Frequently Asked Questions About:

The Family First Prevention Services Act, Qualified Residential Treatment Programs (QRTPs), and the Medicaid IMD Exclusion Rule

The *Family First Prevention Services Act* is a landmark, bipartisan achievement. What are its key reforms?

The *Family First Prevention Services Act* (*Family First Act*), enacted in 2018, represents an historic shift in child welfare policy. Through changes in federal child welfare financing, the *Family First Act* made bold reforms to:

1. keep families together and safely prevent children from needing to enter foster care; and
2. ensure children in foster care are placed in the least restrictive, most family-like setting while also improving access to high quality residential treatment when needed.

The *Family First Act* encompasses other child welfare policy changes. A detailed, comprehensive overview of the Act is available here.

The *Family First Act* created Qualified Residential Treatment Programs (QRTPs). What are they and who do they serve?

The *Family First Act* placed new restrictions on federal reimbursement to child care institutions, which are non-family foster care placements, sometimes known as congregate care. In doing so, the *Family First Act* also created "**Qualified Residential Treatment Programs**" (QRTPs) to ensure children being cared for by families could access appropriate residential treatment when needed. QRTPs can receive federal foster care payments for services provided to eligible children who have treatment needs that cannot be met in a family-based setting.

The QRTP model is a legislative compromise that draws on the best practices of leading providers in the field, as well as the latest science on child development, trauma, and attachment. The establishment of QRTPs also reflects insights and recommendations from individuals with lived experience in the foster care system who have shared sobering testimonies of the harm and further traumatization they experienced within institutional placements. QRTPs are described in this Information Memorandum from the Children's Bureau. Key features include but are not limited to:

- QRTPs provide treatment to eligible children who have an acute clinical treatment need that cannot be addressed in a family-based setting. Clinical assessments are used to determine a child's need for care by a QRTP. These assessments must be completed by a qualified individual within 30 days of the child's placement.
- QRTPs must be licensed and accredited, use a trauma-informed treatment model, engage a family and permanency team, and have registered or licensed nursing and licensed clinical staff on-site and available 24/7 in accordance with a QRTP's trauma-informed treatment model.
- QRTPs must provide six months of family-based services after a child is discharged.
- Within 60 days of placement, a court must approve the child's placement in a QRTP. Through ongoing court oversight of a child's case, the appropriateness of the QRTP setting will be examined regularly.

Does Medicaid cover children in foster care? What services does Medicaid cover?

The vast majority of children in foster care are eligible for Medicaid. Ongoing access to Medicaid coverage is vitally important to children in foster care who have higher rates of special health care needs than their peers not in foster care. Their complex health care needs—which may encompass physical, mental, and behavioral health and developmental

needs—are often related to childhood trauma. There are multiple pathways to Medicaid eligibility for children in foster care, including but not limited to:

- Children who receive Title IV-E foster care maintenance payments
- Children who receive Title IV-E guardianship assistance program (GAP) payments
- Children subject to a Title IV-E adoption assistance agreement
- Children of a minor parent or youth over age 18 in foster care
- Youth formerly in foster care who aged out at age 18 or older and who are under age 26
- Youth who age out of foster care in states that offer the Chafee option

Children covered by Medicaid have access to an array of services, including mandatory services such as physician and pediatric nurse practitioner services, home health, inpatient and outpatient hospital care, and lab and x-ray services, as well as optional services such as dental services, physical therapy, prescription drugs, and clinic services. Medicaid's critically important Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for individuals under age 21 covers any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state.

The majority of states utilize managed care plans to provide Medicaid coverage to children in foster care.

Children eligible for Medicaid **do not** lose their eligibility status if they are placed in an Institution for Mental Disease (IMD), a setting that is generally prohibited from receiving Medicaid payments. The Centers for Medicare and Medicaid Services (CMS) clarified this issue in recent guidance, explaining that while states are prohibited from receiving federal Medicaid funding for services delivered to a child placed in an IMD, the "placement in a QRTP that is an IMD does not impact Medicaid eligibility."

What is the "Medicaid IMD Exclusion" Rule?

Since the Medicaid program was created in 1965, it has largely prohibited federal funding for services provided to individuals residing in Institutions for Mental Disease (IMDs). In other words, states cannot receive federal Medicaid payments for services provided to individuals residing in an IMD setting. IMDs include hospitals, nursing facilities, or other institutions of more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases. This typically includes facilities that provide inpatient and residential mental and substance use disorder treatment. In some cases, settings that provide psychiatric services to children under age 21 are exempted from being deemed IMDs, meaning they can be eligible for federal Medicaid payments. Often referred to as the "psych under 21" benefit, these providers may include Psychiatric Residential Treatment Facilities (PRTFs), a psychiatric hospital, or a psychiatric unit of a general hospital.

