DEPARTMENT OF HUMAN SERVICES

Minnesota Department of Human Services
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Via electronic delivery

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Dear Senators Abeler and Hoffman, and Representatives Schultz and Albright:

This letter is in response to instructions provided by the Minnesota Legislature to the Minnesota Department of Human Services (department) during the 2020 1st Special Session:

> "The commissioner must confer with the Association of Minnesota Counties, the Minnesota Association of County Social Service Administrators, other state and county agencies, Minnesota's tribal communities, National Alliance on Mental Illness Minnesota, AspireMN, and other relevant stakeholders, to make recommendations to the legislature regarding payment for the cost of treatment and care for residential treatment services, including community-based group care for children currently served under Minnesota Statutes, chapter 260D. The recommendations must include the approximate cost of care that will no longer be eligible for federal Title IV-E reimbursement paid to the counties for children currently served through voluntary foster care placements. The recommendations must also explore the impact on youth currently served under Minnesota Statutes, chapter 260D, including access to Medical Assistance and nonresidential services, as well as the impact on equity for over-represented populations in the child protection and child welfare systems in Minnesota. The commissioner must report back to the legislature by January 15, 2021."

To comply with the above request, department staff convened a stakeholder work group comprised of the following members:

Association of Minnesota Counties; Minnesota Association of County Social Service Administrators; Minnesota County Attorney's Association; Children's Justice Initiative, Minnesota Supreme Court; Minnesota Department of Commerce; Minnesota tribal communities; National Alliance on Mental Illness (NAMI) Minnesota; AspireMN; North Homes Children & Family Services; Northwood Children's Services; Minnesota Black Psychologist's

Association; Minnesota Association of County Health Plans; Bemidji Youth Leadership Council; and health insurance companies. Department staff with policy expertise in children's mental health, developmental disabilities, behavioral health, foster care, Title IV-E, and child welfare, participated in the work group. The work group met seven times, on Aug. 26, Sept. 16 and 30, Oct. 14 and 28, Nov. 4 and 18, 2020.

Background

During the 2020 legislative session, the department put forth legislation to bring Minnesota into compliance with new federal requirements for foster care from the 2018 Family First Prevention Services Act (Family First). This legislation applied Family First requirements for Qualified Residential Treatment Programs (QRTP) to both chapters in state law regarding foster care – Chapters 260C, known as the child protection statute, and 260D, known as the voluntary placement for treatment statute. For the department to obtain federal approval for its Title IV-E state plan before the federal statutory deadline of Oct. 1, 2021, legislation that included Family First requirements for children placed in QRTPs needed to pass in the 2020 legislative session.

In March 2020, representatives from NAMI and AspireMN raised concerns that Family First requirements should not apply to families accessing voluntary foster care for mental health treatment for children under Chapter 260D. Advocates believe that these children should not be required to enter foster care through the child welfare system to receive residential treatment services.

After hearing those concerns, legislators advised department staff that they must collaborate with NAMI and AspireMN to reach a compromise before the bill could move forward during the 2020 session. Department staff worked with those agencies to negotiate an amendment they would not oppose. The outcome removed any language that specifically applied Family First requirements to Chapter 260D. The amended language remains in Chapter 260C, sections 702 to 714, in accordance with the new state law and federal Title IV-E. Family First requirements for children placed in foster care under Chapter 260C will be effective Sept. 30, 2021.[1]

Findings

Through work group meetings, discussions with federal partners, and policy research by multiple department business areas, department staff determined that the legislature's decision not to include Minnesota's 260D voluntary foster care statute into Family First compliance would result in the following:

- Counties will lose between $2-3 million in federal Title IV-E reimbursements annually, and department staff will need to remove 260D voluntary placements from the Title IV-E state plan.
- SSIS is not programmed to distinguish children placed in foster care through Chapter 260D from the general foster care population. County agency staff will face significant difficulties in tracking 260D cases in the Social Service Information System (SSIS), ensuring Title IV-E claims are not submitted in error.
- Vulnerable children will be prevented from receiving federal protections intended to better ensure they receive care in the least restrictive environment possible.

[1] The requirements are prospective, and will not impact children in foster care prior to that date.

Recommendations

Given the above findings, department staff makes the following recommendations:
As stated previously, department staff makes the following recommendations to the legislature:

- The legislature should incorporate Family First requirements into Chapter 260D, as originally proposed during the 2020 legislative session.
    - MACSSA has taken a position supporting inclusion of Family First requirements in Chapter 260D[2]
- In recognition of advocate concerns regarding Family First being applied to children placed voluntarily in foster care through Chapter 260D, the legislature should develop an option to access residential behavioral health treatment services for children and families who may be better served outside the foster care system.
    - MACSSA recommends that if a new option for residential treatment is created by the legislature, counties should not be responsible for identifying placement options, funding the placements, or providing administrative oversight for these placements, as currently occurs with Psychiatric Residential Treatment Facilities (PRTF's).
- If the legislature does not incorporate Family First requirements into Chapter 260D, the legislature should:
    - Appropriate a minimum of $2.1 million annually to cover lost federal Title IV-E funding for counties.
    - Appropriate funding to enable Minnesota IT services (MNIT) to update SSIS so county agencies are able to claim Title IV-E reimbursements only for eligible children. The initial cost estimate for this work is $72,000 and $15,000 ongoing.

The remainder of this document provides detailed data and policy information that informed findings and recommendations.

Voluntary foster care

In Minnesota, children enter foster care by court order or voluntary placement agreement for numerous reasons. Children entering foster care through Chapter 260C generally come to the attention of a county social services agency due to allegations of child abuse or neglect. Through this chapter, a small number of children enter foster care voluntarily. Children entering foster care through Chapter 260D come to the attention of an agency because parents voluntarily seek residential mental/behavioral health treatment or developmental disabilities services for their child. Regardless of whether children entered out-of-home placement under statutory authority of Chapters 260C or 260D, they are considered to be in foster care under state and federal law.

Families contact county social service agencies for children's mental health and developmental disabilities case management services, such as assistance with documentation requirements and navigating a complicated system. Requests for services also include voluntary foster care placement for children when a family's private

[2] See: http://cms5.revize.com/revize/macssa/Legislative%20Positions%202021%20-%20proposed/CS9c%20-%20Possible%20Revisions%20to%20MN%20Stat.%20260D%20-%202021%20statement%20.pdf

health insurance provider determines that residential treatment is no longer medically necessary and coverage ends for residential service. Families seek foster care in the form of financial assistance from county agencies because they want their children to continue to receive the same level of residential treatment.
A decision on whether a county social service agency accepts a parent's request to assume responsibility for residential treatment placement of their child is not based on medical necessity. Rather, a county agency brings together a multi-disciplinary team, a juvenile treatment screening team, for review of services, including a parent's request and child's needs. Decisions are based on a child's most recent mental health diagnostic assessment, and consulting with parents and mental health professionals. Decisions to start or continue placement of children in a residential treatment facility are not made by an individual or mental health professional, but by a juvenile treatment screening team. A diagnostic assessment is completed by a licensed mental health professional, who is not required to be a member of the screening team.

