ERRATA

After releasing the Committee Print, two additional State responses to the 50-State letter were identified by Committee staff: Maine and Vermont. Thirty-five States responded to the 50-State letter. The response from Maine can be found below; Vermont did not include a formal letter.

In addition, the responses to the 50-State letter from California and Utah were incomplete in the Committee Print; the complete responses are included in these Errata.

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
Child and Family Services
2 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 624-7900; Fax: (207) 287-5282
TTY Users: Dial 711 (Maine Relay)

July 8, 2015

Becky Shipp, Health and Human Services Policy Advisor
Laura Berntsen, Senior Human Services Advisor
Senate Finance Committee

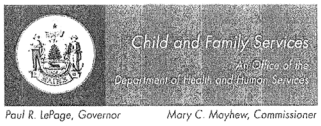
Dear Ms. Shipp and Ms. Berntsen,

I am writing today in response to a letter received from the Chairman and Ranking Member of the Senate Finance Committee requesting information on the privatization of child welfare services. Enclosed is Maine's data as it relates to our policy and practices with regard to privatized foster care.

Please contact me at James.Martin@maine.gov or (207)624-7900 should you have additional questions or concerns. Thank you.

Sincerely,

James Martin, LMSW
Director, Office of Child and Family Services



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July 8, 2015

MEMORANDUM

TO: Becky Shipp, Health and Human Services Policy Advisor
Laura Berntsen, Senior Human Services Advisor
Senate Finance Committee

FROM: James Martin, Director, OCFS

SUBJECT: US Senate Foster Care Study

Summary:

- **To the degree applicable, describe your state's utilization of private entities to provide case management services (e.g. placement of children with particular foster care providers, ongoing casework and oversight of foster care placements).**

  Children with higher level of care therapeutic needs are sometimes placed by the Department with foster families who are affiliated with child-placing agencies which provide treatment foster care services. Children placed in these settings receive from agency staff case management services as well as other services relating to the child's treatment needs. Children in these therapeutic-level placements may also have their visits with birth parents supported and supervised by treatment foster care agency staff.

  The Department is responsible for all placements and not the agencies, even though they are licensed as child placing agencies. The Department contracts with child placing agencies for treatment foster care services for children with higher level of care needs; however, the Department assumes all responsibility for placement decisions.

- **What proportion of the children in foster care in your state is placed by the public agency, not-for-profit providers, and for-profit providers?**

  Maine averages approximately 350 children in treatment foster care homes, which is 20% of the total number of children in care. All of the treatment foster care homes are affiliated with non-profit agencies.

- **Please provide the number and names of private entities providing these core services, as well as information on whether each provider is a for-profit or not-for-profit agency.**

  There are nine agencies with whom the Department contracts for treatment foster care services. Families have the right to choose the agency with which they affiliate. The agencies, all of which are non-profit, delivering treatment foster care services currently in Maine are:

Community Health and Counseling Services
Community Care
KidsPeace
Woodfords Family Services
SMART Child and Family Services
Spurwink
Aroostook Mental Health Services
Family and Children (FACT)
Choices

- **Does your state require that private foster care entities of organizations operating in your state be accredited? If so, by which organization and how often is this accreditation renewed?**

  Maine does not contract with private agencies to approve and license foster homes. All licensing-related tasks are completed by state- agency staff. This includes completion by Department of Health and Human Services' staff of home studies of applicants, pre-service training for applicants, and background checks. A fire and safety inspection of the applicant's residence is conducted by the State Fire Marshal Office, Department of Public Safety. Regardless of whether the home is affiliated with a treatment foster care agency or is a regular licensed foster home, the Department of Health and Human Services is the licensing agent ensuring the home meets licensing standards for either a regular family foster home license or a specialized license. Once licensed, the Department visits the home on at least a yearly basis to ensure compliance with rules and regulations. The home is required to re-apply for re-licensure every two years, at which time the home study is reviewed and updated and a renewal fire inspection occurs.

- **Describe in detail the process you use to select and contract with these private entities, as well as to review and renew such contracts.**

  Treatment foster care agencies are required to be approved as a MaineCare provider, within Maine's Medicaid program. MaineCare enrolls "any willing and qualified provider," meaning they have to incorporate in some fashion, possess a valid Child Placing Agency (CPA) license in the state of Maine and follow the licensing regulations for CPAs.

  Once the Department has placed in a treatment foster care home which is affiliated with a child placing agency, then the Department funds a room and board payment and therapeutic treatment services, individualized for the child. The Department also funds clinical-level treatment which is provided to the child through other Medicaid-delivered services, as needed.

- **Describe in detail the process your state uses to inspect the safety of the foster care settings in which children are placed and the extent to which this process differs for public, not-for-profit, and for-profit providers operating in your state.**

  Department of Health and Human Services' staff are responsible for monthly contacts with each child in a treatment foster home placement to ensure the child's safety and well-being needs are met, just as these staff are responsible for ensuring the safety and well-being needs of children placed in unlicensed kinship homes or in licensed regular family foster homes. There is no difference in the safety requirements in the different types of foster homes.

- **How many instances of abuse in a foster care placement have been substantiated in the last five years in your state? Of those substantiated, how many of these instances related to children placed by not-for-profit providers, for-profit-providers, and public providers?**

Maine DHHS, OCFS, MACWIS Information Services, Data as of 7/7/15
Licensed Foster Home Investigation Data, Calendar Year 2010 - 2014

YEAR	# ALL INVESTIGATIONS	# SUBSTANTIATED	# INDICATED	# UNSUBSTANTIATED
2010	58	2	5	51
2011	63	1	5	57
2012	69	2	1	66
2013	87	1	5	81
2014	102	0	5	97
THERAPEUTIC FOSTER HOMES – non-profit providers (this data is a subset of the data above)				
YEAR	**# THERAPEUTIC**	**# SUBSTANTIATED**	**# INDICATED**	**# UNSUBSTANTIATED**
2010	28	2	2	24
2011	24	0	2	22
2012	34	0	0	34
2013	45	1	2	42
2014	44	0	2	42
FAMILY FOSTER HOMES (this data is also a subset of the data above)				
YEAR	**# Family Foster Homes**	**# SUBSTANTIATED**	**# INDICATED**	**# UNSUBSTANTIATED**
2010	30	0	3	27
2011	39	1	3	35
2012	35	2	1	32
2013	42	0	3	39
2014	58	0	3	55

- **Describe in detail the actions taken when an abuse claim is substantiated while a child is in an out of home placement? Do these actions differ depending on whether the child was placed by the public agency, a not-for-profit provider, or a for-profit provider?**

  When there are allegations of abuse and neglect in a licensed foster home, then DHHS staff in the Office of Licensing and Regulatory Services may investigate the concerns to determine if abuse or neglect occurred in the home. The case may be referred to the Office of Child and Family Services to investigate for possible licensing violations. When licensing violations are identified, there are a range of options which can be taken to address the concerns, depending upon the seriousness of the violation. In some cases, if it is deemed to be in the child's best interests, the child is moved to a different home. For the majority of violations, Department staff engage families in developing a working agreement which addresses the issues of concern without taking a negative action on the license and yet increases the amount of training and support the family receives to prevent future violations.

CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

August 11, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Chairman Hatch and Ranking Member Wyden:

Thank you for the opportunity to share information on California's child welfare services system for vulnerable children, youth, and families. The focus of your questions is on privatized foster care. We do not utilize private for-profit providers; however, as part of our network of providers and others engaged in child welfare, we do work with private non-profit providers and organizations as explained in our responses to your questions, which follow the background below.

BACKGROUND
California has a complex child welfare services system, serving the most populous state in the country with nearly 9.5 million children, and one of the most linguistically diverse regions in the world with the largest minority population in the country, including 109 federally recognized Indian tribes and an estimated 79 tribes that are seeking federal recognition. California's state-supervised child welfare system is administered at the local level by 58 counties, each governed by a county elected board of supervisors. The range of diversity among the counties is immense and there are many challenges inherent in the complexity of this system. However, its major strength is the flexibility afforded to each county in determining how best to meet the needs of its own children and families. The counties, which differ significantly by population and economic base, are a wide mixture of urban, rural and suburban settings, thus driving the need to make their own decisions on how to coordinate local service delivery to children and families.

