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Q&A

Medicaid Services in Foster Care "Qualified Residential Treatment Programs"

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Q: I saw that the Centers for Medicare and Medicaid Services (CMS) recently issued guidance stating that federal funding for Medicaid services to children in some foster care group homes may be prohibited by the "Institutions for Mental Diseases" (IMD) exclusion. How does this impact access to Medicaid services for children in foster care?

A: CMS recently issued guidance on when federal Medicaid funds may be claimed for services provided to children placed in Qualified Residential Treatment Programs (QRTPs). QRTPs are a type of group home for children in foster care with "serious emotional and behavioral disorders and services."[1] The guidance affirms long-standing Medicaid law and policy prohibiting states from obtaining federal Medicaid funds for services provided to residents of mental health facilities with more than 16 beds. Because many QRTPs might be IMDs and ineligible for Medicaid funding, this could impact Medicaid services for kids residing in QRTPS.

Discussion

A new child welfare law, the Family First Prevention Services Act ("Family First Act") creates a newly-defined category of group homes for children in foster care called "qualified residential treatment programs" (QRTPs).[2] A QRTP is a facility with fewer than

[1] 42 U.S.C. § 672(k)(4) (defining a QRTP as a program that "has a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the assessment of the child required under section 675a(c) of this title").

[2] Bipartisan Budget Act of 2018, Pub. L. No. 115-123 (codified as amended in scattered sections of 42 U.S.C.), https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf.

25 beds, designed to address the needs, including clinical needs, of children in the foster care system with serious emotional or behavioral disorders or disturbances.

CMS recently issued guidance on QRTPs, clarifying when federal Medicaid funding will be available for services provided to Medicaid-eligible children in QRTPs. CMS affirmed that if the QRTP can appropriately be categorized as an "Institution for Mental Diseases" (IMD), then federal Medicaid funds will not be available. This Q&A explains what makes a setting an IMD and discusses how to identify when a QRTP may be an IMD. Because the vast majority of health care insurance for children in foster care is provided via Medicaid, it is important for advocates to understand how children's Medicaid services may be affected by placement in a QRTP.[3] Furthermore, by understanding these rules, P&As can help ensure that states are not inappropriately claiming federal funds for children in QRTPs, thereby protecting existing Medicaid incentives to promote community-based alternatives.

The "Institutions for Mental Diseases" Exclusion

States are generally prohibited from claiming federal funding for services to residents of mental health facilities with more than 16 beds. This is commonly referred to as the "Institutions for Mental Diseases exclusion" or "IMD exclusion." Specifically, states may not obtain "federal financial participation" (FFP) for services provided to any individual under age 65 in "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."[4] The limit on FFP extends to any services provided to a resident of an IMD, whether the service is provided inside or outside of the facility.[5]

The exclusion, which has been part of Medicaid since Medicaid was enacted in 1965, plays an oft misunderstood and underappreciated role in incentivizing states to provide services in smaller, more community-based settings. It was adopted against the backdrop of an unprecedented rise in the rate of individuals confined to institutions with horrendous conditions, and reflects a Congressional determination both that these institutions are a state responsibility, and that it is appropriate for Congress to

[3] For most youth in foster care, Medicaid coverage is mandatory, either because the child receives federal foster care payments ("Title IV-E" eligibility), has a disability, or was removed from a family with a very low income. 42 U.S.C. § 1396a(a)(10)(A)(i)(I); 42 C.F.R. § 435.145 (Title IV-E eligibility); 42 C.F.R. § 435.120 (SSI eligibility); 42 C.F.R. § 435.118 (eligible due to low income of family from which child is removed). For other children in foster care, Medicaid coverage is optional, but most states have exercised these options to cover them.

[5] 42 U.S.C. §§ 1396d(a)(30)(B), 1396d(i).

[5] There are limited exceptions to this general rule. For example, as of October 2018, for a woman who are eligible for Medicaid on the basis of being pregnant (including through the end of the month in which the 60-day period beginning on the last day of her pregnancy ends), and in an IMD for substance use disorder treatment the IMD exclusion does not prohibit FFP "for items or services that are provided to the woman outside of the institution." 42 U.S.C.A. § 1396d.

encourage community-based alternatives to large residential settings.[6] Because federal Medicaid reimbursement is available for mental health and substance use disorder (SUD) services in the community, but is not available if such services are provided in an institution, the IMD exclusion provides a powerful financial incentive for states to rely on community-based alternatives to the institutional settings of IMDs. Exceptions to the IMD exclusion exist and have been broadened over the years, but it still serves Congress' initial purpose of pushing states to focus on community-based services.