When children are placed voluntarily under Chapter 260D, the experience begins with signing a Voluntary Placement Agreement (VPA) between parent/s and a county social service agency. This gives a county agency legal responsibility to make decisions regarding placement and care of a child, but parents do not relinquish custody and can remove their child from foster care at any time. Under current federal Title IV-E requirements, county agencies submit a report to the court to inform it of a voluntary placement within 165 days of entering foster care. Within 180 days, an administrative hearing is held to review the report. No in-person court hearing is required.

The first time parents are required to appear in court is between 12 and 14 months from the date of a signed VPA. At this hearing, the court can find that voluntary placement remains in the best interests of a child and the next hearing is scheduled to occur in 12 months. Voluntary placements under this statute do not have a time limit, with some continuing for years.

Data on Chapter 260D voluntary foster care placements

In 2018, 16,500 children experienced out-of-home care in Minnesota; 1,225 experienced care voluntarily under Chapter 260D, with 548 episodes beginning in the calendar year. Of the 548 cases starting in the year, 94% began with parents signing Voluntary Placement Agreements with county social service agencies. The remaining 6% were initial placements under protective holds, or court order through Chapter 260C, but moved to Chapter 260D during an episode.

In 2018, 581 placement episodes through Chapter 260D ended. Most of these children (73%) reunified with their primary caretakers. The remaining discharges were due to aging out of care (15%), runaway from placement (4%), living with other relatives (3%), transfer to another agency (3%), adoption (1%), transfer of permanent and legal custody (1%), guardianship to another individual (<1%), and re-establishment of parental rights (<1%).[3]

Type of placement

Children placed through Chapter 260D receive community-based and residential services in family foster homes, corporate foster homes (license holder does not live in the home; shift staff provide care), group homes, and residential treatment facilities. While almost half of children spend time in residential treatment facilities, they also spent time in a variety of placement settings, including:

[3] Social Service Information System, CY2018

- 53% in residential treatment facilities
- 23% in family foster homes
- 17% in corporate foster homes
- 16% in group homes
- 5% in supervised independent living
- 9% in corrections, and developmental disabilities placement settings.[4]

Race

Children experiencing care under Chapter 260D were 66% white, 14% two or more races, 11% African American/Black,[5] 6% American Indian, and 1% Asian/Pacific Islander in 2018; 8% were identified as Hispanic (any race).

Children experience foster care through Chapter 260D at about one per 1,000 children in the Minnesota population. The table below shows the breakdown by race and ethnicity. African American/Black, American Indian, multi-racial, and Hispanic children (regardless of race) all show higher rates of experiencing care when compared to white children.

Using the rates per 1,000 children in the population, disparities can be evaluated by comparing white children to other race and ethnicity groups. Hispanic children of any race, and African American/Black children are slightly more likely to experience Chapter 260D placement than white children (1.1x and 1.2x more likely, respectively). Multi-racial and American Indian children are much more likely to experience Chapter 260D placement than white children (3.0x and 3.4x more likely, respectively). Asian/Pacific Islander children were much less likely to experience 260D placement (1/5 the rate of white children).[6]

	Child population (2018)[7]	Children experiencing 260D foster care	Rate per 1,000 children	Relative rate per 1,000 compared to white children
African American/Black	134,589	136	1.01	1.2x more likely
American Indian	27,788	78	2.81	3.4x more likely
Asian/Pacific Islander	81,617	15	0.18	0.2x as likely
Two or more races	72,855	177	2.43	3.0x more likely
White	985,588	806	0.82	--
Unknown/declined	--	16	--	--
State Total	**1,302,437**	**1,228**	**0.94**	**--**
Hispanic (any race)	117,068	102	0.87	1.1x more likely

[4] Social Service Information System, CY2018

[5] This represents children who are African American and immigrants.

[6] Social Service Information System, CY2018

[7] Source for population data: https://www.census.gov/content/census/en/data/tables/time-series/demo/popest/2010s-counties-detail.html
See "Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin" (CC-EST2018-ALLDATA)
See "Annual Estimates of the Resident Population for Selected Age Groups by Sex"

In 2018, children who experienced foster care through Chapter 260D and were Title IV-E eligible were disproportionately African American, American Indian, Hispanic and two or more races (see table below).

Title IV-E reimbursement for 260D episodes (2018)

	African American / Black	American Indian	Asian / Pacific Islander	Two or more races	Unknown / declined	White	Total	Hispanic (any race)
$	$328,364	$210,718	$7,405	$308,671	$9,027	$1,186,293	$2,050,477	$228,077
%	16.0%	10.3%	0.4%	15.1%	0.4%	57.9%	100.0%	11.1%

Age and gender

Children placed through Chapter 260D are more likely to be older than the general foster care population, with 81% of cases involving children ages 12 and older; 52% were males and 48% females.[8]

Length of stay

While 43% of children spend less than six months in out-of-home placement, 57% spend six to 24 months or longer. Length of stay in foster care is as follows:

- 43% spend less than six months
- 25% spend six to 12 months
- 10% spend 12 to 18 months
- 5% spend 18 to 24 months
- 17% spend 24 months or longer.[9]

Family First and Qualified Residential Treatment Program (QRTP) requirements

Public Law 115-123, the Family First Prevention Services Act, a major amendment to the Social Security Act, placed limitations on Title IV-E reimbursements for children placed in a child care institution (congregate care), established new criteria for congregate care facilities, and rigorous requirements for placing agencies in 2018. The significant change impacting federal reimbursements for these foster care settings is that Title IV-E funding will no longer be available for congregate care unless facilities meet new QRTP requirements, and a county agency complies with new QRTP placement requirements. Minnesota opted for a delayed effective date of Sept. 30, 2021, to allow time to implement the new requirements. New criteria for congregate care facilities include:

- Trauma-informed treatment model
- Twenty-four hours a day, seven days a week registered or licensed nursing staff, and other licensed clinical staff who provide care for children according to the treatment model
- Participation of family members, as appropriate, in child's treatment program

[8] Social Service Information System, CY2018

[9] Social Service Information System, CY2018

- Outreach to family members, including siblings, and maintain contact information for any known family or kin of children
- Documentation of how family members are integrated into the treatment process for children, including post-discharge, and how sibling connections are maintained
- Discharge planning and family-based aftercare support for at least six months post-discharge
- Licensed in accordance to Title IV-E requirements (i.e., employee background checks)
- Accredited by one of three independent not-for-profit organizations.

