Monday, December 14, 2015

President Vonnetta Allenbaugh called the meeting to order.

President Allenbaugh thanked Conitha and Bill King, volunteer staff and State of Alabama for hosting the meeting.

President Allenbaugh thanked all the corporate sponsors, in particular Anthem and Cenpatico for their additional support for this meeting.

President Allenbaugh thanked Conitha King for printing and binding the reports for the Fall Planning meeting and thanked the attendees for taking their time to attend the meeting.

President Allenbaugh acknowledged Dave Moseley with Navigant was also registered but due to his health issues was not able to attend and President Allenbaugh wished him well in his recovery.

President Allenbaugh explained that committee chairs may move for acceptance of their report in planning meetings only and that only the voting members that are recognized during the roll call from member agencies can make motions or seconds to motions.

Motion was made by Deena Brown of Oklahoma to accept the agenda as printed in the booklets and seconded by Michelle Grosse-Bray of Alaska. Motion carried to adopt the agenda.

President Allenbaugh requested Secretary King to take roll call. Secretary King announced 8 members present and one proxy,

President Allenbaugh announced a quorum.

**Historian Report:**

President Allenbaugh asked Michelle Grose-Bray to present the Historian Report as detailed below:

Madam President, Executive Board, Committee Chairs, and other HSFO Members, the Historian’s report is as follows:

The National Association of State Human Services Finance Officers (HSFo) held it 68th Annual Conference and Business meeting in Sparks, NV from July 26th thru July 30th, 2015 with President Dague Clark presiding. The John Ascuaga’s Nugget Resort Hotel was the location for president’s reception, conference, banquet, and business meeting. This conference was self-hosted by the HSFo past presidents and members of the 2015 conference arrangements committee.
The 2015 conference consisted of the Sunday afternoon workshop on Leadership Communications, conducted by Marnie Green, 23 traditional conference sessions resulting 29.5 CPE hours. Topics covered included national legal issues, Medicaid topics, Title IV E, TANF, federal change updates, cost allocation topics, IT systems development, and maximizing federal revenues. Overall, the program evaluations were positive regarding the conference sessions.

There were 134 conference attendees, including 66 attendees from HSFo member agencies, 19 individual corporate members, 4 non-members, 1 federal employee, 25 speakers, and 19 guests.

The 2015 HSFo conference followed a slightly different format from previous conferences. The conference was held over 3.5 days. This schedule change required three longer session days with only a half day on Thursday, July 30th, 2015. The conference special event started at 4:00pm on Tuesday, July 28th at Virginia City, NV.

Motion to accept the report was made by Ms. Grose-Bray, seconded by Jason Sanchez, New Mexico.

Discussion: None
Vote: Those in Favor: Aye
Opposed: Nay (None)
Motion to accept carried.

**Secretary’s Report:**

President Allenbaugh asked Secretary Conitha King to read the minutes of the business meeting held at the 67th Annual Conference held in Nevada.

Secretary King presented the minutes as follows:

The minutes of the 2015 Business Meeting, held in Sparks, Nevada on July 20, 2015 have been posted to the HSFo website for review.

I have a copy if there are specific questions, but at this time I would move that we dispense with reading of the minutes and accept them as posted.

Second: Tara LeBlanc, Louisiana
Discussion: Michelle Grose-Bray, Alaska noted the minutes are difficult to find on the website and asked that a hyperlink be posted.

Vote: Those in Favor: Aye
Opposed: Nay (None)
Motion carried and the report was accepted.

**Federal Issues Report**

Presented by Michele McDonald, Maryland
Medicaid Program; Methods for Assuring Access to Covered Medicaid Services

AHCA Applauds CMS Action on Issuing Medicaid Final Rule
More Transparency, Accountability in Medicaid Fee-for-Service Rate Determination

AHCAPressOffice@ahca.org
202.898.3165
FOR IMMEDIATE RELEASE

11/11/2015
Washington, D.C. — The American Health Care Association (AHCA) today applauded the Centers for Medicare & Medicaid Services (CMS) for finalizing the rule “Medicaid Program; Methods for Assuring Access to Covered Medicaid Services.” The rule puts additional structures in place that are intended to make Medicaid fee-for-service payment rate development more data-driven and transparent to beneficiaries and providers.

“We applaud CMS for taking action on this long-awaited rule,” said Mark Parkinson, President and CEO of AHCA. “AHCA provided input, and we are pleased to see that CMS had like-minded ideas. This is a framework for more transparency and accountability in the state plan amendment process for both beneficiaries and providers.”

Among the components of the rule are:

- New procedures states must implement and follow in order to receive approval of provider rate reductions or rate restructuring that could have a negative impact on access to care,
- New requirements for states to submit Access Monitoring Review Plans to CMS, including analysis to determine whether beneficiary access to certain services is sufficient, and
- New requirements for states to implement ongoing mechanisms for beneficiary and provider input on access to care (e.g., hotlines, surveys, ombudsman). States will need to promptly respond to the input citing specific access problems, with an appropriate investigation, analysis, and response.

The CMS action finalizes a proposed rule that was issued in May 2011. The rule is especially important due to the Supreme Court’s decision in Armstrong v. Exceptional Child Center, Inc. This decision states that Medicaid providers do not have a cause of action to challenge a state’s Medicaid reimbursement rates, and as a result, beneficiaries and providers must rely on CMS’ oversight role to ensure state compliance with the access requirements this rule is intended to address.

“There will be variation across states in how this is rule implemented,” explained Parkinson. “States themselves have much work to do to make this into reality that ensures access for the beneficiaries receiving these needed services.”
AICPA American Institute of CPA’s
Audits of Federal Funds (Single Audits)

Entities that receive federal funds including states, local governments, and not-for-profit organizations (NPOs), are subject to audit requirements commonly referred to as “single audits” under the Single Audit Act of 1984, as amended in 1996. The Single Audit Act was enacted to standardize the requirements for auditing federal programs. The Act provides that grantees are subject to one audit of all of their federal programs versus separate audits of each federal program, hence the term “single audit.” The AICPA believes that single audits should be performed in a high-quality manner, using appropriate professional standards, and provides guidance to its members through its Governmental Audit Quality Center and through other means such as technical publications, guidance, educational courses, and conferences.

Legislative Proposals

112th Congress

In November 2011, Representative James Lankford, an Oklahoma Republican, introduced the "Grant Reform and New Transparency Act" or GRANT Act, H.R. 3433. While the primary purpose of the bill is to improve transparency in the grant application, award and reporting processes, it also calls for the Office of Management and Budget (OMB) to submit a plan for improving the single audit process. Such a plan would have to include, among other things, a simplified single audit alternative for non-federal entities with expenditures for smaller federal awards. The legislation defines a "smaller Federal award" as $1 million or less.

Because the Single Audit Act currently bases its audit requirement on total federal awards expended of $500,000 or more, the AICPA is concerned that the bill’s language is inconsistent because it implies that an audit would only be required when there is one federal award greater than $1 million. As a result, the AICPA has advocated that the bill be clarified that the simplified audit alternative be explored for recipients expending greater than $1 million in total federal awards.

The bill was favorably reported to the full House by the Oversight and Government Reform Committee in May 2012. The bill saw no further action in 2012.

Earlier Legislative Proposals and Executive Branch Actions

The federal funds provided to governments and NPOs subject to single audits have been significantly increased (by approximately $800 billion) due to the passage of the American Recovery and Reinvestment Act of 2009 (Recovery Act), which was intended to stimulate the economy and create jobs.

Representative Edolphus Towns, a New York Democrat, introduced H.R. 2182 to require 0.5
percent of Recovery Act funds be allocated to conduct oversight to prevent waste, fraud and abuse. The bill passed the House in May 2009. There was no action on the bill in the Senate, and it died with end of the 111th Congress. It also has not been reintroduced in this Congress which began its term in January 2011.

Additionally, President Obama issued Executive Order 13520 on Nov. 23, 2009, creating a working group of federal, state and local officials to recommend improvements that could be made to single audits, including determining whether such audits are effective in identifying improper payments and whether single audit requirements should be streamlined or eliminated where their value is minimal. In March 2010, the Office of Management and Budget (OMB) issued government-wide guidance to the federal agencies (found at http://www.whitehouse.gov/sites/default/files/omb/assets/memoranda_2010/m10-13.pdf) on the implementation of the Executive Order. Under OMB’s guidance, which affects OMB Circular A-123, Management’s Responsibility for Internal Control, federal agencies with programs susceptible to significant improper payments are required to submit a quarterly report on any identified high-dollar overpayments to the agency’s Inspector General and the Council of Inspectors General on Integrity and Efficiency, and also make the report available to the public. Additionally, OMB continues to study the inter-relationship of single audits and the required federal agency reporting of improper payments and whether any changes are needed to single audit legislation or regulation as a result of its study.

Copy of Legislation
Copies of bills and all Congressional actions are available on the Library of Congress’s THOMAS website by bill number after first selecting "Try the Advanced Search" and then the correct Congress.

Obama Administration Initiatives to Address Prescription Drug Abuse and Heroin Use

Joy Johnson Wilson and Rachel B. Morgan RN, BSN 10/22/2015

White House Announcement
The Obama administration issued a memorandum on Oct., 21, 2015, to federal departments and agencies directing two important steps to combat the prescription drug abuse and heroin epidemic:

- **Prescriber Training**: First, to help ensure that health care professionals who prescribe opioids are properly trained in opioid prescribing and to establish the federal government as a model, the presidential memorandum requires federal departments and agencies to provide training on the prescribing of these medications to federal health care professionals who prescribe controlled substances as part of their federal responsibilities.

- **Improving Access to Treatment**: Second, to improve access to treatment for prescription drug abuse and heroin use, the presidential memorandum directs federal
departments and agencies that directly provide, contract to provide, reimburse for, or otherwise facilitate access to health benefits, to conduct a review to identify barriers to medication-assisted treatment for opioid use disorders and develop action plans to address these barriers.

The White House will host a Champions of Change event this spring to highlight individuals in communities across the country who are leading the fight to respond to prescription drug abuse and heroin use.

White House Fact Sheet on Public and Private Efforts to Combat Prescription Drug Abuse and Heroin Use

Additional Federal Actions

U.S. Department of Justice

- **The Drug Enforcement Administration (DEA)** announced that it will continue its National Prescription Drug Take-Back Day program events in the spring and fall of 2016. As the president highlighted in a recent weekly address, Take-Back Day aims to provide a safe, convenient, and responsible means of disposing of unused prescription drugs, while educating the public about the dangers of misusing medications. DEA also finalized a new rule making it easier for communities to establish ongoing drug take-back programs. Read more about the DEA’s drug disposal information.

U.S. Department of Health and Human Services (HHS)

- **The Department of Health and Human Services (HHS)** will undertake a review of how pain management is evaluated by patient satisfaction surveys used by hospitals and other health care providers, including review of how the questions these surveys use to assess pain management may relate to pain management practices and opioid prescribing. HHS also launched this site as a one-stop federal resource with tools and information for families, health care providers, law enforcement, and other stakeholders on prescription drug abuse and heroin use prevention, treatment, and response.

- **The Centers for Disease Control and Prevention (CDC)** will invest $8.5 million on the development of tools and resources to help inform prescribers about appropriate opioid prescribing; track data on prescribing trends; research, develop, and evaluate clinical quality improvement measures and programs on opioid prescribing; and improve public understanding of the risks and benefits of opioid use. U.S. Surgeon General Vivek Murthy is developing an education campaign for doctors, dentists and other health care professionals who prescribe opioid pain medications. Earlier this month, Murthy also
announced that work has begun on the first-ever surgeon general's report on substance use, addiction and health scheduled for publication in 2016.

