COFCCA

Leadership, voice and vision for child welfare in New York State

June 17, 2022

Ensuring the Continuum of Foster Care Capacity in NYS: Qualified Residential Treatment Programs (QRTPs) and the Federal Institutions for Mental Disease (IMD) Exclusion

Statement of Values: It is critical that the state, first and foremost, ensures the availability of the full continuum of safe, appropriate, and well-resourced care and services for families, children and youth in the child welfare system.

Executive Summary

The following paper presents a time sensitive dilemma facing New York as a result of the passage of a federal law (the Family First Act). Per this law which has recently been implemented in New York State in September 2021, most residential programs that serve children and youth in foster care are now designated as Qualified Residential Treatment Programs (QRTPs). According to the Centers for Medicare and Medicaid Services (CMS), QRTPs may be classified as "Institutions for Mental Disease" (IMDs) if they serve more than 16 children. As a result, children and youth placed in a QRTP that is designated an IMD will not be able to access Federal Financial Participation (FFP) in Medicaid for their medical care (even though children and youth in foster care are categorically eligible for Medicaid).

In late fall 2021, CMS proposed a short-term option to avoid the loss of federal financial participation for this population that states may pursue, in the form of an ability to apply for an 1115 SMI/SED Demonstration. It is clear that per the conditions of waiver submission as outlined by CMS, QRTPs that are determined to be IMDs will either need to transition to an RTF model, significantly reduce bed capacity, or close at the end of the waiver period. We detailed our questions and concerns with the waiver approach in a previous IMD QRTP Paper released in January 2022 (Attached- 1 4 22 IMD QRTP Paper).

COFCCA strongly agrees with the state that there is a significant opportunity for systems reform and improvements. We wish to partner with the state on systems reform and making improvements for children and families served through our system, and indeed include as an attachment to this paper *COFCCA's Recommendations for Child Welfare System Improvements and Reform*.

During a May 4, 2022 webinar for stakeholders, the State identified an estimated maximum impact of lost federal Medicaid matching dollars to the State of $41 million (approximately $82.5 million total) as a result of the issues posed by the IMD/QRTP intersection. We are unaware of any financial estimates the State may have assessed for impacts of submission of an 1115 SMI/SED waiver.

We acknowledge that the best long-term solution to the QRTP-IMD issue is the passage of federal statute that will exempt QRTPs from the IMD exclusion. COFCCA has been actively involved in advocacy with our colleagues across the country to encourage passage of *The Ensuring Medicaid*

Continuity for Children in Foster Care Act of 2021 (S. 2689 and H.R. 5414), which would exempt QRTPs from the federal IMD Medicaid exclusion to ensure continued eligibility for Federal Financial Participation in Medicaid and support continuity of medically necessary care. However, unless and until there is a federal solution, we urge New York State to cover the medical care costs of youth in foster care in QRTPs that are IMDs with State only Medicaid, as other states have done. It is essential that children and youth in OCFS certified QRTPs have continued, consistent support of their health and behavioral health care costs, and that we avoid unnecessary disruption to children, youth, and their families.

COFCCA has articulated a statement of values as above in this paper. We recommend that the State and field take from previous experience,[1] and develop a strategic plan that provides significant investments necessary to ensure the availability of the full continuum of safe and appropriate care and services for families, children and youth in the child welfare system prior to any further decisions being made. We are eager to work with the State to assess an appropriate capacity, as well as systems improvements, across the spectrum of service levels.

Background

In New York, the federal **Family First Prevention Services Act (Family First)** went into full effect on September 29, 2021. We applaud Congress for prioritizing prevention to help keep families safely together by providing federal support to states for preventive services via Title IV-e funding under Family First. When Family First created Qualified Residential Treatment Programs (QRTPs), these settings became one of very few residential foster care settings that are eligible for federal Title IV-e funds after the first two weeks of a child's placement.

New York has been deeply engaged in Family First implementation. The state, counties, and voluntary agencies working together have successfully begun to transition more children and youth to placements in community-based family foster homes and kinship resources. From 2019 to 2021, the State achieved a more than 20% reduction in residential placements (instead prioritizing family and kin-based care), and saw a more than 20% reduction in residential capacity during that same period.[2] We support the idea that residential care placements are pursued when a young person is assessed to need that level of care, and we aim to partner with the state to ensure those residential placements are appropriately funded and staffed through a stable, well-trained workforce. New York providers this past year embraced requirements associated with becoming a QRTP--with almost all residential foster care programs becoming QRTPs.

