for special needs children appear to result in total reimbursement in the range of other states' total reimbursement for such children.

C. Medically Fragile Children

Massachusetts PACT system covers all types of special needs including emotional/behavioral needs of children and complex medically involved children who might otherwise require pediatric nursing homes. Many other states have separate designations for "medically fragile" children, and special requirements for foster parents caring for such children. Connecticut requires post-licensure training followed by a certification test for families who wish to care for such children. Rhode Island pays much higher rates to foster parents with nursing licenses and pediatric experience, presumably for children whose care requires such high medical skills. The issues and competencies for foster families differ considerably for such children from those with severe emotional and behavioral characteristics. The rates of reimbursement for such children are generally set at or above the highest level provided for children with emotional/behavioral needs. Table 3 in Attachment D compares the rates and certain aspects of the program model used for medically fragile children.

D. Process

Reviews

Most states for whom we have information review special care supplements every 6 months as does Massachusetts. One state, Vermont mentioned it plans to develop a Utilization Review style system for supplemental funding. However, we do not have information about the specifics of this system.

Wrap around services

States provide certain services which support foster parents. These services, frequently referred to as wrap around services can include training, respite, supervision and consultation, information and referral, and a 24 hour crisis hotline. We do not have information on the wrap around services provided by all the states we surveyed, but many appear to offer more access to wrap around services for foster parents than Massachusetts does. A responsive support system to back-up foster parents with crisis assistance, planned respite, and assistance in implementation of treatment plans is one method of adding flexibility and elasticity to the system.

E. Foster Parent Competencies and Training

We collected information about training requirements for foster parents from many states, particularly those states that provided differential reimbursements for foster parents with more training and experience. Table 4 in Attachment D summarizes these requirements.

- Massachusetts appears to have the most stringent requirement for initial training for non-kinship foster parents, 30 hours of training combined with self-assessment and homestudy before approval as a foster parent. Other states from which we have information require 20 to 24 hours.
- Massachusetts encourages such training for kinship homes, but does not require it.
- In the states surveyed, training requirements extending beyond the first year generally apply to foster parents participating in some form of specialized or intensive foster care programs at enhanced rates. States with such requirements specify an additional 12 to 24 hours of training per year. Massachusetts has no training requirements related to PACT, though parents may need, and may receive training to meet the specific needs of the children in their care. Massachusetts provides ongoing training and support groups for foster parents after the initial required training. However, training is voluntary.
- Vermont's old system required additional training each year for the first 4 years of foster parenting with the basic rate enhanced each year. However, we do not know what percentage of foster parents took the training and to what degree children with more complex needs were placed in their homes. One advantage of this system is that it provides higher reimbursement for more experienced foster parents.
- In our review, only Connecticut provides training for foster parents wishing to be certified to care for medically fragile children. Rhode Island has reimbursement categories which recognize degrees of medical training and experience a foster parent may have through a medical profession.

F. Foster Child Needs Assessment

States used different methods for determining children's levels of need, the needs being met by foster parents, and the qualifications of foster parents. The systems which are of most interest include those used by Vermont, Michigan and Rhode Island. We chose these states based on several criteria:

- degree of specificity in defining the child's level of need;
- flexibility of the system in responding to changing levels of need;
- the degree to which the levels of foster care provided a continuum of intensity and of level of foster parent skill; and
- the value of training requirements for foster parents.

Vermont

Vermont has been using a system which increases the basic board rate for the first four years a foster parent is in the system based on their increased experience and for meeting a 20 hour per year training requirement. They offer two levels of supplemental reimbursement, $100 or $200 per month, based on a point system which was described as "profoundly discretionary". They have recently engaged in a broad based evaluation of their system and are planning to institute a new system. This system will:

- provide an enhanced basic board rate set to match the USDA estimate for middle income families to raise a child in rural communities;
- make supplemental reimbursement vary in response to need (use a utilization review style process to reimburse for additional effort when needed, and reduce or eliminate it when not needed);
- re-distribute private agency wrap-around services from 200 families in the private foster care system - the new contract will be to provide such wrap-around services to all foster parents; and
- continue to recognize different levels of foster parent training and experience (the mechanism for doing so under the new system has not yet been described).

Michigan

Michigan also engaged in a broadly participatory process to develop a point-based system for determining levels of enhanced reimbursement. The point-based process uses assessment forms for Medically Fragile children, and for children and adolescents who are difficult to care for. The assessment forms address a number of aspects of child care, weighting different levels of intensity differently, and assigning more weight to certain functions. The state reports that, while the method is somewhat complex, it has good acceptance from foster parents and agency staff who had large roles in its development.

Rhode Island

Rhode Island has piloted a computerized, task-driven evaluation system which it feels is successful in calculating fair and equitable supplements for special needs children. It has been trying to implement the system statewide, but has had difficulty in setting rates for the new system which will be revenue neutral. They estimated the cost of the system by assessing a random sample from their entire foster care caseload, not just those children already receiving supplemental rates. That assessment identified a number of children eligible for such supplemental rates who are not currently receiving them. Rhode Island has been grappling with the challenge of funding the additional children likely to be identified by statewide implementation.

V. Discussion

These analyses provide a basis for assessing how well Massachusetts' current system meets the criteria we identified at the beginning of this paper: adequacy of rate; consistency and fairness; appropriateness; flexibility; encouragement of progress in treatment; administrative efficiency; and costs within budget. The PACT system is a highly flexible system capable of calculating a reimbursement based on the specific tasks required to be performed to meet the special needs of an individual child. It also provides for 6 month service reviews, and DSS makes ongoing adjustments in PACT services (for more than 40% of the children in our survey sample). The DSS Central office staff who performed the surveys found that children receiving PACT services had significant needs, and that children for whom high value PACT reimbursement was made had very severe conditions. For many medically fragile children, the alternative to foster care would be pediatric nursing homes. Thus the current system meets the criteria for "flexibility" and for "cost within budget".

