REPORT OF THE
DEPARTMENT OF
MEDICAL ASSISTANCE SERVICES ON

Medicaid Coverage of Therapeutic or Personal Care for Adults and Children

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 42

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

House Joint Resolution 368 requested the Department of Medical Assistance Services to study the feasibility of Medicaid coverage of personal foster care for adults and children who would otherwise have to be admitted to nursing facilities at Medicaid expense. This document contains the results of that study. The first two sections of this report describe how the study was conducted and give an overview of Medicaid requirements which affect any evaluation of the expansion of Medicaid coverage. The report then is divided into adult and children's foster care. The section on adult foster care describes adult foster home programs and funding models used around the nation. The sections of the report dealing with children report on foster care directed toward the treatment of emotionally disturbed children and foster care for children with medical needs.

ADULT FOSTER CARE

This study identifies four funding models of adult foster care programs:

- Massachusetts' Medicaid state plan option program,
- Oregon's Medicaid home and community-based care waiver program,
- Virginia's state and locally funded program, and
- The potential of a new model pursuant to Section 1929 of the Social Security Act which will permit federal matching funds for personal care services in adult foster homes.

The type of foster care for adults does not vary widely across the nation. Almost all programs serve physically or mentally dependent adults who require a safe place to live and provide room and board, supervision and personal care services. Personal care services are those services directed to assist an individual with the performance of activities of daily living such as bathing, dressing, toileting and eating.

States which fund adult foster care through state and local funds only have the greatest flexibility to design and manage their programs. If Medicaid funding is used, the services may be covered:

- As an optional service under the State Plan for Medical

Assistance, or

- Through a home and community-based care waiver.

If covered as an optional service, a state is legally required to offer the service to all Medicaid eligible individuals who need it. If offered through a waiver, a state may limit the service to those individuals who otherwise would be served in a nursing home at equal or lower cost. The cost impact of the two options may vary greatly.

The recommendations concerning adult foster care are based on the findings that:

- Virginia's current state and locally funded program does not allow Virginia to bring in additional funding through Medicaid;

- Coverage of adult foster care under Medicaid as a state plan option service could result in additional cost to the Commonwealth in a time of extreme fiscal constraint;

- Implementation of payment for personal care services in adult foster homes under Section 1929 of the Social Security Act presents substantial financial risk to the Commonwealth at this time;

- Permitting coverage of personal care services in an adult foster home through a home and community-based waiver would permit Medicaid expansion into another service program without increasing the number of eligible Medicaid recipients or the total amount expended by the Commonwealth, and even save state funds if the localities were required to continue to participate in funding adult foster care following the conversion of these services to a Medicaid home and community-based waiver program.

Recommendations:

1. Amend the current Medicaid home and community-based care waiver for the elderly and disabled to permit provision of personal care services when the Medicaid waiver eligible client is residing in an approved adult family/foster care home.

2. Explore the feasibility of allowing foster care homes to be enrolled as personal care providers.

3. Await the publication of the federal regulations implementing Section 1929 of the Social Security Act before consideration is given to including personal care as an optional service under the State Plan for Medical

Assistance

4. Request the Secretary of Health and Human Resources to study adult foster/family home approval procedures and requirements to determine if they need to be revised to assure statewide uniformity and to assure that the requirements are coordinated with other long term care community services before allowing Medicaid payments to be made directly to adult foster/family homes.

THERAPEUTIC FOSTER CARE FOR CHILDREN:

Therapeutic foster care differs substantially from traditional or "regular" foster care. Whereas the primary function of regular foster care is to provide a substitute family environment, the primary function of therapeutic foster care is to provide a treatment environment for troubled children. The treatment is agency-led and team-oriented.

Therapeutic foster care is a setting for children whose treatment needs can best be met in a family setting as opposed to a residential facility or inpatient hospital setting. In the preferred therapeutic foster home model, the foster parents carry the main treatment responsibility for the child and are trained, supervised and assisted by professional staff of a licensed child care agency.

Therapeutic foster care is an emerging treatment modality which replaces institutional placement with community-based and family-based services. This movement is reflected in Virginia by the work of the Virginia Council on Community Services for Youth and Families which has proposed a reformed system of care for troubled and at-risk youth and their families. One of the charges to the Council was to seek ways to increase funding for services to children by exploring expanded Medicaid funding of services currently reimbursed by state and local funds. Models of therapeutic foster care are currently funded by the Department of Social Services and the Department of Youth and Family Services.

Under federal law, Medicaid payments may not be made for the costs of room and board except in inpatient medical facilities. However, the special therapeutic activities of the foster parents and the monitoring, supervision and supportive activities of the child placing agency can be reimbursed by Medicaid as a rehabilitative service to treat the child's emotional illness.

Recommendations:

1. Approve Medicaid payment for the therapeutic services of specially trained foster parents in homes licensed as

therapeutic foster homes and for the case management and oversight activities of licensed child placing agencies operating therapeutic foster home programs. The State Plan should include specific service definitions which distinguish these services from regular foster care. Moreover, the State Plan should identify specific qualifications which Medicaid enrolled provider agencies must meet to assure that agencies enrolled in Medicaid have the capacity and skills to treat children with emotional and behavior problems.

2. In the initial phase of the new service program, limit the coverage to those children in custody of public agencies in therapeutic foster home placements now licensed by the Department of Social Services. It is acknowledged that there are individualized therapeutic homes which care for children still in the custody of their own parents; however, more careful study of these homes and their operation needs to be undertaken before Medicaid coverage is extended to them. Care should be taken to develop Medicaid coverage of this service in coordination and cooperation with the approved plan of the Interagency Council on Community Services to Children and Families.

