

Chapter 4:

Mandated Report on Therapeutic Foster Care

Mandated Report on Therapeutic Foster Care

Recommendation

4.1 The Secretary of Health and Human Services should engage the Centers for Medicare & Medicaid Services and the Administration for Children and Families to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

Key Points

- The term therapeutic foster care generally refers to the practice of serving children and youth who have serious emotional, behavioral, mental health, intellectual or developmental disabilities, or medical conditions in a family-based setting, rather than in an institutional or group setting. However, as there currently is no uniform definition of the services that comprise therapeutic foster care in federal Medicaid statute or regulation, states vary in covering these services.
- In the report accompanying the fiscal year 2019 Labor, Health and Human Services, and Education funding bill, the U.S. House of Representatives Committee on Appropriations requested that MACPAC examine therapeutic foster care, noting concerns about lack of a uniform definition within Medicaid and commenting that a uniform definition “could improve the ability for more consistent care and treatment.”
- After examining the role Medicaid plays in covering therapeutic foster care services and the potential implications of a uniform definition of therapeutic foster care in Medicaid for children who need such services and current state practices, the Commission concluded that a uniform definition would not likely achieve the goal of more consistent care and treatment, and in fact, may have unintended consequences.
- Therapeutic foster care represents an important set of services, many of which are already coverable in Medicaid. Because the needs of this vulnerable population are varied, individualized assessments should determine which services are necessary and appropriate. A uniform definition could limit the ability of states and providers to tailor services to address these needs.
- Additional federal guidance could help states design or improve the coverage and provision of therapeutic foster care services. Such guidance could inform states of their options to cover therapeutic foster care services within the existing benefit design flexibility in Medicaid, as well as provide ways to coordinate effectively with other agencies serving the same high-need children and youth.

CHAPTER 4: Mandated Report on Therapeutic Foster Care

Therapeutic foster care is typically described as the practice of serving children and youth who have serious behavioral health or medical needs in a family-based setting, rather than in an institutional or group setting. Although the term can be used to describe various constellations of services, common elements include the clinical services provided (such as crisis support, behavior management, medication monitoring, individual and family counseling, and case management); heightened treatment plan intensity; and higher levels of parent training, supervision, and payment than routine foster care arrangements. A number of the clinical services considered to be part of therapeutic foster care can be covered by Medicaid, although coverage of these services varies by state.

In the report accompanying the fiscal year (FY) 2019 Labor, Health and Human Services, and Education funding bill, the U.S. House of Representatives Committee on Appropriations requested that MACPAC examine therapeutic foster care, noting concerns about the lack of a uniform definition within Medicaid and commenting that a uniform definition “could improve the ability for more consistent care and treatment” (Committee on Appropriations 2018). It requested that, within 12 months, MACPAC:

- conduct a review for the development of an operational therapeutic foster care definition;
- examine the advantages of a uniform definition; and
- include a list of potential services to treat mental illness and trauma that would be within the scope of such a definition.

This chapter responds to the congressional request. It begins by providing an overview of therapeutic foster care, including the common elements of the

practice and the children served. It then describes the role Medicaid plays in covering such services and current state approaches to providing the services in Medicaid. Considerations for a uniform definition are then presented before concluding with the Commission’s recommendation for clarifying guidance on the practice.

It is the Commission’s view that a uniform definition of therapeutic foster care in Medicaid would not likely achieve the goal of more consistent care and treatment, and in fact, may have unintended negative consequences. Therapeutic foster care represents an important set of services, many of which are already coverable in Medicaid. Because the needs of this vulnerable population are varied, individualized assessments should determine which services are necessary and appropriate. Thus, use of a uniform definition could limit the ability of states and providers to tailor services to address these needs.

However, additional federal guidance from the Secretary of the U.S. Department of Health and Human Services (HHS)—specifically, the Centers for Medicare & Medicaid Services (CMS) and the Administration for Children and Families (ACF)—could help states design or improve the coverage and provision of these services. Such guidance could inform states of their options to cover therapeutic foster care services within the existing benefit design flexibility in Medicaid, as well as provide ways to coordinate effectively with other agencies serving the same high-need children and youth. As such, the Commission recommends that the Secretary of Health and Human Services should engage CMS and ACF to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

What is Therapeutic Foster Care?