It is less clear how the PACT system affects appropriate placement of children. There is currently little data to evaluate foster children's level of need and how it is met, though new MIS will provide improved data very soon. Anecdotal reports from DSS staff suggest that the relatively small pool of foster parents can make it difficult to find a good match, especially for children with special needs. In addition, foster parents are not categorized on the Department's MIS by their level of competency, training, and/or experience. Given the complexity of the treatment of medically fragile and severely traumatized children, DSS's plan to license foster parents and create levels of licensure related to foster parent training and competency is likely to be of value in better matching children's needs to foster parent qualifications.

Massachusetts' foster care reimbursement system, as do many foster care systems, has the capacity for time limited approvals of reimbursement with reduction as the child's condition improves. As we discussed, however, this also creates a perverse incentive by reducing reimbursement to foster parents who have successfully promoted their foster child's progress. We could not measure the impact of this effect in discouraging progress in treatment. At the least, anecdotal evidence suggests that foster parents experience reductions in PACT authorizations as negative and it is likely that reductions in reimbursement are more difficult to achieve where expectations may not have been clear initially.

In our opinion, the current foster care reimbursement system is not very effective in meeting the criteria for adequacy of rate, consistency and fairness, or administrative efficiency. Comparison to the USDA expenditures suggests that caring for a foster child may cost a foster parent from $25 (low income estimates) to $229 (middle income estimates) per child per month more than DSS reimbursement. An adequate basic rate provides the foundation for the entire foster care system and should serve as the first tier in a foster care continuum. It must, therefore, fairly reimburse families for the additional costs they incur when they take on the care of a foster child. The current level of the basic rate does not meet this criteria. In our opinion, the USDA standard for low income families represents a minimum below which the first tier should not fall.

The level of rates has been an ongoing issue in Massachusetts. In 1995, DSS conducted a needs assessment which included home visits and interviews with every foster parent. This survey revealed that foster parents felt a great deal of concern about the level of financial reimbursement. When asked to identify the single most pressing issue affecting their foster parenting, increased reimbursement was the most frequently identified issue, and it was also the most frequently requested support service (by over 75% of foster parents). The fourth most requested support service was financial assistance, requested by 63% of families.[5]

The low level of the current basic rate may contribute to competition for PACT reimbursement and make it harder to find foster families for children who do not qualify for such additional reimbursement. The differential between the amount of reimbursement and support available to foster families providing care directly with the Department, compared to those providing care for providers with DSS contracts for specialized foster care, has significant impact on the ability of the Department to recruit foster parents. Many DSS staff stated that foster families frequently provide care under both Departmental and contractor systems, and that the enhanced rates and more intensive supports cause many such families to prefer providing care under contracted providers.

The Area based budgeting and Area based administration of PACT services, without strong Central oversight has resulted in a system which varies considerably between Area offices. Such variation does not mean that funds are not appropriately used; as stated above, our survey revealed evidence that almost half the children had services adjusted upon review. However, it is not clear that children with similar needs in different Areas would get authorized for similar amounts of PACT service or that foster parents would fulfill similar requirements to get their foster child authorized for PACT services. This system has lead to some foster families being excluded from the PACT program, either because they are not aware of it and do not request it, or because the Area has spent its allocation when the need is identified.

Finally, and perhaps most importantly, the procedures required for the authorization of PACT services can be an add-on to the assessment/placement process rather than an integral part of it. In addition, authorization requires a considerable number of reviewers to sign-off and, in some Areas, requires parents to collect considerable documentation from medical, school and mental health systems. The same process is repeated every six months, regardless of the chronicity of the needs.

[5] Watson, Peter, Kennedy School of Government, *An Analysis of the Foster Homes Needs Assessment*, April 1996.

VI. Recommendations

Based upon our review and analysis we recommend that DSS establish a foster care system with four tiers:

> **Tier 1**: for children needing a standard level of daily care in a family setting
> **Tier 2:** for children with a behavioral, emotional, and/or physical need requiring an enhanced level of daily care in a family setting
> **Tier 3:** for children with a chronic and/or acute medical condition requiring an exceptional level of daily care in a family setting
> **Tier 4:** for children with acute/chronic medical and/or behavioral needs requiring an intense level of supervision and care including stabilization in a Therapeutic or Specialized foster care home supported by an OFC licensed foster care agency.

Within each tier there may be additional levels based on children's ages and intensity of needs. This system will fulfill the intention and objectives of the legislature as well as the criteria we have established.

DSS has established the Fourth and most intensive Tier of this program with its current procurement of a new service titled Therapeutic Foster Care, for children exhibiting the kinds of behaviors that would otherwise be treated in a residential program. The children placed in this Tier must be assessed to be capable of the intimacy of family living and their behaviors must be safely managed in a community setting. They may have emotional, physical, medical or cognitive disabilities in addition to their behavioral needs. This program replaces a program of specialized foster care with a wider range of rates and of service intensity.

The Tier is being established with 2 levels based on the level of intensity of the child's need. Reimbursement is related to these levels of need. Children at the first level can be cared for at a 1:2 foster parent to foster child ratio. Children at the second level require 1 to 1 foster care attention. Provider agencies with clinical capacity and case management capacity will recruit, train, and support the foster parents in treating these most troubled children. At least one foster parent must be at home full-time. This is a transitional program with an intended length of stay of less than a year at the 1:1 level, and up to a year at the 1:2 level, though exceptions can be made. After this year of treatment, children may be transitioned back to their biological family, to a permanent foster care placement, pre-adoptive home, or older children, to independent living.

This most intensive Tier meets the legislature's requirement for a program allowing children to be treated in family settings by providing foster parents with a high level of training and clinical and other support. The strong clinical treatment orientation with a behavioral focus provides a strong incentive for the child to make progress. The high level of reimbursement provided for these intensive services enables the foster parent to meet the requirement that one parent forgo outside employment to be at-home full-time to care for the child. Finally, the training requirements for foster parents will create the competencies needed to care appropriately for these high need children.

Our following recommendations to DSS relate to establishing the three tiers which, together with therapeutic foster care create a continuum of foster care services for the Commonwealth.