The California Department of Social Services (CDSS) is authorized by statute to promulgate regulations, policies, and procedures necessary to implement the state's child welfare system and to ensure the safety, permanency, and well-being for California's children. The CDSS is responsible for the supervision and coordination of programs in California funded under federal Titles IV-B, IV-E, and XX of the Social Security Act. Furthermore, CDSS is responsible for developing the state's Child and Family Services Plan. These efforts are achieved within a framework of collaboration with child welfare stakeholders. Due to its complexity and this high degree of

collaboration, California's child welfare services system is ever-changing as we seek to improve our ability to improve outcomes for the state's children and families.

The CDSS has oversight of the state's child welfare services system and plays a vital role in the development of policies and programs that implement the goals of CDSS' mission. In developing policies and programs, the CDSS collaborates with other state and local agencies, tribal representatives, foster/kinship caregivers, foster youth, foster care service providers, community-based organizations, the courts, researchers, child advocates, the Legislature, and private foundations to maximize families' opportunities for success.

RESPONSES TO QUESTIONS

1. To the degree applicable, describe your state's utilization of private entities to provide case management services (e.g., placement of children with particular foster care providers, ongoing casework and oversight of foster care placements).

   In California, we do not contract with private entities to provide case management services. Case management is conducted by the child placement agency at the county level, either by child welfare or probation, and is carried out by the social worker. In our state, we do work with public and private non-profit providers to provide support and services to the foster parent and the child. Social workers support the case planning process in public and private non-profit agencies called Foster Family Agencies (FFAs). Please use the link below to access regulations pertaining to social work provided by FFAs.

   Community Care Licensing Regulations for Social Work FFAs
   Title 22, Div 6, Chap 1, Art 5-6 - General Licensing Requirements
   http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/Ffaman.pdf
   (Sections 88001, 88065.3, 88065.4, 88065.5, 88070.1)

2. What proportion of the children in foster care in your state is placed by the public agency, not-for-profit providers, and for-profit providers?

   Please see enclosed "placement types" chart for relative, foster care, FFA, and group home placements.

3. Please provide the number and names of private entities providing these core services, as well as information on whether each provider is a for-profit or not-for-profit entity.

   The federal government has provided the state with the option to include in its state plan the placement of children in a private facility operated on a for-profit basis, and our state statute authorizes for-profit placement as articulated in

California Welfare and Institutions Code (WIC) section 11402.6. However, it is CDSS's preference to place foster care children in a non-profit group home setting. Currently, counties do not place foster children with for-profit providers. Counties may place children with for-profit group home facilities after all other placement options have been exhausted. Placement into a for-profit group home facility may occur only subject to specified conditions. Please use the links below to access lists of foster family agencies and group homes in which children and youth are placed in California.

Foster Family Agencies: County placement agencies use licensed private FFAs for the placement of children who require more intensive care as an alternative to group homes. By statute, FFAs are organized and operated on a non-profit basis and are engaged in the following activities: recruiting, certifying, and training foster parents, providing professional support to foster parents, and finding homes or other temporary or permanent placements for children who require more intensive care.

The CDSS has statutory responsibility for developing, implementing, and maintaining a rate setting system for FFAs receiving Aid to Families with Dependent Children-Foster Care (AFDC-FC) funds. The AFDC-FC rates vary by age group. For the purpose of determining FFA rates, CDSS regulations specify the purposes, types and services of FFAs. Currently, CDSS sets AFDC-FC rates for approximately 220 FFAs as of January 2015. The rates are organized into five age groupings.

Group Homes (GHs): Group homes provide the most restrictive out-of-home placement option for children in foster care. They provide a placement option for children with significant emotional or behavioral problems who require more restrictive environments. A licensed group home is defined as a facility of any capacity which provides 24-hour nonmedical care and supervision to children in a structured environment, with such services provided at least in part by staff employed by the licensee. Group homes run the gamut from large institutional type environments which provide an intense therapeutic setting, often called "residential treatment centers," to small home environments which incorporate a "house parent" model. As a result, group home placements provide various levels of structure, supervision, and services.

Group homes may offer specific services targeted to a specific population of children or a range of services depending on the design of their program. These services include substance abuse, minor-parent (mothers and babies), infant programs, mental health treatment, vocational training, mental health day treatment, sex offenders, wards only, emancipation and reunification. Many programs provide more than one service and list their primary service function as reunification of children with the biological family.

FFA Provider Lists
FFAs: http://www.childsworld.ca.gov/res/pdf/FFAList.pdf
FFA Regional Centers: http://www.childsworld.ca.gov/res/pdf/FFARC.pdf
ITFC: http://www.childsworld.ca.gov/res/pdf/ITFCP.pdf

GH Provider Lists
GHs & Regional Centers: http://www.childsworld.ca.gov/res/pdf/GHList.pdf
GHs RCL 13 & 14: http://www.childsworld.ca.gov/res/pdf/GH1314.pdf

4. Does your state require that private foster care entities or organizations operating in your state be accredited? If so, by which organization and how often is the accreditation renewed?

   Currently we are engaged in foster care reform through our Continuum of Care Reform initiative. Among many other important changes to California statutes governing foster care, Assembly Bill 403 (authored by California Assembly Member Mark Stone) will require all group homes and FFAs to be accredited by a national accrediting body, identified by the CDSS, as a condition of receiving a foster care rate. We believe that national accreditation brings benefits to an organization, such as professionalizing staff, establishing administrative best practices, improving service delivery, and promoting a culture of continuous quality improvement.

   The Continuum of Care Reform report to the California Legislature, upon which this reform proposal is based, can be found here at the following web address: www.cdss.ca.gov/cdssweb/entres/pdf/CCR_LegislativeReport.pdf

5. Describe in detail the process you use to select and contract with these private entities, as well as to review and renew such contracts.

   The state does not contract with private entities to provide foster care services. Contracts occur between local government and individual providers. The state's role is to license providers and set rates for their services. Please use the links below to access requirements related to licensing and rates.

   Manual of Policies and Procedures, Community Care Licensing Division General Licensing Requirements:
   http://www.dss.cahwnet.gov/ord/entres/getinfo/pdf/genman1.PDF

   Manual of Policies and Procedures, Foster Care Rate Regulations
   http://www.childsworld.ca.gov/PG1343.htm#

6. Describe in detail the process your state uses to inspect the safety of the foster care settings in which children are placed and the extent to which this process differs for public, not-for-profit, and for-profit providers operating in your state.

   California assesses and approves relatives (defined in WIC 361.3(f)) and nonrelative extended family members (defined in WIC 362.7) using the same standards as those used to license foster family homes. This includes: 1) a criminal background check of the caregiver and all adults residing in the home; 2) an assessment of the caregiver's ability and suitability to provide care and supervision; 3) a caregiver orientation/training regarding the standards; and 4) an inspection of the home and grounds.

   The criminal background check is accomplished through LiveScan submission of fingerprints to the California Department of Justice (DOJ), which returns California criminal history and other state convictions held by the Federal Bureau of Investigation. Additionally, a check is made of California's Child Abuse Central Index to learn whether the caregiver or any adults residing in the home have a child abuse history. The criminal background check process also includes a check of other states' child abuse indexes (where they exist) when the caregiver or any of the resident adults declare they have lived in another state within the past five years. If there is no criminal history, the DOJ "clears" the individual.

   For persons with criminal convictions, the DOJ provides the county child welfare agency with the individual's criminal offender record information report (also known as a "rap sheet"). The county reviews the rap sheet to determine whether the crimes are those for which an exemption may be granted through an exemption process. Pursuant to state and federal law there are a number of crimes which cannot be exempted. Individuals who have non-exemptible criminal history are denied a clearance and cannot get an exemption. If a caregiver or any adult living in the home cannot obtain an exemption, then no child can be placed in that home so long as that individual resides in the home.