[1] Accessed 3/29/22. *Cuomo Set Out to 'Transform' Mental Health Care for Kids. Now They Can't Get Treatment.* The City. https://www.thecity.nyc/2022/3/28/22996681/cuomo-transformation-mental-health-care-kids-treatment

[2] Accessed 4/29/22. *FFPSA Outcome Monitoring Report; Statewide Aggregate Capacity Report.* FFPSA Data and Resources | Strategic Planning and Policy Development | OCFS (ny.gov)

Unfortunately, according to CMS[3], as defined by Family First, Qualified Residential Treatment Programs (QRTPs) that are 16+ beds are likely considered part of the federal IMD Medicaid Exclusion. For children and youth placed in these settings, this means "the entire cost of their medical, dental, behavioral, and mental health care will fall to states and counties."[4]

The *Ensuring Medicaid Continuity for Children in Foster Care Act of 2021***,** bipartisan legislation introduced in both houses (S. 2689 and H.R. 5414), would exempt QRTPs from the federal IMD Medicaid exclusion. Passage would maintain eligibility for Federal Financial Participation in Medicaid for children and youth in foster care in these settings and ensure continuity of their care.

COFCCA is part of an active national effort (see national sign on letter), with 615 organizations signed on in support, to encourage passage of this Act. In addition, the National Association of Counties wrote in support of the bill (Attached- QRTP IMD Memo NaCo). The National Association of Medicaid Directors is also advocating for QRTPs to be exempted from the IMD exclusion.[5]

COFCCA's Recommended Solution to the IMD/QRTP Intersection in NYS: Use State only Medicaid Coverage of children and youth in QRTPs that are IMDs

Unless and until a federal solution is reached, we urge New York State to cover the medical care costs of foster youth in QRTPs that the state determines are IMDs with State only Medicaid. This will ensure continuity of care for thousands of the state's children and youth who have been determined to need residential care through the assessment process set up through Family First. It is our understanding that the State has estimated the loss of federal Medicaid funding at approximately $82.5 million per year ($41 million state, $41 million federal).

Wisconsin, Minnesota, and Indiana are all investing state dollars to cover the loss of federal Medicaid matching funds. Wisconsin is covering the full cost of Medicaid for all of the Medicaid enrolled youth who are currently placed in QRTPs that are IMDs. As of the writing of this paper, approximately half of the approved QRTPs in Wisconsin have been designated IMDs (they are still accepting QRTP applications). In 2017 Minnesota declared all their QRTP providers to be IMDs and the state has been covering the medical costs of residents in these settings with state-funded Medicaid since. Indiana has very recently decided not to pursue an 1115 SMI/SED demonstration, indicating that the State will absorb the costs of the loss of federal Medicaid

[3]Accessed 11/30/21. *Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements Q & A October 19, 2021.* https://www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf

[4]Accessed 3/1/22. *Senators introduce bipartisan legislation to maintain Medicaid coverage for certain children in foster care.* NACo. https://www.naco.org/blog/senators-introduce-bipartisan-legislation-maintain-medicaid-coverage-certain-children-foster

[5] Accessed 5/5/22. *Federal Policy Briefs: The IMD Exclusion.* NAMD. https://medicaiddirectors.org/wp-content/uploads/2022/04/IMD-NAMD-Federal-Policy-Briefs.pdf

funding. Among the reasons cited were disruption to the system without any clear benefit, and the creation of access issues for children needing residential services.[6]

1115 SMI/SED Demonstration

In late fall 2021, CMS proposed a short-term option to avoid the loss of federal financial participation for this population that states may pursue, in the form of an ability to apply for an 1115 SMI/SED Demonstration**.** COFCCA detailed our questions and concerns with the waiver approach in a previous IMD QRTP Paper released in January 2022 (Attached- 1 4 22 IMD QRTP Paper). In particular—we raise concern with the Length of Stay restrictions required at the end of two years, as well as the costs associated with compliance on the Restraint & Seclusion requirements required as part of the Waiver approach.

Additionally, per their October 19, 2021 guidance, CMS requires states to submit a plan for transitioning children out of QRTPs that are IMDs. The plan must include "key milestones and timeframes," meaning that the state will be committing to significant changes to occur during the Demonstration period.