The IMD Exclusion Applies to Children

The IMD exclusion applies to anyone under age 65, but there are exceptions. One of these exceptions is for "inpatient psychiatric services for individuals under age 21"—often called the "psych under 21" or "psych 21" benefit. This statutory exception states that FFP is available for services for children under age 21 in three enumerated settings that would normally be considered IMDs: 1) a psychiatric hospital; 2) a psychiatric unit of a general hospital; or 3) "another inpatient setting that the Secretary has specified in regulations" (i.e. a psychiatric residential treatment facility" (PRTF)).[7] A PRTF is a specific kind of longer-term facility for youth that was created via regulations, with

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[6] Ari Ne'eman, *Another Tragedy, Another Scapegoat*, THE AMERICAN PROSPECT (Feb. 27, 2018), https://prospect.org/article/another-tragedy-another-scapegoat#.Wpf4lriOn61.facebook; CMS, STATE MEDICAID MANUAL § 4390. Medicaid was established in 1965, just two years after the Community Mental Health Centers Act of 1963 was passed. Even as Congress allowed for federal funding for individuals over 65 in IMDs, the legislative history suggests that Congress also wanted to encourage community-based alternatives to residential and custodial settings. *See* Comm. on Finance, S. Rep. 404 to accompany H.R. 6675, at 146 (June 30, 1965), https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Amendments%20of%201965%20Vol%202.pdf ("The committee believes it is important that States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963. In order make certain that the planning required by the committee's bill will become a part of the overall State mental health planning under the Community Mental Health Act of 1963, the committee's bill makes approvability of the State's plan for assistance for aged individuals in mental hospital dependent upon a showing of satisfactory progress toward developing and implementing a comprehensive mental health program-including utilization of community mental health centers, nursing homes, and other alternative forms of care."). Even for individuals over 65, IMDs were never intended to be long-term placements, and the state option to receive FFP for service to enrollees over age 65 in IMDs was conditioned on a state showing "that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental disease." 42 U.S.C. § 1396a(21). *See* also Jeffery Buck, Dep't Of Health & Human Servs., HCFA Pub. No. 03339, *Medicaid and Institutions for Mental Disease: Report to Congress II-3* (Dec. 1992), https://babel.hathitrust.org/cgi/pt?id=mdp.39015034439359;view=1up;seq=19 (noting that Congress reaffirmed its intent to encourage states to move away from large institutions and to invest in smaller facilities and community-based settings in 1988, when it amended the Medicaid Act to permit federal financial participation for services to individuals in facilities with 16 or fewer beds).

[7] 42 U.S.C. §§ 1396d(a)(16), 1396d(h).

prescribed staffing and reporting requirements and other specific conditions of participation.[8]

Because the "psych 21" benefit carves some out some exceptions to the IMD exclusion, the IMD exclusion is often incorrectly shorthanded as only applying to individuals 21-64. This is inaccurate. The IMD exclusion applies to anyone under age 65. Exceptions apply for youth under 21, but *only* if those youth are in one of three explicitly carved-out settings. Youth that are in other settings may still be subject to the IMD exclusion. Examples of facilities that could trigger the exclusion, despite the availability of the psych 21 benefit, include but are not limited to residential treatment centers that are not certified as PRTFs, specialty group homes, or some substance use treatment facilities.