- **Centers for Medicare and Medicaid Services (CMS)** will release an information bulletin to states by the end of the year on steps states can take through their Medicaid preferred drug lists (PDLs) and other utilization management mechanisms to reduce the risk of overdose. This includes a recommendation that they consider removing methadone from their PDLs for pain management. The Centers for Disease Control and Prevention has found that the use of methadone in pain treatment is associated with a disproportionately high number of overdose deaths compared to other opioid pain relievers. This fall, CMS is testing three new Medicare prescription drug plan measures designed to identify potential opioid overutilization, with the goal of proposing publicly reportable measures for Part D drug plans next year. These measures are based on the work of the Pharmacy Quality Alliance.

**The Department of Veterans Affairs**
- **The Department of Veterans Affairs** will lead a research initiative to evaluate non-opioid alternative approaches to pain management. The Department of Defense (DoD) and VA are developing a *standardized pain management curriculum* for widespread use in education and training programs.

**The Bureau of Indian Affairs (BIA) and the Indian Health Service**
- **The Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS)** will provide BIA police officers and investigators the overdose reversal drug naloxone and training on its use. In 2016, the BIA, through the United States Indian Police Academy, will provide training to all BIA and tribal police officer cadets in recognizing opioid use disorders and overdose symptoms.

**Moving Forward**
In 2010, the president released his first National Drug Control Strategy, emphasizing the need for action to address opioid use disorders and overdose, while ensuring that individuals with pain receive safe, effective treatment. The next year, the White House released its national Prescription Drug Abuse Prevention Plan to outline its goals for addressing prescription drug abuse and overdose. This year the administration, through the CDC, launched the Prescription Drug Overdose: Prevention for States Program.
Prescription Drug Overdose: Prevention for States Program

The program provided $20 million to states to support strategies to improve prescribing practices and prevent opioid overdose deaths. Through a competitive application process, CDC selected 16 states to receive funds through the program: Arizona, California, Illinois, Kentucky, Nebraska, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont and Wisconsin.

Over the next four years, CDC plans to give states annual awards between $750,000 and $1 million each year, subject to the availability of funds, to advance prevention, including in these areas:

1. Enhancing prescription drug monitoring programs (PDMPs).

2. Putting prevention into action in communities’ nationwide and encouraging education of providers and patients about the risk of prescription drug overdose.

3. Working with health systems, insurers, and professional providers to help them make informed decisions about prescribing pain medication.

4. Responding to new and emerging drug overdose issues through innovative projects, including developing new surveillance systems or communications campaigns.

States can also use the funding to better understand and respond to the increase in heroin overdose deaths and investigate the connection between prescription opioid abuse and heroin use. The president's budget for 2016 includes a request from HHS Secretary Sylvia Mathews
Burwell for the resources needed to expand CDC’s state efforts to all 50 states and launch a national program that will focus on prevention and prescription drug overdose surveillance.

**Additional Resources**

- The Department of Health and Human Services: *Opioids: The Prescription Drug & Heroin Overdose Epidemic*
- The Centers for Disease Control and Prevention (CDC) Vitalsigns: *Today’s Heroin Epidemic*
- CDC Documents: *State Laws on Prescription Drug Misuse and Abuse*
- Substance Abuse and Mental Health Services Administration’s (SAMHSA) Partnerships with State, Territory, County, and Other Governmental Organizations
- SAMHSA Grants to States
- National Survey on Drug Use and Health
- Source: [http://www.ncsl.org](http://www.ncsl.org)

### Helping Families in Mental Health Crisis Act of 2015

The Congressional Budget Office has completed a preliminary analysis of the direct spending effects of title V of H.R. 2646, the Helping Families in Mental Health Crisis Act of 2015, as introduced on June 4, 2015. As described below, title V contains language that makes the implementation of certain provisions contingent on a certification by the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) that the provisions would not increase net costs. At the request of your staff, CBO estimated the cost of those provisions with and without this language.

CBO estimates that, as introduced, title V of H.R. 2646 would increase direct spending by about $3 billion over the 2016-2024 period. Without the language that makes implementation of certain provisions contingent on the certification by the Chief Actuary of CMS, CBO estimates that the title would increase direct spending by between $46 billion and $66 billion over the 2016-2025 period.

**Title V of the bill would:**

- Expand the number and type of mental health services that states may cover under Medicaid if the Chief Actuary of CMS certifies that a certain provision would not increase net Medicaid spending;
• Prohibit both Part D plans under Medicare and state Medicaid programs from using certain tools to restrict access to drugs used to treat mental health disorders;
• Eliminate the 190-day limit on Medicare coverage of stays in an inpatient psychiatric facility (IPF) if the Chief Actuary of CMS certifies that the provision that would not increase net Medicare spending; and
• Expand the Certified Community Behavioral Health Clinics demonstration program.

**Enhanced Medicaid Coverage Relating to Certain Mental Health Services**

Section 501 would expand access to behavioral health services offered under Medicaid. Under the section, states would be required to allow Medicaid payments to be made for primary care and mental health services that are provided on the same day at a community mental health center or federally qualified health center. The section also would give states the option to receive federal reimbursement for medical assistance provided to eligible nonelderly adults at institutions for mental diseases (IMDs). However, section 501 could take effect only if the Chief Actuary of CMS certified that providing that assistance would not increase program spending.

Under current law, the federal government does not make matching payments to state Medicaid programs for most services provided to nonelderly adults in IMDs. (The federal government makes matching payments to Medicaid programs for services provided to children and the elderly in IMDs.) Under a policy that would allow states to provide such services through the Medicaid program, CBO expects that most services for otherwise eligible individuals that are currently financed by state and local governments without a federal matching payment would instead be financed by Medicaid.

Data on how much states spend on IMD services used by adults aged 21-64 are not available. CBO based its estimate of this provision on several data sets collected by the Substance Abuse and the costs of Mental Health Services Administration and the National Association of Psychiatric Health Systems. The data report the number of behavioral health facilities and the number of admissions to and clients served by those facilities. The data also report health insurance status at time of admission into behavioral health facilities.

The estimated effects of this section on federal Medicaid spending are highly uncertain and would depend largely on:

• The extent to which coverage for services provided in IMDs is provided currently to adults enrolled in Medicaid managed care plans;
• The amount that states spend on such services using state mental health agency budgets for individuals who are eligible for Medicaid; and
• Whether the policy would lead to an increase in the number of inpatient psychiatric beds available.

Despite the uncertainty, CBO expects that CMS would determine that providing federal reimbursement for medical assistance in IMDs would increase net spending under Medicaid. Thus, CBO estimates that, as introduced, section 501 of the bill would not affect direct spending
because the provision would not take effect. If the bill did not make the benefit expansion contingent upon the certification, CBO estimates that section 501 would increase direct spending by between $40 billion and $60 billion over the 2016-2025 period.

Access to Mental Health Prescription Drugs

Under current law, Medicare Part D plans must cover substantially all prescription drugs in each of six classes until the Secretary of Health and Human Services has established criteria for determining which prescription drugs in those classes are of clinical concern and must continue to be covered. CMS has taken initial steps toward developing such criteria, and CBO expects that such criteria are likely to be implemented during the coming decade under current law. CBO expects that establishing such criteria will hold down Part D spending because manufacturers of drugs that lose the protection of required coverage will offer larger rebates to get Part D plans to include their products on the plan’s formulary.

Section 502 would make permanent the requirement that all prescription drugs in two classes (antidepressants and antipsychotics) must be covered. CBO estimates that provision would increase Medicare spending by $700 million over the 2016-2025 period because rebates paid to the government for prescription drugs in those classes would be lower.

Section 502 also would prohibit state Medicaid programs from using certain tools to restrict access to drugs used to treat mental health disorders outside of a prior authorization program. CBO estimates that prohibition would increase direct spending by about $800 million on net over the 2016-2025 period. On average, states that implement some utilization management for mental health drugs spend less of their overall prescription drug benefit on mental health drugs than states with no controls over utilization. However, CBO expects that state Medicaid programs would still be able to use some utilization management tools under the prior authorization authority (such as preferred drug lists) to control access to mental health drugs. Therefore, the estimated cost of the provision is less than it would be if all utilization management tools were prohibited.

Elimination of the 190-Day Lifetime Limit on Coverage of Inpatient Psychiatric Hospital Services

Under current law, a beneficiary covered by Part A of Medicare is eligible to receive hospital inpatient care for serious mental illness or alcohol- and drug-related problems in either a general hospital or an institutional psychiatric facility. For care received in an IPF, Medicare will pay for up to 190 days of inpatient psychiatric hospital services over a beneficiary’s lifetime. For most elderly beneficiaries enrolled in both Medicare and Medicaid, state Medicaid programs pay for IPF services for beneficiaries who have exceeded Medicare’s 190-day limit.

Section 503 would eliminate the 190-day limit on Medicare coverage of IPF days if the Chief Actuary of CMS certifies that the provision would not increase net Medicare spending. CBO expects the Chief Actuary would conclude that the provision would increase Medicare spending. Thus, CBO estimates that, as introduced, section 503 would not affect direct spending because the provision would not take effect.
If the bill did not make the benefit expansion contingent on the certification, CBO estimates that section 503 would increase federal spending by $3.0 billion over the 2016-2025 period. That net increase in spending has two components. The Medicare program would spend an additional $3.6 billion for IPF services. That increase would be partially offset by an estimated $0.6 billion in federal Medicaid savings, stemming from the shift of coverage for IPF services from Medicaid to Medicare. Elimination of the 190-day limit in Medicare would interact with the expansion of Medicaid coverage of IMD services under section 501, because both provisions would affect payment for IPF services for dually eligible individuals who are under age 65. The effects of that interaction are included in the estimated cost of section 501.

**Demonstration Programs to Improve Community Mental Health Services**

Section 505 would expand the Certified Community Behavioral Health Clinics demonstration by increasing the number of states that can participate in the demonstration from 8 states to 10 states and increasing the number of years the demonstration can operate from two years to four years. Because payment rates for services provided in certified community behavioral health clinics would be higher under the demonstration than under current law, CBO estimates that the provision would increase direct spending in Medicaid by $1.8 billion over the 2016-2025 period.

Source https://www.cbo.gov/publications

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Centers for Disease Control and Prevention

**HEALTHY AGING**

**What is a Healthy Brain? New Research Explores Perceptions of Cognitive Health Among Diverse Older Adults**

Cognitive health is a major factor in ensuring the quality of life of older adults and preserving their independence. To explore how diverse older adults think about “cognitive health and cognitive decline,” the Healthy Aging Research Network, a group of nine universities supported by the Centers for Disease Prevention and Control (CDC) Healthy Aging Program, conducted a series of group interviews across the United States. This research, identified in The Healthy Brain Initiative: A National Public Health Road Map to Maintaining Cognitive Health (www.cdc.gov/aging) as a priority area, was designed to gain insights into how people view cognitive health and how to maintain it. The findings will be used to further the development of effective public health messages to promote cognitive health in older adults across the nation. Between 2005 and 2007, researchers conducted 55 focus groups with over 450 participants from nine states. The diverse participants included older adults (some of whom were experiencing cognitive impairment), individuals caring for family or friends experiencing cognitive impairment, healthcare providers, residents of rural and urban areas, speakers of English, Spanish, Mandarin, Cantonese, and Vietnamese, African Americans, American Indians, Asian Americans, Hispanics, and non-Hispanic whites. Several key themes emerged from the focus groups.