A. Establish First Tier to meet the USDA Low Income Cost Estimate

In order to meet the criteria of adequacy and fairness, we recommend that the Commonwealth adopt the USDA low income estimates as its minimum reimbursement standard for the First Tier of its foster care system. Therefore, the total of the standard rate, the clothing allowance, and the birthday/holiday allowance should meet this standard. We have estimated the annualized cost of this to be just over $5 million. Please see Attachment F for an explanation of the methods we used to estimate this increase. Establishment of the First Tier at the USDA level will meet a major concern of foster parents, help to strengthen the overall foster care system and provide significant assistance in recruiting and retaining existing foster parents. This is the foundation of the system of care and will provide one more tool for the Department in improving its substitute care system.

This recommendation additionally addresses the Department's wish to divide the current age category used for children, ages 0 to 12, into two groups in order to better distinguish the very different developmental characteristics of early childhood and school age children. To do so consistently, the Department needs to introduce a third age category for the standard rate to match those age categories already used for the clothing allowance. This would establish the standard daily rate at $14.92 for 0-5 year olds, $15.47 for 6-12 year olds and $17.16 for 13 year olds and older. This will provide an ongoing means to better differentiate the needs and associated costs of age groups at different developmental stages.

B. Establish a Second Tier for Children with Emotional/Behavioral Needs

We recommend that the Department develop several levels of intensity of foster care for children with special emotional and behavioral needs. This Tier should also be able to consider other special needs, such as physical or learning disabilities, when determining intensity. The Department should also define the competencies foster parents must have to appropriately meet each level of need of the children they serve. In order to meet criteria of fairness and consistency, each child should be evaluated for such needs during their assessment process, and the child should be placed with a family with the competencies to meet those needs. For this Second Tier, the Department should provide supplemental reimbursement above that of the First Tier. This supplemental reimbursement should be consistent with the level of need of the child. Using levels of need rather than an individualized task list with estimated hours should reduce the variation in services authorized and reimbursed for these difficult to quantify needs, and therefore increase the fairness and consistency of the reimbursement to foster parents.

C. Establish a Third Tier for Medically Fragile Children

Third, we recommend that the Department create a separate Tier for medically fragile and medically involved children with chronic or acute medical needs. Most, if not all, of these children already receive PACT services. In fact the majority of high need cases had some degree of medical or health care related need covered by PACT reimbursement. Medically fragile

children must be placed with specially trained foster parents. They frequently require services from medical professionals, and they have significant care coordination issues which are more likely to be connected to agencies involved with medical and rehabilitative services. In our opinion, DSS can better manage these issues if it can clearly distinguish the group of medically fragile children.

To better understand the scope of the caseload of medically fragile children, we estimated the number of children who might be expected to meet criteria for medical fragility by determining the number of children in our survey sample that had PACT service hours authorized for the following tasks:

- total personal care
- special feeding
- equipment monitoring
- medical monitoring

This method identified 32 low need children, about a fifth of the low need sample, and 74 high need children, almost 75% of the sample. Projecting from the sample to the whole population currently receiving PACT services, we estimate that a total of 163 high need children and 300 low need children would meet these criteria for medical needs. Note, however that the data we were able to collect does not include objective information about the level of the need of the children who are not receiving PACT. DSS should develop criteria for medical fragility and apply it to a random sample of its total caseload to get a more exact estimate of the size of this group.

DSS should consider establishing a centralized method for managing the reimbursement and coordinating certain aspects of care for these small number of very high cost children. Central administration is feasible because the number of such children is relatively small. Movement to a more centralized method does not immediately require a new reimbursement system. The current PACT task list works well for medically fragile children for whom eligibility and the time needed for concrete tasks can be accurately determined. Centralized administration of the process will ensure the consistency which is presently lacking. In the short run, new tasks should be added to the list if needed. In the future, DSS should develop reimbursement levels based upon analysis of needs data collected on the children who meet the criteria for this Tier. This database can also assist DSS to identify problems, training needs, policy issues and needs levels.

Establishing a Tier for medically fragile children will have several advantages:

- Massachusetts can improve its ability to provide appropriate foster care placement for these medically fragile children. It can better determine its need for specially qualified foster parents to care for medical problems by identifying the number of such children in its system and the types of care they need. Such a needs assessment will provide for systematically recruiting and training qualified foster parents in communities where they are needed, rather than rely on Area offices who develop strength in this kind of foster care.
- DSS can determine and train foster parents to make optimal use of Medicaid and DPH services to supplement foster parents' efforts to care for such children, perhaps

eliminating some of the responsibilities carried by foster parents and some exceptional expenses reimbursed by DSS because not accessed through available pathways, thereby meeting the criteria for cost containment.

- Separately identifying the medically involved cases will provide the basis for budgeting separately and administering the budget on a statewide basis. This should provide for greater consistency among children with such needs.
- The ability to systematically collect data on the care needed by such children and the cost of providing it can provide information needed to engage with other state agencies in planning care which makes best use of state resources.
- There is likely to be less case finding in this area and thus fewer unanticipated expenditures. Anecdotal information indicated that most children with significant medical needs are already receiving PACT services. Thus the Tier can be established with some degree of flexibility and budget neutrality by using the current PACT task list and hours, and is not likely to lead to a large increase in the number of cases receiving supplemental funding.

Special needs which do not meet DSS criteria for Tiers 2 or 3 should continue to be addressed through the use of a flexible reimbursement system, such as PACT services, though the scope of these reimbursements should be significantly limited.

D. Further Research Is Needed to Implement Tiered Reimbursements

To implement the Second and Third Tiers, DSS should conduct further research to establish criteria to identify children with special behavioral and emotional needs and those who are medically fragile, and to determine what intensity of care they need. Our data from ASSIST and from our random sample, does not permit us to reliably determine the level of need of current medically involved cases and to assess the projected financial impact of a new definition of eligibility. This data is even more limited in estimating costs to meet other special needs. Our survey, by concentrating on children currently receiving PACT services, was unable to provide information on the number not currently receiving it who might qualify. In DSS there is a consensus that a significant number of children who meet standards for PACT services, especially non-medical needs, are not receiving it. In the foster parents needs assessment, foster parents indicated that approximately 40% of the children currently in their care had one or more special needs. Some of the needs they identified, such as mild asthma, would not warrant additional reimbursement. Other needs, such as AIDS, would warrant it. Before initiating any new system, DSS must better understand the types of needs occurring among the approximately 23% of foster children not participating in PACT whose foster parents have identified a special need. DSS must carefully estimate the total need in the system and set rates which allow it to address these needs within the current budget system.

