The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care

What’s the Appropriate Role of Residential Care?

The Family First Prevention Services Act made important child-centered reforms by limiting financing of institutional care for children in foster care

In 2018, Congress enacted the bipartisan Family First Prevention Services Act (Family First Act) to spur transformational changes in the way children receive child welfare services. Its reforms were shaped by the experiences of young people in care and research on the benefits of family-based care. To address the harms of institutional care for children in foster care, the Family First Act limited federal foster care reimbursement of institutional care to certain programs that meet the treatment needs of youth.

Recognizing that some children and youth have behavioral health needs that require intensive, short-term care that can’t be provided in a family setting, the Family First Act created a new federal foster care reimbursement option for residential treatment by establishing Qualified Residential Treatment Programs (QRTPs). Quality measures for QRTPs assure that they are equipped to provide time-limited, trauma-based treatment to address children’s clinical needs so that they can safely transition to living with a family. These measures include requirements that QRTPs facilitate family participation in the child’s treatment program and provide family-based support after the child’s discharge. In short, the Family First Act established QRTPs as an appropriate residential treatment option, while reinforcing existing federal policy that every child should be cared for in the least restrictive, most family-like setting.

Pediatricians, alumni of foster care, and other child advocates consistently highlight the compelling evidence that shows children fare best in families. This evidence also highlights the harms associated with long-term institutional care for children in foster care when there is no acute clinical need.

The following reports and studies have documented the overuse and harm of institutional care for children in foster care and offer important insights and recommendations:

- In its Reimagining Child Welfare report, the American Academy of Pediatrics recommends eliminating federal funding of any non-therapeutic non-family setting that is not serving a time-limited therapeutic need with a goal of supporting the child or young person’s transitioning to a family setting.
- The 2021 Away From Home report by Think of Us details the harms of institutional care as experienced by youth in foster care and shows that institutions failed to meet basic standards for safety, healing, and family connections.
- The National Foster Youth & Alumni Council Policy Council issued two sets of recommendations on congregate care in 2016 - one focused on improving services and one focused on reducing reliance.
- A 2015 Children’s Bureau report examined the national use of congregate care among children in foster care and found that more than 40 percent of children in congregate care had no clinical indication for their institutional placement.
- A group of leading child development experts published a “Consensus Statement on Group Care for Children and Adolescents” (2014) with ten key findings relevant to policymakers, including that group care is not an appropriate living arrangement, and it can never substitute for a home environment.

To align with evidence-based best practice, QRTPs should remain small (fewer than 17 beds) to protect children from the harms of large institutional settings, and to enable states to leverage federal Medicaid funds.

In passing the Family First Act, Congress made the QRTP provisions effective October 1, 2019, but also allowed agencies to postpone implementation for up to two years (to October 1, 2021). As Family First Act implementation got underway,
questions arose about the availability of Medicaid reimbursement to QRTPs. The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), has twice issued guidance (in 2019 and 2021) to clarify the interconnectedness between QRTP policy in foster care and Medicaid policy on Institutions for Mental Disease (Medicaid IMD). In its guidance, which is organized in a Q & A format, CMS explains that a QRTP with 17 beds or more is likely to meet the definition of a Medicaid IMD. With few exceptions, federal Medicaid funding is prohibited for services delivered to individuals in IMDs; states must bear the full cost of these services. A QRTP that has fewer than 17 beds does not qualify as a Medicaid IMD and therefore is eligible to receive federal Medicaid payment. In its guidance, CMS states that Medicaid IMD policy “has not been changed as a result of the FFPSA” and is applicable to Family First Act implementation: “State Medicaid agencies must review each QRTP, if over 16 beds, to make a determination if the facility meets the definition of an IMD according to Medicaid statute, regulation and guidance in the State Medicaid Manual.”

This guidance is consistent with long-standing IMD policy, more history of which is here. Importantly, the IMD exclusion does not impact a child’s Medicaid eligibility or coverage, and children enrolled in Medicaid residing in an IMD are still entitled to the full suite of Medicaid benefits. However, the IMD exclusion means that a state may bear the full cost of those benefits, rather than the typical state-federal funding arrangement that applies to most Medicaid costs.

Pediatricians, alumni of foster care, and other experts note that if the IMD exclusion did not apply to QRTPs it would be difficult to effect the important child-centered reforms envisioned by the Family First Act. Current policy disincentivizes placement of children in large, institutional settings for long periods of time. These protections are especially important for children of color and LGBTQ2S+ youth, youth with disabilities, and youth who are already at high risk for entering foster care, lingering in institutional settings, and experiencing poor outcomes.

Experts on child health and wellbeing recognize the need for family-based foster care and community-based services to fulfill the vision of the Family First Act.

All children fare best in healthy, stable families. This holds true for children in foster care who have experienced adversity and need safe, stable, nurturing relationships with caring adults to support their well-being. Stable, well-supported family-based foster care is associated with positive outcomes for children in health, education, and family permanence.

In particular, children in foster care do best when placed with someone they know and trust, especially relatives. These “kinship” placements offer numerous benefits to a child’s well-being. Kinship placements minimize the trauma associated with entering foster care, help maintain the child’s connections with family and community, and increase placement stability. Taking a kin-first approach also frees up non-relative foster families to care for children and youth who don’t have viable family options.

While federal and state policies identify relatives as the preferred placement for children in foster care, actual practice does not always reflect this policy. More needs to be done to strengthen the capacity of relative and non-relative family-based foster care to ensure that every child in foster care can have the healing and individualized support that families offer, and community-based mental health services to support them in those settings.

Some state and local agencies have excelled at recruiting, training and supporting relative and non-relative foster families. For example, New Jersey has more than double the available family-based placements than it needs (8,152 beds available and 3,800 children in foster care). It utilized several strategies to achieve these results, including: an emphasis on retention, centralized oversight of recruitment, targeted messaging and advertising, and partnering with current foster families and youth in foster care. These successes offer examples of approaches that work.

Community-based resources are crucial to ensure children, youth, and families are well supported and able to thrive. Pediatricians and other health experts recognize the need to expand access to high-quality, community-based mental health to support the well-being of young people and families.