New requirements for placing agency include:

- A qualified individual must assess children to determine the appropriateness of placement in a QRTP.
- Assessments determine whether the needs of children can be met with family members, or through placement in a foster family home, and if not, which QRTP setting would provide the most effective and appropriate level of care for child in the least restrictive environment.
- If assessments are not completed within 30 days after placement in a QRTP, Title IV-E reimbursements are not available for the duration of a placement.
- A family and permanency team must be established for each child placed in a QRTP, which must consist of all appropriate family members and professionals.
- The case plan for a child in a QRTP must document efforts by the county agency to engage members of their family, follow placement preferences, and include written recommendations of the qualified individual.
- Within 60 days of placement in a QRTP, the court must consider the required 30-day assessment of its appropriateness, determine whether the needs of child can be met through placement in a foster family home, and if not, whether placement in a QRTP provides child with the most effective and appropriate level of care, and approve or disapprove placement.
- Ongoing court review and permanency hearings are required to consider the appropriateness of placement for as long as child is placed in a QRTP.
- For a child placed in a QRTP for more than 12 consecutive months, or 18 nonconsecutive months, or in the case of a child who has not attained age 13 but has been in placement in a QRTP for six months, documentation of the signed approval by the head of the agency to continue placement is required.[10]

The purpose of this section of Family First is to limit the number of placements of children, and the length of time they spend in institutional settings, because children placed in congregate care have poorer outcomes than those placed in family-based settings, and it's more expensive. They are 2.5 times more likely to become a delinquent, have poorer educational outcomes, and more likely to drop out of school than their peers in family-based care.[11]

While some youth may benefit from specialized treatment services available in congregate care placements, most of these services are available through therapeutic foster care or wrap around, and mobile treatment services provided in family-based settings. New Family First requirements ensure that only specific youth who can most benefit are placed in congregate care, and the most appropriate evidence-based interventions are used for the shortest time necessary to achieve safety, therapeutic and permanency goals.[12]

[10] ACYF-CB-IM-18-02; Instructional Memorandum issued April 12, 2018

[11] Strong Families Information Packet by Casey Family Programs, January 2017

[12] Strong Families Information Packet by Casey Family Programs, January 2017

> "Although there is an appropriate role for congregate care placements in the continuum of foster care settings, there is consensus across multiple stakeholders that most children and youth, but especially young children, are best served in a family setting. Stays in congregate care should be based on the specialized behavioral and mental health needs or clinical disabilities of children. It should be used only for as long as is needed to stabilize the child or youth so they can return to a family-like setting. Youth who present with a DSM diagnosis can make improvements in a specialized setting for a limited period of time." [13]

Family First residential services should apply to Chapter 260D

After much consideration, department staff believe that Family First residential services requirements should be applied to children placed voluntarily through Chapter 260D, both for the protections it provides and for federal Title IV-E reimbursements available for counties. Department staff acknowledges that there are differing opinions as to whether these new requirements are in the best interests of children and families.

Concerns raised by stakeholders during the 2020 legislative session regarding 260D focused the discussion on residential treatment settings. This did not include a thoughtful conversation about the importance of serving children and families in the least restrictive setting, and the role current practices, including the juvenile treatment screening team, parent engagement, and court oversight, play in achieving that goal.

The following are examples of why department staff believe Family First residential requirements will result in a reduction of children needing intensive residential mental health services, reduce the time children spend in residential care, and ensure families are actively involved in their children's lives when receiving residential services.

Family and Permanency Team

Within 10 days of a juvenile treatment screening team recommending placement in a QRTP, the county social service agency assembles a family and permanency team for a child. The team is comprised of child's parents, appropriate biological family members, foster care providers, and professionals, as appropriate, who are a resource to child's family, such as teachers, medical or mental health providers, or clergy. If an Indian child, a county agency will make active efforts to include child's tribal representative on the family and permanency team.

When the permanency goal is to reunify a child with their parents, the goal in the majority of cases, the purpose of a relative search and focus of the family and permanency team is to preserve family relationships, and identify and develop supports for a child and their parents. Family and permanency team members participate in case planning, review the assessment completed by a qualified individual, and support the child-parent relationship.

The intended result of implementing this new federal requirement is to provide support to families in ways that preserve the parent-child relationship. Parents can remain actively involved in their child's life when placed in congregate care, and child maintains a relationship with their parent/s that supports attachment and belonging.

[13] Report 114-628 submitted to the 114th Congress, 2d Session, House Of Representatives Committee of Ways and Means on June 21, 2016; Consensus Statement on Group Care for Children and Adolescents: A Statement of Policy of the American Orthopsychiatric Association. American Journal of Orthopsychiatry. 2014, Vol, 84, No. 3, 219–225; U.S. Department of Health and Human Services, A National Look at the Use of Congregate Care in Child Welfare. March 30, 2015.

Qualified individual and assessment

While the requirement for a county social services agency to utilize a juvenile treatment screening team to consider parent's request to voluntarily place their child remains the same as current federal requirements, Family First introduces an independent objective qualified individual in this process. This individual's responsibility is to:

- Conduct an assessment that includes completing an evidenced-based tool such as the Child and Adolescent Needs and Strengths (CANS)
- Conduct interviews with family members
- Review school records, and
- Involve members of the family and permanency team in their assessment process.

The purpose of an assessment is to understand a child's mental health, behavioral and/or developmental disability needs. It determines if needs can be met in a least restrictive setting, such as remaining with their family, or a family-based setting, rather than an institutional setting. Qualified individuals need to be knowledgeable of mental health services available in child's community, culturally competent, and provide an objective review of the appropriateness of residential treatment for an individual child.

The intended result in implementing this new federal requirement is to support more children receiving the mental health, behavioral and developmental disability services within their family and community, rather than receiving services in a residential facility, often not located in their community, and sometimes not in Minnesota.

60-day court review

Family First requirements introduce earlier court reviews for children placed in a Qualified Residential Treatment Program. The 180-day administrative review and the in-person court hearing after 12 months remain the same for children placed through Chapter 260D. What is different is that within 60 days of the beginning of a placement in a QRTP, the court must consider the qualified individual's assessment and determination, and either approve or disapprove of child's placement in a congregate care facility. This 60-day court review can be an administrative process or in-person court hearing, if requested by child, their parents, or county social service agency.