Eligibility criteria for the Tiers and the levels within each should be clinically appropriate, objective, reliable and cost neutral. In order to develop such criteria, DSS must conduct further case review, seek stakeholder input and field (pilot) test criteria. The first step in this process should be to create the eligibility criteria for medically fragile children and identify and flag those

children so that separate information can be collected on their medical needs. Identifying these children at the beginning of the process will allow for a separate data collection and planning process related specifically to the unique needs of medically fragile children. The data collected while developing criteria for both Tiers should also be valuable in planning for levels of licensure for foster parents, defining competencies needed to care for children at each level of need, and determining the number of foster parents needed at each level. As part of this planning, DSS must determine and appropriately address any tax implications of Tier 2 and 3 supplements since these may significantly affect the total available to foster parents for the care of the children.

The introduction of Tiers of need and corresponding reimbursement for selected needs will improve consistency and administrative efficiency for these hard to quantify needs. Based upon the review we have conducted of other states, and the analysis conducted on the available data, the Department is well positioned to develop pilot definitions and rates in the next several months and field test these rates.

If DSS uses the balance of the annualized $8 million for Tiers 2 and 3, it could provide for almost 28% of children in foster care to receive a special need supplement, a significant increase in children receiving additional services for special needs. We base this estimate on the assumption that DSS would set rates for these Tiers which would result in revenue neutrality for those children currently receiving PACT services, and would add new children to the Tiers at an average rate equivalent to the current Median PACT reimbursement.

E. Seek Stakeholder Input and Support

The implementation of changes in the rate structure immediately affects the more than 1100 parents currently providing PACT services and will determine which foster parents become eligible for special needs reimbursement. Modifying the system requires a significant level of input from foster parents, DSS workers, and other stakeholders in the community. We recommend that DSS undertake a broadly participatory process involving these key stakeholders to review proposed tools and options for assessing children's level of need and to determine what training and competencies foster parents should have to meet those needs. Following such evaluation, the selected tool should be tested in a way that would allow DSS to estimate the amount of case finding (and thus budget neutrality) that might result from its implementation.

In our research, the states that have developed new systems emphasized the need to involve foster parents and agency staff in the development process in order to promote acceptance. Involvement of foster parents and agency staff in a participatory process would also carry out a major recommendation of the DSS Foster Home Needs Assessment to involve foster parents in developing new rates. This is likely to take from four to eight months to accomplish.

F. Develop and Implement New Service and Rate Approval Procedures

We recommend that DSS implement and manage any new reimbursement system in a way which better meets the criteria for administrative efficiency and consistency. While we have recommended some centralization of the medically fragile tier, because of the number of children

with emotional/behavioral needs, the system should remain primarily an Area office responsibility, but should have certain central functions including:

- Regular training on assessment standards, criteria, and procedures for authorizing special needs funding;
- Exploration of centralized approval or expanded support of medically involved cases;
- Oversight procedures including selective review of records, at least some portion of which should be selected randomly, with follow-up to address reasons for inconsistent application of the standards; and
- Area and statewide budgeting based on case mix factors to be introduced as DSS has data to reliably measure the case mix of its varied offices.

Within Area offices, we recommend that assessment for special needs funding be incorporated into the assessment, placement and service planning process for every child. This will make consideration of special needs a more child-centered process and will eliminate a second review and approval process outside of those core processes required for all children, potentially increasing the timeliness and reducing the burden of the PACT system as currently operated.

Requirements for documentation from foster parents and outside organizations involved in treating or planning for the child should be uniform and should be of value in the child's ongoing service planning. Such information should be incorporated directly into the child's record, which should serve as the repository of information on the status of special needs funding. PACT coordinators should not continue to maintain a separate system, nor should separate forms be developed.

DSS should establish requirements for reauthorization which allow some flexibility in the periodicity of authorizations so that some time limited child needs are reviewed more frequently, and those likely to be chronic are reviewed less frequently. Establishing these principles will increase the efficiency of the system, and ensure more fairness by considering every child for special needs funding.

This system would continue to reduce special needs reimbursement when children's needs reduce, thereby creating the possible disincentives for children's progress. We recommend that DSS introduce new expectations about the authorization period for special needs funding which lead foster parents to think of it as transitional. This should be a part of foster parent training and orientation. The following mechanisms can be developed:

- Create termination criteria for certain special needs which are by nature temporary.
- Award transitional special needs funding for a specified period of time. Such transitions could include initial placement, pre-adoptive placement, or change in placement.
- Develop criteria for more clearly matching reimbursement levels and needs of children to the training, skills and qualifications of foster parents. This is at the heart of the Department's goals for foster parent licensing and training.

- Develop curricula or service plans which guide foster parents in a structured approach to needs experienced by a large number of children. An excellent example of this is the current policy for subsidy of parents working with adolescents on the DSS Preparing Adolescents for Young Adulthood (PAYA) curriculum which prepares them for independent living.
- Write service plans which expect progress and incorporate indicators of progress. Special needs funding can be planned to reduce as progress is made. If progress is not made, rather than adjust funding, DSS should provide intensive support and assistance to address the reason the child is not making progress. As part of this intervention, special needs reimbursement can be adjusted, if warranted.
- Similarly, consider addressing certain special needs through enhanced case management and support services. Crises may be better addressed by providing direct support from case managers, mentoring from other foster parents, providing respite, or intensive psychiatric assessment and intervention than by adjusting financial reimbursement.

