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Children and Youth in Foster Care Need Family Based Settings: How S. 2689 Harms Children and Youth in Foster Care by Incentivizing Institutional Care

All children and youth, including young people in foster care, deserve to grow up in families and in communities. Institutional care does not meet their needs and often harms them. Years of research and legislative action, most recently culminating with the Family First Prevention Services Act, has led to the move to radically reduce and eliminate institutional care,[1] especially for young people in foster care who have disproportionately been confined to such settings. If passed, S. 2689 would undercut these efforts and result in harm to children. This Fact Sheet details the harmful impact of the bill and why it should be opposed.

The Institution for Mental Diseases (IMD) Exclusion is a Critical Protection Against the Growth and Over-Use of Large Group and Institutional Care.

The term "institution for mental diseases" "means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services".[2] The IMD Exclusion[3] acts as an incentive to serve individuals in the community and dis-incentivizes institutional care. The IMD exclusion rule is part of long-standing federal policy that requires states to use state funds rather than federal Medicaid dollars to pay for services provided to people who are in large mental health facilities. With some exceptions (such as inpatient psychiatric care for youth under age 21[4]), facilities that are considered IMDs cannot draw down Medicaid funds if they exceed 16 beds. These Medicaid limitations establish a critical guardrail against unnecessary institutionalization of vulnerable individuals.

S. 2689 would Remove the Protections of the IMD Exclusion from Young People in Qualified Residential Treatment Programs (QRTPS), a Setting Exclusively for Youth in Foster Care.

S. 2689 would abolish existing limitations on Medicaid funding for services provided to foster children in a QRTP that qualifies as an IMD and has over 16 beds. QRTPs are residential facilities that should provide a high level of clinical care and treatment for young people in foster care. QRTPs, defined by the Family First Prevention Services Act (Family First), are one of the few congregate care facilities that are eligible for federal foster care funding under Title IV-E of the Social Security Act.[5]

S. 2689 Undercuts the Goals of the IMD Exclusion and Family First by Supporting the Growth of Institutional Care.

Family First and the IMD Exclusion both restrict the use of federal funds (Title IV-E and Medicaid, respectively) with the goal of reducing the use of unnecessary and harmful institutionalization. S. 2689 undercuts this goal by incentivizing the use of large group placements for a population at high risk for entering and lingering in institutional care and experiencing poor outcomes as a result.

Children and Youth Deserve to Grow up In Families and Experience Poor Outcomes and Harm in Institutional Settings.

There is national consensus that living in institutional is harmful to children. Family based settings in the community provide the best environment for care and treatment. Institutional settings produce poor outcomes and risk harm to youth. For example, research show that:

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[1] In this document we use the term institutional care to include all congregate and group care settings, including temporary shelter care.
[2] 42 U.S.C 1396d(i)
[3] 42 U.S.C. 1396d(a)(31)(B).
[4] For example, federal law permits Medicaid funding for services to children and youth up to age 21 (or in some cases 22) living in an in-patient psychiatric hospital. 42 U.S.C. 1396d(a)(16)
[5] 42 U.S.C. 672 (k)(4).

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- Young adults who have left group care are less successful than their peers in family foster care.
- Youth with at least one group-home placement were almost 2.5 times more likely to become delinquent than their peers in family 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.[6]

S 2689 Does not Address the Problem of Lack of Appropriate Placements for Youth. Investing in Family Based Settings is the Right Response.

Family First created QRTPs as an exceptional setting that should be used rarely.[7] There is no evidence that large numbers of young people currently in need of placement require this high level of care. Federal support should be targeted at increasing community-based family settings that states need to serve all youth in foster care. If large institutions are built and backed by federal funding, there will be pressure to fill them even if they are not the appropriate placement for a youth and this will do harm to youth.

Young People Retain Medicaid Eligibility in QRTPs that are not IMDs.

Young people retain their Medicaid eligibility in QRTPs that have no more than 16 beds. There is no evidence that QRTPs of more than 16 beds are needed. All young people in foster care, including youth in QRTPS, have a right to a placement in the least restrictive most family-like placement.[8] If they require the level of care provided by a QRTP, that care should be provided on the smallest scale possible rather than in a larger setting of over 16 beds.

Children and Youth in Foster Care Retain Medicaid Eligibility When Placed in an Array of Community and Family Based Settings and Benefit from the Expansion of These Settings.

Current law provides Medicaid funding for services that can be delivered in an array of less restrictive, family settings, such as foster families and kinship care. Examples of services that support family-based settings are (1) Intensive Care Coordination, (2) Intensive Case Management, (3) Intensive Home Based Services, (4) Therapeutic Foster Care, (5) Mobile crisis intervention, and (6) Therapeutic Behavioral Services. In addition, states can use Medicaid Home and Community Based Waivers to provide community-based settings and enhanced services and supports for children who otherwise would need higher levels of care. The IMD exclusion has provided important incentives to states to develop community-based alternatives and to rebalance spending towards more integrated environments.

Private Providers of Institutional Care—not children and communities-- Benefit from the Expansion of the IMD Exclusion.

Making further exceptions to the IMD exclusion would direct federal funds to the support of institutional care at the expense of developing less restrictive community-based services, which can be funded through Medicaid. Investigative reporters have uncovered a financial incentive for institutional placements that enrich providers at the expense of the health and safety of children. *See*, NBC News, A profitable 'death trap': Sequel youth facilities raked in millions while accused of abusing children (December 16, 2020).

[6] What are the Outcomes for Youth Placed in Congregate Care Settings? (Casey Family Programs February 5, 2018)(summarizing the research), available at https://www.casey.org/what-are-the-outcomes-for-youth-placed-in-congregate-care-settings/
[7] 42 U.S.C. 672(k)(4)
[8] 45 CFR 1356.21(g)(3)