For as long as a child remains in a QRTP placement, a county agency must submit documentation to the court that child's placement in a QRTP is the most effective and appropriate level of care for them. County agencies are required to keep the court informed at each administrative review, court review, and permanency hearing, on why a QRTP placement continues to be the most effective and appropriate setting for a child.

The intended result in implementing this new federal requirement is to have a secondary review of reasons why a child cannot receive services within their family and community, and can only access necessary services in a residential facility. Instead of waiting six months to inform the court a child has entered foster care voluntarily to access residential treatment, the court is informed in two months, providing a child and their family with a secondary review of an assessment and determination made by a qualified individual.

Review of extended QRTP placements

For a child placed in a QRTP for more than 12 consecutive months, or 18 nonconsecutive months, or in the case of a child who has not attained age 13 but has been in placement in a QRTP for six months, signed approval by the head of a county social services agency is required to continue placement. Documentation of approval for continued appropriateness of a congregate care placement is submitted to the court.

In 2018, 11% (n=74) remained in congregate care from 12 to 18 months, 5% (n=32) from 18 to 24 months, and 2% (n=11) from 24 to 30 months.

The intended result in implementing a new level of review and scrutiny for children placed in congregate care ensures children do not remain in residential facilities for longer than is necessary. It brings children placed in congregate care placements that exceed 6 to 12 months to the attention of leadership at a county social service agency.

Cost of care and Title IV-E funding

Minnesota has different rate structures to determine payments to foster parents and facilities, regardless if a child was court ordered or voluntarily placed in foster care. Depending on placement setting type, there may be a county, tribal, state and federal share, along with private health insurance and other cost offsets, such as Supplemental Security Income (SSI) benefits, child support, adoption assistance payments, and parental fees.

Rate setting for family foster care is covered under Northstar Care for Children using an assessment tool to determine the daily rate. Costs are shared among county, tribal, state, and federal dollars.[14] For congregate care facilities, such as group homes and children's residential treatment facilities, a facility enters into a lead county contract,[15] which sets a statewide per diem rate. County, tribal and federal dollars pay for the cost of congregate care.

Federal Title IV-E of the Social Security Act provides for federal reimbursement for a portion of the maintenance and administrative costs of foster care for children who meet specified federal eligibility requirements. In Federal Fiscal Year 2018 (Oct. 1, 2017 – Sept. 30, 2018), counties and tribes participating in the American Indian Child Welfare Initiative received $64.6 million in federal Title IV-E reimbursements for the cost of foster care.

Counties made approximately $37.3 million in payments for the cost of out-of-home placement for children placed voluntarily in foster care through Chapter 260D in calendar year 2018.[16] These payments were made on behalf of approximately 1,200 children. Counties received $2.1 million in federal Title IV-E reimbursement for out-of-home placement costs for children through Chapter 260D in 2018. Title IV-E reimbursements for similar children will not be available in the future if new Family First requirements are not applied to those placed through Chapter 260D.[17]

One of the challenges we faced in determining these costs is that SSIS does not have a simple way to differentiate between children placed voluntarily through Chapter 260D and Chapter 260C. The methodology

[14] See Minn. Stat. § 256N.27

[15] See Minn. Stat. § 256.0112

[16] Initiative tribes do not place children through Chapter 260D

[17] Social Service Information System CY2018

the department used produced the most accurate financial data available in SSIS. However, it is possible that the costs for these cases could be greater should Family First not be incorporated into Chapter 260D.

Areas for consideration

After careful study and analysis, department staff has identified federal requirements, legal, technology systems, and equity issues that need to be addressed if children placed through 260D are exempted from Family First requirements.

Federal requirements

Title IV-E is clear that federal requirements must apply to all children who enter foster care, regardless of method for placement (voluntary/court ordered), or specific child's eligibility for Title IV-E.[18]

Under federal and state law, children are in foster care when placed away from parents or guardians for more than 24 hours, and legal responsibility from parents or guardians is transferred to a county or tribal social services agency.[19] Under Chapter 260D, children are placed away from their parents for more than 24 hours, and the legal and financial responsibility for costs associated with placement of a child is transferred from parent/s or guardian to a county or tribal social services agency through the Voluntary Placement Agreement (VPA), although parent/s or guardian retain legal custody of their child. The VPA establishes legal authority for a child to enter foster care.

Since its inception, children placed voluntarily through Chapter 260D have been included in the state Title IV-E plan.[20] Failing to apply Family First requirements and protections to children placed in foster care through Chapter 260D means that as of Sept. 30, 2021, Minnesota would no longer be compliant with its state Title IV-E plan, placing approximately $122 million in Title IV-E reimbursements (foster care, kinship and adoption assistance payments) at risk. Based on the legislative exclusion of Chapter 260D from Family First requirements, Chapter 260D placements must be removed from the state plan.[21]

Removing children placed voluntarily through Chapter 260D from the Title IV-E plan would result in counties becoming 100% financially responsible for foster care costs for children placed through Chapter 260D, since Title IV-E reimbursement would no longer be available. For children placed in residential treatment facilities, counties would assume 100% financial responsibility for the foster care portion of the cost, and Medicaid reimbursement for the treatment portion of the cost would remain the same. As noted previously, Title IV-E reimbursement to counties for these cases was $2.1 million in calendar year 2018.

In addition to financial costs to counties, failing to apply Family First to children served through Chapter 260D means those children will not have the benefit of important Family First protections, such as increased agency efforts to prevent placement in an institutional setting, and increased monitoring by county agency and court of the on-going need for placement in congregate care.

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[18] Social Security Act, section 471 [42 U.S.C. 671]; Social Security Act, section 472 [42 U.S.C. 672]

[19] See 45 CFR 1355.20, Minn. Stat. 260C.007, subd. 18

[20] [Social Security Act, Part 472 (a) and (b); 45 CFR 1356]

[21] Minnesota must demonstrate to the federal Children's Bureau, U.S. Department of Health and Human Services, how children in foster care are cared for according to federal requirements every three years under the state Title IV-E plan. Minnesota is currently working with the Children's Bureau to obtain approval of the state Title IV-E plan, which includes children placed under Chapter 260D, since creation of that statute.

Medical coverage and non-residential services

Children placed in foster care are categorically eligible for Medical Assistance (MA). These youth are also eligible for Education and Training Vouchers, independent living services, and other supportive services to help them successfully transition from foster care to adulthood. If Family First requirements are not applied to children served through Chapter 260D, their eligibility for MA and non-residential services would not be affected because under Minnesota law they would remain in foster care.