Summary

Implementing these recommendations and developing the new reimbursement systems proposed here will require DSS to continue its careful scrutiny when authorizing reimbursement for special needs. This will be accomplished through the central supports we have proposed, improved data collection on child needs and foster parent qualifications and greater clarity in definitions and procedures for reimbursement approval. It will also address the major weakness' of the current system - adequacy of rates and the Area to Area apparent inconsistency in the use special needs reimbursement - while offering opportunities to improve services to children by making good use of upcoming MIS and licensure/training initiatives.

Tiered Foster Care Reimbursement
for
Children with Special Needs

List of Attachments

Attachment A

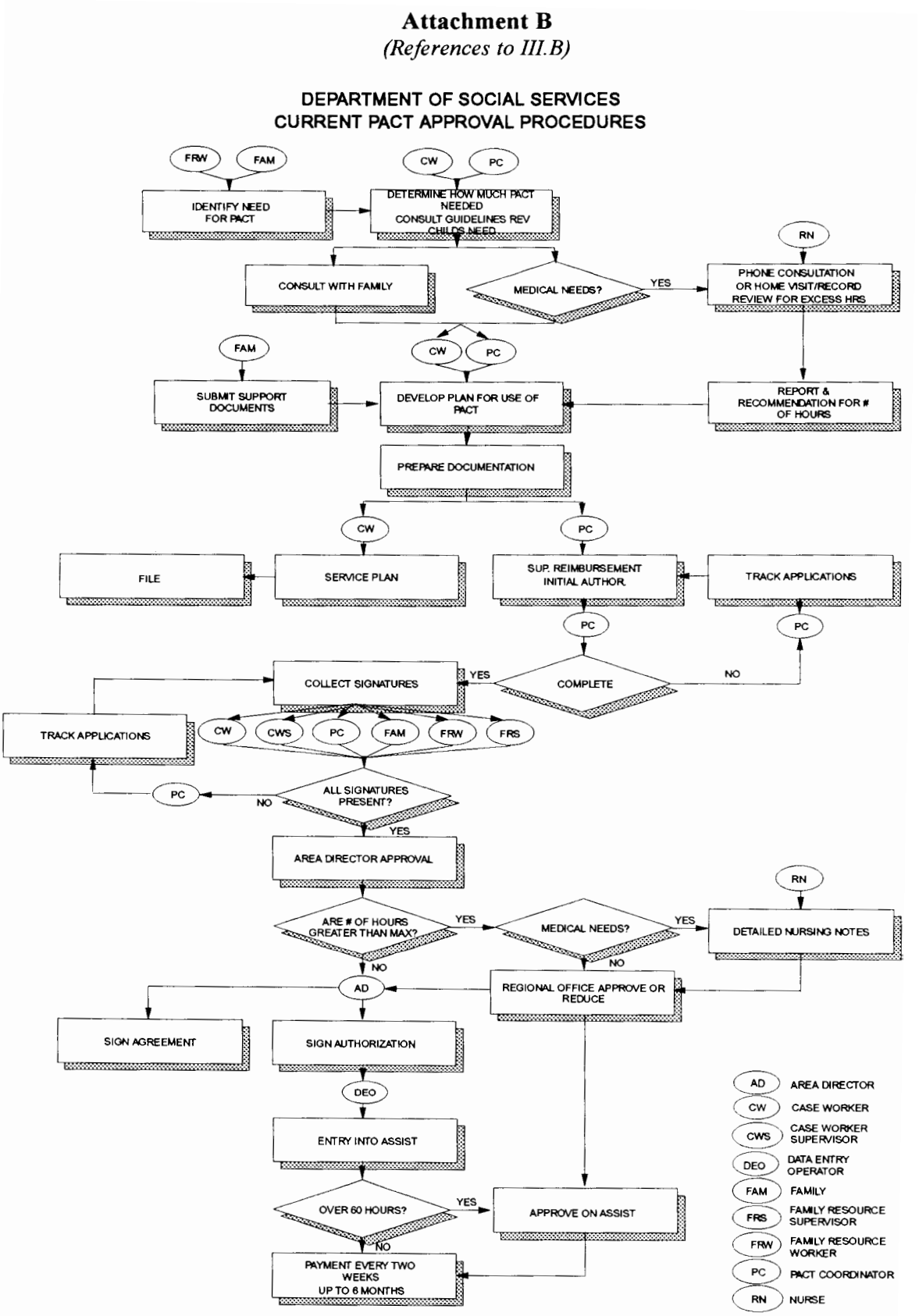
(References to section III.A)

DSS Foster Care PACT Utilization

Area #	PACT #	Total FC #	% Cases	Avg. Pact Hours	Mean - Avg	PACT Hrs/Tot FC
1	106	311	34.1%	6.03	-4.41	2.06
2	73	324	22.5%	8.37	-2.07	1.89
3	81	658	12.3%	6.11	-4.33	0.75
4	109	767	14.2%	10.11	-0.33	1.44
5	54	384	14.1%	10.95	0.51	1.54
6	43	270	15.9%	7.86	-2.58	1.25
7	75	477	15.7%	9.71	-0.73	1.53
8	44	361	12.2%	16.23	5.79	1.98
9	56	433	12.9%	7.5	-2.94	0.97
10	89	379	23.5%	11.2	0.76	2.63
11	76	329	23.1%	14.07	3.63	3.25
12	57	188	30.3%	7.81	-2.63	2.37
13	55	225	24.4%	12.98	2.54	3.17
14	28	253	11.1%	10.71	0.27	1.19
15	22	97	22.7%	7.73	-2.71	1.75
16	22	147	15.0%	8.82	-1.62	1.32
17	37	290	12.8%	8.46	-1.98	1.08
18	41	430	9.5%	11.66	1.22	1.11
19	40	273	14.7%	16.55	6.11	2.42
20	25	477	5.2%	11.48	1.04	0.60
21	61	409	14.9%	7.47	-2.97	1.11
22	50	325	15.4%	7.46	-2.98	1.15
23	42	287	14.6%	10.36	-0.08	1.52
24	41	323	12.7%	11.44	1	1.45
25	39	442	8.8%	10.79	0.35	0.95
26	68	376	18.1%	11.26	0.82	2.04
43	12	14	85.7%	35.08	24.64	30.07
44	1	39	2.6%	4	-6.44	0.10
50	1	39	2.6%	14	3.56	0.36
57	4	29	13.8%	23.25	12.81	3.21
65	2	2	100.0%	28	17.56	28.00
66		4	0.0%	n/a	-10.44	0.00
72	29	32	90.6%	20.24	9.8	18.34
80	17	60	28.3%	20.94	10.5	5.93
81	34	87	39.1%	12.15	1.71	4.75
85	32	62	51.6%	11.63	1.19	6.00
86	90	196	45.9%	8.51	-1.93	3.91
87	69	201	34.3%	10.67	0.23	3.66
89		33	0.0%	n/a	n/a	0.00
Missing		11	0.0%			0.00
Totals	1725	10044	17.2%	10.44		1.79
				statewide mean		