Medicaid's IMD exclusion rule was put in place to prevent the over-institutionalization of mental health patients. It assures that the federal government does not fund inpatient psychiatric services and that if states choose to place individuals in large inpatient psychiatric settings, they must do so with state funds (MACPAC). Importantly, the IMD exclusion rule does not impact an individual's Medicaid eligibility or coverage. Children enrolled in Medicaid are entitled to the full range of Medicaid benefits including the EPSDT benefit even if they reside in an IMD; however, the state cannot draw down federal Medicaid funds for those benefits and services while a child resides in an IMD and instead must bear the full cost.

In child welfare, the IMD exclusion serves as an important safeguard against the over-institutionalization of children. Child care institutions for children in foster care (also known as congregate or group care facilities) have historically been subject to the IMD exclusion. This policy did not change with the enactment of the *Family First Act*. States have authority to make determinations as to whether facilities are IMDs and do so on a case-by-case basis. There have been few instances over the last 50 years where CMS has disagreed with a state's determination of whether a facility was an IMD.

What does the Medicaid IMD Exclusion rule mean for children in Qualified Residential Treatment Programs?

CMS has issued recent guidance (in 2019 and 2021) to clarify policy on federal Medicaid funding for children and youth in QRTPs based on the interaction between QRTP policy in foster care and Medicaid policy on Institutions for Mental Disease (Medicaid IMD).

CMS' guidance states that the existing policy regarding the Medicaid IMD exclusion applies to QRTPs and that QRTPs with more than 16 beds are likely to meet the definition of a Medicaid IMD. This means, with few exceptions (described in next paragraph), that federal Medicaid funding is unavailable for services delivered to individuals placed in these settings. QRTPs with 16 beds or fewer do not qualify as Medicaid IMDs and, therefore, are eligible to receive federal Medicaid payments.

In its guidance on QRTPs, CMS describes limited circumstances under which federal Medicaid funding is available for services for children in QRTPs that are IMDs. One circumstance is if the IMD is also certified as a Psychiatric Residential Treatment Facility (PRTF). However, CMS notes that QRTPs will generally not qualify as PRTFs. A second circumstance is through the Medicaid 1115 demonstration initiative for individuals with serious mental illness or serious emotional disturbances. CMS has claimed authority under section 1115(a)(2) of the Social Security Act to authorize federal Medicaid funding for services provided to eligible individuals in an IMD, where appropriate, when states also commit to ensuring a comprehensive, coordinated system of community-based care. To date, CMS has approved federal Medicaid funding under this 1115 demonstration initiative in six states. CMS states that this same demonstration authority could authorize federal Medicaid funds for services provided to children in QRTPs with more than 16 beds, assuming adherence to other requirements.

Implementation of QRTPs in states has raised questions about the intersection of the *Family First Act* and Medicaid IMD policy. What do policymakers need to know about current law?

As states implement the *Family First Act*, they must also follow existing Medicaid policy around payment of services in large institutions that could potentially be IMDs. Pediatricians and other experts on child health and wellbeing recognize that current law protects the child-centered reforms envisioned by the *Family First Act* that aimed to prevent children in foster care from being placed in large, institutional settings.

Prioritizing large QRTPs of over 16 beds would harm young people because it would:

- Undermine existing policy, which aligns with the goal of eliminating the overuse of large institutional care as placement settings for children in foster care. Maintaining protections against large institutional care is important for improving practices that lead to family-centered and family-based care for children in foster care.
- Likely result in reduced state investment in family-based settings, in direct conflict with what the science tells us about children faring best in families and what young people tell us about what they needed when in foster care.
- Lead to increased federal Medicaid spending in support of large institutional settings for foster children, effectively incentivizing institutional care. This is counter to best practice and could increase the risk of harm associated with institutional care, particularly for children of color and LGBTQ+ youth, who are at higher risk for entering foster care, lingering in institutional settings, and experiencing poor outcomes.
- Spur federal and state funding to large institutions and inhibit institutional providers from shifting their business models to providing care in smaller, more community-based settings which align with best practice, and which are currently eligible for federal Medicaid funding.
- Further strain state budgets. Congregate care is extremely expensive, costing states three to five times more than family foster care, according to the National Conference of State Legislatures. Increasing use of large-scale

institutional facilities would be expensive and limit the ability to invest in prevention, foster parent recruitment and retention, support for relative and non-relative caregivers, community-based services, and other areas that are associated with increased child well-being.

- Remove protections for children in foster care that are in place for other children. In other words, it would create further inequities for children and youth in foster care. The IMD exclusion was created based on wide-spread acceptance that institutionalization in large facilities is harmful, particularly for children whose brains are still developing. Exempting QRTPs—which only serve youth in foster care—from the IMD exclusion would mean the federal government funds and supports placement of foster youth in settings deemed inappropriate for other children, solely on account of their foster care involvement.

What's needed to ensure states/agencies can create enough family-based foster care options to meet the needs of children and youth in care?