The IMD Exclusion May Apply to Congregate Facilities for Children in Foster Care

As noted above, the Family First Act created a new category of group homes, called QRTPs.[9] A QRTP is a facility with fewer than 25 beds, designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances. QRTPs must meet other staffing and treatment requirements, and be accredited by an independent not-for-profit accrediting organization approved by the Secretary of HHS.[10] States may not obtain federal foster care maintenance payments for children who are in congregate care facilities for more than 14 days, unless such children are in a QRTP or another type of exempted group home.[11] Effective October 1, 2019, states may have to re-classify facilities that have been providing long-term congregate housing for children in foster care to determine whether such facilities fall under an enumerated exception, like the QRTP exception.[12] As a result of these new

[8] 42 C.F.R. §§ 441.151-182, 483.350-376;
[9] Bipartisan Budget Act of 2018, Pub. L. No. 115-123 (codified as amended in scattered sections of 42 U.S.C.), https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf.
[10] 42 U.S.C. § 672(k).
[11] Federal foster care maintenance payments are payments made to states to help pay for the cost of food, clothing, shelter and other necessities for children in foster care. Like Medicaid, states split the cost of foster care maintenance payments with the federal government. 42 U.S.C. § 675(4). This provision is intended to ensure that states do not let children languish in group homes, and is structured to incentivize states to move children into foster homes or other family-like settings as soon as possible. Other than a QRTP, federal reimbursement is allowed for group home placement if the setting is one that specializes in providing prenatal, post-partum, or parenting supports for youth; supervised independent living for youth over 18; setting that provides high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims; or a licensed residential family-based treatment facility for substance use.
[12] States do have the option to delay implementation for two years, but if states take this option, the state is limited in its ability to obtain funds for other programs in the Family First Act. For more information on federal funding for foster care, relevant implementation dates, and the full parameters of the Family First Act, see Children's Defense Fund, *et al.*, Implementing the Family First Prevention Services Act, (Oct. 1, 2019), https://www.childrensdefense.org/wp-content/uploads/2019/10/FFPSA-Guide.pdf.

requirements, it should be much clearer to advocates which facilities specifically serve children with mental health needs.

Even if a facility is a permissible QRTP for purposes of federal foster care maintenance payments, states must still undertake a separate analysis to determine if the facility is an IMD for purposes of federal Medicaid funds.

A QRTP may be an IMD if it:

1. Has more than 16 beds; and
2. Is "primarily engaged in providing diagnoses, treatment or care of persons with mental diseases including medical attention, nursing care, and related services."[13]

If the QRTPs has 16 or fewer beds, no Medicaid exclusions would apply, and FFP would be available for Medicaid services to Medicaid-eligible residents. If the QRTP has more than 16 beds, the second prong is central: is the facility "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases"?[14] According to CMS, one indication that a facility may be an IMD is that the facility specializes in "psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs."[15] Other relevant factors include whether the facility is accredited or licensed as a psychiatric facility, whether the facility is under the jurisdiction of the state's mental health authority, and whether "mental disease" is the reason that more than 50% of the residents are in the facility.[16] No single factor is determinative, and the state must make the final determination as to whether a facility is an IMD by looking at the "overall character" of the facility.[17]

It is likely that most QRTPs are IMDs. QRTPs are primarily engaged in treatment or care of persons with "mental diseases," as they are reserved specifically for children with mental health needs. The primarily purpose of a QRTP is to provide "a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances."[18] Furthermore, QRTPs are required to have staff with specialized psychiatric/psychological training, which according to CMS is another indicator of an IMD. QRTPs must have **"**registered or licensed nursing staff and other licensed clinical staff who . . . are on-site according to the treatment model."[19]

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[13] 42 U.S.C. § 1396d(i).
[14] *Id.*
[15] CMS, STATE MEDICAID MANUAL § 4390.
[16] *Id.*
[17] 42 C.F.R. § 435.1010.
[18] 42 U.S.C. § 672.
[19] *Id.*

If the QRTP is an IMD, FFP for Medicaid services is available only if the facility falls into one of the statutorily enumerated exceptions. The only potentially relevant statutory exception is the PRTF exception.[20] However, because the staffing and treatment standards for PRTFs are generally more stringent than a QRTP, "QRTPs also likely would not meet the requirements to qualify as PRTFs." For example, services in a PRTF must be overseen by a physician, while a QRTP only requires oversight from a nurse.[21] As a practical matter, most PRTFs have more than 25 beds, while QRTPs must have fewer than 25 beds. However, there may be isolated cases where a QRTP meets the requirements of a PRTF, and in such cases, FFP would be permitted.