**What is cognitive health?**
A healthy brain is one that can perform all the mental processes that are collectively known as cognition, including the ability to learn new things, intuition, judgment, language, and remembering.

**Race and ethnicity can influence how we define a healthy brain.**
- People from many diverse racial and ethnic groups shared a common language and a core set of beliefs about what comprises a healthy brain. They most often describe cognitive health as “staying sharp” or being “right in the mind” and define it as living to an advanced age, having good physical health, having a positive mental outlook, being alert, having a good memory, and being socially involved.
- Participants also identified areas where their specific ethnic, cultural, or geographic group may be unique in terms of how cognitive health is defined.
- Researchers found differences among the groups in terms of how participants discussed specific issues such as independent living, older adults and driving, the importance of playing games or puzzles, and the effects of “good genes.”

**Older adults believe that physical activity can protect cognitive health but are often less clear on the role nutrition can play.**
- Participants in all groups believed that physical activity, particularly walking, promotes cognitive health, but they were unsure about the frequency, duration, and intensity of walking that would be required to achieve benefits.
- A wide range of healthy physical activities were cited, including Tai Chi, gardening, and housekeeping. However, strength training, which has numerous benefits for older adults (such as improved bone density and decreased risk of falling), was seldom mentioned by any of the groups.
- Many participants acknowledged difficulty translating their knowledge of what they “should” do into healthy actions.
- Participants also believed there is a link between diet and cognitive health, but they were more skeptical about this link than they were about the link between physical activity and cognitive health. There was also considerable variability among groups about what they considered a “healthy” diet; some focused more on moderation and portion size, others on foods that should be avoided.
- Most participants said that fruits, vegetables, and lean meats are good for the brain, but did not identify specific dietary changes, and many expressed confusion over the role of dietary supplements.

“First in staying sharp is exercising, the second is diet, and the third is being active in society. Go often, participate often …” ~by a participant

**Findings can guide development of better messages**
Regardless of gender, race, ethnicity, language, or geographic region, older adults who participated in the group interviews agreed that cognitive health—memory, decision-making, and similar functions—is important to healthy aging.
• Participants shared their views on ways to maintain a healthy lifestyle, including physical activity, a healthy diet, social involvement, participation in enjoyable activities, a positive mental attitude, spiritual activities, and accepting and adapting to physical and cognitive changes.

• Participants also provided many creative and useful ideas that could be used to develop effective public health messages about cognitive health.

• Their suggestions reflected racial and ethnic diversity. African Americans, for example, linked cognitive health to spiritual health, while Chinese and Vietnamese participants felt that a healthy body and a healthy brain go together. White participants emphasized that no matter what your age you can still be healthy and happy.

• Health messages that build on existing perceptions, use cognitive health as a motivator for healthy behaviors, and involve “community champions” as advocates were viewed positively by these groups.

Media messages are rare and often conflicting.

• Participants reported hearing little about cognitive health in the mass media, with most information coming from print media. Although most participants watched a lot of television, they reported little or no information about cognitive health coming from this source.

• All groups expressed a distrust of media messages regarding cognitive health, and felt that conflicting and changing messages contribute to confusion about the media’s promotion of health.

• Social networks and educational programs were identified as more effective ways to reach people with messages about cognitive health, particularly within pre-existing social networks such as clubs or senior centers.

“I don’t know if there’s anything left that really they [the media] know is healthy for you.” ~by a participant

Overall, the findings suggest that messages about cognitive health should be tailored to specific communities and cultural subgroups, and that existing media messages are often conflicting. Researchers will continue to examine these issues to better inform the public about the evolving science of maintaining cognitive health and preventing cognitive impairment.

This work was supported in part by the Healthy Aging Program at the Centers for Disease Control and Prevention.

RESOURCES
To learn more about this research, see the special issue of The Gerontologist: Promoting Cognitive Health in Diverse Populations of Older Adults (Volume 49, Number S1, June 2009).

A good general resource for consumers is NIH Senior Health, an easy-to-use website from the National Institutes of Health that features health and wellness information for older adults. (http://nihseniorhealth.gov/)
TITLE IV-E CHILD WELFARE WAIVER DEMONSTRATIONS

Guidance for the Initial Design and Implementation Report and Subsequent Quarterly Progress Reports

The Initial Design and Implementation Report (IDIR) and subsequent quarterly progress reports are key deliverables described in Sections 2.4, 5.2, and 5.3 of the Terms and Conditions for waiver demonstrations. The following guidance document explains the content to be included in the IDIR and subsequent quarterly progress reports. These deliverables should summarize the planning and activities the title IV-E agency has completed and/or will need to complete in order to successfully implement its demonstration.

This document is intended to serve as a tool for the title IV-E agency to thoughtfully and strategically plan for successful implementation of the waiver project. We encourage the agency to use the IDIR as a “living document,” making revisions and updates as the demonstration evolves. The IDIR is intended to serve as a guide throughout the implementation process.

The title IV-E agency should provide as much of the information below as possible in its IDIR. All areas not sufficiently addressed should be responded to and/or updated in subsequent quarterly progress reports. Once all of the required information is sufficiently addressed, the Children’s Bureau (CB) will approve the State’s IDIR, referencing all subsequent quarterly progress reports as appropriate.

The title IV-E agency should continue adding information to the original IDIR in each quarterly submission prior to waiver implementation. This process will allow all parties to have a complete implementation plan in a single document. In addition to any core areas not sufficiently addressed in the prior reporting period, quarterly progress reports should include updates on any additional activities performed in each content area during the previous quarter as well as planned activities for the upcoming quarter. The template associated with this guidance document can aid the title IV-E agency in the structuring of these deliverables.

I. Overview
The overview should include a short introduction to the waiver demonstration that summarizes the problem(s) the title IV-E agency is attempting to address, the target population(s), and the project’s intervention(s). Depending on the scope of the waiver demonstration, title IV-E agency projects may have one intervention or several.

In addition, the overview should articulate the waiver demonstration’s overall theory of change, including the expected short-term and long-term outcomes of the project and how and why the waiver demonstration interventions are expected to address the identified needs of the target population(s). The theory of change provides an opportunity to tell a concise story of how the title IV-E agency is defining the problem(s) it hopes to address, outline the demonstration’s intended outcomes, and explain how the demonstration’s intervention(s) will address these problems and achieve the intended outcomes.

More importantly, the theory of change should demonstrate the series of connections that link the problems and needs being addressed with the actions the title IV-E agency will take to achieve desired outcomes. This overview might include an outcomes chain that consists of a series of “if-then” or “so that” statements that address the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions. An example of an outcomes chain for one component of a hypothetical waiver demonstration is provided below:

<table>
<thead>
<tr>
<th>Intervention: We implement standardized trauma-informed child assessments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>So That</td>
</tr>
<tr>
<td>Case managers have increased knowledge and awareness of the emotional and developmental needs of child welfare-involved children</td>
</tr>
<tr>
<td>So That</td>
</tr>
<tr>
<td>1) Case managers refer children and families to appropriate trauma-focused behavioral health treatments</td>
</tr>
<tr>
<td>and</td>
</tr>
<tr>
<td>2) Child welfare agencies make better decisions regarding the allocation of resources to provide behavioral health treatments</td>
</tr>
<tr>
<td>So That</td>
</tr>
<tr>
<td>1) Children have improved emotional health</td>
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<tr>
<td>and</td>
</tr>
<tr>
<td>2) Caregivers have improved coping and parenting skills</td>
</tr>
<tr>
<td>So That</td>
</tr>
<tr>
<td>1) Children are safe from future abuse and neglect and</td>
</tr>
<tr>
<td>2) Children avoid out-of-home placement</td>
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</tbody>
</table>

Note in this example that it is possible to have more than one outcome associated with each “link” in the chain. It may be helpful to develop separate, more detailed outcomes chains for each major demonstration component, along with a main chain that articulates the theory of change for the waiver demonstration as a whole. As with the IDIR itself, outcomes chains should be revisited and adapted as necessary as the title IV-E agency’s understanding of the waiver demonstration evolves and the linkages between discrete interventions and desired outcomes are refined.
Sharing the theory about why a program or intervention is proposed to work will be a worthwhile activity as the first step in the waiver demonstration’s initial design and implementation because it provides all stakeholders with a chance to understand one another’s thinking and to clearly identify what outcomes the title IV-E agency will be using to measure its success.

The Children’s Bureau (CB) welcomes drafts of this section and is able to facilitate the provision of technical assistance to support a title IV-E agency in its theory of change development. The title IV-E agency may want to consider submitting its theory of change to CB for review and discussion in advance of developing the remaining sections of the IDIR.

II. Clearly Defined Target Population(s)

Section II should describe the target population(s) for each of the demonstration’s interventions, noting exclusions, geography/locations, or eligibility criteria as appropriate. The target population(s) should reflect the group(s) of children and/or families whose safety, permanency, and well-being outcomes the title IV-E agency intends to impact through the waiver demonstration. In this section, the plan should:

A. Describe the **characteristics and needs** of the identified target population(s).

- **Characteristics** are generally related to demographics or past experiences that are not readily changeable (e.g., age, race, ethnicity, or placement history).

- **The needs** define the circumstances and conditions that are amenable to change (e.g., difficulty dealing with past and present trauma, loss of connection to family members, lack of parental skills and abilities to manage behavior).

Some helpful data sources for defining the target population may include the title IV-E agency’s administrative data, quality assurance data, Court Improvement Program data, targeted case reviews, surveys, focus groups, and stakeholder feedback. Title IV-E agencies may also wish to partner with their evaluator (if currently under contract) or other university partners to engage in the “data mining” activities that will yield a comprehensive understanding of the waiver demonstration’s target population(s).

**Developed description of a target population:**

*The target population for this project is children ages 0-18 who are in congregate care or at risk of entering congregate care. Approximately 70% of those in congregate care are over the age of 14; 80% have four or more placements; 53% are African American, 29% Hispanic, 4% Native American, and 19% white. As defined by State statute, children in or at risk of entering congregate care exhibit one or more of the following behaviors: fire setting, sexual acting out, harm to self/others, untreated substance abuse, and hallucinations. In 2011, of all children in congregate care settings, in the most recent six month period 45% reported a history of school expulsions, 64% expressed suicidal ideation, and 32% attempted suicide. The reason for referral for 68% of these cases was neglect, 23% physical abuse, 5% sexual abuse, and 35% Child In Need of Services.*

**Undeveloped description of a target population:**
The target population for this project is all children statewide ages 0-18 who are in care, at risk of entering care, or have recently exited care. 52% are male and 48% are female; and African American children are disproportionately represented in the foster care population.

B. Provide an estimate of the number of children/families who will initially be enrolled in the demonstration.

The attached “Target Population Template” is available to assist title IV-E agencies in thinking through the above elements. The template is not a required deliverable but instead is provided as a resource to support the development of this section of the IDIR.

III. Clearly Defined Demonstration Interventions and Associated Components

Section III should describe each of the waiver demonstration’s interventions and associated components for the identified target populations. Depending on the scope of the demonstration, State projects may have one intervention or several; similarly, some projects may have a broad systems focus, while others may be more discrete. All interventions must be sufficiently addressed in this section.