The term therapeutic foster care refers to the practice of serving children and youth who have serious emotional, behavioral, mental health, intellectual or developmental disabilities, or medical conditions in a family-based setting, rather than in an institutional or group setting (ASPE 2018 and 2016, Boyd 2013, SAMHSA 2013). Although some view the practice as a more intensive form of foster care, children outside the child welfare system may benefit from and receive these services.¹ There currently is no uniform definition of the services that comprise therapeutic foster care (sometimes referred to as treatment foster care or treatment family care) in either federal Medicaid or child welfare statute or regulation. As such, states have determined what services to include, with variation in the practice.

Common elements of therapeutic foster care

Although there is no uniform definition of therapeutic foster care, common elements include the type of services, intensity of treatment planning, and level of parent training and payment (Box 4-1). The services provided under the practice typically include crisis support, behavior management, medication monitoring, counseling, and case management. Children in therapeutic foster care receive an individualized treatment plan and their treatment team meets on a more frequent basis than the teams for children in standard foster care situations (ASPE 2018, SAMHSA 2013). Compared to other foster parents, foster parents serving these children receive higher levels of training, payments, and case worker support, and are considered part of the treatment team. Many states have multiple levels of therapeutic foster care, with different

BOX 4-1. Common Elements of Therapeutic Foster Care

States often describe therapeutic foster care in state agency administrative rules or contractual requirements. A review of 14 states indicated that the following therapeutic foster care elements are often included:

Treatment planning. An individualized treatment plan is designed to guide and coordinate the provision of services. Treatment teams meet every 30 to 90 days to help ensure that the services are responsive to the changing needs of the children. The treatment team includes the therapeutic foster parents, case managers, biological or other family members, skills coaches, and clinicians.

Specialized training. Therapeutic foster care requires highly trained caregivers who are responsible for implementation of the child's treatment plan. Therapeutic foster parents receive additional preservice and ongoing training compared to traditional foster parents. They are also provided more frequent supervision by trained caseworkers and clinicians.

Crisis support. Therapeutic foster parents and children are provided with crisis support that can include crisis planning, respite care, and access to a case manager or clinician 24 hours a day.

Structured activities. Activities are designed to teach or reteach social skills and coping skills to help children in therapeutic foster care deal effectively with the circumstances or conditions that created the need for treatment.

Behavioral health services. An array of behavioral health services, including individual, group, and family therapy; day treatment; crisis intervention; behavior management; and medication monitoring may be provided (ASPE 2018).

payment levels to families depending on the intensity of a child's needs (ASPE 2018).²

Evidence supporting therapeutic foster care

Although much research has been conducted regarding the needs of children in foster care generally, less is known about the outcomes associated with specific treatment methods and services (SAMHSA 2013). Studies have found positive outcomes for children and youth with complex needs who receive therapeutic foster care; however, the generalizability of these findings is limited because studies have focused on specific subpopulations (e.g., youth in juvenile justice) (SAMHSA 2013, Macdonald and Turner 2008). As such, an expert panel has called for additional research about the effectiveness of various approaches to therapeutic foster care (SAMHSA 2013).

Two evidence-based models of therapeutic foster care have demonstrated positive outcomes: Treatment Foster Care Oregon and Together Facing

the Challenge (Box 4-2). Other models have not been rigorously evaluated.³ Given the costs and difficulty of fully implementing these intensive models, most states have incorporated just some of the programs' elements into their therapeutic foster care programs (ASPE 2018).