3. Study further the issue of local funding of therapeutic foster homes. At the present time, initial payments by local social service agencies are reimbursed at 80% federal funds from the Social Services Block Grant (SSBG) and 20% local funds. When the local agency SSBG allocation is exhausted, expenditures are reimbursed from state and local foster care funds (50% state, 50% local). Medicaid is presently funded at 50% federal and 50% state funds. Without an adjustment of funding ratios for these services, Medicaid coverage of therapeutic foster care may not result in any savings in General Fund expenditures or, under certain circumstances, may result in greater General Fund expenditures.

4. Admissions to Medicaid covered therapeutic foster care must be preauthorized by an interagency case planning team at the local or state level to assure that the placement is appropriate for the child, and that the child's needs cannot be met in a less intensive environment.

SPECIALIZED FOSTER CARE FOR CHILDREN WHO ARE MEDICALLY ILL

Specialized foster care is used in this report to denote foster home care serving children with special medical needs. These children often present special placement problems for local departments of social services. In specialized homes which care for children with special medical needs, the foster parents may require special training or may have additional responsibilities to meet the special needs of children with complex health conditions.

In order to recruit and retain foster parents to care for such children, the agency pays them an additional stipend each month.

Often the medically ill foster child requires many more hours of hands on care than the ayerage foster care child because of physical impairments which prevent them from performing activities of daily living such as bathing, dressing, toileting and eating which healthy children perform independently. Provision of the services of a Personal Care Aide would assist the foster parents in this time and energy consuming task.

Medicaid allows payment for Personal Care through a home and community-based care waiver for individuals who would otherwise require care in a nursing facility, and Medicaid regulations also permit the provision of Personal Care Services under the provisions of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Medicaid Personal Care Services could provide a resource to assist foster parents in caring for children with physical impairments. These services can be provided through the EPSDT program without requiring the child to be approved for participation in the elderly and disabled home and community-based waiver program through which Personal Care Services are now reimbursed. Local departments of social services would have to secure preauthorization of Personal Care Services from the Department of Medical Assistance Services for foster care children under EPSDT.

Recommendation:

The Department of Medical Assistance Services should provide technical assistance to local departments of social services in EPSDT preauthorization requirements to obtain personal care services for children in foster care.

I. STUDY ORIGIN AND ORGANIZATION

The purpose of this study was to examine the feasibility of Medicaid coverage of therapeutic or personal foster care for adults and children. This report contains the findings of the study and is divided into several major sections. First, the report describes the federal statutory requirements for Medicaid which have an impact on any evaluation of expanded Medicaid coverage. Then the report sets forth separately the findings and recommendations regarding Medicaid coverage of adult family care, therapeutic foster care for emotionally disturbed children and specialized foster care for children with special medical needs.

II. MEDICAID OVERVIEW

Medicaid, authorized under Title XIX of the Social Security Act, provides health care financing within a statutory framework. Medicaid is an entitlement program which means that all individuals in the Commonwealth who apply for Medicaid and who meet the eligibility criteria set forth in the State Plan for Medical Assistance must be enrolled. The State Plan sets forth the services to be covered based upon Section 1905(a) of the Social Security Act. The statute defines some of the services listed in 1905(a) as mandatory and some as optional. States have considerable latitude to define the amount, duration and scope of optional services but must obtain the approval of the Health Care Financing Administration (HCFA) United States Department of Health and Human Services (HHS). The vehicle for obtaining this approval is the State Plan for Medical Assistance which is a contract between HCFA and the state. Payments for services made pursuant to an approved state plan qualify for federal matching funds.

The entitlement provisions of Title XIX have major service and financial impacts which any state must carefully consider when deciding to amend its State Plan for Medical Assistance. Any evaluation of expansion of Medicaid services must refer to these basic statutory requirements and exceptions.

Title XIX of the Social Security Act sets forth specific requirements a state must meet in administering Medicaid.

1. The program must be operated statewide and services must be available statewide in sufficient amount, duration and scope to reasonably achieve their purpose and generally accessible to Medicaid clients to the same extent that the service is available to the general population.

2. For the group of eligible individuals called the Categorically Needy, the state must cover:

   - inpatient hospital services;

- o outpatient hospital and rural health clinic services;
- o laboratory and x-ray services;
- o nursing facility services;
- o Early, and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
- o family planning services and supplies;
- o physician services; and
- o home health services.

The services available to any categorically needy recipient under the plan may not be less in amount, duration and scope than those services available to a medically needy recipient, and the plan must provide that the services available to any categorically needy individual are equal in amount duration and scope for all categorically needy.

3. For the group of eligible individuals called the Medically Needy, the state must cover at least:

   - o prenatal and delivery services for pregnant women; and
   - o ambulatory services for children under age 18 and for individuals entitled to institutional services.

   The state plan must provide that the services available to any medically needy individual are equal in amount, duration and scope for all recipients within a covered medically needy group, e.g. all medically needy children are entitled to the same coverage.

   In Virginia, the State Plan covers the same services for medically needy as for categorically needy except for intermediate care facility services in facilities for the mentally retarded (ICF/MR) and services in facilities primarily serving the mentally ill and which meet the federal definition of an institution for mental diseases (IMD).

4. A state is prohibited from arbitrarily denying or reducing the amount, duration or scope of a mandatory service to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition. However, with an optional service, states may impose limits which

target the service to specific populations, disabilities or illnesses.

Exceptions:

1. States must pay whether or not the service is covered under the State Plan for all medically necessary services required to treat a condition detected through an EPSDT screening if the service is listed in Section 1905(a) of the Social Security Act.