In this section, the plan should describe:

1. The waiver demonstration interventions planned for each target population, including a clear description of the interventions’ core components;

2. Who will receive demonstration programs and services (e.g., child, parents, foster parents, caseworkers);

It is possible that the recipient of an intervention may be different from the target population whose outcomes the title IV-E agency is trying to improve. For example, the title IV-E agency may want to improve the social and emotional well-being outcomes of children and youth with identified behavioral and mental health needs due to trauma. One intervention may be the implementation of a new trauma-informed training model for caseworkers. In this instance, the target population is still the children and youth with identified behavioral and mental health needs due to trauma, but caseworkers are the recipient of this particular intervention.

3. How the waiver demonstration’s interventions will address the various needs of the target population(s) as identified in Section II;

4. The specific outcomes expected for each intervention (which should link back to the overall theory of change for the waiver demonstration outlined in Section I);

5. The existing evidence linking each intervention to the identified safety, permanency, and well-being outcomes the demonstration is supposed to address (i.e., research and evaluation findings and other data demonstrating support for the application of the chosen intervention(s) to the defined target population(s) in order to achieve the intended outcomes of the waiver demonstration);
6. The program development and/or adaptation work that needs to be done to prepare each intervention for implementation.

The attached “Intervention Template” is available to assist title IV-E agencies in thinking through the above elements. The template is not a required deliverable but instead is provided as a resource to support the development of this section of the IDIR.

IV. Assessing Readiness to Implement the Demonstration

Section IV should include an analysis and overview of the requirements for the child welfare system, related organizations, and community partners in implementing each demonstration intervention as intended, as well as specific activities to be completed prior to implementation. This includes:

A. Describing the fit of each demonstration intervention with community values, culture, and context, and how this was or will be assessed.

B. Describing the title IV-E agency and/or local jurisdiction’s capacity to implement the demonstration, including available training and technical assistance resources and capacity, and how this was or will be assessed. Assessments of the capacity to implement should focus on:

1. Organizational and Systems Capacity, including a description of:
   a) Leadership support (i.e., the current status of state, county, and local leadership buy-in and where further engagement may be necessary);
   b) Staff characteristics. Please describe the staff requirements for each demonstration intervention (e.g., number of staff, roles in the demonstration, qualifications in terms of education and experience) and compare that to the child welfare agency’s current staff characteristics;
   c) Availability of technical and financial resources to implement the program as intended (e.g., required hardware, required software, access to certain curricula or intervention manuals, start-up funding to aid in the initial implementation of the waiver intervention(s) prior to the accrual of title IV-E savings);
   d) Availability and quality of linkages to and support from community organizations.

2. Current processes and service system functioning that need attention because they are incompatible with or not aligned to ensure the successful implementation of the demonstration’s key components and therefore will not facilitate the achievement of the demonstration’s desired goals and outcomes (e.g., union agreements that may impact staff selection processes for new programs, current levels of coordination
and cooperation between community service providers and what may be needed for successful implementation of waiver interventions).

3. Implementation supports (e.g., infrastructure enhancements, policy changes) that need to be developed to ensure that demonstration components are able to be executed as intended.

V. Work Plan

Section V should provide a plan and estimated timeline for activities associated with the implementation of each component of the demonstration. To the extent possible, this section should include a description of the key tasks, responsible parties, timeframes for beginning and completing activities, and products or benchmarks of progress that will serve as evidence of completing the activities, noting the phasing or staging of provider contracts, services, or other activities if there are multiple implementation locations. Title IV-E agencies may choose to include a Gantt chart to support the narrative. Activities that may be particularly time-consuming or require action or approval by those outside of the child welfare agency to complete (e.g., State legislation, contractual agreements) should be identified. This section should address the following areas:

A. Developmental Activities: A summary of the title IV-E agency’s plan to develop the resources needed to support the waiver demonstration, including:

1. Cost estimates for interventions and activities associated with each demonstration component;

2. Decisions on how title IV-E dollars will be allocated, including projections of how savings will be realized;

3. Selection of and contracts with any partnering agencies;

4. Expected processes and dates for hiring needed staff, and schedules for training staff;

5. Developing supervision and coaching plans;

6. Installing or modifying any required data systems²;

7. Plans for initiating service delivery (e.g., referral protocols that describe how families or children will be selected to participate in the demonstration, how these selections will be made, and how the suitability of services will be determined; selection of units/sites that will begin implementation of the demonstration; and when and how staff will begin providing services associated with the initiative/interventions);

² Activities conducted as part of the demonstration that affect the title IV-E Agency’s Child Welfare Information System may require the submission of an Advance Planning Document to ensure compliance. See PI-10-05 for more information. Agencies are encouraged to contact the Division of State Systems within CB for further assistance.

B. Teaming and Building an Accountable, Collaborative Governance Structure:
Detailed information should be included related to the teaming structure to manage implementation of the demonstration, including:

1. Identification and description of the lead agency, partner organizations, and collaborative partners and their respective roles and responsibilities, including financial commitments to the demonstration;

2. Description of the standards of quality and safety and practice requirements identified by the title IV-E agency to be incorporated into any agreements with public and private providers that are expected to provide supports and services;

3. Identification of implementation teams along with clarified purposes, core features, functions of the teams, communication protocols that link teams, and teaming challenges or risks;

4. Identification and description of management procedures, positions, and functions;

5. Description of the processes for monitoring implementation progress, including ongoing identification of barriers or emerging implementation issues.

C. Communication Plan and Strategies: A description of the processes, procedures, and strategies for maintaining efficient and effective communication internally among all applicable partners, and externally with the public and policymakers.

D. Quality Assurance: A framework for continuous quality improvement and implementation and a description of the role of monitoring and evaluation in informing the implementation and refinement of the demonstration project’s components.

E. Evaluation Schedule: A timeline illustrating the inter-relationship between demonstration and evaluation activities, including efforts to engage a third-party evaluator and the evaluator’s expected hire date in relation to the proposed start date of the demonstration.

F. Phase Down Plan: A description of the plan for phasing down the demonstration so that case plans for children and their families can be adjusted, if necessary, for the post-demonstration portion of their placement, and to revert to traditional title IV-E claiming.

VI. Training and Technical Assistance Assessment

Section VI should include a description of the training and technical assistance (T/TA) resources the title IV-E agency anticipates it will need in order to implement the waiver demonstration, making note of any strengths and gaps in those resources. This description should include federally supported and non-federally supported T/TA resources. The agency should consult
with CB to determine the extent to which CB’s T/TA Network can be used to support the implementation and evaluation of the demonstration.

VII. Anticipated Major Barriers and Risk Management Strategies

Section VII should identify any anticipated major barriers to implementing the waiver demonstration’s interventions and any planned strategies to address them.

VIII. Program Improvement Policies

Section VIII should include a description of the new program improvement policy(ies) the title IV-E agency will implement within three years of the submission of the proposal, as required by the authorizing legislation. Please include a summary of implementation activities and describe the title IV-E agency’s progress towards full implementation of the proposed policies. If one or both of the new program improvement policies is included specifically as a waiver intervention and is fully addressed in the preceding sections, the information does not need to be repeated in this section.

IX. Quarterly Updates

Please provide as many quarterly updates as needed prior to the implementation of the State’s waiver demonstration. The “additional activities” section should include any notable information and progress made towards implementation during the applicable quarter that is not captured in the core areas of the IDIR. The “planned activities” section should illustrate the key activities planned for the upcoming quarter. Please add new fields for additional quarters as necessary, using a different color font with each quarterly submission.

Source: Children’s Bureau
www.acf.hhs.gov/programs/cb/resources

HOW THE NEW MEDICAID MANAGED CARE REGULATIONS WILL IMPACT YOUR STATE

Myers and Stauffer managed care experts offer the most important elements of the new regulations for state Medicaid programs.

CMS released the first major update of federal rules for health plans in state sponsored programs in more than a decade. The proposed rule impacts both Medicaid managed care and Children’s Health Insurance Program (CHIP) delivered in managed care and seeks to align the rules governing Medicaid managed care with those of other government-sponsored programs. Myers and Stauffer managed care experts prepared the following summary to assist government officials in understanding how their State may be impacted.

MEDICAL LOSS RATIO

The proposed rule implements an 85 percent minimum medical loss ratio (MLR) as well as provides guidance and regulations for how this is to be calculated and utilized during the capitation rate setting process for Medicaid and CHIP managed care plans, which include
managed care organizations (MCOs), pre-paid inpatient health plans (PIHPs), and pre-paid ambulatory health plans (PAHPs). The purpose is to bring consistency and standardization across all health insurance markets to promote fiscal stewardship, administrative efficiency, and comparability across states and markets. Key points include:

Actuarial sound rates developed using projected revenues and costs must be set to achieve an MLR of at least 85 percent. States may choose to implement a higher percentage as long as they allow for reasonable administrative costs and do not degrade beneficiaries’ access to services, quality of care, provider participation and continued viability of the Medicaid managed care plans in that market.

States must utilize the annual MLR calculation and reporting as part of developing future years’ rates.

The MLR reporting year will start with contracts beginning on or after January 1, 2017. States will have the option of utilizing a calendar year basis or aligning their MLR reporting year with their contract year as long as the MLR reporting year is the same as the rating period. The MLR reporting year cannot exceed 12 months.

States will not be required to collect remittances for failing to meet the 85 percent threshold; however, it is encouraged to utilize this as a performance incentive tool.

States may decide whether to require new health plans to report their MLR for their first year of operation in the new market. However, coverage of new Medicaid beneficiary populations will not be granted carve out exemption from the MLR calculation.

A periodic audit of the MLR reports will be required.

**ENHANCED AUDIT REQUIREMENTS**

The proposed rule significantly enhances the government’s inspection and audit rights by expanding the existing standard to include access to the premises, physical facilities and equipment of contractors and subcontractors and clarifies that the inspections or audits may be conducted at any time. The inclusion of subcontractors recognizes that health plans routinely delegate several key operational activities and the review of those operations will need to be included within the scope of any health plan audit or inspection. The proposed rule also requires that health plans submit annual audited financial reports conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards (GAAS). This audited financial data is one of the sources of base data that must be used in the development of rates by the actuaries.

In addition, the proposed rule requires states to periodically, but no less frequently than once every three years, conduct or contract for an independent audit of the “accuracy, truthfulness, and completeness of the encounter and financial data” submitted by each health plan. The results of these audits must be posted on the State’s website or be available upon request.

**PROGRAM INTEGRITY**
The proposed rule clarifies and introduces program integrity requirements for states and MCOs. Many of these requirements mirror requirements that are currently in place in the Medicare Advantage program. Key points include:

States must enroll all network providers of MCOs, PIHPs and PAHPs that are not otherwise enrolled with the state to provide services to FFS Medicaid beneficiaries.

States must conduct federal database checks to confirm the identity of and determine the exclusion status of the MCO entity, any subcontractor, any person with an ownership or control interest, or any agent or managing employee at the time of entering into the contract and no less frequently than monthly thereafter.

MCOs must certify the data, information and documentation, including encounter data and other rate setting data, MLR data, and data used to ensure solvency standards are met.

MCOs must take affirmative action (for example, routine auditing and monitoring) to detect and prevent fraud, waste and abuse.

Subcontractors that are delegated responsibility for coverage of services and payment of claims by the MCOs must have a program integrity/compliance plan.

States must make provisions for the MCO to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments.