Children Served by Therapeutic Foster Care

Children receiving therapeutic foster care most often have serious emotional or behavioral health needs that cannot be appropriately addressed in their own home; or, in the case of children that are in the child welfare system, within a standard foster care arrangement. Some of these children may also have serious medical conditions, although that is less common. Children receiving therapeutic foster care services have often experienced trauma due to child abuse and neglect, being removed from their homes, or other situations. These children are most often adolescents, and are typically in child welfare custody. Therapeutic foster care provides a

BOX 4-2. Evidence-Based Approaches to Therapeutic Foster Care

Treatment Foster Care Oregon (TFCO) provides an alternative to institutional or group care placements for children with severe emotional and behavioral disorders. Formerly called Multidimensional Treatment Foster Care, TFCO was originally designed to serve youth involved in the juvenile justice system but now serves other populations, including preschoolers and children and adolescents not involved in the juvenile justice system. It focuses on structured behavioral management techniques and a high level of supervision. For example, adolescents face increasing expectations for self-management of behavior as they move through a point system that monitors and rewards their behavior. Children and youth enrolled in TFCO typically stay in a treatment home for nine months. Staff in these homes receive initial and ongoing training, daily monitoring, weekly group support, and coaching (TFCO 2018, Child Trends 2016).

Together Facing the Challenge is a hybrid approach combining TFCO and other practice models, focusing on training for therapeutic foster care parents and therapeutic foster care supervisors. The training focuses on building therapeutic relationships, performing and teaching cooperation, implementing effective parenting techniques (such as setting expectations and reinforcing positive behaviors), teaching youth independence skills, and creating a positive home environment (CEBC 2017, SAMHSA 2013).

less restrictive environment than congregate care settings and allows the needs of the children to be met in the community (ASPE 2018, SAMHSA 2013).

There is no national data source that provides the number of children and youth receiving therapeutic foster care or their characteristics (e.g., age, gender,

diagnoses) (SAMHSA 2013).⁴ A recent study examining the use of behavioral health services by children enrolled in Medicaid found that only 0.5 percent of children covered by Medicaid used therapeutic foster care in 2011, declining from 2005 (Table 4-1). The rates of use of therapeutic

TABLE 4-1. Rates of Use of Therapeutic Foster Care in Medicaid, Selected Years

Child characteristics	2005		2008		2011	
	Percent	Number	Percent	Number	Percent	Number
All children	0.8%	14,758	0.9%	17,531	0.5%	11,711
Age						
0–5	0.8	1,815	0.9	3,001	0.5	2,397
6–12	0.5	4,093	0.6	5,629	0.3	3,603
13–18	1.0	8,850	1.1	8,901	0.6	5,711
Gender						
Female	–	–	0.9	7,611	0.5	5,206
Male	–	–	0.8	9,919	0.4	6,505
Race/ethnicity						
White	–	–	0.8	8,343	0.5	6,094
Black/African American	–	–	0.9	4,694	0.4	2,588
American Indian/Alaska Native	–	–	2.4	815	1.8	645
Asian	–	–	0.6	75	0.2	41
Hispanic/Latino	–	–	0.4	840	0.2	629
Native Hawaiian/Pacific Islander	–	–	0.4	12	0.2	10
Eligibility category						
Poverty	0.3	3,306	0.3	3,729	0.2	4,069
Foster care	3.0	8,918	3.8	10,442	1.7	4,915
SSI/disability	0.7	2,534	0.9	3,360	0.6	2,727
Diagnosis						
ADHD	–	–	0.9	6,403	0.5	4,954
Conduct disorder	–	–	1.3	8,308	0.7	6,275
Mood disorder	–	–	1.2	7,185	0.7	5,654
Anxiety	–	–	1.0	3,679	0.6	3,114
PTSD	–	–	3.4	3,530	2.0	3,088
Developmental disability	–	–	0.7	714	0.5	650
Psychosis	–	–	1.3	707	0.9	606
Substance use disorder	–	–	0.9	1,110	0.7	1,138
Other diagnosis	–	–	2.4	2,147	1.3	1,682
No diagnosis	–	–	1.3	4,084	0.7	2,183

Notes: SSI is Supplemental Security Income. ADHD is attention deficit hyperactivity disorder. PTSD is post-traumatic stress disorder. – Dash indicates information not available.