Children eligible for Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI), Brain Injury(BI), and developmental disability MA waivers, remain eligible regardless of whether they are in foster care or not. When children are placed in residential treatment facilities, the waiver is suspended during this time and reinstated when discharged.

Impact on information technology

If Family First is not applied to children placed through Chapter 260D, and funds are not appropriated to make necessary changes in the Social Service Information System (SSIS), there will be significant difficulties for department and county agency staff.

SSIS is Minnesota's child welfare information and reporting system, as well as the system that county agencies utilize to submit foster care Title IV-E claims to the department. In SSIS, there is no automated way to distinguish Title IV-E claims submitted for children placed through Chapter 260C or 260D.

If Family First is not applied to Chapter 260D cases, county agencies could submit Title IV-E claims for costs no longer eligible for federal reimbursement. If this occurs and a foster care case is selected for a federal Title IV-E foster care on-site eligibility review, the case would be found in error and the county agency would be responsible for repaying the amount in error. If there are more than four error cases out of 80 reviewed from across the state in a federal Title IV-E foster care on-site eligibility review, the state is found to be out of substantial compliance. In past federal Title IV-E foster care on-site eligibility reviews, voluntary placement cases comprised 10% of reviewed cases.

In addition to clearly identifying the populations of children placed through Chapters 260C and 260D, SSIS would need to be programmed to exempt cases involving 260D children from the Family First QRTP requirements, and create the functionality to retain a child's Title IV-E eligibility status prior to the federal effective date.

Updating SSIS to separately track Chapter 260D cases is imperative if the legislature decides to not apply Family First to Chapter 260D. This is a complicated MNIT project, taking an estimated 12 months; an initial appropriation of $72,000 is needed for MNIT to begin this work. Given the complicated nature of updating SSIS for this purpose, with MNIT working at capacity on current Family First requirements through calendar year 2021, these changes will not occur until late 2022.

If Chapter 260D remains exempt from Family First, department and county agency staff will need to devise a plan to track exempt cases separately for purposes of Title IV-E claiming. It has not been determined if and how such a plan would work, but it would likely be inefficient, complicated, and entirely a manual process; it would result in increased work for county staff, and provide inadequate safeguards against inaccurate Title IV-E claiming.

Equity

The Family First Prevention Services Act was passed to amend the Social Security Act, Titles IV-B and IV-E to invest in funding prevention and family services to help keep children safe and supported at home, and to ensure that children in foster care are placed in the least restrictive, most family-like, and appropriate settings for their special needs.[22]

Setting aside federal requirements for children placed through Chapter 260D means vulnerable children who spend more time away from their families in institutional care settings than the general foster care population, and who have serious mental, behavioral and developmental disabilities, will not have the enhanced protections provided by Family First.

Since counties also have ability to make voluntary placements through Chapter 260C, the loss of Title IV-E reimbursements through Chapter 260D might incentivize placement of additional Title IV-E eligible children. Title IV-E has income-based eligibility criteria from the federal Aid for Families with Dependent Children (AFDC), in effect since 1996; this means these children and their families who are eligible are very poor, and in the child protection system are disproportionately African American and American Indian or children of two or more races. This means that children and families previously seeking behavioral health treatment services through the treatment-focused and less-restrictive requirements of Chapter 260D may instead be funneled into voluntary placements under 260C, which is a system that is more punitive, results in a Child In Need of Protection or Services (CHIPS) petition if a child is not home within 6 months, and may negatively impact parent's or guardian's ability to maintain employment (due to a finding of maltreatment) if it requires a background study. Consequently, the failure to apply Family First requirements to Chapter 260D may exacerbate existing problems of over-representation in Minnesota's child protection system for African American and American Indian or children of two or more races who would be better served through a voluntary foster care placement designed to meet the treatment needs of children.

Creating a non-foster care residential treatment option for families (see below) could have a positive impact on equity by providing families from communities that are distrustful of entering the child protection system, an option that does not involve court or other child protection-related proceedings. As long as there are protections in place to ensure children do not stay in congregate care for longer than is necessary, the ability to obtain mental health care and disability services for their children outside the foster care system may encourage more African American, American Indian, Hispanic and Asian American families to seek care their children need. This may in turn result in better long-term outcomes.

Non-foster care options

During work with stakeholders, it was clear that there was a desire among some that the Minnesota Legislature create a new path for families to obtain mental health treatment with less government oversight, and without foster care placement. The work group explored two specific existing models of care that might achieve that goal, identified below.

Colorado model

Work group members representing county, tribal, NAMI, AspireMN, MACSSA, and the department met with state staff from Colorado to learn more about how it enacted and implemented its Children and Youth Mental

[22] H.R. 253, 115th Congress 1st Session, January 4, 2017

Health Treatment Act. Through this program, families can apply for funds to cover up to six months of residential mental health treatment completely separate from the child welfare system. Children receiving services from this program are not in foster care, since the county social service agency is not involved and a voluntary placement agreement is not signed. This program is funded with $3 million in state general funds, $300,000 from the marijuana fund, and Medicaid match, if child is SSI eligible.

Psychiatric Residential Treatment Facility

Psychiatric Residential Treatment Facility (PRTF) provides active treatment to children and youth under age 21 with complex mental health conditions. This is an inpatient level of care provided in a residential facility rather than a hospital. PRTFs deliver services under the direction of a physician, seven days per week, to residents and their families, which may include individual, family and group therapy. PRTF is a 100% Medicaid covered service.[23]

Non-foster care considerations

The two above options are just examples of what the legislature could consider. Department staff is currently providing technical assistance to interested stakeholders that could serve as a model for a non-foster care treatment model.

When considering new options for providing mental health treatment for children currently served through Chapter 260D, it is important to note that these children will no longer be categorically eligible for MA, and they will no longer be eligible for non-residential services, and other benefits provided to young adults exiting foster care. Any new model would need to consider how care is funded (state, counties, parental contributions), how eligibility is determined and by whom, what standards and requirements must be met to determine the level of care needed by a child, MA eligibility, and whether there should be post-treatment services for youth who age out of a residential care placement.

A non-foster care option may provide an alternative pathway to access mental health, behavioral health, and developmental disability services for families coming from communities experiencing historical trauma, discrimination, and institutional racism. Families may be more likely to access critical services for their children if services are outside the child welfare system.

