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FAMILY FIRST PREVENTION SERVICES ACT HEIGHTENS CONFLICT WITH THE MEDICAID IMD EXCLUSION

The surprise enactment of the Family First Prevention Services Act (FFPSA) last month has reanimated NACBH's decades-long fight to eliminate the antiquated and discriminatory Institutions for Mental Diseases (IMD) exclusion in federal Medicaid law. By creating in the FFPSA a federal definition of a new type of residential facility that appears to be an excluded IMD – qualified residential treatment programs (QRTPs) – Congress has given national visibility to child welfare institutions that have flown under the IMD enforcement radar since Medicaid was created in 1965.

What FFPSA does:

For a narrative description of what the FFPSA includes, please see three sets of "Cliff Notes" prepared by *The Chronicle of Social Change*. Part One describes services to prevent foster care placements, Part Two, provisions limiting federal financing for congregate care, and Part Three, miscellaneous amendments to kinship navigator programs, family reunification, foster home recruitment and retention, Chafee programs, and others. The Children's Defense Fund has posted a brief summary, a detailed summary, and an implementation timeline of the law's various provisions.

What are the restrictions on congregate placements?

For NACBH, the most critical provisions in the law are restrictions on IV-E reimbursement for children in congregate care, and the unanswered question – which we raised many times with the relevant Congressional committees as the bill was developing – of who will pay for their health care. This section of the FFPSA is euphemistically titled Ensuring the Necessity of a Placement That Is Not In a Foster Family Home.

Beginning in the third week that a child is formally placed in foster care, states may only claim IV-E foster care payments on behalf of a child living:

- in a foster family home licensed or approved by the state,
- with their parent(s) in a licensed, family-based residential substance abuse treatment facility,

or in one of the following child-care institutions:

- a qualified residential treatment program (QRTP), defined below,
- a setting specializing in providing prenatal, post-partum, or parenting supports for youth,
- a supervised independent living setting, or
- a setting providing high-quality residential care and support services to children who have been or are at risk of becoming sex trafficking victims

How the IMD exclusion comes into play:

Any of these four types of child-care institutions could potentially be identified under Medicaid as an excluded IMD. QRTPs would be most likely to fit the federal definition, the other three, less so. In addition, family-based residential substance abuse treatment facilities could fit the definition of an excluded IMD.

States may not legally claim federal Medicaid reimbursement for any health care services provided to residents of excluded IMDs – although we know they do. Enforcement of the IMD exclusion is inconsistent because CMS relies on states to comply against their own financial interest, and difficult because CMS can't identify from what look like outpatient claims that beneficiaries are, in fact, residing in excluded IMDs.

This is an egregious disconnection of the federal child welfare and Medicaid statutes, which NACBH has raised repeatedly with Congress in advocating for a legislative fix, and with CMS in advocating for regulatory or policy changes. We will follow up in next month's NACBH News with an update on our advocacy plan to address the IMD exclusion.

Additional restrictions on congregate placements:

Children living with their parent(s) in a licensed, family-based residential substance abuse treatment facility:

- The child's case plan must recommend this placement
- The treatment facility must provide parenting skills training, parent education, and individual and family counseling
- The treatment and related services must be trauma-informed
- The placement is limited to 12 months

Children placed in QRTPs:

- Within 30 days of placement in a QRTP, a qualified individual must assess the child's strengths and needs using an age-appropriate, evidence-based, validated, functional assessment tool to determine if the child's needs can be met with family members, in a foster family home, or one of the other approved settings.
- If the QRTP placement is determined to be appropriate, the reasons must be documented in writing. A shortage of foster family homes is not an acceptable reason.
- Within 60 days of placement, a court must review the assessment and approve or disapprove of the placement.
- If the court determines that QRTP placement is not appropriate, the state must transition the child to an appropriate setting within 30 days. During that time, IV-E reimbursement will continue.
- At every permanency hearing for children remaining in QRTPs, the state agency must demonstrate ongoing assessed need, as well as updated treatment and discharge planning.
- For children under age 13 in a QRTP for 6 consecutive or non-consecutive months, the state must submit to HHS the most recent evidence and documentation supporting the placement, with a signed approval by the head of the state agency.
- The state must do the same for children 13 and older in a QRTP for 12 consecutive or 18 non-consecutive months.

What are QRTPs?

The FFPSA's describes the new qualified residential treatment program, to be further fleshed out in federal regulations, as a program that:

- Has a trauma-informed treatment model that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.
- Has registered or licensed nursing staff and other licensed clinical staff who
  - provide care within their state-defined scope of practice
  - are on-site consistent with the QRTP's treatment model, and
  - are available 24 hours/day, 7 days/week.
- As appropriate, facilitates participation of family members in the child's treatment program.
- Facilitates and documents outreach to family members, including siblings, and maintains contact information for any known biological family and fictive kin of the child.
- Documents how family members are integrated into the treatment process, including post-discharge, and how sibling connections are maintained.
- Provides discharge planning and family-based aftercare support for at least 6 months post-discharge.
- Is state-licensed and is accredited by CARF, COA, the Joint Commission, or another independent, nonprofit accrediting organization identified by the HHS Secretary.

Please email pat.johnston@nacbh.org with questions and comments, as we develop more information materials and track the development of regulations and guidance.