   For a caregiver or other adult in the home who has criminal history which is not prohibited from exemption, a process is applied which includes gathering documentation regarding the crimes and convictions, evidence of good character and rehabilitation, and the individual's statement about the crime/conviction. This information is evaluated and a determination is made as to whether to provide an exemption. To ensure continued safety, at the initial submission of fingerprints, a subsequent arrest notification process is established for each fingerprinted individual. If an individual is arrested subsequent to the initial fingerprinting, the DOJ notifies the county having jurisdiction of the case and the county is required to investigate the circumstances of the arrest and crime and take appropriate action consistent with statute and regulations.

Separately, the county child welfare agency assesses the caregiver's ability to provide care and supervision by evaluating if the caregiver can: 1) provide a safe, secure and stable environment for the child; 2) exercise proper and effective care and control of the child; 3) provide a home and the necessities of life for the child; 4) protect the child from his or her parents as appropriate; 5) facilitate court-ordered reunification efforts with the parents; 6) facilitate visitation with the child's other relatives; 7) facilitate implementation of all elements of the case plan; 8) provide legal permanence for the child if reunification fails; and 9) arrange for appropriate and safe child care, as necessary. Additionally, the county utilizes a state-required assessment document to further evaluate the caregiver's suitability consistent with statutes and regulations for the proper care and supervision of the foster child.

The safety of the home is assessed by using a state-required form to evaluate the home's compliance with safety standards. Items assessed in the home include verifying that there is: telephone service in the home; a safe vehicle for transporting children and that only a licensed driver will transport the child; an individual bed (or crib) with a clean, comfortable mattress, clean linens, blankets and pillows for each child in the home; consideration of bedroom occupancy standards, which takes in to account shared rooms with adults, those of the opposite gender, and those of different ages; adequate closet and drawer space for the child's clothing and personal belongings; protection from bodies of water so that they are safe/inaccessible; a safe yard or outdoor activity space that is free from hazards that endanger the child's health and safety; and at least one toilet, sink and tub or shower in safe, clean operating condition and hot water is delivered at a safe temperature. In addition, the home must be in otherwise good repair, clean, safe and sanitary; well-lit and maintained at a comfortable temperature; and store and dispose of waste in a way that will not permit the spread of disease/odor, or attract insects and rodents. The home is also assessed to ensure the safe storage of medications, poisons, firearms and other dangerous weapons.

The county child welfare agency also provides an orientation and/or training to the caregiver. This includes a copy of the approval standards and regulations. Caregivers also are informed about the child's personal rights, the prudent parent standard, and a child's participation in age and developmentally appropriate extracurricular/enrichment activities.

7. How many instances of abuse in a foster care placement have been substantiated in the last five years in your state? Of those substantiated, how many of these instances related to children placed by not-for-profit providers, for-profit providers, and public providers?

See the enclosed table for abuse in out-of-home care data by placement type. As previously noted, there are currently no placements with for-profit entities.

When an abuse allegation is substantiated, the actions that can be taken include exclusion of the perpetrator and/or revocation of the license. Cross reports are made to the appropriate law enforcement agencies, which may result in criminal investigations and charges.

We appreciate the opportunity to provide information on California's child welfare services system and would be pleased to discuss our policies and practices in more detail with your staff. We are very excited about our Continuum of Care Reform initiative and the important improvements we are making to create better outcomes for the vulnerable children, youth, and families who need out-of-home care. Further questions can be directed to Greg Rose, Deputy Director of the Children and Family Services Division, at (916) 657-2614, or Greg.Rose@dss.ca.gov.

Sincerely,

WILL LIGHTBOURNE
Director

Enclosures

Maltreatment in Foster Care in California

Calendar Year	Placement Type								Total
	Pre-Adopt	Kin	Foster	FFA	Court Specified	Group	Shelter	Guardian	
	n	n	n	n	n	n	n	n	n
2010	0	66	46	183	3	44	0	26	368
2011	0	81	32	128	2	58	0	18	319
2012	0	84	44	108	0	37	1	25	299
2013	0	74	25	99	0	30	5	24	257
2014	0	91	34	65	3	45	2	28	268

Note: Observed differences in these aggregate frequencies may be due to reporting practices or other factors, and not necessarily reflective of likelihood ofmaltreatment within the respective placement types.

Data Source: CWS/CMS, California Child Welfare Indicators Project, Q1 2015

	YOUTH IN FOSTER CARE BY PLACEMENT TYPE (CHILD WELFARE AND PROBATION AGENCIES)													
YEAR	**RELATIVE PLACEMENT (KIN)**		**FOSTER CARE (FOSTER)**		**FOSTER FAMILY AGENCY (FFA)**		**GROUP HOME (GH)**		**Guardian (Dep/Non-Dep)**		**Other**		**TOTAL (n)**	**TOTAL (%)**
	n	%	n	%	n	%	n	%	n	%	n	%		
JAN. 1, 2011	18,866	33.4%	5,546	9.8%	16,382	29.0%	3,795	6.7%	7,575	13.4%	4,364	7.7%	56,528	100.0 %
JAN. 1, 2012	19,130	35.2%	5,253	9.7%	14,783	27.2%	3,681	6.8%	7,110	13.1%	4,461	8.2%	54,418	100.0 %
JAN. 1, 2013	20,200	35.9%	5,180	9.2%	14,460	25.7%	3,696	6.6%	7,133	12.7%	5,543	9.9%	56,212	100.0 %
JAN. 1, 2014	21,708	35.9%	5,412	8.9%	15,244	25.2%	3,714	6.1%	7,006	11.6%	7,454	12.3%	60,538	100.0 %
JAN. 1, 2015	22,053	35.3%	5,582	8.9%	15,604	25.0%	3,744	6.0%	6,740	10.8%	8,784	14.1%	62,507	100.0 %

Data Source: CWS/CMS 2015 Quarter 1 Extract

Note: Other category includes shelter. SILP, Runaway, and other non-foster care placements.

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

DEPARTMENT OF HUMAN SERVICES

ANN SILVERBERG WILLIAMSON
Executive Director

MARK L. BRASHER
Deputy Director

LANA STOHL
Deputy Director

May 27, 2015

To: United States Senate Finance Committee

RE: Letter to Governors on Private Foster Care

In response to the request from the Senate Finance Committee, the State of Utah, Department of Human Services (DHS), Division of Child and Family Services (DCFS) issues the following:

Background

Utah bases its foster care evaluation model on a continuum with seven levels of care. As the levels of care progress, they are designed to provide more intensive services and supervision than the prior level of care. An assessment is completed for each child in foster care and the result of the assessment is a recommendation for a level meeting the child's needs. Services provided by direct care staff and/or out-of-home caregivers at each level are defined by the needs of the children being served.

The first three levels of care (Level I, Level II, and Level III) are most frequently provided in foster family homes licensed by the State of Utah, DHS, Office of Licensing (OL), and supervised by DCFS. Children with a need for higher intensity services and/or with a higher level of behavioral needs are most often provided care and supervision services through a private provider with whom the state contracts (Levels IV, V, or VI). There is some flexibility built into the model that permits a higher level of care to be achieved when a child is in a placement that would traditionally rate a lower level of care on the continuum, but has additional services in place to reach the intensity of services needed for that child. Utah's Level VII care is provided in an institution, such as a psychiatric hospital or the Utah State Hospital.

For all levels of care, DCFS caseworkers provide oversight and case management services for children in their placement. As of May 1, 2015 Utah's data shows approximately 25 percent of children in care are placed with private providers in Levels IV, V, and VI. Utah can provide further historical or cumulative data regarding foster care placement levels upon request.

To the degree applicable, describe your state's utilization of private entities to provide case management services (e.g., placement of children with particular foster care providers, ongoing casework and oversight of foster care placements).