The proposed rule also covers the recovery of overpayments made by MCOs. CMS proposes that recoveries of overpayments made by the MCO to providers that were excluded from Medicaid or that were due to fraud, waste or abuse are to be retained by the MCO. This proposal may have a significant impact on a state’s ability to recover overpayments identified by the state. CMS is requesting comment on alternative approaches, including imposing a timeframe between six months to one year for which the MCO may retain overpayments.

QUALITY IMPROVEMENT INITIATIVES
In developing this proposed rule, CMS recognized that states have expanded the use of managed care for the delivery of primary care, acute care, behavioral health services, and long term services and support (LTSS) to Medicaid beneficiaries. Throughout the rule, CMS proposes changes to maximize the opportunity to improve health outcomes over the lifetime of individuals. Specifically, CMS proposes to strengthen quality measurement and improvement efforts in managed care by focusing on the three principles of transparency; alignment with other systems of care; and consumer and stakeholder engagement.

The proposed regulations contain specific provisions to promote the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. To that end, the proposed rule includes provisions that will strengthen the ability of states to use managed care to promote innovative and cost effective methods of delivering care to Medicaid and CHIP beneficiaries, to incent managed care plans to engage in state activities that promote certain performance targets, and to identify strategies for value-based purchasing models for
provider reimbursement. The proposed rule includes provisions that strengthen the quality of care provided to Medicaid beneficiaries, including measuring and managing quality and improving coordination of care and it also promotes more effective use of data in overseeing managed care and promotes advances in health information exchange.

As managed care expands as the delivery system of choice for most states, it is clear that CMS has taken the opportunity to utilize these proposed regulations to further their goal of promoting the Triple Aim within a managed care environment to improve the experience of care, improve the health of populations, and to reduce the cost of health care without compromising quality.
NETWORK ADEQUACY

CMS’ goal is to establish minimum standards in the area of determining the adequacy of Medicaid managed care program provider networks, thereby allowing for the ability to analyze member access across programs and the country in a more consistent manner. CMS has indicated that it is eager to hear states’ input on whether the time and distance method of determining network adequacy is the most appropriate measure of network adequacy or whether other measures, either mandated by CMS or at each state’s discretion, provide a more accurate picture of members’ access to care. Key points of the proposed rule include:

- A requirement that each state establish time and distance standards for specific types of providers, including primary care, OB/GYN, behavioral health, specialist, hospital, pharmacy, pediatric, dental and long term services and support (LTSS), and others as determined appropriate by CMS.

- Time and distance standards could vary by provider type and geographic service area.

- States will be required to consider a list of factors that plans must use in establishing and maintaining a network when developing the time and distance standards.

- States may require other adequacy measures in addition to the time and distance standard.

- States will have the flexibility, within certain rules, to grant exceptions to their network adequacy standards.

ABOUT MYERS AND STAUFFER

For more than 35 years, Myers and Stauffer has provided professional accounting, consulting, data management and analysis services to state and federal agencies managing government-sponsored health care programs. The firm’s health care practice has helped more than 47 state Medicaid programs address complex reimbursement issues and provide independent oversight for managed care entities, hospitals, long term care facilities, home health agencies, federally qualified health centers, rural health clinics, pharmacy providers, physicians and other practitioner providers. For more than a decade, we have provided managed care audit and consulting services and are a trusted partner to state Medicaid agencies and the Centers for Medicare & Medicaid Services (CMS) assisting these entities with providing regulatory oversight. Our services also include Medicare and Medicaid audit, program integrity, investigative services and other delivery system consulting services to state Medicaid agencies, state Medicaid Fraud Control Units, federal health care agencies, including CMS, U.S. Department of Health and Human Services (HHS) Office of the Inspector General, and U.S. Department of Justice and the Federal Bureau of Investigation. We welcome the opportunity to speak to you regarding the new Medicaid Managed Care rules.

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Overview

Committee staff for Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR) of the U.S. Senate Committee on Finance have outlined at a high level the compromise legislation they are currently drafting in child welfare. The timeline moving forward as outlined by these staff is to bring this legislative proposal before the U.S. Senate Committee on Finance for its consideration on Wednesday, December 9 as part of a markup session that also would consider tax legislation. Staff however indicated that should the tax markup be postponed, the markup of this legislation also would be postponed.

The below summary is based on a verbal presentation by U.S. Senate Committee on Finance staff on Friday, November 20 and is intended to provide a high-level overview of the provisions as currently being considered. This remains a bill very much in draft form and further revisions are possible as discussions continue and cost implications are released by the Congressional Budget Office. As further written details are provided and information made available, this summary will be updated.

U.S. Senate Committee on Finance staff also indicated that they are not actively working with their staff counterparts in the U.S. House of Representatives, but see conversations with the U.S. House of Representatives as a next step in the process moving forward.

Legislative Proposal Summary

Current Title: The Family First Act

As currently outlined, the legislative proposal would have two sections – one to provide funding for prevention services as well as other legislative changes, and one to outline federal policy around placement setting for children in foster care.

Section 1 – Provisions around prevention services

Would include numerous provisions to create in the Title IV-E program an option for states, as well as tribes who administer a Title IV-E program, an option to operate a statewide prevention program. Effective date for this section is October 1, 2017.

- Would amend Section 471 to create a new subsection E outlining the provisions for this program.
Earlier versions indicated the markup was scheduled for December 2. However, the tax legislation markup has been postponed until December 9, and so this version updates this information.
- Would require eligible states and tribes to outline their program to provide preventive services, based on the construct below, with a requirement that the U.S. Secretary of Health and Human Services (HHS) approve the outlines of the plan (as already done for the title IV-E foster care program).

- Would allow state and tribes to provide specific services, and receive federal reimbursement for up to 12 months for children, parents or kin caregivers, who are defined as “candidates” for entry or reentry into care by the state or tribe, or are a pregnant or parenting youth in foster care. Federal reimbursement for these services would not be available for children in foster care, or their parents or kin caregivers
  o No income criteria would apply for eligibility for reimbursement for the prevention program. The legislative proposal makes no changes to current income criteria for eligibility for reimbursement under the title IV-E foster care program.
  o Services eligible for reimbursement in this new program would be substance abuse prevention services, mental health services, and in-home parent skill based programs defined to include parent training as well as individual and family counseling.
  o To be eligible for reimbursement, the services must be specified in advance in the child’s prevention plan which also identifies the permanency goal for the child. Services provided must be linked to the placement and permanency goals and must be trauma-informed.

- Would specify that prevention services eligible for reimbursement must be evidence-based, with the federal financial participation (FFP) phased in over time as follows:
  o Beginning 10/1/2017, FFP is 40% and services eligible for reimbursement must be promising, supported, or well-supported (with definitions for each of these categories defined in law)
  o Beginning 10/1/2020, FFP is 50% and services eligible for reimbursement must be supported or well-supported
  o Beginning 10/1/2023, FFP is the state or tribes FMAP and services must be well-supported.
    ▪ Staff provided that the definitions for the above three categories align very closely with the definitions for these categories as specified in the California Evidence-Based Clearinghouse for Child Welfare. Specifically, in the supported and well-supported categories the requirement that programs be evaluated with a randomized-controlled trial would be adjusted to allow for other evaluation techniques.

- Would also establish and reimburse for up to 12 months specific services for kin caregivers who are caring for relative children who cannot be cared for by their birth parents and are identified by the state or tribe as a “candidate” for foster care.
  o Services eligible for reimbursement for kin caregivers would be short-term financial support and access to kinship navigator programs.
  o Would specify that these specific kinship services would be reimbursed at the state or tribe’s FMAP rate with eligibility phased in over time based on the age of
the candidate child. These specific kinship services also would not be subject to the evidence-based requirement.
- States or tribes who chose to operate a prevention program also would be eligible for reimbursement for administrative or training costs associated with this prevention program at 50%. As with the preventive services, no income eligibility criteria would apply to this aspect.
- States or tribes who administer the program would be required to report data as specified in the proposal.
- States or tribes also would be subject to a maintenance of effort provision.

Other provisions in this section would
- Provide federal reimbursement for title IV-E foster care maintenance payments made on behalf of a child who is placed in a residential family drug treatment program with a parent who is receiving treatment
- Provide short-term crisis intervention services to help support a family in crisis or to support kinship placements
  o Would create a capped mandatory funding amount for this short-term service from within the Title IV-B program, with this set-aside amount TBD.
- Rename within the Title IV-B-2 Promoting Safe and Stable Families (PSSF) program the “time-limited family reunification services” to “family reunification services.” Also removes the current law limit which says services under this category may only be offered to or on behalf of children who have entered foster care within the last 15 months and permits these services for any child in foster care and allows them to be provided for up to 15 months after a child is reunited with the biological family.
- Require the Secretary of HHS to establish, by regulation, national model foster care licensing standards for relative caregivers. States or tribes who deviate from these standards would be required to explain why they deviate.

Section 2 – currently titled “Ensuring the Necessity of a placement that is not a foster family home. Effective date for this section is October 1, 2019.
- Would specify that after 2 weeks in care, FFP would only be provided for placements in a family foster home (defined), qualified residential treatment program (QRTP, also defined), a facility for pregnant and parenting teens, or an independent living arrangement.
  o Foster family home was described to define that there be no more than 6 foster children in the home, with exceptions for a parenting youth in foster care, siblings, meaningful relationships, or a child with a severe disability.
  o Quality residential treatment program (QRTP) also is defined, and was described (at a minimum) to be a program with a clinically, recognized treatment model, that can provide the treatment as identified by the assessment through licensed and clinically-trained staff. Would further require that the QRTP involve the
child and family in the treatment, and that the program provide post-discharge services and support for at least 6 months. QRTPs also for FFP would be required to be licensed and accredited by a nationally-recognized body.

- Would require an assessment to be completed 30 days after placement in a QRTP.
- Would require that within 30 days of the placement, a qualified individual (defined) must make an assessment (defined) that the QRTP is the appropriate placement, and if the assessment determines the QRTP is not the appropriate placement require the change in placement (up or down) must be completed within an additional 30 days.
  o Would require that the assessment is done in conjunction with a team of individuals, comprised to include among other relatives, fictive kin, professionals including medical and mental health professionals, teacher, and/or clergy.
    • Assessment is defined as a functional needs assessment using a valid assessment tool that is age appropriate and evidence-based.
    • Qualified individual is defined and was described to be a trained professional or licensed clinical worker who is not an employee of the state or tied to the QRTP, although would allow the Secretary to waive if appropriate.
      o Staff described the intent of the definition as working to ensure those with a vested interest in the placement are not making the determination of the appropriateness of the placement.
  o Would require that within 60 days of a placement in a QRTP, a court must review and approve the placement. Further specifies that the appropriateness of the placement should be reviewed at each status review and permanency hearing for the child to document it remains the appropriate placement.
  o Would specify that for youth 13 years and older placed in a QRTP for 12 months consecutive/18 months non-consecutive, the state agency must notify the parents, kin caregivers or others involved with the child that the child has a private right of action to the least restrictive environment. For youth under 13, this notification would be required after 6 consecutive months.
    ▪ There is in current statute a requirement that a child in foster care be placed in the least restrictive environment. Court rulings around this requirement have not been consistent. This provision would clarify Congressional intent that this private right of action does exist for youth in foster care.

*Other provisions in this section would*

- Require protocols in the state child welfare plans to prevent inappropriate diagnosis of youth in care to inappropriately place them in a QRTP.
- Specify data and evaluation requirements around these provisions.
- Require the Government Accountability Office (GAO) to issue a report to Congress related to the impact of this policy on the juvenile justice system. Staff expressed their
interest in being sure states are not shifting children from congregate care settings to the juvenile justice system with this policy

Ms. McDonald made a motion to accept the report, seconded by Michelle Grose-Bray.