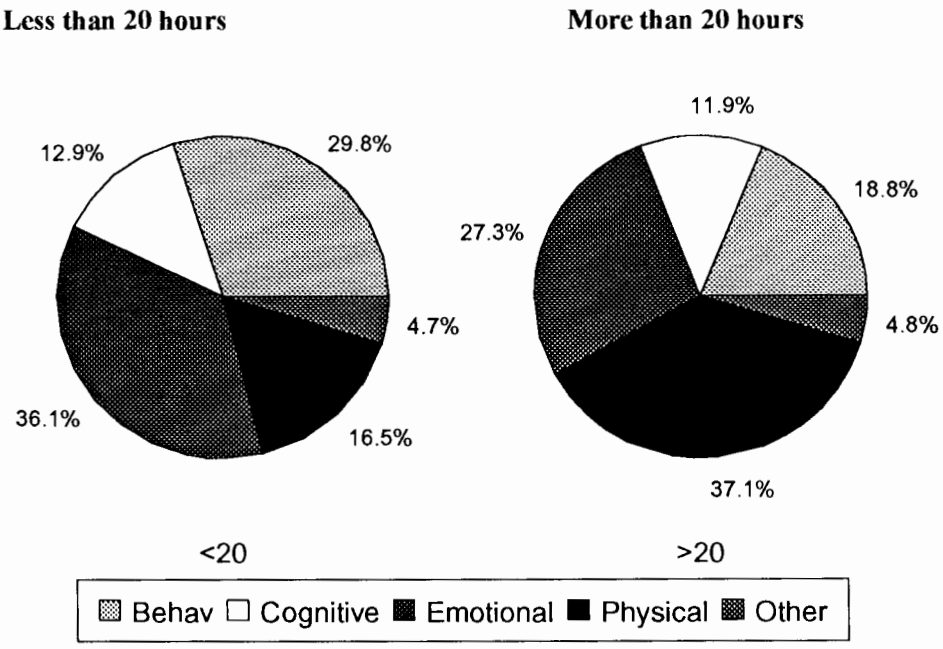
Attachment B

(References to III.B)



Attachment C
(References to III.C)

Needs of Children receiving PACT



Attachment D
(References to IV)

Review of State Foster Care Systems

Table 1
Comparison of Payments for Foster Care in Several Urban States

	Total Monthly Payments for Basic Foster Care[1]					
	Value of total reimbursement			As a percent of low income UDSA estimates		
Age	0-5	6-11	12+	0-5	6-11	12+
Northeast Urban USDA Middle Income Estimates				**$661**	**$687**	**$756**
Northeast Urban USDA Low Income Estimates				**$484**	**$513**	**$582**
Massachusetts	$445	$445	$553	91.9%	86.7%	95.0%
Connecticut	$567	$586	$637	117.1%	114.2%	109.5%
New York-Metro	$449	$508	$608	92.8%	99.1%	104.5%
Rhode Island	$279	$279	$341	57.6%	54.4%	58.6%
Midwest Urban USDA Low Income Estimates				**$469**	**$441**	**$503**
Michigan	$392	$377	$486	83.6%	85.5%	96.6%
South Urban USDA Low Income Estimates				**$468**	**$488**	**$554**
Maryland	$535	$535	$550	114.4%	109.6%	99.2%

[1] Total reimbursement includes clothing and any other allowances prorated on a monthly basis.

Attachment D

(References to IV)

Review of State Foster Care Systems

Table 2

Total Payments for Meeting Emotional/Behavioral Needs

State	First Special Need Level	Second Special Need Level or First Level Therapeutic Foster Care	Third Special Need Level or Second Level Therapeutic Foster Care	Comments
Family rates				
Massachusetts - PACT: Average 25th Percentile 50th Percentile 75th Percentile PACT Maximum	$607-$715	$785-$893 $672-$780	$900-$1008 $1745-$1853	Many levels available within maximum.
Connecticut - old		$750	$1200	
New Hampshire	$509-$626			Varies by age. Competencies required to get this rate.
Rhode Island	$544-$601			Point system
Vermont	$419-$481 $448-$520 $478-$559	$519-$581 $548-$620 $578-$659	$530-$621 $611-$700 $630-$721 $711-$800	Varies by age and foster parent training.
Kentucky	$377-$433 $407-$464	Special needs training incentive Special needs child placement (doesn't require training)		
Kentucky - Family treatment homes		$798	$859 $920	Training standards for each level.
New York		$879	$1,332	Maximums. Criteria for kids and for homes.
Michigan	$544-$668	$696-$820	$847-$972	Weighted point system
Maryland	$650	$850		
West Virginia		$989	$989	Two levels at same rate.

For comparison, we present the total reimbursement made to foster parents recieving supplemental rates, including basic reimbursement.