Utah does not utilize private entities to provide case management services. Casework activities and oversight of foster care placements are provided through staff employed through DCFS, with the exception of a small cohort of high-need mental health cases. For these welfare cases, DCFS contracts with a local county mental health authority such as Wasatch Mental Health Services. Wasatch Mental Health Services is a public agency, and as of May 1, 2015, manages 26 cases, which is 0.9 percent of the total number of foster care cases in Utah. Wasatch Mental Health case managers utilize the State Automated Child Welfare Information System (SACWIS) for case management and are subject to the same performance requirements as DCFS casework staff.

What proportion of the children in foster care in your state is placed by the public agency, not-for-profit providers, and for-profit providers?

The public agency, DCFS, makes all (100 percent) placement decisions of children in foster care. Private agencies in Utah may make a placement recommendation to the state; however, the placement decision authority ultimately rests with DCFS.

Please provide the number and names of private entities providing these core services, as well as information on whether each provider is a for-profit or not-for-profit entity.

Requested information is contained in the attached spreadsheet (Attachment 1). Services provided by private entities are limited to care, supervision, and treatment of children in foster care. None of the entities provide case management services.

Does your state require that private foster care entities or organizations operating in your state be accredited? If so, by which organization and how often is this accreditation renewed?

Utah does not require accreditation; however, agencies may choose to become accredited on their own through an accreditation entity.

Describe in detail the process you use to select and contract with these private entities, as well as to review and renew such contracts.

DCFS develops a scope of work and a Request for Proposals (RFP) specific to the services we require for each level of care (Levels IV, V, and VI). The RFP is issued and private agencies have the opportunity to apply. When applications are received through the state purchasing process, they are scored according to the criteria in the RFP. Proposals from a private entity that meet requirements of the RFP are offered a contract.

Contracts are issued on a five-year cycle. The process is ongoing and providers must apply for a new contract at each contract cycle. The process to apply for a contract is

outlined on the DCFS website located at the following link: http://dcfs.utah.gov/pdf/HowtocontractwithDCFS.pdf. Attached is a sample of our last RFP for Level IV services that contains the scope of work and the criteria and process by which a private entity would apply for a contract for foster care services (Attachment 2).

Describe in detail the process your state uses to inspect the safety of the foster care settings in which children are placed and the extent to which this process differs for public, not-for-profit, and for-public providers operating in your state.

For state licensed and supervised foster homes (Levels I, II, and III), initial safety inspections of foster care homes is completed by the state Office of Licensing (OL) at the time of licensure. A copy of the OL Administrative Rule (R501-12) outlining foster home requirements can be found at the following link: Human Services, Administration, Administrative Services, Licensing - Foster Care Services. State licensed and supervised homes for Levels I, II, and III must renew their foster license on an annual basis. In addition to the OL initial and renewal processes, DCFS employees are dedicated to support and monitor quality care for children placed in foster homes. These staff, known as Resource Family Consultants (RFCs), are familiar with the homes they support to make informed placement decisions. RFCs are also required to make monthly contact with each foster home, as well as site visits to each foster home a minimum of once every six months. RFCs are experts in OL rule and DCFS safety requirements, and are therefore able to identify and report any problems they observe. RFCs also provide support to caseworkers for individual cases and follow up with visits to homes if safety is uncertain.

Private entities with family-based placements (Level IV) must meet comprehensive OL requirements of a child placing agency found in the OL General Provisions (R501-1), Core Rules (R501-2), and Foster Care Services (R501-12), which can be accessed here: Human Services, Administration, Administrative Services, LICENSING.

However, once the private entity has achieved status with OL as a child placing agency, they may oversee and "certify" their own family-based foster homes. The child placing agency is required to ensure that their "certified homes" meet OL requirements for foster homes. At irregular intervals, OL completes on-site reviews of a random sample of homes certified through the child placing agency to ensure they are in compliance with OL rules. OL completes a regular audit of the files kept by child placing agencies, and if discrepancies or errors are noted, OL may require on-site visits to foster homes overseen by the agency as a part of the audit as well.

Homes certified through child placing agencies do not have the direct state oversight and training that licensed foster homes have, despite taking on placements requiring higher levels of care. This can lead to inconsistency in training and oversight as it becomes largely incumbent upon the private entity to create and self-monitor their programs. In addition, private child placing agencies may have a financial incentive to certify homes that could create a conflict of interest in their quality assurance. Because of these issues, DHS is evaluating if this service delivery method that allows child placing agencies to certify their own foster homes should be changed.

Residential placement settings (Level V and VI) must also meet OL requirements for the types of service they are contracting with DCFS to provide. The comprehensive OL requirements can also be found at this link under R501-19 Residential Treatment Programs and/or R501-22 Residential Support Programs. OL conducts file audits and site visits of these entities as well.

In addition to the OL process, DCFS has an internal Audit Team that conducts annual audits of private entities that provide Level IV, V, and VI foster care services and Level V and IV residential treatment programs through contracts with DCFS. The DCFS audit team reviews personnel files maintained by the private entity and conducts interviews with foster parents and staff to verify they have completed all training requirements outlined in their DCFS contract. The audit also ensures that all foster parents and individuals over age 18 in the home and all residential treatment staff have the required, approved background screenings from OL. Furthermore, the audit team randomly selects and interviews children placed in these homes or facilities about issues regarding safety, treatment services, and relationships with foster parents and/or other staff. Two to four "certified" foster homes are randomly selected for inspection and the audit team inspects all residential treatment facilities to ensure they meet health and safety elements outlined by OL and in the contract with DCFS.

In accordance with federal ASFA and CFSR requirements, Utah requires caseworkers to complete a minimum monthly face-to-face visit with each child in foster care in their placement. The monthly visit must include a private conversation with each child to address safety and other issues. The requirement is built into the SACWIS system and an "action item" is sent to the caseworker each month for each child they oversee in foster care. The caseworker must enter an activity log with details of their visit with the child. According to the Utah quantitative review process, the performance rate is more than 96 percent annually for successful visitation of children in their foster care placements. If any safety concerns are identified by the child or caseworker during the caseworker's visit, the caseworker reports the safety concerns for investigation to Child Protective Services (CPS) Intake.

How many instances of abuse in a foster care placement have been substantiated in the last five years in your state? Of those substantiated, how many of these instances related to children placed by: not-for-profit providers, for-profit providers, and public providers?

Over the past five years, Utah has served 23,196 children in foster care, and has had 89 substantiated instances of abuse of children in care. Please refer to Attachment 3 for a breakdown of instances of abuse, number of perpetrators, and number of victims for each level of care. The information was obtained for federal fiscal years 2010, 2011, 2012, 2013, 2014 where the child victim was in foster care and the relationship to the victim was recorded as foster mother, foster father, or residential treatment staff. The data also includes cases that were substantiated against licensed kinship providers. Some of the entities with substantiated cases no longer have existing contracts with DCFS. Utah can

provide further information regarding substantiated instances of abuse in foster care placements if needed.

Describe in detail the actions taken when an abuse claim is substantiated while a child is in an out of home placement? Do these actions differ depending on whether the child was place by the public agency, a not-for-profit provider, or a for-profit provider?

The Office of Services Review (OSR), Related Parties Investigations Team is the state agency assigned to investigate claims of abuse or neglect against a child in an out of home placement. The agency is housed within DHS, but is distinct from DCFS and is not overseen by DCFS. Since DCFS makes all placement decisions for children in out of home care, the actions taken to address a substantiated claim do not differ between levels of care.

If an allegation of abuse or neglect is substantiated in an out of home placement, OSR notifies the director of the DCFS region that oversees the placement of the child, informs DCFS of the identity of the perpetrator and relays any further safety concerns. Based upon the identity of the perpetrator and nature of other case-related details, OSR may also notify OL, the DCFS audit team, high-level administrators of DCFS, or the executive director of DHS to follow-up with concerns, recommendations, or a further assessment of the provider.

When OL is notified by OSR of a substantiated allegation of abuse or neglect against a provider, OL will assess if the provider still meets the background screening requirements as well as conduct an assessment of whether the provider is still in compliance with OL rule. OL will determine if action is needed against the license of the provider such as corrective action or revocation of the license.