Source: Pires et al. 2018.

foster care services are higher among adolescents, females, and children and youth who are eligible for Medicaid as a result of their child welfare involvement. Children with post-traumatic stress disorder, psychosis, and conduct disorder had the highest rates of therapeutic foster care use (Pires et al. 2018). However, due to differences in Medicaid coding and billing practices across states, the use of therapeutic foster care by Medicaid enrollees may be understated if those services are covered in other Medicaid benefits, such as targeted case management, as discussed in the next section.

Medicaid Coverage of Therapeutic Foster Care Services

For the purposes of Medicaid, therapeutic foster care is not a specific benefit identified in the statute or regulations; however, a number of services considered to be part of therapeutic foster care can be covered by Medicaid. States have taken different approaches, but have typically identified therapeutic foster care services as either a Medicaid state plan rehabilitative service or targeted case management service; others have adopted coverage of therapeutic foster care services through waivers. Even if therapeutic foster care services are not explicitly identified in a state plan, the clinical and therapeutic services that comprise the practice may still be paid by Medicaid. For example, a state may provide case management services in the state plan, but not label these as therapeutic foster care services. Furthermore, in covering the services in Medicaid, some states only allow limited types of services, whereas others provide a broader array of benefits.

Some components of therapeutic foster care cannot be covered by Medicaid. These include room and board, and training and supervision of therapeutic foster parents. States cover these with state-only funds or other sources, such as federal child welfare funds (ASPE 2018).

Rehabilitative services

In Medicaid, rehabilitative services are an optional state plan benefit. This benefit encompasses a variety of services to treat behavioral or physical health conditions designed to return children to function at an age-appropriate level (§ 1905(a)(13)(C) of the Social Security Act (the Act)).⁵ States often elect to cover certain behavioral health services, such as therapy and counseling, under rehabilitative services. Such services can be provided in a variety of community-based settings, and by a broad range of qualified providers, including licensed and non-licensed practitioners, if they meet any applicable state and federal qualifications. This flexibility allows states to offer a variety of rehabilitative services in both clinical and non-clinical settings or from non-traditional providers (Crowley and O'Malley 2007).⁶

Most states cover therapeutic foster care services in their state plans under the auspices of rehabilitative services. In a survey of states conducted in 2012, 31 of 38 states responding reported having specific Medicaid billing codes for therapeutic foster care under rehabilitative services (BUSSW 2012). For example, South Carolina and Virginia define therapeutic child care and therapeutic group home services (the terms used by these states instead of therapeutic foster care) as rehabilitative services (CMS 2017a, 2017b). States have also covered therapeutic foster care services as behavioral health services within the rehabilitative services category. In North Carolina, for example, therapeutic foster care is considered a covered behavioral health service in the state plan (CMS 2017c). Although not defined in the state plan, Illinois state regulations define specialized foster care as a behavioral health service (ASPE 2018).

Targeted case management

Case management services assist individuals living in the community in accessing needed medical, social, educational, and other services. Case management activities include assessment of individual needs; development of a care plan; and

referrals and related activities to link the individual with medical, social, and educational providers and programs (42 CFR 440.169). States may also offer targeted case management services, limiting case management services to a subset of beneficiaries within a state.⁷

Some states cover therapeutic foster care services in their state plans under targeted case management. Twenty-two states (including several that also reported having billing codes under rehabilitative services for purposes of therapeutic foster care) reported having specific therapeutic foster care billing codes under the targeted case management option (BUSSW 2012). For example, in North Dakota, targeted case management assists children and youth in the child welfare system in gaining access to needed medical, social, educational, and other necessary services (ASPE 2018, ND DHS 2016).

Waivers

Some states use waiver authority to provide therapeutic foster care services. For example, New York uses a Section 1915(c) home- and community-based services waiver to create a bundle of services, such as care coordination, respite, and family support, provided to children with severe emotional disturbances. These may be provided in the child's home or community. Additional home- and community-based services are provided through New York's Section 1115 research and demonstration waiver (ASPE 2018, NY 2017).⁸

Evolution of coverage

As with many benefits, state coverage of services under therapeutic foster care is not static. There are a number of factors that influence these changes, including state and federal policy and advances in the field.