Sue Abderholden, Executive Director of NAMI Minnesota, recommended in 2020, and again in feedback to the agency during stakeholder consultation, that the legislature create a non-foster care option that is state funded.[24]

Similarly, AspireMN recommends developing a new chapter in statute to assure delivery of mental health treatment for children and youth requiring an intensive level of care, and to support otherwise unreimbursed care via state funding.
Counties recommend that consistent with advocate preferences for a separate access process, counties should not be responsible for identifying placement options, funding the placements or providing administrative oversight for these placements, as currently occurs with Psychiatric Residential Treatment Facilities (PRTF's).

[23] Minn. Stat. 252.27

[24] Email from Sue Abderholden to the department dated November 14, 2020: Our recommendation would be to have a separate path, like PRTFs for these children and their families.

Department recommendations

As stated previously, department staff makes the following recommendations to the legislature:

- The legislature should incorporate Family First requirements into Chapter 260D, as originally proposed during the 2020 legislative session.
    - MACSSA has taken a position supporting inclusion of Family First requirements in Chapter 260D[25]
- In recognition of advocate concerns regarding Family First being applied to children placed voluntarily in foster care through Chapter 260D, the legislature should develop an option to access residential behavioral health treatment services for children and families who may be better served outside the foster care system.
    - MACSSA recommends that if a new option for residential treatment is created by the legislature, counties should not be responsible for identifying placement options, funding the placements, or providing administrative oversight for these placements, as currently occurs with Psychiatric Residential Treatment Facilities (PRTF's).
- If the legislature does not incorporate Family First requirements into Chapter 260D, the legislature should:
    - Appropriate a minimum of $2.1 million annually to cover lost federal Title IV-E funding for counties.
    - Appropriate funding to enable Minnesota IT services (MNIT) to update SSIS so county agencies are able to claim Title IV-E reimbursements only for eligible children. The initial cost estimate for this work is $72,000 and $15,000 ongoing.

Stakeholder feedback and recommendations

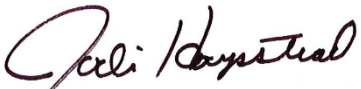
***60-day court review hearings*.** Applying Family First to children placed through Chapter 260D would impact the current court process, especially in terms of the timing of when 260D cases get filed with the court. Many placements under 260D involve the types of settings that, if Family First applies, would need to meet new qualified residential treatment program (QRTP) requirements, including court review within 60 days of placement, which is much earlier than when a court would normally become aware of a 260D placement and involved in its review. Pursuant to Minn. Stat. 260D.06, notification to the court of a voluntary placement currently needs to occur within 165 days of placement with review by the court within 10 days of that notification. Many 260D cases are filed at 165 days of placement with initial review by the court at 175 days of placement. Further discussion with court administration staff will be necessary to identify and measure the impact of changing the court process to more quickly file and review these 260D cases.

Additional stakeholder feedback is at the end of this letter.

[25] See: http://cms5.revize.com/revize/macssa/Legislative%20Positions%202021%20-%20proposed/CS9c%20-%20Possible%20Revisions%20to%20MN%20Stat.%20260D%20-%202021%20statement%20.pdf

Thank you for your partnership in child protection and child welfare matters. We look forward for continuing our work together this legislative session.

Sincerely,



Jodi Harpstead
Commissioner

Enc.

Cc: Senator Michelle Benson (michelle.benson@senate.mn);
Senator Omar Fateh (sen.omar.fateh@senate.mn);
Senator Melisa Franzen (sen.melisa.franzen@senate.mn);
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An association of resources and advocacy for children, youth and families

www.aspiremn.org

December 15, 2020

HHS Committee Chairs and Leads,

With implementation of the federal Family First Prevention Services Act (FFPSA), Minnesota has an opportunity to actively build a continuum to meet the needs of children, youth and families. FFPSA requires two fundamental service changes seen at the early intervention and the intensive service areas of the continuum. Early intervention services can be added to Minnesota's service array to help prevent out of home placement or reentry into services. Intensive mental health treatment and other services provided within congregate care settings will need be designated as Qualified Residential Treatment Program (QRTPs) to continue to receive federal Title IV-E child welfare funding.

For Minnesota, the QRTP level of care reflects much of the established best practice level of care for Children's Residential Treatment. To deliver enhanced value to Minnesota children, youth and families as part of designing our QRTP level of care, AspireMN recommends that QRTP be defined as a level of care that includes Crisis Stabilization and Community Based Group Care – to assure continuity of care, increase access to individualized responses to treatment needs, and to continue growth of trauma-informed care. Unfortunately, fundamental QRTP requirements are incongruent with Minnesota's commitment to voluntary placement for children in need of treatment. QRTP is designed from a child welfare practice standpoint and holds no nuance in requirement for engaging with families who are involved in services from a treatment standpoint.

The following comments respond to the DHS report and recommendations on 260D voluntary placement, as required by the 2020 legislature out of shared concern for QRTP implementation adversely impacting voluntary placement and children, youth and families in need of intensive mental health treatment. AspireMN leaders anticipated shared development of a report to make recommendations on:

- How Minnesota can maintain the value of voluntary placement for children in need of intensive mental health treatment, in light of federal requirements focused on child welfare and not on mental health treatment as the focus of treatment?
- Designing funding to sustain voluntary placement outside of a Title IV-E funding environment.
- Development of a continuum of services that responds to diverse mental health treatment needs of child and youth within MN's design for FFPSA implementation

AspireMN agrees with report recommendations to design a children's mental health service, funded with state investments and designed to sustain vital access to treatment for children, youth and

families. We look forward to opportunities in the 2021 session to design and sustainably fund this critical service.

The report throughout also describes the implementation of the FFPSA child welfare reform as introducing new standards of care for Minnesota's children's residential care. This is far from accurate as Minnesota's children's mental health service continuum and residential treatment responses have long met and exceeded best practice, national best standards and other measurement of quality care. Key components of current practice by Children's Residential Treatment providers include:

- Diagnostic Assessment conducted by a Mental Health Professional required for placement, and includes review that indicates community based care was unsuccessful in ameliorating problems, thus necessitating the more intensive placement
- Transition planning that begins at admission, including anticipation of required community based services
- Family involvement in treatment planning and therapies as appropriate
- Family and youth centered service delivery
- Accreditation by a national accrediting body with requirements for operational, infrastructure, program design and client outcomes measures that exceed other state and federal requirements

Professionals in the children's mental health continuum are bound by licensure, ethics, and practice standards to recommend and deliver residential care to children and youth with intensive mental health care needs that exceed levels of support available within the community. Positively, residential care remains a viable, quality, critically important service – that meets complex individual needs of children, and youth so that they can return to family and community life with the skills and supports needed to live their full and vibrant lives.