When the DCFS audit team is made aware of a substantiated allegation of abuse or neglect against a private provider, the audit team will discuss the substantiated claim with DCFS administration and determine whether or not DCFS will continue placing children in the facility. If DCFS decides to discontinue placing children with the provider, the provider is contacted (phone and email) and informed of DCFS's decision. Each DCFS region is also notified (phone and email) of the decision. DCFS is in the process of developing a tracking system housed within the SACWIS system to "flag" the provider so that DCFS will make no further placements with a provider that has a substantiated case of abuse or neglect. This will ensure that if the foster parent attempts to change to another provider entity, they will not be able to continue to provide foster care services.

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Contractor	Address	City	State	Zip	Contract Purpose Statement	Legal Status	Contractor's Representative
1st Choice Youth Services, LLC	66 S 360 E	American Fork	UT	84003	Proctor	LLC/Partnership	Teo, Ephraim
4 the Youth, Inc.	1344 W State Road	Pleasant Grove	UT	84062	Proctor	For-Profit-Corporation	Grover, Stephanie
AIGA Youth Services, Inc	1355 N Main Suite #5	Bountiful	UT	84010	Proctor	For-Profit-Corporation	Solipo, Curry
Alan Brooks Crossroads LLC	5150 South Washington Blvd, Suite 1	South Ogden	UT	84405	Proctor	LLC/Sole Proprietor	Brooks, Alan
Alliance Youth Services, L.L.C.	4735 N Thanksgiving Way	Lehi	UT	84043	Proctor	LLC/Partnership	Jensen, Devin
Anchor Stone Youth, Inc.	624 N 1280 E	American Fork	UT	84003	Proctor	For-Profit-Corporation	Faaootoa, Sonny
Ascent Individual Residential Treatment, Inc	330 E 400 S Suite 2	Springville	UT	84663	Proctor	For-Profit-Corporation	Cope, Cyle
Blomborn, Inc.	252 East Calgary Dr.	St. George	UT	84790	Proctor	For-Profit-Corporation	Blomquist, Mike
Blue Hills Residential Treatment, LLC	PO Box 461	Moroni	UT	84646	Proctor	LLC/Partnership	Pay, Todd A.
Brighter Futures, Inc.	715 E 3900 S #101	Salt Lake City	UT	84107	Proctor	For-Profit-Corporation	Hosea, Charles
Brookshire, Inc.	410 North Harrison Blvd.	Ogden	UT	84404	Proctor	For-Profit-Corporation	Purin, Julie H.
CBTS, Inc.	220 E 3900 S #16	Salt Lake City	UT	84107	Proctor	For-Profit-Corporation	Nadeau, Lori
Colbren Management, LLC	PO Box 461077	Leeds	UT	84746	Proctor	LLC/Sole Proprietor	DeMille, Brent
Come About... Youth Services, Inc.	PO Box 1218	Pleasant Grove	UT	84062	Proctor	For-Profit-Corporation	Sirkel, Shelly
Community Treatment Alternatives	4444 S 700 E Suite 203	Salt Lake City	UT	84107	Proctor	Non-Profit Corporation	Naylor, Justin
Cornerstone Programs Corporation	9085 E. Mineral Circle #235	Centennial	CO	80112	Proctor	For-Profit-Corporation	Maldonado, Daniel
Country Cottage, Inc.	435 E Tabernacle, Suite 201	St. George	UT	84770	Proctor	Non-Profit Corporation	AhQuin, Joseph
Crossroads Youth Services, Inc	120 W Main Street	Lehi	UT	84043	Proctor	For-Profit-Corporation	Ofahengaue, Carey
Ensign Peak Services, Inc.	3270 Meadowbrook Drive	West Valley City	UT	84119	Proctor	Non-Profit Corporation	Hussey, Dianna
Extended Family, Inc.	704 North SR51	Spanish Fork	UT	84660	Proctor	For-Profit-Corporation	Wiederhold, Terie
Foundations L.C.	4601 West 3245 South	West Valley City	UT	84120	Proctor	LLC/Sole Proprietor	Butler, Kraig
Front Line Services, Inc.	9287 South Redwood Road, Suite A	West Jordan	UT	84088	Proctor	For-Profit-Corporation	Memmott, Ricky Dean
KT&T Ventures LLC	1140 E 36th Street Suite 160	Ogden	UT	84403	Proctor	LLC/Partnership	Horman, Ben
Larry Linde, Inc.	31 E 1600 N	Spanish Fork	UT	84660	Proctor	For-Profit-Corporation	Linde, Corbin
Lighthouse Academy, L.L.C.	1500 S 580 W	Manti	UT	84642	Proctor	LLC/Corporation	Bailey, Paul
Maleta A Barela	883 W 4100 S	Riverdale	UT	84405	Proctor	Sole Proprietor	Barela, Maleta "Mickey"
Milestone Counseling Services, L.L.C.	3149 N HWY 89 #200	Pleasant View	UT	84404	Proctor	LLC/Sole Proprietor	Campbell, Brian
New Beginnings PPA, Inc.	1478 West 1950 South	Syracuse	UT	84075	Proctor	For-Profit-Corporation	Moss, Cindy
Perfetto Clinical Contracting, Inc.	PO Box 900342	Sandy	UT	84090-0342	Proctor	For-Profit-Corporation	Perfetto, Bill
Pinnacle Youth Services, Inc.	3895 W 7800 S Suite 204	West Jordan	UT	84088	Proctor	For-Profit-Corporation	Brown, Kevin
Pioneer Youth and Adult Community Services, Inc.	3030 S Main Street Suite 400	Salt Lake City	UT	84115	Proctor	For-Profit-Corporation	Olevao, Tiare
Quality Youth Services, Inc.	2240 N Highway 89 #C	Harrisville	UT	84404	Proctor	For-Profit-Corporation	Otsuka, Rebecca R.
Redwood Therapy and Youth Services, PLLC	154 W Main St	American Fork	UT	84003-2359	Proctor	LLC/Professional	Reid, Adney
RISE, Inc.	1358 W Business Park Drive	Orem	UT	84058	Proctor	Non-Profit Corporation	Bellah, Wendell
SAI, Inc.	2480 S Main Suite 205	Salt Lake City	UT	84115	Proctor	For-Profit-Corporation	Tavake, Sione

Stepping Stones Child Placement Agency, Inc.	1363 S State Street #140	Salt Lake City	UT	84115	Proctor	For-Profit-Corporation	Valdez, Jody
Strengthening Teens, LLC	165 N 1330 W Suite A-1	Orem	UT	84057	Proctor	LLC/Corporation	Landon, Eric
The Journey Counseling Center: Provo, LLC	619 N 500 W	Provo	UT	84601	Proctor	LLC/Partnership	Goodman, Vicki
The Journey Counseling Center: Salt Lake, LLC	741 E 9000 S Suite 100	Sandy	UT	84094	Proctor	LLC/Partnership	Goodman, Vicki
The Journey Counseling Center: Sanpete, LLC	41 W 700 S	Ephraim	UT	84627	Proctor	LLC/Partnership	Goodman, Vicki
The Journey Counseling Center: Uintah, LLC	134 W Main Street Suite 202	Vernal	UT	84078	Proctor	LLC/Partnership	Goodman, Vicki
The Journey, LLC	619 North 500 West	Provo	UT	84601	Proctor	LLC/Partnership	Goodman, Vicki
Today's Youth, Inc.	349 North 780 East	Lindon	UT	84042	Proctor	For-Profit-Corporation	Kennedy, Mary Kay
Tristan, Inc.	1140 36th Street Suite 202	Ogden	UT	84403	Proctor	For-Profit-Corporation	Banks, Judy
Turnaround Solutions, Inc	357 S 200 E Suite 308	Salt Lake City	UT	84111	Proctor	For-Profit-Corporation	Robinson, Sallee
Turning Point Family Care, Inc.	PO Box 789	Washington	UT	84780	Proctor	For-Profit-Corporation	Milne, CPA, Adam
Utah Family Care LLC	3575 S 3200 W #6C	West Valley City	UT	84119	Proctor	LLC/Partnership	Lavekihelotu, Maria
Utah Youth Village	5800 S Highland Drive	Salt Lake City	UT	84121	Proctor	Non-Profit Corporation	Draper, Shanna
UTBS Heart Inc	6011 Redwood Rd	Salt Lake City	UT	84123	Proctor	Non-Profit Corporation	Sanders, Sarah
Youth Health Associates, Inc.	501 W 2600 S Suite 200	Bountiful	UT	84010	Proctor	For-Profit-Corporation	Anderson, Steve
Youth Net Services, LLC	758 W 2100 N	Provo	UT	84604	Proctor	LLC/Partnership	Tuiletufuga, Sonna
Youthtrack, Inc.	862 South Main Street # 4	Brigham City	UT	84302-0887	Proctor	For-Profit-Corporation	Stringam, Scott

