Meeting Summary/Minutes
Family First | Fiscal and Revenue Enhancement Workgroup
March 4, 2021 | 2:30 - 4:00 pm | MS Teams Meeting

Purpose and Goal

- The co-leads for the workgroup, Cindy Butterfield and Allison Blake, began the meeting by reviewing the workgroup's purpose and goal, which is to model the programs put forward by the Programs and Service Array workgroup (PSAWG) and advise the Governance Committee of the fiscal/revenue opportunities of developing its Family First Prevention Plan.
- The Governance Committee will make the final decision on which programs will be included in the plan.

The Analytical Process

- For this meeting, Fiscal will be focusing on Tier 1 models.
- PSAWG is still assembling its recommended Tier 3 models.
- Each Evidence-Based Program (EBP) will undergo a cost-benefit analysis focusing on the most relevant identified variables.
- We will look at several variables, including cost per slot and the necessary diversion percentage to breakeven (diversion from the caseload and diversion from foster care).
- As a reminder, Title IV-E is the payer of last resort, so programs that are funded by Medicaid or already funded by the state may not be eligible for Title IV-E.
- Foster care usually last around 13 months, and the average caseload length is 23 months. We will use these averages when looking at the cost of foster care or being on the DCF caseload.
- One person asked whether, seeing as it could take up to three years to see a result in certain programs and FFPSA is only one year, how do we take mismatched timeframes into account? Cindy explained that this is an imperfect process, and we may end up seeing short-term losses before we see long-term gains. JoShonda added that Family First services last for one year - at that point, we can do a redetermination to see if the child still needs the service, so in the question above, the child would not be hamstrung into just one year of service if more is needed.
- Another member asked about Medicaid services - could IV-E fill a gap? Cindy used Methadone Maintenance Therapy as an example. DCF works with DSS to pick this up. It is a Tier 1 service, which is good to keep in mind, but it is mostly funded through Medicaid. While it is true that IV-E might be able to cover some additional costs (e.g. administrative costs), this may not be the most effective plan.
- Cindy added that for each program, we will show what percentage bills to Medicaid. Some programs may have some parts covered by Medicaid, but not enough to be

considered a Medicaid-covered service. FFT falls into this category - although there is a small amount of Medicaid funding, the service overall is not funded this way.

- One person asked how DCF is predicting/measuring the percentage of children that would be diverted from care using the service. This was measured using the outcome data for the programs.
- The federal government allows latitude in terms of determining whether someone is eligible. We need to flag how folks fall into our candidacy definition but not "prove" they are at risk of foster care. The federal government is also primarily concerned with decreasing out of home placement, which includes residential treatment (in their definition).
- Cindy asked whether we are overlooking any key variables.
- One person asked whether we are looking at DCF costs or all costs. Cindy said we are mostly looking at DCF costs - we could expand out, but this is intended to look mainly at the short-term. We know that there is an intersection between DCF and other systems, but for now we want to generate that initial interest in funding prevention.
    - Homelessness, educational achievement, and incarceration will all be impacted by DCF; however, it is difficult to speculate on these outcomes. It would require a longer-term study that tracks outcomes and levels of risk in a wide pool, which is not feasible right now.
- One person asked about whether Tier 1 services reach every age group - is there a flip side for *not* providing services to a certain age group? Olivia Wilks (Chapin Hall) confirmed that PSAWG did take a look at these gaps.
- Given the complication of implementing this (a system initiative), one participant suggested going for the highest impact to children and families across the largest population without regard for the cost. If the service is high-impact, we will see the return over time. If we focus on a smaller population across many models, it gets complicated and is harder to analyze the impact.

Selected EBPs

- Most services are not Medicaid-reimbursable. Most are widely available in CT, except HFA and BSFT. The workgroup went through the services and offered feedback on the analysis for each service. Please see the slides for the content of the analysis (slides 10-14).

HFA

- One person pointed out that the duration of this service is around three years, and this should be reflected in the analysis. They wondered whether a shorter program might be easier to manage.
- Another person felt that it does have nice connections and benefits in the long term. The goal is to serve the whole household of pre-school aged youths.

- The severity level of the family/children also matters in the analysis - one provider has had conversations with the model developers and found that their staff is not as comfortable working with families at a greater risk. The expectations depend on the population being served.
- A member asked whether OEC has been involved with this model. Another member said that it is a model that OEC is supporting. There was an OEC staff member on the call, who explained that they could not talk too much about this due to an ongoing RFP. DCF confirmed that we will work with OEC representatives and take that into account as the Department is concerned with the overall system.
- Cindy noted that some planning and decision-making aspects may need to be done within DCF if there is a concern about a conflict of interest.
- HFA staff need a BA or lower, and community health workers will be billable through DSS - we should keep an eye on this.
- Another person pointed out that the outcomes listed come from multi-year involvement, and we should consider when we can expect to see these outcomes.

NFP

- One person pointed out that only a parent's first child is eligible for the program, and engagement must occur *during* pregnancy, so the intake criteria is limited.
- Another person added that OEC is participating in a program to enroll a second-time parent, but they are unsure whether this is ongoing or what the details are.
- At this point, the criteria is that a parent must engage before the 28th week of pregnancy (although as was mentioned, this may change in the future).
- Some felt that the price listed was too small given the start-up costs. Cindy agreed to double check these costs.

PAT

- One person recommended seeing how much is funded.
- Another person wondered whether we should consider the MOE for MIECHV.
- One question was what the credential is of the people delivering the service. This needs to be double checked.
- Another person asked for the costs to be double checked - some have QI built in while others do not, and there may be additional start-up and training costs too. Cindy agreed to check these.
- The learning collaborative model was brought up as one way to make sure costs are included.
- Another person recommended factoring in length of service and effect size.

PCIT

- A member shared that the implementation team for PCIT has weakened over the years, which they feel may cause it to cost more.
- Another person said The Village looked at it and there may be a place for it, but there are unique implementation challenges.
- One person asked whether it is a CHDI model, and another replied that it is not.

FFT

- Cindy highlighted that while Medicaid may cover some of the components, it does not cover a large portion.

MST

- MST had results listed from both the federal Clearinghouse and from CT (at the time of discharge).

BSFT

- We currently have little data about BSFT and are still looking for more information.

MI

- MI can be seen as an "accelerator" that is low-cost and helps with other programs.
- Another person said that when we think about it as an add-on, we should also consider it with community supports for families.
- Another person said that we need to understand who is using it - that is where the cost comes in (it is a method). It is not really possible to do a "cost per slot" because the cost lies in training people in this technique.
- Cindy agreed to re-work the analysis, since it is more of a flat rate than a cost per slot.
- One person suggested looking at it along with CBT (a substance use treatment).

Comparison Between Similar EBPs

- Cindy compared EBPs that were similar and asked for feedback on the groupings (slides 20-21).
- HFA, NFA, and PAT
    - It was suggested that comparisons should also be made by outcomes, not just by the cost and breakeven. We need to dig into what we really need/gaps to determine the best fit.
    - Cindy explained that the results will go to PSAWG and Governance.
- FFT, MST, BSFT
    - A workgroup member felt it was hard to compare these; although the costs are wildly different, we need to add the goals.

Next Steps

- Fiscal will continue to coordinate with PSAWG.
- Fiscal's next meeting will be **March 12, from 1:30 - 3:00 pm.** We will use this meeting to clean up the costs, along with added duration and outcome times. We hope that at the end of the March 12 meeting we will have a final product to present to Governance on March 16.
- A draft will be complete by mid-April, and the final version will be submitted to the federal government in May.
- Please feel free to reach out to the co-leads with other considerations that may have been missed.