Discussion: President Allenbaugh welcomed Ms. McDonald back after her absence.

Vote: Those in Favor: Aye
Opposed: Nay (None)
Motion carried.

**Membership Report:**

Presented by Mr. Chris Smith of Oklahoma

Madame President, Board Members, Regional Coordinators, Past Presidents, and Committee Chairs:

I’d like to start by thanking President Allenbaugh for the opportunity to take over the HSFO membership chair for 2016. She’s been instrumental in helping me understand the duties and responsibilities of the role. Also thanks to Michelle Grose-Bray, the previous Chair, for directing me and establishing a guide to get me started.

Activities for the membership chair since the annual conference in Sparks, Nevada – which was held in July and August of this year - consist of:

1. Updating the historical membership listing
2. Reviewing the documentation for the roles and responsibilities of the Membership Chair
3. Working with Regional Coordinators to establish new regional layouts and establishing conference calls to create plans for 2016

Planned future activities include the following:

1. Continue efforts to increase membership. With the annual conference being held in Tampa, Florida in 2016, we believe we can add to the membership list by pulling in new members; while keeping new members enrolled
2. Work with Regional Coordinators to assist the Treasurer in gathering membership dues from member states
3. In coordination with the Regional Coordinators, perform outreach activities from prior member states which have lapsed in their membership

Mr. Smith moved for acceptance.
Discussion:  Around need to clarify the number of members, which Mr. Smith indicated was 47. 
Motion to accept as amended by Michelle Grose-Bray was seconded by Scott Carson, Arizona

Vote:  Those in Favor:  Aye
     Opposed:  Nay (None)
Motion Carried.

**Regional Coordinators Report:**

Presented by Mr. Hank Fitzer of Maryland.

Madam President:

The four HSFO Regional Coordinators serving in 2016 are: Christal Kelly of North Carolina, Tara LeBlanc of Louisiana, Jesse Bratton of Oklahoma, and Hank Fitzer of Maryland.

Prior to the Fall Planning and Business Meeting, the four incoming Regional Coordinators, along with Chris Smith, the incoming Membership Chair, were able to conduct two conference calls to discuss plans for 2016.

The previous Regional Coordinator (or Regional Director) structure in HSFO provided for eight individuals, each assigned to a clearly defined grouping of states within a region; eight regions in total. With the number of Regional Coordinators now reduced to four, and no specific re-grouping of states yet defined by the organization, a first order of business for the incoming coordinators is to propose an assignment of states, and a grouping of these into four regions. The proposed state and regional assignments, as reflected in the attachment, is generally geared toward the geographic locations of the four 2016 Regional Coordinators: Region 1 (in light blue), Hank Fitzer of Maryland; Region II (in green), Chrystal Kelly of North Carolina; Region III (in yellow), Tara LeBlanc of Louisiana; and Region IV (in dark blue), Jesse Bratton of Oklahoma. (Jesse and Tara can work things out over Oklahoma – otherwise, some unsightly gerrymandering on the map). Again, this is a draft, start-up plan with respect to area assignments for the four 2016 coordinators. There are some stretches in the state groupings. We request input on what the organization might want in the way of a more permanent arrangement of regions.

Once we have a Region, what do we do with it? We referred to the organization’s Bylaws for a refresher. We look forward to working with the President, and to assisting and supporting the various Chairs, particularly Membership, Marketing and Training, in promoting organization membership and activities. Time did not permit extensive discussion on particulars, prior to the Fall meeting, but we need to work out regularly-scheduled communications on what is needed, where, and by when.
This concludes my report.

Motion to accept report was made by Mr. Fitzer and seconded by Deena Brown of Oklahoma.

Vote: Those in Favor: Aye
Opposed: Nay (None)
Motion carried.

**Time and Place:**

Presented by Mr. Stan Mead of Louisiana

Madam President, Board Members, Past Presidents and Attendees,

It is my pleasure to present the Time and Place report.

The 2016 Spring Planning Meeting will be held in Burlington, VT at the Hilton Garden Inn. The dates of the meeting are April 23 – April 27, 2016. The rate is $104 plus 11% tax.
The 2016 Annual Conference will be held in Tampa, FL, at The Westin Tampa Harbour Island Hotel. The dates of the conference are July 31 – August 05, 2016. The rate is $104 plus 12% tax.

Several sites are consideration for the 2016 Fall Planning Meeting as well as the 2017 Spring Planning Meeting. The sites of the meetings will be posted on the HSFO website went a decision is made.

New Orleans, LA is under consideration for the 2017 Annual Conference. The decision on New Orleans will be made at this meeting.

We are currently soliciting a host site for the 2018 Annual Conference. Any member interested in hosting our conference should contact me. My phone number and e-mail address maybe found on the HSFO Web Site.

The $104 rate for Tampa will be adjusted based on the Federal Per Diem Rate in effect at the time of the conference.

Motion to accept the report was made by Mr. Mead and seconded by Deena Brown.

Discussion: None

Vote: Those in Favor: Aye
                Opposed: Nay (None)
Motion carried.

Resolutions Report:

Presented by Mr. Mark Story of Arkansas

To date, no potential resolutions have been offered by the membership. In January 2016, I plan to submit to the webmaster a request to Members via email asking them to consider suggestions for appropriate submissions. Members will be encouraged to submit suggestions and to begin work with the Resolutions Chair as soon as possible.

Motion to accept the report was made by Mr. Story and seconded by Scott Carson.

Discussion: President Allenbaugh noted she was glad to see Mark back.

Vote: Those in Favor: Aye
                Opposed: Nay (None)
Motion Carried.

By-Laws Report:
Presented by Mr. Harry Roberts of Delaware.

President Allenbaugh asked me to serve this year as the By-Laws Chair and I would like to provide the following report.

During the 2015 HSFo Annual Conference business meeting in Sparks, NV, Mr. Jesse Bratton(OK), Chair of the Audit Committee prepared a Management Letter for President Dague Clark. President Clark appointed a sub-committee to review the management letter and develop recommendations. Members of the Audit Sub-Committee are: Chair, Jesse Bratton(OK), Conitha King(AL), Jason Sanchez(NM), Tara LeBlanc(LA), Rick Brennan(WV), Richard Humiston(ID). The Sub-committee met and the following bylaw change was requested arising from discussions concerning the 2015/16 Accounting services contract.

Article IV. Officers, Section 6. The Treasurer shall have custody ensure all funds of the Association. The funds shall be deposited are held in a bank in which deposits are protected by insurance coverage through a Federal Agency. Funds shall be withdrawn by means of checks or other electronic means authorized signed by the Treasurer or the President. All expenditures shall be supported by appropriate bills or statements and shall be subject to approval by the Executive Committee. He/she shall pay or direct to be paid by the Arrangements Chairperson all financial obligations officially incurred during his/her term in office. He/she shall direct the accounting methods and procedures to be used by the Arrangements Chairperson. He/she shall direct the preparation and submit to the Board of Directors the Annual Financial Statements in accordance with the Association's accounting system and reporting requirements as approved by the Board not later than the Spring Planning Meeting after the close of the Association's fiscal year. He/she may advance funds to his/her successor prior to officially closing the records. He/she shall perform all other duties pertaining to the office. The Treasurer's records will be forwarded to his/her successor, to be retained in accordance with the Association's legal requirements.

As of 11/20/15 I have not received any additional requests for bylaw changes.

Motion to accept the report was made by Mr. Roberts and seconded by Jason Sanchez.

Discussion: Mr. Roberts indicated the he would like to look at ways to amend bylaws when needed between meetings and better define corporate sponsors/members.

Richard Brennan expressed the need to clarify the difference between signed/authorized. In the discussion, it was mentioned by Dick Humiston that both the Treasurer and the President have access on-line to all accounts.

Vote: Those in Favor: Aye
     Opposed: Nay (None)
The motion carried.
Marketing and Communications Report:
Presented by Ms. Roberta Blythe of Arizona

The 2016 Marketing and Communication Committee is pleased to be utilizing and expanding upon existing methods of communication and developing new methods to reach both our members and non-members. With approval from the board, communications will include:

- Maintaining an ongoing social media presence including frequent posts about the organization, upcoming events, and interaction with sponsors and/or organizations with similar goals and interests
- Utilizing networks outside of HSFo membership
- Coordination with the Membership Chair and Regional Coordinators to more directly target communications to states
- At a minimum, publications will include:
  - Conference save the date
  - Supplemental registration materials for new attendees and those who have attended previously
  - Meet your conference speakers series
  - Advertisement of the conference charitable campaign

Advertisement(s) of training opportunities

Motion to accept the report was made by Ms. Blythe, seconded by Jason Sanchez.

Discussion: None

Vote: Those in Favor: Aye
  Opposed: Nay (None)

Motion Carried.

Nominating Report:
Presented by Mr. Scott Carson of Arizona on behalf of Mr. Dague Clark of New Hampshire.

Madam President, Board Members, Past Presidents and Attendees,

It is my pleasure serve as the Nominating Committee Chair and to present the Nominating Committee report.

The Nominating Committee and Executive Board had a conference call on September 14, 2015 and voted to confirm President Elect, Vonnetta Allenbaugh’s, appointments for the two (2) 2016 Regional Coordinators positions. The two Regional Coordinator appointments are as follows:
Hank Fitzer (MD)

Christal Kelly (NC)

Hank Fitzer will be acting as a Mentor/Lead for the 2016 Regional Coordinator group.

Motion to accept the report was made by Scott Carson and seconded by Tara LeBlanc.

Discussion: None.

Vote: Those in Favor: Aye
Opposed: Nay (None)
Motion Carried.

Training Committee Report:

The report was presented by Mr. Rick Brennan of West Virginia.

Since the HSFO Annual Conference in Reno, NV, HSFO has offered two Training Sessions. The first was an Advanced Cost Allocation held September 1 through September 3, 2015, in Phoenix AZ. This Training was presented by PCG, and was offered as a substitute for a Medicaid II originally scheduled for this slot. The Session had 40 Registrants and 3 Trainers. Registrations consisted of 26 from Arizona, 2 from Wisconsin, 3 from Utah, 2 from Ohio, 1 from Louisiana, 1 from Michigan, 2 from Nevada, 1 from Missouri, and 2 from Maine. Eight of these Registrants received CPEs for the Training.

Child Welfare I was held at the Hyatt Regency in Louisville, KY, on November 10-12, 2015. Training was presented by SIVIC Solutions. The were 15 Registrants for this Training, with: 2 from Kentucky, 1 from New Mexico, 3 from Maryland, 1 from Arkansas, 1 from Illinois, 2 from Missouri, 2 from Vermont, 1 from Wyoming, 1 from Nevada, and 1 from New Hampshire. Within this group, there were 2 staff from consulting groups (IVA and Sequoia) and 1 faculty member (Maryland). CPEs were awarded to two Registrants.

Over the last several months the Training Committee has met on Conference Calls every two weeks, with all calls arranged by President Allenbaugh. We have covered a number of issues, including: how to improve publicizing Training offerings; the composition of new Medicaid and Grants Management Trainings; the format of Training offerings; and related requirements to support the types of Trainings offered, including technological options.