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Utah Division of Child and Family Services

Supported Allegations of Abuse of Children in Foster Care by Foster Caregiver or Residential Staff

FFY10 October 1, 2009 to September 30, 2010						
PLACEMENT/LEVEL OF CARE	**Instances of Abuse**	**Number of Perpetrators**	**For Profit Provider**	**Not for Profit Provider**	**Public Provider**	**Relative**
DFB--Brighter Futures	1	1	yes			
DFB-MILLCREEK CFS	3	3	yes			
DFB-New Beginnings PPA	1	1	yes			
DFB-Pinnacle Youth Service INC	1	1	yes			
DFB-THE STARLIGHT PROGRAM	1	1	yes			
DLS-FUTURES THROUGH CHOICES	1	1		yes		
FHX-RISE INC	2	1		yes		
Licensed Family Foster Home -non kin	24	8			yes	
Unlicensed kin foster family (BHR)	5	2				yes
Total Instances of Abuse	**39**					
Number of Unique Perpetrators	**19**	19				
Number of Unique Victims	**27**					

FFY11 October 1, 2010 to September 30, 2011						
PLACEMENT/LEVEL OF CARE	**Instances of Abuse**	**Number of Perpetrators**	**For Profit Provider**	**Not for Profit Provider**	**Public Provider**	**Relative**
DHX-No Eastern Svs-Lakeside Logan Group Hm	2	1	yes			
DHX-PIONEER YOUTH	1	1	yes			
DHX/FHX-Rise Inc	4	4		yes		
DIB, Child & Family Empowerment	1	1	yes			
DPB CBTS INC	1	1	yes			
DPB- New Beginnings Respite Foster Plmt	1	1	yes			
DPB-NEW BEGINNINGS PPA	1	1	yes			
DPB Utah Youth Village	1	1		yes		
DPB-FOUNDATIONS LC	5	2	yes			
Licensed kin foster family home	5	2				yes
Licensed family foster home-non kin	4	4			yes	
Unlicensed kin foster family (BHR)	3	2				yes
Total Instances of Abuse	29					
Number of Unique Perpetrators	21	21				
Number of Unique Victims	25					

FFY12 October 1, 2011 to September 30, 2012

PLACEMENT/LEVEL OF CARE	Instances of Abuse	Number of Perpetrators	For Profit Provider	Not for Profit Provider	Public Provider	Relative
DHX-Rise	2	2		yes		
DSF-YHA/Clearfield East Eagle	1	1	yes			
DPB-KT & T Ventures LLC	1	1	yes			
Licensed family foster home -non kin	2	2			yes	
Total Instances of Abuse	6					
Number of Unique Perpetrators	6	6				
Number of Unique Victims	4					

FFY13 October 1, 2012 to September 30, 2013

PLACEMENT/LEVEL OF CARE	Instances of Abuse	Number of Perpetrators	For Profit Provider	Not for Profit Provider	Public Provider	Relative
DMD-Youth Utah Village/Sorensen	2	1		yes		
DBF- Extended Family	4	1	yes			
DPB-Youth Net Services LLC	1	1	yes			
BGH-JJS plmt with Anchor Stone Youth Services	1	1			yes	
PC1-Foundations LC	1	1	yes			
Licensed Family Foster Home -non kin	9	5			yes	
Total Instances of Abuse	18					
Number of Unique Perpetrators	10	10				
Number of Unique Victims	15					

FFY14 October 1, 2013 to September 30, 2014

PLACEMENT/LEVEL OF CARE	Instances of Abuse	Number of Perpetrators	For Profit Provider	Not for Profit Provider	Public Provider	Relative

DPB -Plmt Foundations LC Respite	1	1	yes			
DPB-Youthtrack	1	1	yes			
WHX-DSPD Waiver Chrysalis Group Home	1	1		yes		
DHX- Community Trmt	1	1		yes		
Licensed tribal foster family home	1	1				yes
Licensed kin foster family home	5	2				yes
Licensed Family Foster Home -non kin	7	6			yes	
Unlicensed kin foster family (BHR)	1	1				yes
Total Instances of Abuse	18					
Number of Unique Perpetrators	14	14				
Number of Unique Victims	18					

Note: Instances of abuse of a combination of victim and perpetator

RESPONSE OF COMMITTEE STAFF TO OCTOBER 26TH LETTER FROM MENTOR

On October 26, 2017, the MENTOR Network sent Chairman Hatch and Ranking Member Wyden a letter following the report's public release on October 17, 2017. The letter outlines several areas of disagreement with respect to the report's findings. Finance Committee staff agreed to make this letter public on the Committee website to give the company an opportunity to express its views in the record.

As indicated below, Committee staff agreed that MENTOR raises valid points in its letter. However, Committee staff disagreed with the two main issues raised by the company in the October 26th letter. With respect to the other issues raised, the bipartisan Committee staff has considered them and stands by the report. The October 26th letter from MENTOR and the Committee staff's response are included here.

WILMERHALE

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October 26, 2017

By E-Mail

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510-6200

Dear Chairman Hatch and Ranking Member Wyden:

Thank you for your continued dedication to the critically important issues surrounding foster care in this country. As you know, MENTOR voluntarily cooperated throughout the entire course of the Committee's two-and-a-half year inquiry into privatized foster care. It produced more than 5,000 pages and provided an additional 16,000 pages for in camera review. To our knowledge, no other entity cooperated to nearly the same level. Since the early days of the Committee's inquiry in 2015, MENTOR requested an opportunity to bring some of its child welfare experts to Washington to brief Committee staff and answer questions, and it appreciated the opportunity to engage with Committee staff on October 5, 2017.

Given MENTOR's nearly 40-year track record of providing foster care services to children with complex conditions, MENTOR believes it is uniquely qualified to provide feedback on the policy recommendations contained in the Committee's recent report dated October 17, 2017. MENTOR is pleased with the recommendations to support funding and oversight for foster parent and caseworker recruitment and retention, as well as the recommendation to allow states and tribes to use title IV-E funds to support evidence-based services aimed at safely preventing entries into foster care. If implemented, these reforms could go a long way towards addressing some of the chronic issues facing child welfare service providers.

MENTOR is concerned, however, that several items in the report that are specific to MENTOR are either wrong or create an impression that is inaccurate. In particular, MENTOR wanted to raise two key issues:

- First, the report uses "unexpected deaths" as a benchmark to create the misimpression that a death marked as "unexpected" in MENTOR's internal incident reporting system represents a lapse or a failure by MENTOR. MENTOR strongly disagrees with this characterization; use of the data in this way is inaccurate and unnecessarily prejudicial. As demonstrated by the data MENTOR provided, "unexpected" deaths do not reflect a lapse or failure.

    - Internal incident reports, from which the number of "expected" and "unexpected" deaths were derived, are completed within hours of the occurrence of an incident and represent the facts as known by the author at that early point in time. In most states, these must be completed within 24 hours of the incident or less.

    - The reports are completed prior to any internal or external investigation, autopsy, or medical examiner review. Unless a child's death was imminent, for example a child in hospice care, it is categorized as "unexpected." That does not mean, however, that a child died due to abuse, neglect or maltreatment.

