Transforming Systems: Reducing Reliance on Congregate Care for Better Outcomes

By Jen MacBlane and Sarah Sparks

The Problem

In 2022 the Senate Committee on Finance investigated allegations of abuse and neglect at Residential Treatment Programs operated by four large providers, over a 2-year period. As a result, in June of 2024, a 130-page investigative report titled "Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities" was released[1]. Findings from the committee's investigation of youth in residential treatment facilities included reports of physical, sexual, and verbal abuse; inappropriate use of seclusion and restraints; exposure to unsafe and unsanitary living conditions, and lacking delivery of behavioral health services and supports to youth. Among other recommendations the committee called for congressional legislation to improve the conditions in residential treatment facilities and specifically called on CMS and ACF to prioritize spending on community-based behavioral health services as an alternative to placement in residential treatment.

The Evidence

Federal Financial Restrictions on the Use of Congregate Care

The federal government has made attempts to disincentivize the use of congregate care settings, through restrictions to federal financial participation (Title IV-E and Medicaid) for certain settings and has incentivized the use of community-based alternatives through the addition or expansion of funding options, such as waivers.

Title IV-E

Historically, states would only receive federal child welfare funding if a child had been removed from their home and placed in "foster care," even if that first placement is a congregate care setting. More recently (2018), the federal government limited funding for youth placed in "non-family-like" settings, by introducing Qualified Residential Treatment Programs (QRTP) as a new placement setting, as a part of the Family First Prevention Services Act (FFPSA). This new placement setting establishes standards that must be met to continue receiving Title IV-E reimbursement for placements in a Congregate Care Institution (CCI). Among other things, the standards are aimed at ensuring residential treatment is needed for a specific youth and enhancing residential program quality.

The American Academy of Pediatrics (AAP) conducted "A One Year Review of State Progress in Reforming Congregate Care"[2]. The review was based on a 50-state survey of child welfare agency leaders and focus groups with child welfare administrators, providers, and young people with lived experience. AAP found that states have reduced the use of congregate care and simultaneously increased the use of kinship foster care, however, also found that quality treatment, staff capacity, and aftercare in QRTPs are lacking.

Medicaid

Since Medicaid's inception in the 60's, states have had the authority to determine institution for mental disease (IMD) status. The IMD exclusion states that federal financial participation (FFP) is not available for any medical assistance under title XIX (Medicaid) for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. The creation of QRTP as a part of FFPSA has brought attention to the IMD exclusion within Medicaid law. States have assessed the status of their congregate care settings, and in some cases determined that Medicaid funding is unallowable for their CCI's. In October 2021, the Centers for Medicare and Medicaid (CMS) released a Q&A notifying states of a modification to the terms of the Medicaid section 1115 demonstration which would allow title IV-E beneficiaries to receive coverage in a qualified residential treatment program (QRTP) that is an institution for mental disease IMD for longer than that demonstration model currently allows[3].

Current State

After implementing the FFPSA reforms to congregate care, 28 states reported a decrease in the use of congregate care, 16 reported that placements remained at the same level, and one state reported an increase. Before FFPSA, 25 states placed 10% or fewer youth in congregate care. After FFPSA implementation, 32 states placed 10% or fewer youth in congregate care[4].

The limited capacity of therapeutic (foster care) models, foster families, and appropriate residential specified settings paired with limited workforce capacity and the need for additional funding are reported reasons that thwart states' ability to provide timely and appropriate placements for youth[5].

States continuously report shortages of foster care homes, and in other areas of the nation, they face the challenge of both recruiting foster parents and retaining them, with the turnover rate of foster parents ranging from 30 to 50 percent across the nation[6]. Anecdotally, as the overall number of children in foster care has declined, so has the use of congregate care. However, the needs of children being served in foster care and congregate care settings have become difficult. The system needs to continue to evolve to meet the needs of children and youth

Many states are experiencing shortages in behavioral health services for children and young people, especially for those with complex needs. Only about 20% of children with mental, emotional, or behavioral disorders receive care from a specialized mental health care provider[7]. Supporting children with complex emotional and behavioral needs in family-like settings requires access to in-home services and supports. While programs like high-fidelity wraparound and intensive skills-based programs approved by the Title IV-E clearinghouse show promise for reducing out-of-home care, the time, effort, and cost to implement and maintain these programs can seem daunting.

Solutions

States should celebrate the progress made to date and continue forward momentum in expanding community-based services, reducing reliance on congregate care, and enhancing the quality of congregate care programs. Public Consulting Group (PCG) recommends the following practical steps to achieve this.