2. There are some specific services which the statute exempts from comparability or statewideness requirements, e.g. targeted case management, and prenatal services for pregnant women.

3. States may request a waiver of statewideness, comparability and amount, duration and scope under Section 1915 of the Social Security Act to offer services not covered in 1905(a) of the Act if those services are necessary to keep a recipient out of an institution and if the aggregate expenditures under a waiver do not exceed the estimated expenditures for institutional services for the same population in the absence of the waiver.

Medicaid home and community-based care waivers are special programs authorized under Sections 1915(c) and (d) of the Social Security Act to permit Medicaid funds to purchase services for individuals who otherwise would be placed in a nursing home at Medicaid expense. Under the provisions of the Social Security Act, the Secretary of Health and Human Services may grant a State a waiver of the statutory requirements that Medicaid services be offered statewide and that the same services be offered to all Medicaid recipients. Both of these requirements are entitlement features. By granting a state a waiver, the Secretary is authorizing the state to offer the services only to those who would qualify for a Medicaid nursing home payment.

Section 1915(c) requires that a state may be granted a waiver only when it assures that the payments under a waiver will not exceed the amount of funds that would be paid for waiver eligible clients if they had gone to a nursing home in the absence of the waiver. Section 1915(d) differs from Section 1915(c) in that it does not require this assurance. Instead, 1915(d) requires that the state assume the full cost of services without federal matching funds once the expenditures under the waiver exceed those projected to be spent without the waiver. Oregon is the only state to have obtained a

1915(d) waiver and has so far avoided any losses.

Without the special authority granted under the waiver to waiver entitlement requirements (like statewideness and comparability), the state would have to provide the service to every qualified individual even if the cost was higher and even if the individual would not have been eligible for a nursing home.

Virginia has had a Section 1915(c) home and community-based care waiver program approved by the Secretary of Health and Human Services since 1982. Virginia's current program covers personal care aide services, adult day health care and respite care. Other services may be added to the waiver as long as the overall services remain cost effective.

III. ADULT FOSTER CARE

A. Background:

Care for the Elderly and Disabled has long occupied the attention and resources of public policy makers. During the decades of the 1970's and 1980's, and now into the 1990's, states have struggled to keep up with the growth in the cost of caring for the increasing numbers of elderly individuals who are living longer and have greater impairments. By the year 2000, it is estimated that there will be 799,550 citizens in Virginia over the age of 65. Of these, it is estimated that 85,000 will be Medicaid eligible. Most elderly individuals live independently for years but then as changes in their health begin to occur, many require assistance in maintaining their independence. As they become more physically frail, they become less able to perform activities of daily living like shopping, house and yard work, laundry, etc. and then, with increasing frailty, bathing, dressing, toileting and eating. Families initially provide the bulk of care-giving for elderly relatives; however, as the elderly relative becomes more frail, families may "burn out" or the care needs of their elderly relative become so great that the family can finally no longer manage without the assistance of a formal care-giving system.

The formal care-giving system is operated by both public and private agencies and these agencies provide various levels of service that are consistent with the needs of the individuals served. The services provided include: home-based services like chore, companion, personal care aide and home health services; residential services like supervised apartments, assisted living centers, continuing care centers, and homes for adults; and finally, health care facilities like nursing homes and geriatric hospitals. An individual may move between any of these service levels at various times depending on their overall health status and physical functioning. The need for a particular service may be short or long term.

For a number of years, the Commonwealth has sought to develop a continuum of long term care services to assure that the frail elderly and disabled receive the services they need in the least restrictive environment thus assuring that they maintain their independence as long as possible. Since 1972, Medicaid has been a major funder of long term care services in the Commonwealth. During Fiscal Year 1991, Medicaid paid $462,067,046[1] for long term care services. The following Table identifies the long term care services, the expenditure for each service and the number of recipients who benefitted from each service in FY 91.

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[1]1991 State HCFA 2082 Report

SERVICE	EXPENDITURES	RECIPIENTS
Home Health	$ 14,173,905	8,819
Personal Care	$ 9,115,070	5,889
Adult Day Health Care	$ 239,405	93
Respite	$ 47,412	40
Nursing Facility	$310,296,036	26,951
Geriatric Mental Hospital	$ 17,804,033	640
Mental Retardation Facility	$128,108,023	2,869

Other state agencies also administer important community-based and residential long term care services. The Department for Aging has provided home delivered and congregate meals, home maintenance, and senior center programs. The Department of Social Services administers services partially funded through the Social Services Block Grant, General Fund appropriations and local funds for chore and companion services delivered in the homes of eligible clients. The Auxiliary Grant Program has assisted the elderly and disabled to pay the cost of care in homes for adults and adult family care homes.

B. Funding Models of Adult Foster Care:

Nationally, there are three models for funding adult foster care: 1. Medicaid payment for supplemental services as part of an optional service package under the state plan for medical assistance; 2. Payment for foster care services under a Medicaid Home and Community-based Care Waiver 3. Payment through state and local funds;

1. A Program funded through Medicaid as an Optional State Plan Service

The Massachusetts Adult Foster Care Program

The Massachusetts Adult Foster Care Program is designed to provide room, board and personal care services in a family-like setting to elderly or disabled individuals who are at imminent risk of institutional placement. Clients of Adult Foster Care include individuals who reside in the community or who are hospitalized and who are at high risk of requiring nursing home placement, patients in nursing homes who would benefit from living with a host family and chronically disabled individuals who require supervision. Adult foster care participants may require 24-hour supervision, assistance with activities of daily living such as bathing, dressing, walking and assistance with management of medications. The participant's primary care physician must certify that adult foster care services are appropriate to meet the medical needs of the participant.