Oklahoma has provided therapeutic foster care as part of its Medicaid program for more than two decades. Over that time, the needs of the children, the systems serving them, and the requirements

facing these systems have all changed. The state has long identified therapeutic foster parents as paraprofessionals in the state plan, which allows them to bill for their services. Under the current design, the benefit is structured with limitations on the types of therapies and hours of services available. There is a daily upper limit on unbundled services, with providers documenting and billing for every individual service on a fee-for-service basis. The state is moving away from this approach to one that is more evidence based and that provides a broader array of services (McGaugh 2019, ASPE 2018, Boyd 2013).

In response to a 2011 settlement agreement, California is in the process of implementing therapeutic foster care as a specialty mental health service. The state has developed a Medicaid manual regarding specialty mental health services provided under therapeutic foster care, intensive care coordination, and intensive home-based services. The state has also developed an integrated core practice model guide that describes how the county-based child welfare and mental health systems and service providers can work together (DHCS 2019, DHCS and CDSS 2018).

Limitations on Medicaid funding

Although Medicaid funding is available for a wide variety of services, there are some services, such as room and board, that cannot be covered by Medicaid. As they do for other health services provided to children involved in the child welfare system, states often use Medicaid funds to pay for the clinical aspects of therapeutic foster care, such as behavioral health treatment, and child welfare funds to pay for living expenses, such as room and board, administrative costs, and recruitment and training of foster parents (ASPE 2018, MACPAC 2015). Depending on the nature of the program, states may also use other behavioral health or juvenile justice funds to support the service (ASPE 2018).

Medicaid is the payer of last resort and can only pay when third parties—including other public programs, private insurers, and certain other entities—do not

have a legal obligation to do so (CMS 2014a, 2014b). As a result, states may claim federal Medicaid funding only for services that are not the specific responsibility of a child welfare or other agency.

States generally cannot limit Medicaid benefits to certain groups of children. When provided in the state plan, services must be based on individual assessments of medical necessity, and all children in the state with similar health needs must be provided the same level of assistance. This is true even if particular services would seem appropriate only for a specific group of children (such as children in foster care) because of their high levels of need and potential to benefit from such specialized care. As such, if a state Medicaid program covers therapeutic foster care through its state plan, then the state must also indicate how similar services are covered for children who are not involved with the child welfare system. Furthermore, for all children under age 21, Medicaid's early and periodic screening, diagnostic, and treatment (EPSDT) benefit requires Medicaid coverage of any service allowed under Section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate a physical or behavioral health condition (CMS 2014c).

In light of the requirement to provide medically necessary services to all children with Medicaid coverage, states may choose to finance therapeutic foster care through a Medicaid waiver as described above or choose to use other funding sources, such as child welfare or juvenile justice in order to provide therapeutic foster care to targeted groups of children.

Considerations for a Uniform Definition of Therapeutic Foster Care in Medicaid

In its request to MACPAC, the House Appropriations Committee expressed concern regarding the lack of a uniform definition of therapeutic foster care in Medicaid, and suggested that such a definition could

result in more consistent care.⁹ In addition, some stakeholders have supported a universal definition as a means to improve the quality, consistency, and professionalism of therapeutic foster care services (ASPE 2018, Boyd 2018, Sciamanna 2018). Below we analyze these perspectives.

Consistency of covered benefits across states

The effect of creating a uniform definition of therapeutic foster care would depend upon whether it is considered a mandatory or optional Medicaid state plan benefit. Designating therapeutic foster care as a mandatory benefit would require all states to cover the service, and could ensure that all states provide a prescribed set of services under the therapeutic foster care umbrella. It may also require states currently providing therapeutic foster care to alter their approach to come into compliance. Adding therapeutic foster care as an optional benefit would not require states to provide therapeutic foster care, but may provide states that do not currently offer these services with a simpler way to provide a consistent package of services, as opposed to piecing together therapeutic foster care from other available benefits, such as rehabilitative services and targeted case management.

It is important to note that designating therapeutic foster care as a benefit under Section 1905(a) of the Act, whether mandatory or optional, could also create new EPSDT-related obligations for states. EPSDT requires states to provide any medically necessary service named in the Medicaid statute—including optional services not otherwise covered by the state—without caps or other limits.