Importantly, we also know that meeting the mental health needs of children and youth is a primary strategy to prevent out of home placement into foster care. Intensive mental health needs in residential care are conducted with the active support of the child's family, while delivering treatment, building skills, and actively planning for a positive transition back into the family and community.

As the legislature continues to provide oversight and engagement with the administration on the process of full implementation of FFPSA in Minnesota, AspireMN strongly recommends that the process:

- Lean on Minnesota's storied history of active compliance with creative implementation to enhance quality care for children and youth. Begin this by starting with the existing foundation of the children's mental health continuum to drive QRTP development
- Engage the community of practice to drive future work and assure quality of care within this new level of care
- Engage current providers who demonstrate and exceed national best practice standards of care, lean of Minnesota leader to design FFSPA-required after-care for youth, defining trauma-informed service delivery and other quality measures
- Design service delivery standards to exceed FFPSA requirements that are not in the best interest of children and families – specifically Minnesota should improve upon the initial federal definitions of:
    - Qualified individual – this duplicative step for Minnesota's process will delay needed placement, add significant cost, and place far too much decision-making authority in one individual role within the system; instead, MN should leverage existing placement

process that requires mental health professionals to assess and determine appropriate level of care

- 30 day review of placement – creates potential for placement disruption and related trauma for the child, is in conflict with current practice of requiring a Diagnostic Assessment to determine the required individualized care for each child that is then followed by treatment planning and countless additional therapeutic strides taken by the child and treatment team; 30 days is far too long to review and potentially require a change in treatment
- Court review process – explicit incorporation of family, child and youth voice are fundamental to a positive court process

Minnesota's children's mental health continuum is far from perfect – it is in the process of being built. We know all too well that each day in Minnesota hundreds of children and youth are on waiting lists for care – across the service continuum. At this critical juncture Minnesota must be strategic and leverage existing systems, experts, and strengths to continue the shared work of building a system that meets unique treatment needs, strengthens families, and helps all children and youth to live their full lives.

Sincerely,

Kirsten Anderson
Executive Director

From: Sue Abderholden <sabderholden@namimn.org>
Sent: Saturday, November 14, 2020 8:10 AM
To: Johnson, Kris A (DHS)
Subject: RE: Sharing your recommendations for 260D Voluntary Placements

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Our recommendation would be to have a separate path, like PRTFs for these children and their families.

Sue Abderholden, MPH
She/Her/Hers
Executive Director
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Join us on Saturday, November 14th for the (virtual) 2020 NAMI Minnesota State Conference: *Mental Health in Challenging Times*.
Click here to learn more about keynotes, breakout sessions and to register.

MACSSA
Minnesota Association of County Social Service Administrators

January 15, 2021

Minnesota Association of County Social Service Administrators (MACSSA) response to the Department of Human Services Commissioner draft report regarding Laws of MN 2020, First Special Session, Ch. 2, Art. 5, Sec. 96

Members of the Minnesota Legislature,

In the First Special Session of 2020, the Department of Human Services (DHS) was directed by the Legislature to confer with counties, tribes, NAMI-MN, AspireMN, and other stakeholders on recommendations regarding payment for the cost of treatment and care for residential treatment services, including community-based group care, for children currently served under Minnesota Statutes, chapter 260D. After reviewing the commissioner's draft report, the Minnesota Association of County Social Services Administrators (MACSSA) was compelled to include our own direct feedback in response to DHS's consultation and draft report being shared with legislators.

MACSSA supports the service delivery approach as provided by MN Statute 260D incorporating the proposed requirements of Qualified Residential Treatment Program (QRTP). This allows counties to respond to requests for children's mental health and/or developmental or intellectual disability services by considering the best interests of the child, examining the treatment options best suited to the needs of the child, and does not rely on all county funding for services. It provides for trauma-informed services and a planned discharge from placement with ongoing services, all positive aspects to service delivery. Recognizing that different views of what a child needs may emerge between parents/caregivers, mental health or other health professionals, and county agencies, retaining a structure that provides oversight and impartial decisions regarding any differences is important to serving the best interests of the child. These elements are central to MACSSA's support of this enabling legislation.

MACSSA also welcomes further discussion with NAMI-MN and AspireMN to seek a shared approach to addressing concerns about QRTP implementation within MN Stat. 260D. We will also commit to engaging in discussions around the interest NAMI-MN has expressed in a third path to accessing treatment placement that relies on medical necessity and does not include county involvement.
DHS has consulted with counties, providing information on their recommendations and allowing for feedback and direct input, and we appreciate that partnership. However, we think it is important to note that the scope of the workgroup and this resulting report is not the same scope of the discussion that was sparked with the QRTP enabling legislation proposed last session. The scope required for this process was not able to land on an agreed-upon assessment of financial impact of QRTP requirement implementation decisions between counties and DHS. It also could not include direct discussions among the key stakeholders to seek agreement on potential solutions to the concerns. MACSSA hoped this workgroup could engage in a deeper and broader discussion that could more fruitfully mitigate concerns about the FFPSA implementation's broader impacts to the system and the people we serve, but that was not the scope in the directive. There remains an opportunity for robust conversation among stakeholders about how the requirements could be implemented in a different manner from the

assumptions that raised concerns about the QRTP requirements. That broader discussion similarly might have surfaced important context necessary for sound policy decisions had there been the opportunity, but we offer some perspective in lieu of that broader discussion below.

The children served in community-based settings under the current MN Stat. 260D demonstrate positive changes from the years of work to de-institutionalize the needed care for these children. Concerns raised by stakeholders during the 2020 legislative session regarding 260D focused the discussion on treatment settings, so that the importance of serving children and families in the least restrictive setting largely was lost. The statutorily-required juvenile screening team includes the child's parents as members, the guardian ad litem appointment to bring the child's voice into proceedings, and the neutral oversight in court support accessing the right services at the right depth, ensuring that residential treatment away from family transitions appropriately to community-based services. MN Stat. 260D has established the path to publicly-supported treatment placements without requiring families to be in the arena of "child in need of services" in the traditional CHIPS Court system, but it also has required commitment from counties in seeking community-based service options that have been important in moving forward Minnesota's still inadequate continuum of care for children with disabilities and their families.