    - This point is underscored by a review of the following examples, each of which was characterized as an "unexpected" death on MENTOR incident reports, but none of which had anything to do with abuse, neglect or a failure by MENTOR:

        - A 20-year-old with cerebral palsy who became unresponsive at her private school after waking from a nap; she subsequently passed away at the hospital. [*See* MENTOR0004922-04925]

        - A 5-month-old baby with diagnoses including partial trisomy 14, heart disease, hypothyroidism, Dandy-Walker Malformation, and a history of seizures. The child stopped breathing and passed away; 911 was called but resuscitation efforts were not performed by paramedics because the baby had a Do Not Resuscitate order in place. [*See* MENTOR0005077-5080]

        - An 18-year-old who was on an approved home visit with his biological uncle and was shot and killed in a restaurant during an attempted robbery. [*See* MENTOR0005125-5128]

    - Leaving readers with a misimpression that an "unexpected" death is a preventable death is counterproductive, prejudicial, and incorrect. To the best of MENTOR's recollection, the Committee did not ask for a definition of "unexpected," nor did it ask how MENTOR uses that term. Given the misunderstanding this has created for readers of the Committee's report, the report's press release, and related press coverage, we believe it is important that this information be clarified.

- Second, MENTOR believes the report requires clarification of the Committee's analysis of the mortality data provided by MENTOR.
    - At no point did MENTOR mislead the Committee. MENTOR contracted with an independent third party—the Center for Developmental Disabilities Evaluation and Research (CDDER) at the University of Massachusetts Medical School—for its mortality analysis.
    - As MENTOR demonstrated in the data provided to the Committee, it provides therapeutic foster care and higher-acuity services at a rate four times higher than the national average. This includes a large number of medically fragile children, yet the report fails to account for this important distinction.
    - The data that MENTOR provided included multiple benchmarks and explained the rationale behind each, as none of the benchmarks allow for a perfect apples-to-apples comparison.
        - As the Committee is aware, the mortality analysis was completed by an experienced and respected biostatistician affiliated with CDDER. It was her professional judgement to provide three different benchmarks to provide as comprehensive of an analysis as possible.
        - In critiquing her work, the Committee's report focused on two of the three benchmarks but overlooked entirely the benchmark comparing deaths as a percentage of discharges. Regardless of whatever disagreement the Committee may have with the benchmarks, it is worth noting that the national mortality rate as a percentage of discharges for 2015, the last year for which this data is available, was .138% compared to a 5-year average rate for MENTOR of .140%. That means MENTOR's mortality rate as a percentage of discharges is just 1.4% higher—and it serves a much more acute population.
        - Characterizing the material that MENTOR provided as "false" impugns the company and the professional competence and integrity of the biostatistician. The characterization is also inappropriate: the data is in fact accurate.
    - Moreover, the Committee's report cited an out-of-date analysis that included data through 2014 rather than an updated analysis provided to the Committee in September 2017 which included data through 2017. All benchmarks reflect better outcomes over this broader time frame.
    - Finally, MENTOR asks that you correct the record with regard to MENTOR's cooperation in reviewing the mortality data; we have provided you with an email

indicating that MENTOR did not object to peer review and in fact on March 31, 2016, specifically authorized the Committee to share the material for the purpose of completing a peer analysis.

Also attached for your benefit are additional points of clarification. For purposes of ensuring the long-term probative value of the report, MENTOR respectfully requests that the Committee update its report to reflect this feedback prior to submitting to the GPO for printing. Alternatively, MENTOR requests that the Committee include this letter and attachment as an appendix to the Committee's report, or separately enter it into the congressional record.

MENTOR has a long history of serving the highest-need children and achieving positive outcomes. It is proud of the work that it does and the communities that it serves, and it looks forward to continuing to work with the Committee and its state and local regulators to make sure that children in foster care receive the care that they need and deserve.

Sincerely,

Reginald J. Brown

Enclosure

Appendix A – Key Points of Clarification

1. **The report states that these incident reports provided by MENTOR "capture the agency's most serious incidents of injury, assault, abuse, or other similar events." It also notes that 86 children died during a ten-year period (FY2005-FY2014). [*See, e.g., Report at 20*]**

   Key Points:

- It is inaccurate to state that the incident reports provided to the Committee represent "[MENTOR's] most serious incidents of injury, assault, abuse, or other similar events." In fact, some reports represent very ill children who succumbed to their medical conditions in the loving home of a family rather than in an institution or hospital.

- The most recent data that MENTOR provided to the Committee included information and incident reports for all foster care deaths for a 13-year period from 10/1/2004 to 9/30/2017. 94 children passed away during that period.

- The critical context that was not clear in the report or the subsequent reporting is that of those children, 56 had medically complex conditions and/or diagnosis(es) that would cause premature death. At least 48 of the 56 are believed to have succumbed to those medical complexities. There was no injury, assault, abuse, or anything similar implicated in their deaths.

- Other deaths also resulted from circumstances unrelated to MENTOR's care. For example:

  - 9 children died out of MENTOR's care. This includes deaths that occurred during visits with the biological family, at school, out in the community, and traffic fatalities.

  - 2 deaths were ruled homicides involving biological family members. These were children that were abused by their biological families, placed into MENTOR's care, and succumbed to their injuries while in care.

  - One was the victim of a drive by shooting.

- In fact, just a small subset of the 94 involved findings of abuse or neglect. The most recent data provided to the Committee covered the last three years of care. There were ten deaths over this period. We are not aware of a single finding of abuse or neglect by a MENTOR employee or foster parent in connection with those deaths.

- Put simply, it is inaccurate to imply that all the children that unexpectedly passed away during that period died due to abuse, neglect or maltreatment in a MENTOR home.

2. **As support for the claim that children in care with private for-profit agencies have been "abused, neglected and denied services," the report notes that the "vast**

majority of children who died were not the subject of internal investigations" and "autopsy reports which were pending years ago were excluded from files." Elsewhere the report alleges that only 13 internal investigations were done as a result of these deaths. [*See, e.g., Report at 2, 21*]

Key Points:

- The claim that only 13 internal investigations were conducted is inaccurate. This represents only the number of investigations underway and known to the MENTOR field employee reporting the incident immediately after the incident took place. Investigations frequently are initiated after the incident report has been filed.

- Moreover, in many states, MENTOR is not permitted access to autopsy reports. In fact, MENTOR often requests the autopsy reports and is denied. A child who passes away in care is discharged from MENTOR's care and MENTOR no longer has the right or authority to request medical information, including autopsy reports and other medical records.

- The report further asserts that the incident reports "include information that is diagnostically inaccurate." [*Report at 22*] MENTOR's incident reports reflect the health diagnoses in the child's case file as supplied by the state and external medical professionals.

- The report notes that the "incident reports contain information that conflicts with media reports of the incident." [*Report at 23*] This perfectly illustrates the issue with treating an incident report as the full accounting of the circumstances surrounding an incident rather than what it is: a snapshot of what is known in the moments immediately following the incident. It is not accurate to say that the incident report and media reports "conflict"; in this case, the child in fact did suffer cardiac arrest. Only after a full investigation was it determined that the foster mother played a role in his death.

3. **The report suggests that the states of Illinois and Texas initiated the decision to terminate MENTOR's contract. [*See e.g., Report at 12*]**

Key Points:

- MENTOR made the decision to discontinue providing services in these states; any suggestion to the contrary is incorrect.

- In 2014—before either press or the Committee began inquiring about MENTOR's child welfare services—the company's executive team made a decision to conduct a comprehensive strategic review of all our children's services. As MENTOR CEO Bruce Nardella said at the time, this effort, which was undertaken in close collaboration with third-party experts, was focused on consistent "clinical and service excellence" and "the goals of safety, permanency and stability for each young person" in MENTOR's care.