On the other hand, establishing a uniform definition of therapeutic foster care would not necessarily result in a more consistent approach across states for several reasons. First, if therapeutic foster care was added to the statute as an optional benefit, states could choose whether or not to adopt it. States may view their current approach as the most appropriate for their circumstances, and may not wish to adopt the standard definition. As

discussed above, all states currently provide some form of therapeutic foster care or the services that comprise it and, as is the case for many other Medicaid policies, the existing variation in the practice likely reflects both the needs of enrollees and state decisions regarding available resources. Second, regardless of whether therapeutic foster care was considered a mandatory or optional benefit, states would continue to have the flexibility to define medical necessity criteria and the amount, duration, and scope of the benefit.

Finally, a uniform definition may have unintended consequences. If the definition is too prescriptive, it may not be sufficient to meet the unique needs of children now receiving these services. For example, a definition in the statute or regulations that describes specific services or qualified providers could restrict existing state and provider flexibility, and limit the services available to children. In addition, it would be difficult to define the practice to account for future practice changes as therapeutic foster care evolves. For example, new research on the negative effects of trauma on individuals' health and well-being is leading to development and adoption of trauma-informed treatment approaches (CHCS 2017). As researchers, states, and providers gain knowledge about children's needs, particular approaches to providing services, and outcomes associated with specific methods, a uniform definition could limit state Medicaid programs from responding to this evolving evidentiary base.

Quality and appropriateness of services provided

A uniform definition of therapeutic foster care may assist in improving the quality and appropriateness of services to the extent that states, federal agencies, advocates, and researchers are better able to assess access to and quality of these services. The provision of therapeutic foster care in Medicaid has not been widely studied and, given the various ways states have implemented their programs, it is difficult to develop a complete understanding of the services provided and the children and youth receiving those services. A uniform definition may

provide an avenue for future research into the quality and effectiveness of therapeutic foster care interventions and monitoring access to services and compliance with standards of care.

On the other hand, a uniform definition in Medicaid would not, in and of itself, address other concerns regarding the availability of therapeutic foster care, including the need for highly skilled and committed caregivers. Although therapeutic foster care programs provide additional training, support, and payment for these parents, recruitment and retention are challenging in most states. Concerns have also been raised regarding the quality of therapeutic foster care providers and agency screening of foster parents (Committee on Finance 2017). In addition, therapeutic foster parents need support from qualified caseworkers and clinical staff. Training and accreditation are not generally considered Medicaid-covered services.¹⁰

It is important to note that children in need of or receiving therapeutic foster care services are typically served by multiple agencies, including Medicaid, child welfare, juvenile justice, behavioral health, and education. Furthermore, as therapeutic foster care is not typically a permanent placement, the need for coordination of services may be heightened as children and youth transition home or to adulthood. For example, parental training and coaching may be necessary when a child returns home so that the ongoing needs of the child can be met. Parent education and training may be covered by Medicaid only if the services are for the direct benefit of the child. As children exit child welfare custody to adulthood, Medicaid coverage can continue up to age 26 for these former foster youth and the child welfare agency is responsible for developing a transition plan that includes specific options related to health insurance coverage (MACPAC 2015).¹¹ Given the complex needs of children receiving therapeutic foster care and their transitions between placements, collaboration across agencies is important to coordinate the services they receive and finance these services appropriately. Nevertheless, a uniform definition of therapeutic foster care within Medicaid would not address these issues.

Commission Recommendation

In this report, the Commission makes one recommendation that HHS more clearly inform states of their options related to Medicaid coverage of therapeutic foster care services.

Recommendation 4.1

The Secretary of Health and Human Services should engage the Centers for Medicare & Medicaid Services and the Administration for Children and Families to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

Rationale

As discussed above, the Commission does not find that a uniform definition of therapeutic foster care in Medicaid would necessarily result in more consistency in covered services or improve the quality and appropriateness of the services provided. In addition, establishing a uniform definition may have unintended consequences that limit services provided to particular children or impede state flexibility and practice improvement. As such, it is the Commission's view that development of a uniform definition of therapeutic foster care in Medicaid is not advisable.