1. Spend your money on what's best for children and families: divert funds from congregate care to pilot intensive community-based support services.

Since the inception of QRTP, congregate care rates have been on the rise. Many QRTP rates are upwards of $500 per day. It's time to reimagine what could be done with that sum of money to support more children and families at home, or in family-based settings. One effective strategy is to focus on sub-populations of children and youth to identify what could have been done to divert them from congregate care or return them home sooner. Subpopulations of focus could include:

- Children in high-cost placements, or lower-cost placements
- Children placed out of state
- Children under 13 residing in congregate care
- Children whose first placement was congregate care
- Children with specific characteristics, such as I/DD, aggressive behaviors, or behavioral health conditions.

Focusing on specific sub-populations of children can illuminate opportunities to better meet their needs with community-based interventions. Funds can be diverted from congregate care to small-scale pilot programs, which, if successful, free up more congregate care funds to re-invest in more community-based interventions and so on.

This approach allows jurisdictions to implement evidence-based practices on a small scale, improving, and scaling up over time, and leveraging dollars that are already in the system. Additional sources of funding that can hasten scale-up include SAMHSA system of care grants, Title IV-E, and Medicaid.

2. Coordinate systems: increase access to behavioral health services and increase provider capacity.

The behavioral health care needs of youth extend beyond the realm of the child welfare system. Families need access services and supports outside of the child welfare system. Combining various funding streams can create conditions for more coordinated services and increase access.

To meet the complex needs of youth in the community, state agencies need to collaborate. However, many states work in silos leading to inefficiency in resources and funding. This collaboration requires working together to create a comprehensive continuum of behavioral health care services, reducing the barriers to accessing services (including addressing the affordability of care) and increasing provider capacity by building a competent workforce.

There are state and local public systems out there that have built the structure for coordinating and integrating funding streams. Still, it requires having the necessary infrastructure in place to support these initiatives, for example, Virginia's Children's Services Act and New Jersey' Children's System of Care. To build a similar infrastructure child welfare agencies should:

1. Engage their partners and build buy-in and collaboration including government agencies, service providers, and community organizations.
2. Complete a needs and gaps analysis to identify services not available and barriers to accessing services already offered.
3. Identify all of the potential funding streams including federal, state, and local funds. Outlining the allowable uses of each of the identified funding sources.
4. Create a plan that details the integration of funds, specifying objectives, methods, and accountability protocols.
5. Implement your plan while continuously monitoring its effectiveness and make adjustments as needed.

3. If congregate care intervention is needed, enhance monitoring.

It goes without saying that children in congregate care settings should receive quality treatment and care and should be safe from harm. Improved outcomes for residential interventions are achieved for youth when there is family involvement, shorter lengths of stay, and aftercare supports provided[8]. Licensing and contracting standards exist for this very reason, but licensing and contracting reviews generally don't occur more than once or twice per year. Collecting a limited set of metrics, on a regular basis, would allow oversight entities to track trends, and identify potential red flags more quickly. Examples of the types of data that may be helpful for regular safety and program quality monitoring:

- Number of restraints or seclusions
- Direct care staff vacancies
- Clinical staff vacancies
- Average staff tenure
- Number of critical incidents
- Number of abuse/neglect reports
- Length of stay data
- Discharge data
- Return to care data

Keeping the list of metrics small keeps the focus on what is most important and reduces the burden on providers. If a centralized data collection system does not already exist, a simple online database can be created for submission of data.

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Endnotes

[1] Senate, United States. “Warehouses of Neglect: How Taxpayers are Funding Systemic Abuse in Youth Residential Treatment Facilities.”

[2] Pediatrics, American Academy of. “Family First Implementation: A One-Year Review of State Progress.”

[3] Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements Q & A October 19, 2021 (medicaid.gov)

[4] Most States Reduced Use of Congregate Care After Family First Prevention Services Act Went Into Effect - OPEN MINDS

[5] Pediatrics, American Academy of. “Family First Implementation: A One-Year Review of State Progress.”

[6] Ed.D, Dr. John N. DeGarmo. “Foster Parent Retention: What are the Foster Parents Saying?” n.d. *Foster Focus*

[7] Martini R, Hilt R, Marx L, et al.; for the American Academy of Child and Adolescent Psychiatry. *Best principles for integration of child psychiatry into the pediatric health home*. pdf

[8] Initiative, Building Bridges. “Best Practices for Residential Interventions for Youth and their Families: A Resource Guide for Judges and Legal Partners with Involvement in the Children’s Dependency Court System.”

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