

Meeting the Complex Needs of Young People: What if we're doing it wrong?

By Jennifer MacBlane

The recent report “They were promised protection. Instead these kids with disabilities died in foster care.” (NPR, 2026)¹, once again highlights the shortcomings of children’s services systems in meeting the needs of young people with complex behavioral health and co-occurring medical or I/DD needs. Sometimes, a child’s need for treatment presents as challenging behaviors, such as aggression or defiance. When parents need help managing those behaviors, children may be referred for residential treatment. **It’s time to reconsider that approach.**

The underlying causes of severely challenging behaviors are a combination of many things – a medical condition, a mental health diagnosis, trauma - and those factors and how they combine are unique to each child. Residential treatment fundamentally conflicts with the need for specialized, individualized care. Here’s why:

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- **Residential treatment is designed around programs, not individuals.** Staffing complements are fixed and organized around embedded treatment models. There is limited flexibility to adjust programs to meet individual needs.
- **Specialized residential treatment programs are difficult to scale.** Specialized programs incorporate program elements specific to their target population(s). These programs can meet more complex needs, but due to low demand, young people admitted to these programs are often far from their families and home communities, impeding family engagement and transition back home.
- **Group living requires group cohesion.** Individuals with significant behavioral health issues, with or without other co-occurring disorders or medical needs, may struggle to assimilate to group living and follow rules, exacerbating group dynamics and impeding treatment goals.
- **Financing reforms alone cannot solve the problem.** Alternative funding models (such as add-on rates, value-based payments, etc.) can add flexibility, but core program elements and staffing levels cannot be significantly altered to meet the needs of a specific child.

For these reasons, many young people with the most intensive needs are denied access to residential settings and may be boarded in emergency rooms until suitable settings are found, often out of state. Alternatively, they may be served by residential programs ill-equipped to meet their needs, resulting in long lengths of stay, limited treatment progress, serious safety incidents, or death. Assigning blame to individual programs ignores that **the residential treatment model itself isn’t designed to meet highly specific, individual needs.**

What’s the Alternative?

Reframe and redesign intensive in-home services as the highest level of treatment, outside of hospitalization.

Parents are almost always the experts at meeting their children's needs, especially when those needs are complex. Too often, young people are placed in residential treatment because there are not intensive enough at-home supports, even when their parents have a desire and ability to manage their needs with more help.

Many states offer intensive in-home services, but generally these programs offer a lower level of support and care than residential treatment. Families need intensive approaches that divert the same level of funding from residential treatment to support young people at home.

Specialized residential treatment programs are routinely priced at \$1,500 (or more) per day. In an in-home model, those funds could be distributed across therapy, crisis response, direct care support, medication management, medical equipment and supplies, peer support, care coordination, respite, and whatever else is needed to support the family, without removing young people from their communities and support systems. Table 1 illustrates what this could look like, recognizing that the service package would vary depending on the young person's needs.

Table 1: Estimating the cost of an intensive in-home services program

Service	Frequency	Medicaid Rate ²	Daily Cost
Psychotherapy	3 hours per week	\$150 per hour	\$64.29
Home Health Aide	16 hours per day	\$60 per hour	\$960.00
Behavior support	1 hour per day	\$125 per hour	\$125.00
Parent Peer Support	1 hour per week	\$60 per hour	\$8.57
Youth Peer Support	1 hour per week	\$60 per hour	\$8.57
Mobile Crisis Response	2 interventions per week	\$1,000 per response	\$285.71
Intensive Care Coordination	As needed	\$1500 per month	\$49.18
Grand Total			\$1,501.32

In this scenario, the cost per day of serving a young person at home is roughly the same as if they were in a residential setting. But the likelihood of reduced service duration and better long-term outcomes is improved by the sustained involvement of parents in the treatment and lack of disruption to the young person's home and community connections, which could create savings over time.

Financing Options

Medicaid, Medicaid, Medicaid...