The state Medicaid agency must review each QRTP, and make an individual determination if the QRTP is an IMD. If a state is currently improperly claiming federal Medicaid funds for services provided to children in foster care facilities that qualify as IMDs, the state must cease such claiming or risk a CMS audit and recoupment.[22]

CMS is inviting states to request federal financial participation for QRTPs that are IMDs via Section 1115 demonstration applications.[23] Section 1115 demonstrations can only be approved if they are an experiment that is "likely to assist in promoting the objectives" of the Medicaid Act.[24] Furthermore, the Secretary can only waive a state's compliance with requirements of Section 1396a of the Medicaid Act, and notably, the IMD exclusion lies outside of Section 1396a, in Section 1396d.[25] Finally, the Secretary may only grant the waiver to the extent and for the period necessary to enable the state to carry out the experiment.[26]

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[20] In guidance, CMS explains why PRTFs are the only potentially relevant exclusion: "A QRTP would not meet the definition of 'inpatient' as set forth in the Medicaid regulations and therefore would not qualifiy as a pyshciatric hospital or a psychiatric program in an acute care hospital." CMS, *Qualified Residential Treatment Programs and Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers (*Sept. 20, 2019), at 4, https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf (hereinafter "CMS QRTP Guidance")

[21] *Compare* 42 C.F.R. § 441.151-156 (prescribing PRTF conditions of participation, including a requirement that the services be provided at the direction of a physician) and 42 U.S.C. § 672(k)(4) (defining QRTPs).

[22] CMS QRTP Guidance at 4.

[23] CMS QRTP Guidance at 5.

[24] 42 U.S.C. 1315.

[25] 42 U.S.C. 1315; *see also* Jane Perkins, Nat'l Health L. Prog., *Section 1115 Demonstration Authority: Medicaid Provisions That Prohibit a Waiver* (Jul. 5, 2017), https://healthlaw.org/resource/sec-1115-demonstration-authority-medicaid-provisions-that-prohibit-a-waiver/.

[26] 42 U.S.C. § 1315(a)(1). For more discussion of Section 1115 Demonstrations and the IMD exclusion, see generally Jennifer Lav, Nat'l Health Law Prog., *Public Comments on Medicaid's Institution for Mental Diseases Exclusion (*June 4, 2019), https://healthlaw.org/resource/public-comments-on-medicaids-institutions-for-mental-diseases-imd-exclusion/

If a state proposes such a demonstration, advocates will have an opportunity to submit comments.[27] Even if CMS were to improperly approve a waiver that permits FFP for QRTPs that are IMDs, CMS has indicated it will place limits on such waivers. CMS states it intends to require any state that seeks federal Medicaid funds for a QRTP to limit the average length of stay to 30 days for all IMDs included in the waiver, ensure compliance with CMS regulations regarding seclusion and restraint," and not seek reimbursement for room and board.[28] Advocates should be particularly wary of any attempts to circumvent these limits.

Conclusion and Recommendations

Placement in a QRTP may affect children's access to Medicaid-funded services. States must determine if QRTPs are IMDs. If the QRTP is an IMD, federal Medicaid funding is not available for services to children while they are placed there. State advocates can help ensure that states are not improperly circumventing the IMD exclusion by doing the following:

1. Coordinate with child welfare advocates and the state child welfare agency to obtain a list of QRTPs and to monitor such facilities when possible;
2. Ensure that the state Medicaid agency makes a determination of whether each facility operating as a QRTP is an IMD;
3. Monitor any state initiatives to obtain Section 1115 demonstrations that could circumvent the IMD exclusion.

The National Health Law Program and NDRN are available for technical assistance and consultation regarding the applicability of the IMD exclusion to QRTPs and any related potential Section 1115 demonstration waivers.

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[27] *See* Catherine McKee et al., Nat'l Health Law. Prog., *Quick Review Section 1115 Waiver Requests: Transparency and Opportunity for Public Comment* (Apr. 28, 2017), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2017/04/Sec1115TransparencyCommentQR2-4.28.17.pdf. *See also*, Nat'l Health Law Prog*., Comments, Indiana SMI/SED Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver* (Oct. 11, 2019), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/NHeLP-IN-SMI-Final-3.pdf; Nat'l Health Law Prog., *Comments, District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program* (July 10, 2019), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/07/NHeLP-Comments-on-DC-1115-Application-FINAL.pdf.

[28] CMS QRTP Guidance at 5-6.