This recommendation calls for subregulatory guidance in the form of an informational bulletin from HHS to assist states in designing therapeutic foster care services that meet the diverse needs of children within the existing program structure.¹² Further direction from the Secretary could help provide important clarification to states on how they can use the benefit design flexibility already afforded them in Medicaid to cover therapeutic foster care services and provide states examples

of what can be considered a Medicaid-financed service, while still leaving flexibility for states to operationalize the benefit and for the practice of therapeutic foster care to evolve over time.

The Commission recognizes that therapeutic foster care is an important set of services for a vulnerable population, the services provided should meet the needs of the children, and a continuum of services provided by multiple agencies may be necessary and appropriate depending upon the child's needs. Although there is a role for congregate care along the continuum of care, a consensus exists across multiple stakeholders that most children and youth are best served in a family setting (Children's Bureau 2015). Moreover, the Americans with Disabilities Act (P.L. 101-336) requires states to provide services to individuals with disabilities in the most integrated setting possible. In addition, the Families First Prevention Services Act (P.L. 115-123), federal child welfare legislation enacted in 2018, focuses on ensuring that children in foster care are placed in the least restrictive and most family-like setting possible.¹³ As federal and state policymakers work to reduce the reliance on congregate care, therapeutic foster care may provide an alternative for those children and youth who need greater levels of care, and additional information could help states meet these requirements.

The subregulatory guidance should be developed jointly between CMS (which administers Medicaid) and ACF (which administers federal child welfare programs).¹⁴ Children in need of or receiving therapeutic foster care services are typically served by multiple agencies, including Medicaid and child welfare, as well as juvenile justice, behavioral health, and education. Although not all children in need of or receiving therapeutic foster care are in child welfare custody, state child welfare agencies are typically responsible for certifying therapeutic foster homes and federal child welfare funds may pay for living expenses, such as room and board, administrative costs, and recruitment and training of foster parents.

At a minimum, such guidance should:

- clarify which therapeutic foster care services can be covered under Medicaid and which services can be provided using federal child welfare funds (under Title IV-E of the Act) and how these and other funding streams can be blended together to serve children;
- share examples of current state approaches to providing therapeutic foster care using Medicaid;
- highlight the use of evidence-based practices and trauma-informed services, as well as other promising practices in therapeutic foster care and parent recruitment, training, and retention; and
- describe ways to effectively coordinate services with other agencies serving the same high-need children and youth, including child welfare, juvenile justice, education, and behavioral health agencies.

In making this recommendation, the Commission points to other instances in which multiple HHS agencies have collaborated to provide subregulatory guidance. For example, CMS and the Substance Abuse and Mental Health Services Administration previously released joint informational bulletins that described Medicaid coverage of behavioral health services for children with significant mental health conditions or substance use disorders, including how the services can be offered through existing authorities and state examples of how the authorities have been used (CMS and SAMHSA 2015, 2013). CMS and ACF could build on these earlier efforts to provide direction for states regarding therapeutic foster care.

Implications

Federal spending. This recommendation would not have a direct effect on federal Medicaid spending.

States. Additional guidance related to Medicaid coverage of therapeutic foster care services may assist states in designing a benefit package

to address the needs of children with complex behavioral health or medical needs in the least-restrictive setting possible. It could also clarify which services can be billed to Medicaid and which are the responsibility of other agencies and how best to coordinate these services.

Beneficiaries. Guidance may help beneficiaries and their families understand what Medicaid services may be available to meet their needs.

Plans and providers. This recommendation may assist plans and providers in understanding appropriate coverage and billing practices for therapeutic foster care services and the responsibilities of various agencies.

Endnotes

¹ Children in traditional foster care are in the custody of a child welfare agency because they have experienced abuse or neglect. Therapeutic foster care may be provided to children in child welfare, juvenile justice, or parental custody. Some states use a term other than therapeutic foster care to make it clear that a child who meets medical necessity criteria for the service does not have to be in foster care.