The Massachusetts program requires that the participant be able to understand his responsibilities under the program and requires the participant to sign an agreement to pay his or her share of the cost of care at the beginning of each month for room and board. The participant must agree to follow the plan of care established with the provider, the physician and the family. The participant must:

- Be able to communicate his or her needs and be oriented to time, place and person although he may have intermittent periods of confusion or forgetfulness;
- Ambulate and transfer independently or with the assistance of one other person;
- Require supervision and may require some assistance to perform activities of daily living such as bathing, dressing, toileting, and eating with supervision or limited assistance;
- Be continent on admission to the family home or be an active participant in an ongoing bladder/bowel program;
- Be able to take medications independently or may require supervision with medications; and
- Not exhibit behavior harmful to himself or others.

Providers of adult foster care for disabled/elderly adults include certified home health agencies, licensed hospitals, home care corporations and other community agencies or organizations who wish to offer services and meet the provider requirements. The provider agencies recruit, train and monitor foster families. Foster families must be approved by an enrolled Adult Foster Home Program provider agency and meet stipulated characteristics. The foster family must not abuse alcohol or drugs, have no physical or emotional problems which would interfere with the provision of appropriate care, and have sufficient family income so that they do not rely substantially on the income from foster family care payments. The Massachusetts program does not reimburse natural family members for providing personal care services and specifies which degree of relationships are excluded. Excluded relationships are: children, parents, siblings, grandparents, stepparents, uncles and aunts, nephews and nieces and relatives by marriage.

Massachusetts imposes specific physical requirements for the foster home. These include size, cleanliness, food preparation, bathing facilities, bedrooms and safety and fire protection. The home must be accessible to meet the specific needs of the physically handicapped participant.

The foster family must provide 24 hour supervision to the participant, keep the participant's room clean and provided with fresh linens, provide personal laundry, provide 3 meals a day and snacks. The foster family must provide supervision and assistance with activities of daily living, assist with shopping, provide or arrange for transportation, and provide supervision of health related activities such as reminding the participant to take his medications, securing refills for prescriptions, assisting with or arranging for regular physician care and promptly obtaining medical care from the physician should the participant become ill. The foster family home must also manage and maintain complete records of the participant's personal funds if requested by the participant.

Foster homes must be approved by the enrolled provider agency. All placements are arranged by the provider agency. The provider agency must interview the potential participant together with a home health agency staff nurse or the hospital's continuing care coordinator to obtain information about the general health, psycho-social condition and the nutritional habits of the applicant, a description of the participant's previous home support system and other relevant data.

The program director matches each applicant with a suitable foster family. Each participant and foster family must sign a letter of agreement which states clearly each party's responsibilities prior to the participant's admission to the foster home. The provider agency is required to monitor the adjustment process for both the participant and the family. On site visits are required weekly during the first four weeks and monthly thereafter.

If the placement is not successful or the participant's condition changes, the provider agency is responsible for arranging an alternative placement or discharge from the service. The circumstances under which the provider may terminate services is carefully controlled.

The program has a complicated and extensive set of requirements covering leaves of absence, and record keeping.

Foster families are approved for up to two participants. In rare instances, a third participant may be admitted if the requirements for approval are met. Only the Massachusetts Department of Public Welfare may authorize a foster home to admit a third resident.

The Massachusetts program has 13 adult foster care agencies. The unduplicated census for the last program year was 569 foster home clients. The average monthly census of

clients in foster homes is 362 and 94% of them are Medicaid eligible. Forty-three per cent of the residents of foster homes are under age 60 and many of these are mentally retarded.

The client pays $9 a day from his own income to the host family for room and board. Medicaid pays an average of $32.53 per day for foster care. The payment is divided into two units: $13.60 per day paid to the host family for personal care services and $18 per day paid to the foster care placement agency for supervision of the placement. This latter fee is designed to cover the foster care agency's administrative cost for staffing, maintenance of clinical records and activities such as home finding, client placement and 24 hour emergency assistance. The latter fee is paid from Medicaid administrative funds, not service funds.

2. A Program Funded through a Medicaid Home and Community-Based Care Waiver -

The Oregon Adult Foster Care Program

According to a report in "State Health Notes", Oregon has the nation's largest network of adult foster care homes.[2] The Oregon Adult Foster Care Program has been an integral part of the continuum of home and community-based services covered under a Medicaid waiver. Nineteen per cent of Oregon long term care clients reside in foster homes.[3] Oregon operates its Medicaid home and community-based care programs under both Section 1915(c) and 1915(d) waivers. Its adult foster home program is operated under the Section 1915(d) waiver. (See Section II of this report.) Unlike Massachusetts, Oregon Medicaid will enroll individual foster homes as Medicaid providers.

In Oregon, an Adult Foster Home (AFH) means "any family home or other facility in which residential care is provided for compensation to five or fewer elderly or disabled adults who are not related to the provider by blood or marriage."[4] These homes include specialized living facilities for physically handicapped persons so long as the personal care

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[2] Wessner, Connie; "State Health Notes"; published by the Intergovernmental Health Policy Project, George Washington University, Number 116, September, 1991, Page 3.

[3] Ibid.

[4] Section 411-50-400.(4), "Administrative Rules for Licensure of Adult Foster Homes", State of Oregon. November 1, 1988.

services are provided by the adult foster home provider and not an outside agency. All adult foster homes are required to be licensed. Although the home may exceed the five person limit with special permission, the criteria for granting exceptions are very strict. Homes may be operated in such a way that the care is provided by resident staff.