States can utilize Medicaid to cover the costs of intensive in-home services such as those listed in Table 1, for example:

- **Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.** Under EPSDT, states must provide all medically necessary and appropriate services needed to correct and ameliorate health and behavioral health conditions for children and youth. This benefit is often underutilized to support children's behavioral health, and CMS recently released a toolkit for accessing EPSDT benefits to support children's behavioral health programs³.
- **Medicaid Home and Community Based Waivers.** 1915(c) waivers provide an array of support services to young people with complex medical, intellectual/developmental, and/

or behavioral health needs such as therapeutic services, respite, and home adaptations. These waivers were designed to shift care for people with complex needs out of institutions and into their homes and communities. This is the shift in care that children and youth deserve.

- **Medicaid State Plan Services.** The Medicaid Rehabilitation Option and Behavioral Health Home Option offer states flexibility to provide multiple services under their framework, but states can also create or access stand-alone State Plan Amendment services.

Additionally, states can access **Title IV-E Prevention Services Funds** to support evidence-based interventions for young people who are at “imminent risk” of foster care. States have latitude in how they define who is at risk of foster care as long as they document and collect the information. Programs like Functional Family Therapy and Multidimensional Family Therapy (as well as many others) are rated as well-supported in the Title IV-E Prevention Services Clearinghouse and are allowable for reimbursement.

Potential Challenges

Adapting infrastructure (and hearts and minds).

Reframing and redesigning intensive in-home services as the highest level of treatment outside of hospitalization requires changes to both long-held beliefs and infrastructure. Challenges may include:

- **Workforce shortages** – Finding sufficient staff with the right qualifications and training to support young people and their families will be a challenge, particularly in rural areas.
- **Community-based service shortages** – In addition to workforce shortages, factors such as funding limitations can result in service shortages or waiting lists.
- **Some young people may not be safe in their homes due to abuse or neglect** – In these instances, suitable out-of-home settings need to be found.
- **Changing mindsets** – The evolution of residential treatment as the highest level of treatment has evolved over many years and is deeply ingrained in hearts, minds, and systems.

These challenges would require creative, localized approaches designed by system and community partners to develop new ways of thinking and operating. For example, one benefit of Home and Community Based self-directed programs is that participants can hire family members, friends, or neighbors to provide their care, opening new workforce solutions. The key is starting small and scaling up gradually to develop the necessary service, workforce, and funding infrastructure, as well as build buy-in.

A Better Path Forward

The current system of care is failing too many young people with complex needs and their families. For decades, states have responded to complexity by seeking increasingly specialized and expensive residential placements, without evidence of widespread success. States now have an opportunity to redirect resources toward flexible, individualized home- and community-based supports that can meet intensive needs while preserving family relationships and community connections. The path forward begins with testing these approaches locally, measuring outcomes, and scaling the models that help young people remain safely at home whenever possible.

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About the Author

Jennifer MacBlane has more than 25 years of experience in child and family services systems. She has been employed by PCG for 20 years and specializes in helping jurisdictions develop effective systems of care for children, families, and individuals, including program design, payment and contracting strategies, and program evaluation. She has led service array assessments, rate studies, and evaluations in dozens of states across the nation, addressing substance use, behavioral health, and child welfare issues. Jen holds a Master of Public Administration from Arizona State University.

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Endnotes

¹ National Public Radio (NPR). (2026, September 30). They were promised protection. Instead, these kids with disabilities died in foster care. NPR. <https://www.npr.org/2026/09/30/nx-s1-5534203/foster-care-disabilities-children-bad-outcomes>

² These rates were pulled from general searches for Medicaid rates nationally and do not represent any one state in particular.

³ Centers for Medicare & Medicaid Services. (2026). State Medicaid & CHIP toolkit for children's behavioral health services and the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements. U.S. Department of Health and Human Services. <https://www.medicaid.gov/federal-policy-guidance/downloads/state-medicaid-chip-bh-epsdt.pdf>