² In traditional foster care, foster parents provide care and supervision; in therapeutic foster care, parents also provide care and supervision, but are expected to implement the child's treatment plan in the home (ASPE 2018). States typically require that therapeutic foster care be provided in a home, and not, for example, in a residential setting with staff serving as therapeutic parents in shifts.

³ Evidence-based models have demonstrated improved outcomes through rigorous evaluation; evidence-informed models are based on research and follow strict implementation standards, but have not been rigorously evaluated (ASPE 2018).

⁴ Federal Adoption and Foster Care Analysis and Reporting System data on child welfare only include children in foster care and do not distinguish children and youth receiving therapeutic foster care from those receiving other types of child welfare services (SAMHSA 2013).

⁵ Rehabilitative services are services to help individuals restore or relearn skills lost due to illness or injury. Habilitative services are not explicitly defined in Medicaid but are generally considered to be services that help individuals attain skills or developmental milestones not yet acquired. Examples of habilitative services may include speech therapy or physical therapy.

⁶ A 2007 proposed rule would have further defined the scope of rehabilitative services. However, Congress placed a moratorium that prohibited the HHS Secretary from imposing criteria that were more restrictive than those in effect on July 1, 2007, effectively halting implementation. The rule was later withdrawn (CRS 2010).

⁷ Targeted case management services can be provided without regard to the standard Medicaid requirements related to statewideness (meaning the service is provided in all geographic areas in a state) or comparability (meaning the service is provided to all enrollees). However, for children under age 21, a state must provide case management to any child for whom the service has been determined medically necessary under the early and periodic screening, diagnostic, and treatment (EPSDT) requirements. The Deficit Reduction Act of 2005 (P.L. 109-171) narrowed the definition of targeted case management. Final regulations issued in June 2009 rescinded certain provisions of an earlier interim final rule that were thought to restrict beneficiary access and limit state flexibility (CRS 2010).

⁸ New York also has Section 1915(c) waivers to provide home- and community-based services for children with physical disabilities, intellectual or developmental disabilities, autism, and traumatic brain injuries (CMS 2018).

⁹ The Senate Finance Committee issued a report in October 2017 examining the lack of oversight of private providers in foster care. One recommendation among many in the report was that HHS establish a common definition of therapeutic foster care for the purposes of Medicaid and Title IV-E (Committee on Finance 2017).

¹⁰ States can mandate the use of evidence-based training programs for foster parents (such as the Incredible Years program), as well as accreditation and licensing of foster care agencies.

¹¹ The Patient Protection and Affordable Care Act (P.L. 111-148, as amended) required states to continue providing

Medicaid coverage to youth under age 26 aging out of foster care (either Title IV-E or non-Title IV-E) who were receiving Medicaid, with the option of covering youth who have aged out in other states. The Support for Patients and Communities Act (P.L. 115-271) updated this provision, requiring that states cover youth who aged out of foster care in other states, beginning January 1, 2023. States also may cover former foster care children up to age 21 without requiring them to have prior Medicaid enrollment or be in foster care in the same state in which they currently reside (known as the Chafee option).

¹² Center for Medicaid and CHIP Services Informational Bulletins share information, address operational and technical issues, and highlight initiatives or related efforts. They do not establish new policy or issue new guidance.

¹³ The Families First Prevention Services Act was enacted in February 2018 as part of the Bipartisan Budget Act of 2018 (P.L. 115-123).

¹⁴ Programs authorized under Title IV-E of the Act are administered by the Children's Bureau, which is an office of ACF.

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Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission’s policies regarding conflicts of interest, the Commission’s conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation that the Secretary issue guidance regarding therapeutic foster care services in Medicaid. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on the recommendation in this chapter on April 11, 2019.

- 4.1 The Secretary of Health and Human Services should engage the Centers for Medicare & Medicaid Services and the Administration for Children and Families to develop joint subregulatory guidance to assist states in understanding what therapeutic foster care services can be covered under Medicaid and how to coordinate services with other agencies in order to meet the needs of children and youth with significant behavioral health or medical conditions in a family-based setting.

Yes: Bella, Burwell, Carter, Davis, Douglas, George, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil, Weno

16	Yes
1	Not present

Not present: Cerise