Attachment D
(References to IV)

Review of State Foster Care Systems

Table 3
Rates to Care for Medically Fragile Children

State	Monthly Rate*	Comments
Massachusetts	Max of +$1,300	Flexible system to compensate for specific medical tasks. Same as system for other special needs.
Connecticut	$1,200	Usually 1 or 2 children -no more than 3, must be certified by passing test
Maine	no information	
New Hampshire	no rate information	
Rhode Island	+$173 Drug exposed infants +$433 AIDS/HIVV infants +$1,517 RN, LPN, EMT +$3,142 RNs with pediatric intensive care experience	Have moved to a case by case consideration of reimbursement for drug exposed infants
Vermont	+$100 or +$200	Same system as for other special needs
Michigan	$617-$709 $770-$861 $922-$1,031	Point based rating system to determine level of supplement
West Virginia		Separate system outside of child welfare, but available to foster children at risk of institutionalization
Maryland	$650 $850	Same system as for other special needs
Kentucky	$920	Only available when child is medically fragile. Parents must be approved to care for such children.
New York	$879-$1,332	Same system as for other special needs

* + sign indicates that amount is added to basic rate. Amounts with no + sign indicate total reimbursement.

Attachment D

(References to IV)

Review of State Foster Care Systems

Table 4

Foster Care Training Requirements

State *License required?*	Training provided	Requirement?
Massachusetts *Homestudy approval required*	30 hours MA Approach to Partnership in Parenting (MAPP)Training 48 hours additional training to become a MAPP trainer	Required for non-restricted foster parents Option for interested foster parents
Conn. Current *Licensure*	24 Hours - 1st yr 20 hrs/yr thereafter Must include material from course Effective Foster Parenting	Required for CHOICE foster care parents Described as "specially trained and highly skilled"
Conn. Med Fragile *Certification to care for medically fragile children*	Theory and Skill Demonstration (12 hours) CPR (8 hours) Experience in home setting (by certified foster parents and agency staff) (20 Hours) Certificate testing	Must pass test in 3 areas Theory on the practical knowledge concerning most frequent diagnoses and skilled training on hospital demonstration equipment CPR for children and infants observation and practice testing
New Hampshire - specialized care *Licensure required*		Competencies and a curriculum to get specialized care rate
Rhode Island *Licensure required*		Special rates for foster parents who are RNs, LPNs, EMTs, and RNs with pediatric intensive care experience
Vermont -Levels within basic system *Licensure required*	20 hrs/yr advanced training in each of 1st 3 years post license	
Michigan *Licensure required*		
W. Virginia - Therap. Foster Care *Licensure required*		"specially trained and recruited foster parents"
Maryland - Treatment Foster Care *Licensure/approval*	24 Hours of training	
Kentucky Special Needs Training Incentive *Approval/certification*	(not required to care for special needs child at enhanced rate) 24 Hours of initial training 12 hrs/yr thereafter	
Kentucky - Family Treatment Home	24 hours/yr training for 1st 3 years	Levels of training/experience reimbursed

Attachment D

(References to IV)

State *License required?*	Training provided	Requirement?
New York *Licensure or approval*		4 or 5 hrs/yr of training required for special or exceptional foster care

Attachment E

(References to Section IVA.)

United States Department of Agriculture

Estimated Expenditures on Children by Families in the Urban Northeast
1995

Table 3. Estimated annual expenditures* on a child by husband-wife families, urban Northeast,† 1995

Age of child	Total	Housing	Food	Transportation	Clothing	Health care	Child care and education	Miscellaneous‡
Income: Less than $33,500 (Average=$20,900)								
0-2	$5,750	$2,520	$880	$580	$380	$360	$510	$520
3-5	5,870	2,500	980	560	370	340	580	540
6-8	6,090	2,470	1,250	660	420	390	330	570
9-11	6,230	2,330	1,490	730	470	420	190	600
12-14	7,030	2,500	1,560	850	790	430	140	760
15-17	6,930	2,150	1,680	1,170	700	450	220	560
Total	$113,700	$43,410	$23,520	$13,650	$9,390	$7,170	$5,910	$10,650
Income: $33,500 to $56,300 (Average=$44,500)								
0-2	$7,830	$3,240	$1,030	$940	$450	$480	$870	$820
3-5	8,030	3,220	1,180	920	440	460	970	840
6-8	8,190	3,190	1,500	1,020	490	520	600	870
9-11	8,290	3,050	1,770	1,090	540	560	380	900
12-14	9,020	3,220	1,770	1,200	920	570	280	1,060
15-17	9,130	2,870	1,970	1,540	820	590	480	860
Total	$151,470	$56,370	$27,660	$20,130	$10,980	$9,540	$10,740	$16,050
Income: More than $56,300 (Average=$84,300)								
0-2	$11,340	$4,790	$1,320	$1,360	$590	$560	$1,350	$1,370
3-5	11,590	4,780	1,490	1,340	570	540	1,480	1,390
6-8	11,620	4,740	1,790	1,440	630	610	990	1,420
9-11	11,660	4,600	2,090	1,510	680	650	680	1,450
12-14	12,520	4,770	2,180	1,630	1,150	660	520	1,610
15-17	12,740	4,420	2,300	1,980	1,040	690	900	1,410
Total	$214,410	$84,300	$33,510	$27,780	$13,980	$11,130	$17,760	$25,950

*Estimates are based on 1990-92 Consumer Expenditure Survey data updated to 1995 dollars using the regional Consumer Price Index. The figures represent estimated expenses on the younger child in a two-child family. Estimates are about the same for the older child, so to calculate expenses for two children, figures should be summed for the appropriate age categories. To estimate expenses for an only child, multiply the total expense for the appropriate age category by 1.24. To estimate expenses for each child in a family with three or more children, multiply the total expense for each appropriate age category by 0.77. For expenses on all children in a family, these totals should be summed.

†The Northeast region consists of Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

‡Miscellaneous expenses include personal care items, entertainment, and reading materials.

Attachment F

(References to Sections II. and V.)