Case Managers provide client assessment, care planning and placement decisions for public paying residents under a comprehensive case management system which authorizes all care under the home and community-based waiver. Individuals are approved for adult foster home placement in lieu of a nursing home. There is a uniform functional assessment and the payment to the home for personal care services varies based upon the level of functional impairment as determined through the assessment.

In all Section 1915 waivers, clients must participate in the cost of their care if they have countable income which exceeds the maintenance standard. The client is allowed to keep a portion of his own income (the maintenance standard) to pay for room and board because Medicaid cannot pay for room and board costs under a 1915(c) waiver.

3. A Program funded with State and Local Funds -

<u>The Virginia Adult Foster/Family Care Program</u>

The Virginia Adult Foster/Family Care Program provides room and board, supervision and special services to an adult who has a physical or mental condition or an emotional or behavioral problem. The adult must be incapable of living independently or unable to remain in his own home. Adult Foster/Family Care must be provided in a home that has been approved by the local department of social services and the home may provide care for no more than three adults. (Homes which care for more than 3 unrelated adults must be licensed as a Home for Adults.) The adult foster/family home providers give room and board, supervision and special services.

The Adult Foster/Family Care Program provides a nursing home placement alternative for some adults and maintains them in the least restrictive, most appropriate setting. It also provides transitional services for handicapped emancipated foster care children who are in need of continued agency services.

Virginia's Foster/Family Care Program is really two programs which are closely related but funded from two different sources. Adult Foster Care is funded by 80% federal funds through the Social Services Block Grant (SSBG) and 20% local funds. Social Service Block Grant Funding is capped.

Adult Family Care is funded by the Auxiliary Grant Program (AG) with 80% state and 20% local funds. The programs are complimentary in that Adult Foster Care Homes and Adult Family Care Homes have to meet identical requirements. Fourteen localities operated Adult Family Care programs through Auxiliary Grants and the total expenditures under Auxiliary Grants were $22,293. The General Fund appropriation for adult family care for FY 90-92 is $350,000. Three localities offer services under the Adult Foster Care program and thus use funds from the SSBG: Chesapeake, Portsmouth and Virginia Beach. Expenditures for Adult Foster Care in FY 91 were $31,856.96. The average cost per individual served is approximately the same in both programs.

Individuals who receive Auxiliary Grants must meet categorical and financial eligibility criteria and must apply their income toward the cost of care at the family care home. Auxiliary Grants will supplement their payment up to the state established maximum payment. At the present time, there is no uniform assessment process to determine the necessity of adult family care placement, nor is a physician certification for the service required. Local departments of social services adult service workers evaluate each case individually and approve the placement.

Individuals who receive funding for Adult Foster Care through the Social Service Block Grant, do not have to meet state established eligibility standards. Local social service agencies have flexibility in the use of SSBG funds and may set their own requirements.

All providers of Adult Foster/Family Care must be approved by a local department of social services in order to receive a payment through either the SSBG or AG program. The Department of Social Services has standards which govern approval as a Foster/Family Care Home. These standards stipulate that adult foster/family care providers must be at least 18 years of age, not have been convicted of a felony or misdemeanor which jeopardizes the safety or proper care of clients, successfully demonstrate that they are able to care for the client, and have sufficient financial income or resources to meet the family's basic needs. The provider must submit evidence that he and his family is free of tuberculosis. The provider must have a plan for obtaining aid in an emergency and the provider must supply three meals a day appropriate to the daily nutritional needs of the client including special diets if prescribed by a physician. The provider may assist the client to take medications ordered by his physician. The provider shall have sufficient and appropriate space and furnishings for each client including sleeping space on the first floor for non-ambulatory residents. No more than two adults shall share a sleeping

room and the home must provide space for privacy for the adult to entertain visitors. All homes must be free of safety hazards.

Relatives of an AG eligible disabled or elderly candidate for adult family care may be approved as an adult family care provider but the relative must be to accept other clients in his home to which he is not related if they are referred by the department of social services. Relatives are allowed to be approved as adult family care providers in order to strengthen the services and support already provided to family members and create additional placements in adult family care.

C. Another Potential Funding Model For Medicaid Coverage of Services in Foster Homes:

The Omnibus Budget Reconciliation Act of 1990 added a new Section 1929 to the Social Security Act called Home and Community Care for Functionally Disabled Elderly Individuals. This section allows states the option to provide one or more of the following services as a Medicaid optional service: homemaker, home health aide, chore services, nursing services, respite care, personal care services, training for family members and adult day care. In addition, states may choose to offer day treatment, partial hospitalization, clinic services or psychosocial rehabilitation for a person with mental illness; and other services as the Secretary may approve.

To be eligible for service under Section 1929, an individual must be 65 years of age or older, meet the Supplemental Security Income Program income and resource standards (or more restrictive requirements in states like Virginia which apply additional eligibility criteria) or be medically needy. Eligible individuals must also be unable to perform at least two of three of the following activities of daily living (ADLs) without substantial assistance from another person: bathing, dressing, toileting, transferring, or eating. A person who has Alzheimer's disease and needs substantial human assistance with two of five ADLs (bathing, dressing, toileting, transferring, eating) or who needs substantial supervision to monitor inappropriate behavior is also eligible.

To determine eligibility for the Section 1929 services, the state must conduct an interdisciplinary assessment. This assessment can be performed by a public or private agency which has no direct or indirect affiliation to an entity which provides institutional or community services. The assessment serves as the basis for an Individual Community Care Plan which is developed by a case manager and reviewed every 90 days. Case management may be provided by a public or private non-profit agency; however, if the agency is private, it cannot be an agency which provides institutional or community services.