Restraint and Seclusion

CMS has indicated that QRTPs "need to comply with the restraint and seclusion requirements as outlined in our guidance, which are the same as the ones that PRTFs must comply with"[7] during the waiver period. There are several state and federal government regulations that address this. On the federal level it is Title 42 part 483.358 and 483.362-.364. On the state level it is Part 526.4 and Mental Hygiene Law 33.04. Currently, under federal regulations, the use of restraint must be ordered by an appropriately licensed healthcare professional. Additionally, under state regulations, a physician is required to do post restraint assessments within 30 minutes.

There will be additional state costs associated with the application of restraint and seclusion requirements in QRTPs as applied to RTFs during the waiver period, including the need for hiring staff to cover 24 hour a day coverage requirements—nurses to receive orders for restraints and a physician(s) to be available to order the restraint and conduct restraint reviews in accordance with this requirement. The full scope of the impact of this new requirement is difficult to assess. However, one of our members with a combined 30 QRTP beds estimates that based on the current costs within their RTF, the annual fiscal impact could be $900,000. That total includes additional nursing staff ($650,000 at a rate of one nurse to fourteen children/youth as in the RTF), and

[6] Accessed 4/26/2022. Letter from The Indiana Department of Child Services. https://view.smcmail.dcs.in.gov/?qs=25c488c5b488130eabd383daee5196a78f1bc03bf00ec4c4cc4456d57e48d5342611bddddcdf6c44c60fabe7e5369aaff9155935bcd3e65d81386226830a57c17a44dcc980979dbc9138c57955a37388.

[7] Accessed 6/2/22. https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf. *Centers for Medicare & Medicaid Services Qualified Residential Treatment Programs (QRTP) and Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers September 20, 2019*

additional costs for contracts with physicians ($250,000 at the same rate within the RTF per bed, with a small increase for additional workload.)

Residential Care Capacity for Children and Youth in Foster Care

In the May 2022 webinar for stakeholders, the State identified ways to "ameliorate conditions that result in facilities meeting the criteria of an IMD whenever possible" including reducing lengths of stay, reducing the size of residential programs to 16 beds or fewer, and licensing programs as PRTFs as appropriate. We discuss each of these options below from the provider perspective.

Length of Stay

Length of stay restrictions are required as part of the 1115 SMI/SED waivers. CMS Guidance indicates that states will have up to two years from the effective date of the demonstration to be exempt from the length of stay restrictions typically required as part of the 1115 SMI/SED Demonstrations. However at the conclusion of two years, as a result of waiver submission--New York State will be required to adhere to a 30-day average statewide length of stay, and a maximum 60-day length of stay limit, in order to continue to receive Federal Financial Participation.[8] These length of stay restrictions are extremely difficult to achieve for the New York foster care population, placed in care for any number of different reasons. A June 2016 joint NYS DOH/OCFS presentation[9] shows this information regarding foster care length of stay: "The average length of stay in foster care in New York State is 290 days, while in NYC it is 334 days." This is more than nine times what the federal government will require in two years at the end of the waiver period.

Even given the expected impact that the Family First Act will have on reducing lengths of stay—it is not a long-term solution to expect that an average length of stay of 30 days and a maximum length of stay for 60 days is realistic to achieve in instances where children and youth have been assessed to require the highest level of care. The Family First Act provided timelines for review of placements in QRTPs that go well beyond the length of stay timeframes as set forth by CMS for 1115 SMI/SED waiver. Under Family First, Qualified Individual reviews must be conducted by the 30-day mark in placement, and a Family Court Review by the 60-day mark in placement and residential placements are also reviewed for "long stayers."

[8] Accessed 11/30/21. *Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements Q & A October 19, 2021.* https://www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf

[9] Accessed 4/21/22. *Health Homes Serving Children in Foster Care Information on the NYS Child Welfare System and Defining the Collaborative Roles.* https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/webinars/docs/2016/hhsc_webinar_6_1_2016.pdf

QRTP Size

There are approximately 2700 residential beds that have been classified as QRTPs in New York.[10] As of February 28, 2022, 1480 children and youth were placed in a QRTP; while 774 were in a "non-specified setting."[11] A subset of these beds might be considered IMDs. It is important to consider that context as to how the State will define these settings will be needed in order to determine the full scope of the impact of any such limitation for QRTPs in New York. There have been different approaches to the question of how a state counts 16 residential beds (therefore determining IMD status) across the country. While states make an IMD assessment and determination, federal Medicaid auditors can determine whether a program is an IMD based on the "character" of a program. To our knowledge, CMS has not weighed in on the following interpretations made by Florida, Arkansas and Colorado:

- Florida and Arkansas are using separate licensure to determine whether their QRTP beds qualify as IMDs. In Florida, if a QRTP has three separately licensed 10-bed cottages, even if they are on a single campus, Florida is concluding the agency is not an IMD.[12]

- Colorado is applying a tiered distance standard in distinguishing between QRTPs.[13] When there is a distance of 1 mile between separately licensed facilities: Each facility must have dedicated staff that ensures a stable milieu, and residents must not move between facilities during their care. For home-like facilities (ex. a cottage, house, apartment) they can be considered separately if they are 750 feet apart, provided they are: Not on a single campus or adjoining properties, and within a community setting that includes publicly used infrastructure (roads, parks, shared spaces, etc.).

Given the economies of scale of running a residential program, a statewide move to QRTPs with 16 or fewer beds, will likely significantly reduce the availability of residential placements in the state. We have seen this attempt previously in another state: Nebraska put out an RFP for 16 bed QRTPs, but received no responses. They have since abandoned implementation of QRTPs.

To ensure the availability of a full continuum of safe, appropriate, and well-resourced care and services for families, children and youth in the child welfare system, in considering this option we raise the need for the following:

- Significant investment in home and community-based services for children and youth as well as system reforms to offset the capacity reductions in residential settings;

[10] Accessed 4/29/22. *List of Approved Qualified Residential Treatment Programs as of 4-1-22.* Approved-QRTPs-2022-04-01.pdf (ny.gov)
[11] Accessed 4/29/22. *2021 Q4 FFPSA Outcome Monitoring Report.* From FFPSA Data and Resources | Strategic Planning and Policy Development | OCFS (ny.gov)
[12] Accessed 11/30/2021. *Institutions for Mental Disease: Frequently Asked Questions (April 2021).* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Snapshot_Institutions_Mental_Disease_04162021.pdf

[13] Accessed 11/30/2021. *IMDs and Family First.* https://co4kids.org/strengthening-families/family-first/faq/IMD

- QRTP rates needed to support the safe and appropriate care of children and youth in residential settings that reduce their beds to 16 or less would have to be enhanced, given the likely elimination of administrative and program efficiencies of the transition;
- We must ensure that there is adequate in-state capacity for residential care placements needed for children and youth in foster care, to avoid out of state placements and to ensure appropriate capacity to support needs in state.

QRTPs include community-based settings that are separate residences constituting fewer than 16 beds (for instance, Agency-Operated Boarding Homes and Group Homes). In addition, in New York State, QRTPs support special populations that have been assessed to require an enhanced level of care due to their needs. Therefore, in recognition of these factors, **COFCCA recommends that in considering whether QRTPs are IMDs, New York should give special consideration to the uniqueness of the foster care system in NY, and not include as part of the bed count:**

- **Agency-Operated Boarding Homes (AOBH):**
- **Group homes or other community based residential settings;**
- **Programs serving young people with developmental disabilities;**
- **Committee on Special Education (CSE) placements; and**
- **Programs serving Juvenile Justice involved youth.**

Psychiatric Residential Treatment Facilities (PRTFs)

Conversion of QRTPs to Psychiatric Residential Treatment Facilities (known as PRTFs in federal conversations and RTFs in New York) because they are not subject to the IMD exclusion is not a solution for the vast majority of children and youth in residential care. The New York State Office of Mental Health (OMH) defines RTFs for children and youth as follows:

> *"A 24 hours per day inpatient treatment program which provides intensive treatment services to children and adolescents age 5 - 21 who need longer term treatment than would be provided on an inpatient psychiatric program operated by a general, private mental hospital, or state psychiatric center."*[14]

Given the QRTP and IMD intersection, several states have chosen to have convert to use of these types of facilities. Kansas sent a notice to all of their QRTP providers that they would need to either limit capacity to 16 beds or convert to a PRTF. North Carolina increased PRTF placements after IMD enforcement by CMS in 2009, and has seen a 119% increase in PRTF placement since 2010.[15] They are now being sued regarding PRTF usage.