Congress provided states with significant funding in 2019 when it enacted the *Family First Transition Act*. This Act provided child welfare agencies with $500 million in new federal grants to assist them with implementation efforts like bolstering support and recruitment of relative and non-relative foster families and offering critical support for family finding. These flexible funds were provided without any state matching requirements.

To assist states in increasing the capacity of high-quality family-based care and related community-based services, including community-based mental health, pediatricians and other experts in child health and wellbeing recognize the importance of:

- Requiring family finding, engagement, and support for relative caregivers, from first contact with the child's case throughout the duration of time a child is in foster care.
- Utilizing emergency licensing and non-safety licensing waivers for kin and funding dedicated kinship staff positions.
- Ensuring child welfare agencies offer a core set of supportive services for relative and non-relative foster families, including peer support and access to crisis and stabilization support.
- Expanding support for community-based trauma-informed mental health services to support children and youth in family-based foster care placements.

A poll conducted by the Dave Thomas Foundation for Adoption found that more than a third of adults in the U.S. have already considered, or would consider, fostering. This indicates that the right policy approaches can and should be implemented to harness this strong interest in communities.

It's important to emphasize that QRTPs are not an appropriate first placement option for most children in foster care. QRTPs are intended to provide time-limited treatment services for children who have serious mental health or substance use treatment needs that cannot be met in a family-based setting.

Does the *Family First Act* change existing Medicaid law?

No. The *Family First Ac*t did not amend current Medicaid law in any way. The IMD exclusion is a long-standing policy and predates the passage of the *Family First Act*. States have had authority to determine IMD status for institutional facilities since Medicaid's inception in 1965. The *Family First Act* made no change to this process. There is no evidence that foster care services cannot be provided while still complying with this long-standing requirement.

What does science tell us about the best placements for children and youth in foster care?

Research makes it clear that supporting children and youth in family-based care leads to better outcomes compared to group or institutional foster care. Family-based settings are also more equitable and cost-effective.

Stable family-based foster care	Group foster care
• Minimizes child stress and trauma • Decreases emotional and behavioral disorders in children • Increases academic achievement • Maximizes continuity of therapeutic services • Decreases overall program costs • Nurtures healthy relationships with adults and siblings • Leads to more positive outcomes into adulthood • Better prepares children to live in a family	• Places youth at increased risk for physical and sexual abuse compared with children placed with families • Deprives children and youth of critical parenting figures • Increases likelihood of behavior problems • Is often used even when there is no clinical reason for it • Is disproportionally used as a placement for Black and LGBTQ+ youth in foster care • Is associated with an increased involvement in the juvenile justice system • Is 6 to 10 times more costly per month than foster care • Is 2 to 3 times more costly than treatment foster care
Excerpted from this policy brief. See brief for citations to supporting research.	

What do the data tell us about the outcomes associated with congregate care?

A report by Casey Family Programs highlights research about outcomes for youth in congregate foster care placements. In general, research indicates:

- Young adults who have left group care are less successful than their peers in foster care.
- Youth with at least one group-home placement are 2.5 times more likely to be involved in juvenile delinquency than their peers who are not in group foster care.
- Youth placed in group homes, rather than in family care, have poorer educational outcomes, including lower test scores in basic English and math.
- Youth in congregate care are also more likely to drop out of school and less likely to graduate high school.
- Youth who have experienced trauma are at greater risk for further physical abuse when they are placed in group homes, compared with their peers placed in families.

What do people with lived experience in congregate care settings tell us?

In February 2020, the National Foster Care Youth & Alumni Policy Council released a statement: A Historic Opportunity to Reform the Child Welfare System: Youth & Alumni Priorities on Quality Residential Services. The six priorities outlined in this statement align with earlier recommendations made by youth and young adults involved with the policy council and include:

Priority 1: Ensure QRTPs are taking care of the needs of the “tough” kids, and not just those with the easiest to meet needs.

Priority 2: Ensure any entry into a QRTP intervention is fair and appropriate.

Priority 3: If it is determined a QRTP intervention is the best option, it should be within the young person’s community. If it can’t be, it is incumbent on child welfare professionals to ensure the young person has access to and is able to retain their community, family, and cultural connections.

Priority 4: Part of curbing the over-reliance on medication is to ensure informed consent and have an established and independent appeal process available to youth with a medication regimen (especially while the regimen is being considered regardless of whether the medication is over the counter or prescribed including off label use).

Priority 5: Systems should have standards and measures of wellbeing, and QRTP's should be held accountable to meet these standards in a young person's treatment plan.

Priority 6: Urgently address the vulnerabilities to sex trafficking that are associated with placement in a QRTP.

> ***"All youth in foster care want to feel genuinely loved, accepted and a part of a family unit. Group and residential care often just doesn't provide that. A lot of times in group care youth experience treatment that is similar or worse than what they endured while in their home of origin...All placements should provide youth with a loving home where they can grow, thrive, and develop into the person they are meant to be. This shouldn't be a privilege or an option. This should be the bare minimum."***

— former foster youth interviewed in the *Away From Home* report