To date, we have posted an RFI for Medicaid Trainings, including designs of curricula and offering formats. This has been posted and can be accessed on the
HSFO website. We really appreciate the editing done to this RFI by Mr. Harry Roberts, who obviously spent a lot of time and effort on it. This has also been sent to all of our Sponsors, to Mostly Medicaid, and has been copied to Matt Salo at the National Association of Medicaid Directors.

Ms. Allenbaugh and I have had separate conversations with Clay Farris of Mostly Medicaid and Trinity Tomsic regarding options for Medicaid and Grants Management Trainings. The results of these discussions have been presented to the Training Committee for their analysis.

A variety of Training issues have been scheduled to be addressed in Training Committee meetings this week. These will be presented to the Executive Board as they are formalized and/or acted upon.

Motion to accept the report was made by Mr. Brennan and seconded by Deena Brown.

Discussion: None

Vote: Those in Favor: Aye
    Opposed: Nay (None)
Motion Carried.

**CPE Committee Report:**

Presented by Chris Smith for Jerry Berry.

Good afternoon, President and members.

At the annual conference in Sparks, Nevada – held July 26th through July 30th, 2015 – twenty-five individuals requested and received up to 29.0 CPEs.

Since the annual conference in Sparks, HSFo has offered two other trainings for CPE’s. The first was an Advanced Cost Allocation training held in Phoenix, AZ from September 1st through 3rd. Up to 16.5 CPE’s were available. Eight individuals requested and received CPE’s.

The second was a Child Welfare I training held in Louisville, KY from November 10th through 12th, 2015. Up to 16.5 CPE’s were available. Two individuals requested and received the CPE’s.

HSFo is in the process of working on the details for trainings to be held in 2016.

Motion to accept the report was made by Mr. Smith and seconded by Michelle Grose.
Discussion: Corrections to dates for Child Welfare Training, correction is reflected above. There was also discussion to clarify number of CPE available for Reno.

Vote: Those in Favor: Aye
     Opposed: Nay (None)
Motion Carried.

Arrangements Report for Annual Conference 2015 Sparks, NV:

Presented by Mr. Stan Mead – Louisiana

It is my pleasure to present the 2015 Annual Conference Arrangements report.

The 2015 Annual Conference was held in Sparks, Nevada, at the John Ascuaga’s Nugget Resort Hotel. The dates of the conference were July 26 - July 31, 2015. The conference was hosted by HSFO for the first time. It was an overwhelming success and ended with a surplus.

There are two (2) attachments to my report. The first detailed the attendees at the conference and will be presented by Past President Deena Brown. The second is the financial statement for the conference and will be presented by Past President Richard Humiston. I would like to pause now for the presentations of the attachments.

Attachment #1
Breakdown of attendees is as follows:

66 Members from State Agencies
19 Corporate Members
4 Non-Members
25 Speakers
1 Federal Agency Staff
19 Guest

Important to note that of all those attending, there were 32 total that stated they were first time attendees when they registered.

Attachment #2

National Association of State Human Services Finance Officers
2015 Annual Conference Sparks NV
Statement of Budget to Actual Comparison FYTD through 11/30/2015

<table>
<thead>
<tr>
<th>Actuals</th>
<th>Budget</th>
<th>Variance</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>+Good/-Bad</td>
</tr>
</tbody>
</table>
### Income

<table>
<thead>
<tr>
<th></th>
<th>Early</th>
<th>Reg</th>
<th>Non Member Early</th>
<th>Non Member Reg</th>
<th>Fed Early</th>
<th>Fed Reg</th>
<th>Guest</th>
<th>Youth</th>
<th>Single Day</th>
<th>Half Day</th>
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</thead>
<tbody>
<tr>
<td>Conf Reg Annual Dues</td>
<td>$22,500.00</td>
<td>$13,000</td>
<td>$9,500.00</td>
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<td></td>
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</tr>
<tr>
<td>Corporate Sponsors</td>
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<td>$36,000</td>
<td>$(3,000.00)</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Corporate Donations</td>
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<td>$6,000</td>
<td>$4,600.00</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Conf Inc Member Early</td>
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<td>$44,000</td>
<td>$(14,450.00)</td>
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<td></td>
<td></td>
<td></td>
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<td>Conf Inc Member Reg</td>
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<td>$(3,250.00)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conf Inc Non Member Early</td>
<td>$4,000.00</td>
<td>$</td>
<td>$4,000.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Conf Inc Non Member Reg</td>
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<td>$</td>
<td>$950.00</td>
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</tr>
<tr>
<td>Conf Inc Fed Early</td>
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<td>$</td>
<td>$650.00</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Conf Inc Guest</td>
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<tr>
<td>Conf Inc Youth</td>
<td>$</td>
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<td></td>
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<tr>
<td>Conf Inc Single Day</td>
<td>$</td>
<td>$</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Conf Inc Half Day</td>
<td>$</td>
<td>$</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Total Income

$102,000.00 | $106,625 | $(4,625.00)

### Expenses

<table>
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<tr>
<th></th>
<th>Early</th>
<th>Reg</th>
<th>Non Member Early</th>
<th>Non Member Reg</th>
<th>Fed Early</th>
<th>Fed Reg</th>
<th>Banquet</th>
<th>Vehicle Rental</th>
<th>Volunteers Travel</th>
<th>Program Equipment</th>
<th>Registration &amp; Support</th>
<th>Conference Room Rebate</th>
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</thead>
<tbody>
<tr>
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<td>$(636.33)</td>
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<td>$(3,157.50)</td>
<td>$(10,374.45)</td>
<td>$(897.36)</td>
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<td>Conf Exp Bd Dinner</td>
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<td></td>
<td></td>
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<td>$(3,636.33)</td>
<td>$(8,069.65)</td>
<td>$(3,157.50)</td>
<td>$(10,374.45)</td>
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<td></td>
<td>$(521.28)</td>
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<td>$(10,374.45)</td>
<td>$(897.36)</td>
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<td>$(877.88)</td>
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<td>$(636.33)</td>
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<tr>
<td>Conf Exp Guest Event</td>
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<td></td>
<td></td>
<td>$(521.28)</td>
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<tr>
<td>Conf Exp Banquet</td>
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<td>$(836.33)</td>
<td>$(10,374.45)</td>
<td>$(897.36)</td>
</tr>
<tr>
<td>Conference Room Rebate</td>
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<td>$(8,000)</td>
<td>$(897.36)</td>
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<td></td>
<td></td>
<td>$(877.88)</td>
<td>$(272.12)</td>
<td>$(272.12)</td>
<td>$(636.33)</td>
<td>$(10,374.45)</td>
<td>$(897.36)</td>
</tr>
</tbody>
</table>

Total Expenses

$(77,659.75) | $112,800 | $35,140.25

Net Surplus/(Deficit)

$24,340.25 | $(6,175) | $30,515.25

In closing I would like to thank everyone who helped with the conference and made it such a successful one. I have been an arrangement chairperson on three (3) previous
occasions but never have I had an arrangement committee to equal the one I had in Sparks.

Motion to accept the report was made by Mr. Meade and seconded by Scott Carson.

Discussion: Stan Meade specifically thanked Richard Billera for his efforts in raising $10,000 of corporate sponsor funding. Also clarification of the room rebate as being $20 per room per night as well as one comped room for every 50 rented.

Vote: Those in Favor: Aye
        Opposed: Nay (None)
Motion Carried.

**Arrangements Report for the Annual Conference 2016 Tampa, FL:**

Presented by Ms. Deena Brown, Oklahoma

HSFO will host the Annual Conference at the Westin-Tampa Harbour Island Hotel in Tampa, Florida. The scheduled dates are Sunday July 31, 2016 thru Thursday Evening August 4, 2016.

Room rates will be at the prevailing federal per diem rate for 2016 which is currently $106 per night for a single or double.

Team Tampa is currently exploring ideas for the Conference event as well as the guest event. Information will be forth coming as we begin to make decisions. We are expecting a youth presence and are exploring the options of possibly hosting a hospitality room for them during the times that parents are attending conference functions such as the President’s reception and Conference banquet. At this time we are not planning on any outside activities for the youth.

Last year members from this group were asked to bring door prizes or bag gifts from their local states. Many individuals and states contributed and we successfully had a good amount of give a ways.

We would like to ask members to contribute again for the Tampa conference. If you have any questions just let me know. We’ll be sending out reminders over the next several months. Thanks in advance for any contributions you can provide.

Motion to accept the report made by Deena Brown and seconded by Hank Fitzer.
Discussion: There will not be youth hospitality suite.

Vote: Those in Favor: Aye
     Opposed: Nay (None)
Motion Carried.

**Arrangements-Spring Meeting 2016 Burlington, VT** – Presented by Jason Sanchez of New Mexico on behalf of Richard Donahey of Vermont:

Madam President, Board Members, Past Presidents and Attendees,

It is my pleasure to present the Arrangements Report for the HSFo Spring 2016 Planning and Business Meeting, to be hosted by the Vermont Agency for Human Services.

The meeting will be held in Burlington, VT at the Hilton Garden Inn. The dates of the meeting are April 23 – April 27, 2016. The room rate is $104 plus 11% tax. The deadline for hotel registration is March 22nd, 2016. There is a free shuttle from the airport to the hotel. A link to the HSFo room-block is provided on the HSFo website, dates tab.

The Hilton Garden Inn is a beautiful brand-new hotel in downtown Burlington, overlooking Lake Champlain. Burlington, Vermont is consistently named one of the best places to live in the United States.

Motion to accept report by Jason Sanchez, seconded by Jesse Bratton of Oklahoma

Discussion: Commended efforts to get a hotel rate of $104, rack rate is $169.

Vote: Those in Favor: Aye
     Opposed: Nay (None)
Motion Carried.

**Audit Committee** - Mr. Jesse Bratton of Oklahoma

Madam President, Board members, Regional Coordinators, Past Presidents and guests:

The audit of HSFO financial records for the period of December 1, 2014 through Nov. 30, 2015 will begin at the conclusion of the December 2015 Fall planning meeting. The audit will include transactions from the December 2014 Fall planning meeting held in Tampa, FL, the April 2015 Spring planning meeting held in Oklahoma City, OK, the July 2015 Annual meeting held in Sparks, NV, the financial records maintained by Mr. Richard Humiston, and any other transactions that occurred during the audit scope. The full audit report will be available at the annual conference in Tampa, FL, with an update at the Spring Business/Planning Meeting in Burlington, VT.

Motion to accept report made by Mr. Bratton
Seconded by Jason Sanchez
Discussion: None

Vote: Those in Favor: Aye
Opposed: Nay (None)
Motion Carried.

**Accounting Contract**-Vonnetta Allenbaugh of Oklahoma, President

The accounting contract for Dick Humiston was discussed after Mr. Humiston was excused from the room. Current contract to be extended for one year, with the provision added for a fidelity bond, which has been provided in past years, but never formalized in the contract. A provision was also added regarding time frame for payments. A requirement was also added to require the contractor to assist HSFo Treasurer with preparation of required IRS documents. There were other amendments that were basically intended to memorialize other duties that have been done, but never formally required.

Amended Contract shown as Appendix 1.

Conitha King made a motion to accept renewal of Mr. Humiston’s contract, motion was seconded by Jesse Bratton.

Discussion: Richard Billera mentioned that the bond amount that Mr. Humiston carries is less than the organization’s assets. Mr. Stan Meade noted that HSFo also has a security bond and that perhaps Mr. Humiston would be covered by that bond as an ex-officio officer. Michelle Grose-Bray asked if there is documentation of Mr. Humiston’s bond and President Allenbaugh stated that Mr. Humiston provides a copy. Also discussed that all executive board members are covered by the organization’s fidelity bond.