Services may be offered in the recipient's home or in a "community care setting". A community care setting may be large (8 or more residents) or small (more than 2 but less than 8 residents), residential or non-residential. Thus, these services may be offered in adult foster/family homes since such settings would be considered the client's home.

Section 1929 of the Social Security Act contains strict requirements for maintenance of effort and imposes a cap on the amount of federal funds that may be allocated to states electing to participate in this program through 1995 ($70 million in FFY 92, $130 million in FFY 93, $160 million in FFY 94 and $180 million in FFY 95). States electing to participate are required to continue coverage for a minimum of 12 months. Participating states must also agree to continue to implement the program even if the allocation of federal funds is insufficient to fund the usual federal match for the full 12 months.

The Secretary of Health and Human Services has not yet issued implementing regulations for this section. Without regulations, states have no protection from unexpected federal requirements and no assurance of the stability of federal funding. The capped federal funds are to be allocated among participating states based on the per capita percentage of elderly individuals in their population. Because of a defect in the wording of the section which governs the allocations, a state currently electing to participate must do so without knowledge of how many other states will be allowed to participate within the federal fiscal year. At the present time only Texas and Florida have elected to participate. Virginia could elect to participate based upon the amount of federal funding available in the 1992 federal fiscal year only to find that other more populous states joined the program in subsequent quarters. If that were to happen, the amount of federal funds available to Virginia would be substantially reduced but Virginia could not terminate participation. Federal authorities have indicated that they intend to issue regulations which will correct this problem and in the interim are advising inquiring states about this potential funding dilemma.

Section 1929 of the Social Security Act may provide an avenue to offer personal care services in foster homes and even in homes for adults. However, it is not possible to project the cost of adopting coverage under this option until the federal regulations are issued. There are less federal restrictions on the coverage provided under Section 1929 than under a Section 1915 waiver because states are assuming all the financial risk if expenditures exceed available funding. States are required to maintain expenditures at current levels and accept major entitlement provisions without assurance of full federal funding. However, this option may be limited to less than statewide implementation and other benefit limits.

It is important to keep in mind the restriction on eligibility to persons age 65 and older when evaluating Section 1929. Many persons appropriate for adult foster/family care are under age 65. In 1991, 31% of all Auxiliary Grant recipients in adult family care were under the age of 65. Because of this factor, if Section 1929 is adopted in Virginia, it would be advisable to provide coverage of personal care in adult family homes as part of the home and community-based waiver for those under age 65.

Finally, any decision to adopt Section 1929 coverage under Medicaid should be closely coordinated with other efforts underway through the Long Term Care Council and the Home For Adults Task Force studying levels of care in Homes for Adults. Adult Foster/Family Care is only a part of a larger long term care system for the elderly and disabled. Each part of the system must be carefully coordinated with all other parts.

D. Problems and Concerns About Expanding the Adult Foster Home Program in Virginia:

1. Placement Services-

The Adult Foster/Family Home Program in Virginia is very small. It has been implemented as a local option program and its growth has been dependent upon the interest and resources of the individual local department of social services. An Adult Foster/Family Home Program is labor intensive; each home must be approved and monitored closely. Clients must be assessed and determined to need care and be suitable for foster home placement in lieu of home for adults or nursing home placement. Clients must be carefully matched to a foster home with which they can be compatible and which can meet their care needs.

In Fiscal Year 1991, only 17 of Virginia's 124 local departments of social services elected to participate in adult foster/family care. Because of the constraints imposed by the limited resources available to local agencies, adult foster/family care will probably remain small; however, if funding can be shifted to Medicaid, more resources may be available for program growth. In Massachusetts placement services are purchased from the private sector. Such arrangements could be instituted in Virginia but should be studied carefully before a decision is made that such a system is desirable for Virginia.

Unlike nursing homes or homes for adults which are carefully regulated congregate living sites, adult foster/family homes house only one to three residents. This dispersion of clients makes monitoring more costly and difficult and, at the same time, the small setting makes it more difficult to evaluate the care.

If the Medicaid Home and Community-based Care waiver were to

be used as the vehicle for Medicaid coverage of personal care in foster homes, the administrative structure to assess the client's need for the service and refer for services is already present in the Nursing Home Preadmission Screening Program which performs screening for Medicaid home and community-based care services as well as nursing homes. In addition the Department of Medical Assistance Services performs utilization review and quality assurance activities for all waiver clients.

2. Approach to Provider Recruitment:

The Massachusetts program relies on the private sector to provide foster homes. The parent agency also provides other kinds of health care. These private agencies can approve foster homes without state agency licensure. The state approves the provider agency who then recruits foster homes and places public paying clients in them. The state regulations set minimum standards that provider agencies are required to follow.

Such an approach in Virginia would relieve the administrative pressure on local departments of social services to approve foster homes but would require regulatory revision. Such action should be approached carefully in order to assure that foster homes meet uniform quality standards.

If adult foster care were expanded through Medicaid coverage and the present system for foster home approval continued, the administrative impact on the local departments for approval of additional foster care homes must be considered. There would be additional administrative costs to the Department of Social Services due to program expansion; however, if Medicaid funds were tapped to replace Social Service Block Grant funds or state and local funds now used to purchase foster care, these funds will be available to cover the additional administrative costs.

Another possible avenue to increase the availability of Virginia's foster homes serving the frail elderly is to approve qualified foster home providers as personal care providers. This option would require the provider to have special training and would also necessitate the provision of registered nurse supervision to the foster home. Groups of homes could contract for this service through a home health agency or other entity. This option would take considerable development and further study prior to its implementation.