Table 1

Estimated Cost of Current Foster Care Reimbursements

Current Foster Care Reimbursement	Cases		Daily Rate	Average Monthly Reimbursement	Estimated Annualized Cost
	Number	Percent			
Basic Reimbursement					
Children	$7,450	74.2%	$13.65	$415.19	$37,117,763
Adolescents	$2,583	25.7%	$16.20	$492.75	$15,273,279
Unknown	$11	0.1%			$58,033
Subtotal - Basic Reimbursement	$10,044	100.0%			$52,449,075
Clothing - Quarterly rate					
0-5 years	$3,345	33.3%	$53.50	$17.83	$715,830
6-12 years	$3,895	38.8%	$90.50	$30.17	$1,409,990
13 years and over	$2,793	27.8%	$141.50	$47.17	$1,580,838
Age missing	$10	0.1%			$35,882
Subtotal	$10,043				$3,742,540
Birthday/Holiday - yearly	$10,044		$150.00	$12.50	$1,506,600
Subtotal - Basic reimbursement					$57,698,215
PACT Reimbursement	$1,725	17.2%	$11.19	$340.36	$7,042,805
Extra Care	$26	.3%	varies	$215.51	$67,240
Subtotal - Extra reimbursement					$7,110,045
Total	$10,044				$64,808,260

Source: DSS Assist Data. Snapshot of all authorizations as of June 14, 1996.

Method: We used enrollment on the snapshot date, and calculated costs assuming that the number and ages of the children enrolled on that date would be substantially the same for the rest of the year. To determine the annual costs of basic payments, we multiplied daily rates by 365 days times the enrollment for the relevant age group. We calculated the rates for the few cases without age designations by calculating a weighted average based on those cases for which we did have ages. Quarterly payments were multiplied by 4 times the enrollment, and annual payments by the enrollment.

Attachment F

(References to Sections II. and V.)

To calculate extra payments, we assumed that the percentage of children receiving those payments, and the distribution of reimbursement amounts would remain constant. We used the average rate for those cases and the total number of cases to calculate the annual cost.

Sensitivity Analysis: We evaluated the reasonableness of assuming that our snapshot was representative of a year's enrollment by comparing it to actual monthly enrollment data from FY89 to FY96, and estimated enrollment data used by DSS to calculate the FY97 budget amount. We were most concerned about potential underestimates.

In FY96, June enrollment was lower than the average annual enrollment. Thus, our estimates of total cost, by being based on one day in a low enrollment month, understate the true cost. We estimated a total of $64.8 million while DSS actual figures show a total of $69.1 million.

Table 2

United States Department of Agriculture

Estimated Expenditures on Children by Families in the Urban Northeast

1995

UDSA Estimate	Daily	Monthly	
Children 0-5	$15.92	$484.17	
Children 6-11	$16.88	$513.33	
Children 12-17	$19.12	$581.67	

Method: The USDA estimates are made for smaller age ranges than those above. To calculate the rates for the ranges above, we added together the relevant age groups and computed a simple average of the estimated costs. We then calculated the daily and monthly amounts.

Attachment F

(References to Sections II. and V.)

Table 3

Estimated Cost Of Establishing Tier 1 At The USDA Estimates For Low Income Families

Current Foster Care Reimbursement	Cases		Daily Rate	Average Monthly	Addition to Daily Rate	Tier 1 Daily Rate	Addition to Monthly Rate	Estimated Annual Addition
	Number	Percent						
Basic Reimbursement - Daily rate								
Children 0-5 years	$3,345	33.3%	$13.65	$415.19	$1.27	$14.92	$38.65	$1,551,244
Children 6-12 years	$3,895	38.8%	$13.65	$415.19	$1.82	$15.47	$55.48	$2,593,096
Adolescents	$2,793	27.8%	$16.20	$492.75	$0.96	$17.16	$29.25	$980,343
Unknown	$11	0.1%						$5,627
Subtotal - Basic Reimbursement	$10,044	100.0%						$5,130,310
New Allocation								$8,000,000
Balance remaining for special needs								$2,869,690
Estimate of New Special Needs Funding								
Current PACT Reimbursement	$1,725	17.2%	$11.19	$340.36				$7,042,805
New special needs	$703	7.0%		$340.36				$2,869,690
Subtotal	$2,428	24.2%						$9,912,495

40.8% Percent increase in special needs cases

Note: Clothing and birthday/holiday allowances are added to the daily rate in order to reach the low income levels.

Method: We calculated the difference between the total of the basic reimbursement (basic, clothing and birthday/holiday) and calculated how much would have to be added to the daily rate to result in a total reimbursement which equaled the USDA minimum for each age group. Note that the USDA estimates include 12 year olds in the teen-age range, while Massachusetts includes them with younger children. We then calculated the cost of this differential for the enrollment in each age group for the entire year, using enrollment data from our June 14 snapshot, and added them together to compute the total cost. As with our current cost estimates, we employed a weighted average to calculate the cost of those few cases without age data.

We then subtracted the total cost of establishing the First Tier at this level, and subtracted it from the annualized $8 million available for establishing tiered reimbursement. We then estimated how many cases could be authorized for funding at higher tiers, assuming that the tiers would be set at levels which were revenue neutral for the cases currently receiving PACT. We used the median rather than the average PACT reimbursement for this calculation, because anecdotal information suggests that most high need children are receiving PACT, and those who qualify but are not receiving it - and are thus most likely to be added in the future - are those a moderate or low special needs. Therefore, the median measure may be a better indicator of the cost of additional cases.

Sensitivity Analysis: Using the snapshot enrollment to estimate the cost of increasing the first tier to the USDA low income estimates during FY97 is reasonable because the enrollment on that date is similar to that estimated as the average enrollment for FY97. Foster care placements have been falling from FY95, and DSS has estimated that the average enrollment for FY97 will be 10,000. This is less than the enrollment figure we used, and therefore our estimates may slightly overstate the actual cost of establishing this tier.

We computed the cost of establishing the First Tier in several different ways. To compute high enrollment, we used FY96 total enrollment. To compute a method consistent with DSS FY97 estimates, we used their FY97 estimate for total enrollment. We also revised our age distribution to result in an average daily rate that matched their estimated average daily rate for FY97, so as to incorporate their estimate of a younger age distribution. This resulted in a range of costs from $5.1 million to $5.4 million, and allowed for a total of 25% of 28% of foster children to receive funding at higher tiers. We also used the average PACT reimbursement for all three enrollment levels to estimate foster children who could receive higher tiers. The range of these estimates was from 22% to 24%.