Vote:
- Those in favor: Aye
- Opposed: Nay (none)
Motion passed.

**Treasurer Report**: Mr. Jason Sanchez of New Mexico

Report was presented as shown in Appendix 2 of these minutes.

Motion to accept report was made by Jason Sanchez and seconded by Michelle Grose-Bray.

Discussion: None
Vote:

Those in favor: Aye
Opposed: Nay (none)

Motion passed.

**Review Fee Schedule**

President Allenbaugh distributed the current fee schedule and proposed no changes be made for the coming year. Upon suggestion from Stan Meade, discussion was postponed until later in the day so fees could be discussed in conjunction with the budget. Rick Brennan also asked that training fees be flexible.

**Sponsor Development Report** – Presented by Jason Sanchez of New Mexico on behalf of Richard Donahey.

Madam President and fellow Board Members,

I am sorry that I cannot be in attendance, and I wish you all the very best this holiday season.

Invitations to this meeting were sent to our 2015 Corporate Sponsors. Additionally, a request was made of our Sponsors to contribute to this fall planning meeting. As of December 10, Anthem pledged $2,000 and Cenpatico pledged $1,000 toward the fall Planning Meeting. Invoices were delivered, as well.

I am awaiting the final decision on fees for next year prior to preparing invoices for 2016 Corporate Sponsorship. The invoices will be mailed in early January 2016, pending final rates.

In closing, as always, we greatly appreciate the presence and support of our sponsors.

This concludes my report and I ask that a motion be made for its acceptance in my absence.

Motion to accept report was made by Jason Sanchez and seconded by Deena Brown.

Discussion: Rick Brennan asked if anyone was reaching out to new sponsors and expressed a need to do so. Deena Brown indicated that members do outreach and send the information to Mr. Donahey for his action. Discussion was that we added to last year’s number and outreach is ongoing. Stan Meade also asked if PCG had been asked to pledge any additional funds and whether they did so.

Michelle Grose-Bray asked about Anthem, apparently they are the new parent group of Amerigroup.
Vote:
Those in favor say: Aye
Opposed: Nay (none)
Motion passed.

Budget Submission and Approval:

President Allenbaugh presented her proposed budget for 2016.

President Allenbaugh discussed various aspects of the budget as a report, including several one-time increases or needed expenditures and changes from previous years, including internet service transition, marketing, and additional site-selection visits.

Based on input received from the Executive Board and Regional Coordinators, and the Program, Training and Arrangement Chairs for each of their respective budgets, the initial proposed budget reflected a proposed net deficit for the year of $82,662.

Conitha King moved to accept the report and the motion was seconded by Scott Carson.

Stan Meade pointed out that we couldn’t discuss the budget based on the acceptance of the report.

Motion to accept the budget was made by Michelle Grose and seconded by Tara LeBlanc.

The discussion followed was centered around the increased expenditures, the reason for the increases, and the need to increase revenues to cover the increased expenditures.

Jason Sanchez asked for the history of a “required” bank balance. Discussion indicated that it was not written, but was an unwritten policy to have enough to cover conference expenses.

Michelle Grose indicated that the expectation was that the conference would cost less than what was approved in the arrangements budget. Stan Meade said there is nothing of substance that is negotiable in the hotel budget. Deena Brown stated that the hotel rate needs to stay at or below the federal per diem rate.

Hank Fitzer stated that the proposed budget is a “worse-case scenario”.

Also discussed the number of expected conference attendees, and the whether the expenses would be reduced if there are fewer attendees.

Discussion also centered around the cost of internet services in the future years and cost of transition. Some of the costs are one-time costs, some are due to “catching up” on conference planning activities, but some costs will continue to rise.
The discussion was supportive of the level of expenditures needed, but there is a need for additional revenue to support that level.

Stan Meade suggested that costs could be reduced by picking conference locations earlier and holding planning meetings there rather than having separate site selection visits.

Conitha King made a motion to accept the budget as presented by President Allenbaugh, with consideration given that the board would try to keep the expenditures as low as possible. Motion was seconded by Michelle Grose-Bray.

After clarification, Conitha King amended her motion to accept the budget as presented in total. Michelle Grose-Bray seconded.

Motion carried with no opposing votes.

President Allenbaugh made a motion to accept the proposed fee schedule, seconded by Conitha King.

Discussion of if the fee schedule changes, what happens to the proposed budget that was approved. Does the budget have to be re-adopted for increased revenue, which results in a lower deficit.

President Allenbaugh called for a vote, but discussion continued.

Harry Roberts suggested dues be raised to $1,800 and conference fees be raised by $100.

Conitha suggested we take this year to make the organization more marketable by increasing our presence and not put the cart before the horse by increasing our fees before we increase our marketability.

Harry Roberts commented that we need to go ahead and raise the fees.

Hank Fitzer stated that if we don’t raise the fees this year, then Scott would be in a very difficult position next year.

Margaret Wahrer asked if the membership is raised to $1,800, then do we increase the amount taken from dues and credited to conference registration. Stan Meade stated it doesn’t matter, but whatever we raise registration fees too, should be shown as a transfer to the conference registration.

Scott Carson stated that a choice may have to be made that we accept the fact that we have 100 or so attendees at the conference and make the conference less expensive. Stan gave reasons to increase registration such as more CPEs, etc.

Comments still express concern that we can’t adopt a deficit budget and would not do that in our real jobs.
If we don’t address the issues, we will stagnate. We should use the reserve we have to turn things around.

We lose money on every conference attendee, so it’s not about the number of people who attend, but how much we spend on each attendee and therefore, lose money. We need to either increase conference fees or decrease the cost of the conference. Are there items we could trim to make the conference cost less?

Discussion then went to how much membership fees should change and whether it would affect membership.

Also discussed whether an increase to conference registration would result in lower attendance.

The discussion went to amending the Tampa budget to remove paying for airfare for spouses of volunteers.

There was also discussion about the need for $20,000 in the budget for conference speakers. President Allenbaugh explained the reasons for leaving it at $20,000 including the innovative program schedule and expanding the conference back to 4 full days. The program doesn’t expect to use the full budget but needs the flexibility and that the whole purpose of the conference is the program.

Scott suggested that we not do a full conference event in New Orleans and allow attendees to have free time to explore the city on their own.

The meeting was suspended to allow the board to go into closed session to discuss possible changes to the fee schedule and the resulting changes to the proposed budget.

Upon return, the fee schedule was discussed and after discussion of proposed fee changes, President Allenbaugh moved for acceptance of the revised fee schedule as follows:

**2016 - HSFo Fee Schedule**
(Final approved 12/15/15)

**Annual Dues:**
- Membership includes one conference registration: $1,800.00
- Corporate Member Dues: $3,500.00(1)

**Annual Conference Fees:**
- Member or Corporate Sponsor Early (before June 29th) Annual Conference Registration Fee: $700.00
- Member or Corporate Sponsor Annual Conference Registration Fee: $750.00
• Non-Member Early (before June 29\textsuperscript{th}) Annual Conference Registration Fee: $\900.00$
• Non-Member Annual Conference Registration Fee: $\950.00$
• Federal Employee Early (before June 29\textsuperscript{th}) Conference Registration: $\750.00$
• Federal Employee Conference Registration: $\800.00$
• Guest (over 19) Registration for Annual Conference: $\250.00$
• Youth (8 to 18) Registration for Annual Conference: $\50.00$
• Single Day Registration for Annual Conference: $\250.00$
• Half Day Registration for Annual Conference: $\150.00$

\textbf{Host State Annual Conference Fees:}
• Full Conference Registration, Early (before June 29\textsuperscript{th}): $\600$
• Full Conference Registration, Regular: $\650$
• Single Day Conference Registration: $\125$ (50\% of $\250$
Single Day Rate)
• Half Day Conference Registration: $\75$ (50\% of $\150$ Half Day Rate)

\textbf{Planning Meeting Fees:}
• Member or Corporate Sponsor Registration: $\150.00$
• Non-Member Registration: $\200.00$
• Guest Registration: $\50.00$

\textbf{Training Fees:}
• Member or Corporate Sponsor Registration: $\600.00$
• Non-Member Registration: $\850.00$

\footnotesize{(1) A one-time waiver in the amount of $500 will be applied to invoices submitted to 2015 Corporate Members as a token of appreciation for continued membership in 2016, effectively reducing their 2016 Corporate Member dues to the 2015 Corporate Member rate of $3,000.00 annually.}

Motion was seconded by Deena Brown.

Motion carried.

President Vonnetta Allenbaugh (OK) presented the revised proposed budget for HSFo 2016, which included planning and training components, with a total projected revenue of $360,400 and projected expenses of $407,312, a projected loss of <$46,912$.

Ms. Allenbaugh requested a move for acceptance of the budget “In Total”. 
Scott Carson made the motion to accept the budget, seconded by Conitha King.

Vote:

Those in favor: Aye
Opposed: Nay (none)

Motion passed with the budget approved “in total”, at the expenditure level of $360,400.

Budget as adopted is presented as Appendix 3 to these minutes.

New business – Member Survey Report

There was also discussion about the need to clarify the definitions of corporate member and conference sponsor. After lively discussion, the following was decided:

Corporate Member defined as:
A paid HSFo Corporate Membership. Annual fee provides one free annual conference registration fee + as a member, provides reduced registration fees to annual conference attendees, reduced registration fees for planning meetings, preference on training RFP bids, preferred locations for an Annual Conference booth, receipt of HSFo newsletters and access to the full HSFo membership mailing lists.

Percentage of preference was not specified, but the current Training RFP will give a 5% preference to Corporate Members. Motion by Conitha King, seconded by Michelle Gross. Motion carried with no nay votes.

Conference Sponsor defined as:
An HSFo Sponsor, typically pays full registration fees to attend HSFo events, would receive only the list of attendees for a particular event and of course would receive other values specified in the exchange agreement. The contribution could be cash or in-kind.

President Allenbaugh reported the Member Survey initiated by 2015 President Dague Clark has been completed, with a Survey Summary Report generated by the chosen contractor. President Allenbaugh established an HSFo Sub-Committee, with Roberta Blythe, Chair of the Marketing and Communications Committee, in charge of the Sub-Committee to; establish sub-committee members, review the results of the survey, and make recommendations to President Allenbaugh. Dependent on the ability of members of the sub-committee to complete the review of the summary report, it is hoped further recommendations can be reviewed with Leadership at the Spring Planning Meeting in Burlington, VT.

Program Committee Report – Ms. Margaret Wahrer of Kentucky
Ms. Wahrer presented the proposed program for the 2016 Annual Conference in Kentucky. The committee proposed to introduce a fictional family and follow the family’s experience in the Human Services arena. The tentative program schedule was presented, along with explanation of how the family story will be integrated into several sessions. There will be concurrent section tracks as developed through the program.

There will be between 28 and 30 CPEs offered. Sunday afternoon will be Ethics in Government Financing.

There was positive feedback around the concept presented.

Motion to accept the report was made by Margaret and seconded by Conitha King.

Vote:
   Those in favor say: Aye
   Opposed: Nay (none)
Motion passed.

There being no further business, Scott Carson made a motion to adjourn the meeting, motion was seconded by Tara LeBlanc.

Discussion: Conitha King thanked the group for coming to Montgomery.

Vote: Those in favor say: Aye
   Opposed: Nay (none)
Motion passed and the meeting adjourned.