3. Cost:

In this time of fiscal constraint, it is important that the long range budgetary impact of new program development be carefully evaluated. The Massachusetts approach involving the private sector is the approach which can be expected to have the greatest growth

potential. The private sector can expand to provide this service without the necessity for funding and staffing approval of state and local governments. This approach is, therefore, attractive when the need for additional non-institutional alternatives is considered. No special certificates of public need are required to develop additional foster homes and the only constraint is the funding and the availability of foster homes.

However, with Medicaid's entitlement requirements, adding personal care as a state plan option service could have substantial fiscal impact implications in view of the number of frail elderly living at home and in homes for adults. Medicaid currently offers personal care services through the existing home and community-based care waiver for the elderly and disabled. Expanding the waiver by allowing payment for personal care services in foster care homes as well as in a client's own home would require no additional funding but would provide an alternative for the individual at risk of institutional placement.

E. Recommendations:

1. Amend the current Medicaid home and community-based care waiver for the elderly and disabled to permit provision of personal care services when the Medicaid waiver eligible client is residing in an approved adult foster/family care home.

2. Explore the feasibility of allowing foster/family care homes to be enrolled as personal care providers.

3. Await publication of the federal regulations implementing Section 1929 of the Social Security Act before consideration is given to including personal care as an optional service under the State Plan for Medical Assistance

4. Request the Secretary of Health and Human Resources to study adult foster/family home approval procedures and standards to determine if revision is necessary to assure statewide uniformity and to assure that the requirements are coordinated with other long term care community services.

IV. THERAPEUTIC FOSTER CARE

Therapeutic foster care is a setting for children whose treatment needs can best be met in a family. Often these children cannot receive the treatment they need in their own home but their needs can best be met in a family setting. Residential or inpatient treatment is not the best treatment milieu for all children. According to recent developments in treatment philosophy for children, treatment should take place in the least restrictive, community-based, family-oriented service alternatives. "Therapeutic foster care can be defined as a service which provides treatment for troubled children within the private homes of trained families. The approach combines the normalizing influence of family-based care with specialized treatment interventions, thereby creating a therapeutic environment in the context of a nurturant family home."[5]

There has been a recent proliferation of therapeutic home programs which have a variety of names and characteristics. This has made it difficult to define the programs consistently. In some models, agency staff carry the main responsibility of therapist; in others, the foster parent is the main therapist but receives supervision and support from trained professional staff in the licensed child placing agency. Child placing agencies may be either public or privately operated. But, however different the models and labels, the program is distinct from traditional or "regular" foster care. "The primary function of regular foster care is to provide a substitute family environment for dependent children, whereas the primary function of therapeutic foster care is to provide a treatment environment for troubled children."[6]

The distinctions between regular foster care and therapeutic foster care are substantial. They pertain to the types of persons recruited as foster parents, the training and preparation required for their role, and the supervision they receive from the placing agency. Although regular foster parents are usually volunteers selected because they are willing to take a child into their home and give it nuturance and custodial care, the treatment foster parents "are selected based upon their skills and motivation to

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[5] "Series on Community-based Services For Children & Adolescents Who are Severely Emotionally Disturbed: Volume III: Therapeutic Foster Care", CASSP Technical Assistance Center, Georgetown University Child Development Center, (Washington, 1989), p. 13.

[6] Ibid.

handle the challenges posed by severely disturbed children."[7] For this reason the cost of therapeutic foster care is much higher than regular foster care payments. This additional payment compensates the foster parents for the skill, effort and difficulties involved in caring for these children with emotional problems and the unique therapeutic role they play in the child's treatment.[8]

Therapeutic foster care is designed to conduct therapeutic intervention programs with clearly stated treatment goals within the home environment. Treatment parents are provided extensive training. This training is designed to provide treatment parents with the coping skills and intervention techniques to implement treatment programs for children in their care. Extensive professional assistance and supervision is provided by the professional agency overseeing the therapeutic foster home placement.[9]

The Foster Family-based Treatment Association (FFTA) has defined "Treatment Foster Care as " a program for children, youth and their families whose special needs can be met through services delivered primarily by treatment foster parents, trained, supervised and supported by agency staff.[10] The FFTA has further defined a program as "a coherent, integrated constellation of services specifically designed to provide treatment within a foster home setting." Treatment foster care is agency-led and team-oriented. "It is not simply the provision of higher payment and more training to foster parents for work with more difficult children and youth."[11]

Some other names which describe this same therapeutic approach include:

Special foster care
Specialized foster care
Intensive foster care
Treatment foster care
Family treatment homes
Individualized Residential Treatment
Teaching homes
Professional foster care
Professional treatment homes
Foster family-based treatment
Treatment Family Care

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[7]Ibid.

[8]Ibid.

[9]Ibid.

[10]"Program Standards for Treatment Foster Care", Published by the Foster Family-based Treatment Association, 1991, p. 6.

[11]Ibid.

Models of therapeutic foster care are funded by the Department of Social Services, the Department of Youth and Family Services and the Department of Education. These programs are called by some of the names in the list above, but they are administered according to the model described.

For many years, the usual method of treatment for disturbed children was institutional or residential admission. Now there is a movement away from institutional admissions and toward providing community-based and family-based services. This movement in Virginia is reflected in the work of the Virginia Council on Community Services for Youth and Families. This organization, was established by the Secretaries of Health and Human Resources, Education and Public Safety in the Spring of 1990 to make significant changes and improve the current system of services to children who would otherwise be placed in residential treatment facilities. It is comprised of 145 people from the public, private and family sectors. The Council has proposed a new direction for services that is child centered, family focused and community based. According to the "Proposal for Community Systems of Care and Support For Virginia's Troubled and At-Risk Youth and Their Families", published this past summer, the Commonwealth should preserve families and serve children in the least restrictive setting while protecting child welfare and public safety.