- A number of important management actions resulted from that strategic review, including:
    - Scaling down MENTOR's services for at-risk youth and focusing on a smaller number of states;
    - Implementing a single evidence-informed, safety-oriented foster care model across all states; and
    - Establishing and supporting a Center of Excellence composed of child welfare experts to enhance training programs and clinical support, monitor adherence to internal and external standards, and measure and report on outcomes.
- As a result of the strategic review, in mid-2015, MENTOR decided to exit the states of Louisiana, Indiana, Florida, North Carolina, and Texas as a foster care provider. Separately, MENTOR earlier had decided to exit Illinois.
    - In a letter dated March 17, 2015, MENTOR and Alliance Human Services jointly notified DFCS of our decisions to withdraw from providing at-risk youth services in Illinois. This was explained to the Committee in our production at MENTOR0001773.
    - In a meeting with two company representatives in the fall of 2015 after MENTOR had announced its decision to exit the foster care service in Texas, Texas DFPS Commissioner John Specia indicated his disappointment in MENTOR's decision and noted the valued role MENTOR had played in the state for many years.

4. **The report features a case study from the state of Maryland as an example of MENTOR's failures as a provider and to illustrate the alleged risks of privatized foster care.** [***See Report at 13-14***]

Key Points:

- The appendix to the Committee's report includes documentation from the state of Maryland that indicates that there were 39 substantiated cases of abuse during the period 2010-2014. Despite the fact that there were 39 substantiated cases of abuse in that five-year period in Maryland, the report highlighted only a case involving MENTOR.
- Even a single case of abuse or neglect is one too many. But to focus on MENTOR without accompanying context misrepresents the quality of services that MENTOR provides.
- Of the 39 substantiated cases of neglect and abuse, the state of Maryland reported to the Committee that only 6% of the cases were the responsibility of a for-profit provider.

- With respect to the MENTOR case, an Administrative Law Judge noted in 2012 that MENTOR Maryland had a "stellar" record as a foster care provider and wrote, with respect to this case, that there was a systemic failure and multiple parties were deceived. He wrote:

  "Social workers and therapists from the Appellant (MENTOR), as well as from the DJS and the local DSS had constant and regular contact with the children who were being abused and even inquired of the children whether they were safe, felt safe or whether they were afraid. None of these people discovered the abuse. Even therapists, psychologists, and psychiatrists most closely interacting with the children found nothing amiss. Even the biological parents of the children, who in some cases had frequent interaction with the children, failed to detect any abuse."

5. **The report features a case study from the state of Texas as another example of the alleged risks of privatized foster care. [*See, e.g., Report at 18*]**

   Key Points:

   - Across all providers, 47 children died while in foster care in Texas from FY2012-2013. At least 10 of those fatalities were attributed to abuse or neglect. One of those deaths occurred in MENTOR's care. Yet only the MENTOR incident is studied in the report. We believe that the other 9 children who died of abuse or neglect were in the care of public or non-profit providers during the same period.

6. **The report states that MENTOR was "often out of compliance" with regard to background checks. As support for this, the report claims that MENTOR "waived" the outcomes of background checks in the case of the Maryland home. It also states that Texas MENTOR "placed children in a home with a household member who had previously been convicted of aggravated kidnapping and robbery when she kidnapped a pregnant convenience store employee." [*Report at 13*]**

   - This section contains several inaccuracies. First, the report states the following: "Committee staff found that the husband of a foster parent, who was later convicted of sexually abusing foster children in their home, had been the subject of four previous abuse allegations. The MENTOR worker marked in handwriting on the criminal background search results, 'Not Mentor [sic] parent,' **presumably indicating that the husband's criminal history was irrelevant because the foster mother was the primary caretaker**."

     - This is incorrect. The background check to which the report refers was conducted in 2010, a decade after MENTOR originally opened the home. The notation on the document ("Not Mentor parent") was to indicate that the background check yielded results for an entirely different person with the same first and last name (as evidenced by the different middle initial, date of birth and spelling of "Steven").

- No criminal background checks for Stephen Merritt reflected any sexual abuse.

- With regard to the report's allegations about background check issues in Texas, the "household member" refers to the adult daughter of Sherill Small, the foster parent convicted of murdering Alexandria Hill. The daughter did not reside in the home, and thus was not a "household member." Moreover, she was in no way involved in the death of the child.

STAFF RESPONSE

Unexpected vs. Expected Deaths

MENTOR objects to the categorization of "unexpected deaths" in the report, noting this is not a term generally used by State child welfare agencies or otherwise. On page 2 of the October 26th letter, the company asserts "...the report uses 'unexpected deaths' as a benchmark to create the misimpression that a death marked as 'unexpected' in MENTOR's internal incident reporting system represents a lapse or a failure by MENTOR." While the bipartisan staff report made no assertion or representation that expected or unexpected deaths constituted fault or blame, we acknowledge MENTOR's concern that its use could be misinterpreted by others. Committee staff were not trying to establish a new substantive standard, but instead simply used a term that MENTOR itself used in its Level 4 incident reports. Use of this term was also intended to help explain the implications of the data, presented by MENTOR, in its mortality report. Staff did not intend to create any impression that its use implicated MENTOR as to the cause or circumstances of the event.

As explained in the report (beginning on page 21), Section D ("Incident Descriptors") on *each* of MENTOR's Level 4 incident reports has a check-box if the death is expected or unexpected. If the report did not involve a death, the box is left blank. The report never discusses the use of this term otherwise. Committee staff did not question or second-guess MENTOR's reporting of whether a death was expected or unexpected. The Committee Print simply reported the outcome MENTOR's documents reported. Committee staff did so to test the contention made by MENTOR that it would be expected to have a higher number of deaths because they had more children requiring therapeutic foster care, or "TFC" services. Part of the justification for including the incident reports in the Committee Print's appendices was for readers to have the opportunity to see the circumstances surrounding child fatalities as well as the health conditions. However, as MENTOR observed in its letter, it did not have access to autopsy findings at the time reports were completed nor, in some cases, afterwards. The committee staff did not itself request or review autopsy findings.

Peer Review of the MENTOR Mortality Report

The company letter also questions the report's critique of MENTOR's mortality report and its statements regarding the extent to which MENTOR allowed it to be submitted for peer review by the Committee. The letter addresses the issue of peer review on pages 3 and 4, noting a March 31, 2016 email "specifically authoriz[ing] the Committee to share the material for the purpose of completing a peer analysis."

The Committee Print does *not* say MENTOR refused to have the mortality study peer reviewed. The report says: "MENTOR indicated that this would only be possible with the company's approval," which reflects Committee staff's understanding of the company's position. As the March 2016 email noted, the company permitted the mortality study "being shared with Federal Government-employed statisticians for purposes of doing a peer review, al-

though we would otherwise like to keep the information confidential." Consequently, the bipartisan staff's understanding of MENTOR's position, as conveyed in this email and in other exchanges, was that the submission of the mortality report by the Committee to outside, academic child welfare experts for peer review was not authorized.

It should also be clear that Finance Committee staff did not request the mortality study. It was presented to the bipartisan staff by MENTOR as a principal element of its defense of its performance. Consequently, staff devoted a significant effort to its analysis, including a phone interview with the principal author on November 4, 2016. This analysis was done primarily by Dr. Emily Douglas, then a Society for Research in Child Development fellow with Senator Wyden's office. Dr. Douglas is also a specialist in this field. The same criticisms detailed in the report were communicated to the researcher and company representatives on the November 4, 2016 call.

Other Matters Raised

The MENTOR letter raises other concerns, such as the extent to which the staff accurately characterized the information contained in MENTOR's incident reports and accurately described individual deaths and related events based on those reports. For example, one includes a death ultimately determined to have been caused by a foster parent, but reported in an incident report as a cardiac arrest. Staff concluded that that incident report was inconsistent with the actual cause of death. MENTOR points out in its letter that they are not necessarily inconsistent given the information that was available at the time the incident report was completed. Staff agrees that they are not necessarily inconsistent.

As explained fully in the report, MENTOR, one of the largest foster care providers, was used as a case study of how foster care services are provided within the current foster care system. It was not possible, nor necessary, to investigate every other foster care provider. Although the report compared MENTOR's performance to State and national averages, it repeatedly noted that staff was not drawing conclusions about how MENTOR performed against other individual providers.