The current status of QRTP implementation in Minnesota only has QRTP requirements for treatment placements accessed through the child welfare system under MN Stat. 260C, primarily child protection situations. This is untenable, as when QRTP is implemented on September 30, 2021, federal IV-E reimbursement for eligible children and youth in treatment placements is allowed if the court finds through petition that the child is in need of protection or services or neglected in foster care. Counties currently experience movement between 260C and 260D petitions in court. For example, a child protection court file may be largely resolved, parents having completed changes to ensure child safety and children returning to parents with the exception of a sibling with disabilities who remains in placement with additional treatment needs. Changing the child's petition for placement from a 260C child protection issue to a 260D child disability petition allows the parents to regain custody while the child remains in a needed treatment placement. Similarly, there are situations where a child is in a treatment placement and parents have declined to provide consent for care, do not participate in family therapy, do not visit nor allow visits home, and decline to participate in discharge planning, expressing the intent not to have the child discharge. These situations may eventually move to a 260C child protection petition to allow planning to begin with a relative placement or other permanency planning. This current discrepancy in IV-E reimbursement availability for eligible children is likely to raise concerns alleging financial motivations for 260C petitions in circumstances that already can be difficult to navigate when parents feel strongly about not wanting a child to be discharged from placement for treatment. The ability to align the type of petition to the child's circumstances is vital to case work.

The highly individual family circumstances complicate tracking in the Social Services Information Systems, the case management and claiming system for IV-E. There is no box to check to indicate the type of petition for a placement, and even its current status SSIS has many opportunities for error. This is important for two reasons. First, the complexity of placement information made pulling fiscal estimates challenging: both MACSSA and DHS inquired of the DHS data warehouse for information regarding the fiscal impact of foregoing IV-E reimbursement for eligible children in MN Stat. 260D placements. While we each offered our best criteria for approximating the loss, DHS's criteria estimated a loss of between $2 million and $3 million. MACSSA's criteria resulted in an estimate from the DHS data warehouse that was greater, over $4 million. MACSSA holds the view that the criteria we submitted to

the data warehouse was better grounded in operational realities, and in both instances the requests relied on older data given the interference of IV-E reimbursement lost for congregate settings as an unintended consequences of statutory changes in 2019, and then the atypical pandemic year of 2020. The second reason that the challenges of SSIS are relevant is noted in the report, namely that if QRTP requirements are not included in 260D placements so that the IV-E revenue must not be claimed, additional modifications will be needed in SSIS to ensure the placements are separated from claiming processes—more complexity and more opportunity for social worker data entry errors.

Finally, MACSSA writes to comment on the broader discussion about treatment placements that is leading to a recommendation that a path to access treatment without county involvement be considered. The elements that support the least restrictive environment create this balance—county screening team decisions and eventual court oversight that could ultimately include a petition to terminate parental rights if a child remains in placement without compelling reasons—create uncertainty for parents who worry if their children will function well enough at home and in the community. In the discussions of changes needed to comply with FFPSA's Qualified Residential Treatment Programs, the worries of some parents and advocacy organizations led to proposals that would end county screening team decisions and eventual court oversight. Because the federal requirements for QRTPs have similar language to child protection requirements, there is concern that they will be received as punitive to parents. At the same time, the discussion has not drawn forward the instances of placements found by courts not to be in children's best interests.

National Alliance on Mental Illness Minnesota (NAMI-MN) and AspireMN are key stakeholders in this issue. NAMI-MN has expressed interest in a third path to accessing treatment placement that relies on medical necessity and does not include county involvement. In this way, families' concerns about some of the 260D regulations could be avoided, and populations with distrust of public systems—especially African American, American Indian, and other Communities of Color—would have access to needed mental health services without requesting county services. An option exists for people under age 21 years to access medically necessary mental health treatment in a residential setting without county involvement at Psychiatric Residential Treatment Facilities (PRTFs) as established in MN Statutes 256B.0941. These health care services do not need county involvement for room and board costs, and are not subject to counties assessing whether they are the appropriate level or duration of care: eligibility and coverage occurs through health coverage. DHS leads the development and licensure of PRTFs. While Minnesota PRTF's offer only one level of care, other states have opted to create additional tiers of care within PRTFs to respond to a slightly wider range of the continuum of care needed by children and youth. There are currently drawbacks of PRTFs in Minnesota including the lack of discharge transition planning to community-based supports, the frequent unavailability of openings in PRTFs, and difficulty in gaining the right focus of interventions to a patient's needs. It bears noting, however, that it is difficult to find timely availability in the current residential treatment centers in Minnesota, and programs often determine that children or youth are not a good match to a program. County staff often spend an inordinate amount of time seeking placements in residential treatment. These are issues in our continuum of care, and not reasons to rule out PRTFs as an option for those with medical necessity for residential treatment and a desire to avoid county involvement. Emphasis could be placed on enhancing Minnesota's PRTF options rather than foregoing the QRTP requirements and IV-E reimbursement.

In addition to examining the use of PRTFs, there is opportunity for robust conversation among stakeholders about how the QRTP requirements could be implemented in a different manner from the assumptions, building both formal and informal supports into case planning for the child or youth and

strengthening the role of parent voice in the juvenile screening team process. There is more nuance to this issue that underscores both the means for parents to have an active role in service planning for their children and the benefit of having the interests of children and youth reviewed when placement continues and the appropriate level of care is in question. MACSSA welcomes discussion with NAMI-MN and AspireMN to seek a shared approach to addressing concerns about QRTP implementation within MN Stat. 260D. Potential areas to explore include supporting enhancement of PRTFs in Minnesota, taking steps that amplify parent voice and support in the current county system, including requirements about staging kinship involvement, supporting resources for programs to transition to QRTPs or PRTFs or other ideas that are congruent with the county interest in maintaining a process for appropriate level and duration of care with protection for children's best interests and utilize available funding streams for services.

In summation, MACSSA supports implementing the elements required under federal Title IV-E for Qualified Residential Treatment Programs, and supports residential treatment programs and group home settings that provide treatment placements in receiving assistance to transition to meet QRTP requirements. Ultimately if QRTP requirements excluded and treatment placements are intended to occur without the current oversights of MN Stat. 260D, treatment placements should be administered and funded at the state level rather than by counties. This would transfer responsibility for locating placements and managing the public costs of the treatment placements to the state rather than leaving them at counties without oversight on appropriateness or duration of placements. MACSSA stands ready to engage with DHS, NAMI, and other stakeholders and advocates to engage with that conversation. It is our hope, however, that we can also work with stakeholders and partners to design practice approaches within the QRTP requirements that are responsive to parent concerns while considering the best interests of children.

We appreciate the opportunity to offer our perspective and comments.

Sincerely,

Matt Freeman
MACSSA Executive Director