One of the charges of the Council is to seek ways to increase funding for services to children by exploring expanded Medicaid funding for services currently reimbursed by state and local funds. Medicaid is a program funded jointly by federal and state funds and Virginia could realize savings by converting services to Medicaid which are now funded through state and local funds.

Several states have begun Medicaid reimbursement for parts of the cost of foster care. Federal regulations prohibit Medicaid payment for room and board costs. However, a significant portion of the daily costs of therapeutic foster care are for special therapeutic activities of the foster parents and for the monitoring, supervision and supportive activities of the child placing agency responsible for the overall plan of treatment for the child. Medicaid can cover these costs under rehabilitative services and case management options.

Recommendations for Medicaid Covered Therapeutic Foster Care:

1. It is recommended that Medicaid payment be approved for the therapeutic services of the specially trained foster parents in homes approved as therapeutic foster homes and for the case management and oversight activities of licensed child placing agencies operating therapeutic foster home programs. The State Plan should include specific service definitions which distinguish these services from regular foster care. Moreover, the State Plan should spell out specific qualifications which Medicaid enrolled

provider agencies should meet to assure that agencies enrolled in Medicaid have the capacity and skills to treat children with emotional and behavior problems. The Medicaid fee should be set at a level that will assure that the General Fund expenditures under Medicaid do not exceed the General Fund expenditures that would have been paid for these children under the state and local foster care program.

2. In the initial phase of the new service program, the population to be served should be those children in placements now approved by the Department of Social Services as foster home programs and restricted to children in the custody of public agencies. It is acknowledged that there are individualized therapeutic homes which care for children still in the custody of their own parents; however, more careful study of these homes and their operation needs to be undertaken before Medicaid coverage is extended to them. To allow for coverage within existing appropriations, care should be taken to develop Medicaid coverage of this service in coordination and cooperation with the approved plan of the Interagency Council on Community Services to Children and Families.

3. It is further recommended that there be careful study of the issue of local funding of therapeutic foster homes. At the present time, initial payments by local agencies are 80% federal funds from the Social Services Block Grant (SSBG) and 20% local funds. When the SSBG allocation for a local agency is exhausted, additional expenditures come are reimbursed from state and local foster care funds (50% state, 50% local). Medicaid is presently funded at 50% federal and 50% state. Without an adjustment of funding ratios, Medicaid coverage of therapeutic foster care might not result in any saving in General Fund expenditures and under certain circumstances, might result in greater General Fund expenditures.

4. Finally, it is recommended that admissions to Medicaid covered therapeutic foster care homes be preauthorized by an interagency case planning team at the local or state level to assure that the placement is appropriate for the child, and that the child's needs cannot be met in a less intensive environment.

V. SPECIALIZED FOSTER CARE

Specialized Foster Care and Therapeutic Foster Care are terms often used interchangeably. However, for purposes of this report, the two types are foster homes are different. Specialized foster care is used in this report to denote foster care in which difficult children are placed, but the foster child is not considered emotionally disturbed. Many foster care children are difficult to place and care for so the foster parent is specially trained, selected and matched to the foster child. The child may have special medical needs or may have special behavior problems, or a combination. In order to recruit and retain foster parents, the agency pays them an additional stipend each month which reimburses them for the additional costs required to care for such children.

Children who have special medical needs often present special placement problems for local departments of social services. Such children require many more hours of hands on care than the average child. Some require that the foster parents be health care professionals or that they perform assistance in activities of daily living such as bathing, dressing, toileting and feeding that healthy children perform for themselves. These are the children with which this report will deal. Children who are difficult to place because of non-medical reasons will not be addressed here since payment for their care is not relevant to Medicaid reimbursement.

One of the service programs under Medicaid is the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT). This program provides for comprehensive health evaluations, diagnostic and treatment services. The federal Medicaid statute requires Medicaid to pay for any service necessary to treat a condition detected through an EPSDT screening if that service is one listed in Section 1905(a) of the Social Security Act. Thus, if a foster parent needs Personal Care assistance in order to care for a child with special medical needs, then Medicaid can pay for that service even though it is not otherwise covered under the State Plan for Medical Assistance. Through the provision of this service, it may be easier to locate foster care placements for children with special medical needs who require greater than normal hands-on care.

No changes to the State Plan for Medical Assistance are required to implement EPSDT services; however, preauthorization from the Department of Medical Assistance Services must be obtained before payments can be made. Preauthorization procedures are

presently in place and local departments of social services require training in how to access Medicaid services through EPSDT.

Recommendation:

Train local department of social service's child welfare workers in EPSDT preauthorization requirements in order to obtain personal care services for children in foster care.

VI. APPENDIX

HOUSE JOINT RESOLUTION NO. 368

WHEREAS, many elderly and disabled individuals who enter nursing homes would prefer to remain in a more home-like setting; and

WHEREAS, the availability of a comprehensive continuum of noninstitutional long-term care services is necessary to assure that individuals receive the service most appropriate for their needs; and

WHEREAS, the cost of providing for the long-term care needs of Virginia's growing elderly and disabled populations consumes a significant portion of the financial resources of the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services is requested to study the feasibility of Medicaid coverage of therapeutic or personal foster care for adults and children who would otherwise have to be admitted to nursing facilities at Medicaid expense.

The Department of Medical Assistance Services shall complete its work in time to submit its findings and recommendations to the Governor and the 1992 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.