[14] Accessed 3/24/22. *Licensed Program Type Definitions.* https://omh.ny.gov/omhweb/licensing/definitions.htm

[15] Accessed 12/1/21. *Punching, predators, neglect. Traumatized NC children suffer inside dismal psychiatric centers.* The Fayetteville Observer. https://www.fayobserver.com/in-depth/news/2021/11/08/investigation-uncovers-treatment-failures-inside-mental-health-facilities-for-youth/8581506002/

RTFs are subclass psychiatric hospitals, which represents a significantly higher level of care than is required for most children and youth in QRTPs. While there are some children and youth with Child Welfare System involvement and custody that may have a psychiatric acuity level appropriate for placement in RTFs, we assess this to be a small portion of the population. We affirm the importance of ensuring the most appropriate care and services in the least restrictive settings possible. Trading one congregate care bed for another, let alone one that does not most appropriately meet the needs of the children and youth being served, is not an appropriate solution for our children and youth in foster care.

There are also a number of other considerations with this option. First, RTF placements are made on a voluntary basis. There would be no mechanism for a Family Court Judge to order placement into an RTF in the way that a Family Court Judge can make a foster care residential placement now (and indeed, the Family First Act requires that there be both a Qualified Individual review by the 30-day mark in placement, and a Family Court Review by the 60-day mark in placement). Additionally, there are significant differences in who directs treatment, and how decisions around home visits, discharges, etc. are made.

Transitioning to an RTF model would require significant additional state investment as well--both in time, and in funding to meet staffing and physical plant requirements. In order for any QRTPs to transition into RTFs and to meet all the associated requirements, we have assessed that the state would need to pay for the following (we provide a cost example for some of these components on pages 4-5 above):

- Hiring 24-hour nursing staff required for RTF facilities;
- Investing in additional psychiatric time as the psychiatrist plays a bigger role in the admission process and treatment planning, including review and approval of all plans for RTF facilities;
- Ensuring each RTF has a qualified "Director" who is a nurse, physician, psychiatrist, psychologist, social worker, teacher, recreation therapist (masters) rehabilitation counselor (masters);
- Hiring a physician(s) to conduct restraint reviews within the State required 30 minutes; and
- Physical plant and safety upgrades such as doors and non-ligature fixtures. For new construction, one of our member organization's facility team staff has assessed the cost could be an additional 20%. Retrofitting existing buildings would be costly, and would not always be practical due to the size and age of the buildings.

Additional Items for Consideration

- **The State must consider the impact of next steps for the State's special education system**, as the residential foster care system/QRTPs intersect with special education 853 schools and Special Act school districts serving children and youth in foster care that are placed in congregate settings. They will be impacted by a changing residential care landscape. The State must consider the appropriate level of capacity for special education placements and ensure these stakeholders are included in the larger discussion about this

issue given the way they're currently funded. Conversations related to a redesigned special education tuition rate methodology must factor into any State policy on the QRTP/IMD issue.

- **The State must also assess the full continuum of care capacity of OMH and OPWDD programs for children and young adults**. A lack of access to these services, hinders the ability to transition otherwise eligible children and youth from Voluntary Agency programs and 853 residential placements to the most appropriate setting.

Conclusion

The best long-term solution to the QRTP-IMD issue is the passage of federal statute that will exempt QRTPs from the IMD exclusion. The *Ensuring Medicaid Continuity for Children in Foster Care Act of 2021* would exempt QRTPs from the federal IMD Medicaid exclusion to ensure continued eligibility for Federal Financial Participation in Medicaid and support continuity of medically necessary care. However, barring a federal solution, **the State must cover the medical care costs of youth in foster care in QRTPs that are IMDs with State only Medicaid.** To continue prioritizing children's best interests, and to better achieve the goals of Family First, it is essential that children and youth in OCFS certified QRTPs have continued, consistent support of their health and behavioral health care costs.

As described above, submission of an 1115 SMI/SED Demonstration will have both immediate and long-term impacts. We believe that the impacts associated with the waiver would likely cause significant disruptions and access to care issues for children and youth in foster care, given the challenges laid out in this paper.

COFCCA is eager to work collaboratively with the State, as well as our county partners, to assess an appropriate path forward. We agree with the State, as noted in the April 15th letter to stakeholders, that there is opportunity to engage in a meaningful conversation regarding the ways in which New York State can "continue to enhance our service provision and strengthen our commitment to eliminate the over institutionalization of children." We note that this opportunity (and the need for reforms) exists aside from the federal issues. Please see attached COFCCA's ***Recommendations for Child Welfare System Improvements and Reform*** which advances many of our child welfare system improvements that would improve outcomes for children and youth and strengthen families.