

Medicaid Coverage of Qualified Residential Treatment Programs for Children in Foster Care

Medicaid and the State Children's Health Insurance Program (CHIP) often cover physical and behavioral health services for children in foster care living in group homes and institutional settings, commonly referred to as congregate care (Pires 2019, Casey Family Programs 2020).¹ Low-income children who have been removed from their homes and who are eligible for child welfare assistance under Title IV-E of the Social Security Act (the Act) are automatically eligible for Medicaid. Those who are not receiving Title IV-E assistance may be eligible for Medicaid on another basis, such as having low income or a disability.² These children often have substantial health, behavioral, social, and other needs for which a range of Medicaid-covered services, including mental health and substance use disorder (SUD) treatment, may be necessary (MACPAC 2015).³

Enacted as part of the Balanced Budget Act of 2018 (P.L. 115-123), the Family First Prevention Services Act (FFPSA) makes significant reforms to the child welfare system, including placing restrictions on the use of federal funding for congregate care. Specifically, the FFPSA generally restricts the availability of Title IV-E foster care maintenance payments to 14 days unless the child is placed in a newly defined category of group homes called qualified residential treatment programs (QRTP).^{4, 5} QRTPs provide trauma-informed care to children with serious emotional and behavioral health disorders and meet other federal requirements.⁶ They are intended to be used for time-limited placements when family-based settings cannot meet a child's needs.

Depending on their size and other factors, QRTPs may be considered institutions for mental diseases (IMD) for the purposes of Medicaid payment. An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases.⁷ This typically includes both inpatient and residential mental health and SUD treatment facilities. Generally, the exclusion applies to all physical and behavioral health services delivered to patients residing in an IMD, whether they are furnished in or outside of the facility. Under a longstanding provision of Medicaid statute, state Medicaid programs are generally prohibited from making payments for care in these settings. As states work to comply with the Title IV-E funding changes by the October 1, 2021, deadline, many are grappling with how the IMD exclusion affects access to Medicaid-funded services for children residing in QRTPs.

This fact sheet examines the intersection of the Medicaid IMD exclusion and the recent changes to Title IV-E funding. First, we describe QRTPs and the IMD exclusion policy, including Centers for Medicare & Medicaid Services (CMS) guidance highlighting relevant exemptions for QRTPs that are deemed IMDs. We then discuss how states are approaching FFPSA implementation and compliance with the IMD exclusion.⁸



Payment for Residential Treatment for Children in Foster Care

In many states, Medicaid supports a wide range of medical, behavioral health, and supportive services for children in foster care, including residential treatment programs, with room and board covered by Title IV-E or another funding source if the child is not Title IV-E eligible (Casey Family Programs 2020, Pires 2019).^{9,10} State child welfare agencies are required to ensure that the health needs of children in foster care are met, but they may not use federal funds under Title IV-E to do so (ACF 2021b, MACPAC 2015).

The longstanding Medicaid IMD exclusion policy, coupled with recent changes to Title IV-E, may affect the availability of Medicaid funding for children in foster care. Below, we discuss the intersection of these two programs.

IMD exclusion

Since its inception in 1965, Medicaid has largely prohibited payments for services provided to beneficiaries residing in IMDs. As noted above, the IMD exclusion applies to facilities over 16 beds and is one of the few instances in which Medicaid federal financial participation (FFP) is not available for medically necessary and otherwise covered services for certain Medicaid beneficiaries receiving treatment in a specific setting.

Under certain circumstances, psychiatric services provided to children under age 21 have been exempted from the IMD exclusion. This exemption has been in place since the passage of the Social Security Amendments of 1972 (P.L. 92-603) (§§ 1905(a)(14), (16), (29)(B) of the Act).¹¹ For children under age 21, services delivered in psychiatric residential treatment facilities (PRTFs), a psychiatric hospital, or a psychiatric unit of a general hospital are exempted from the Medicaid IMD exclusion under what is commonly referred to as the “psych under 21” benefit. PRTFs are non-hospital-based facilities that have an agreement with a state Medicaid agency to provide the psych under 21 benefit. To qualify as a PRTF, a provider must meet certain staffing and medical oversight standards and obtain accreditation. Regulations also place limits on the use of physical and chemical restraints, and seclusion (MACPAC 2019) (42 CFR 448.350 et seq.).¹²

In practice, few behavioral health facilities qualify as PRTFs.¹³ As such, states must determine whether many residential and inpatient settings are an IMD and therefore subject to the payment exclusion. The policy applies to any institution whose “overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases” (CMS 2015). Section 4390 of CMS’s *State Medicaid Manual* defines the criteria that a state must consider in determining whether an institution is an IMD. These include whether:

- the facility is licensed or accredited as a psychiatric facility;
- the facility is under the jurisdiction of the state mental health authority;
- the facility specializes in providing psychiatric or psychological care and treatment (e.g., as evidenced by a review of patient records and the proportion of psychiatric or psychological specialized staff);¹⁴ and
- more than 50 percent of all patients in the facility require institutionalization because of a psychiatric condition (CMS 2015).

If a facility has multiple components, states may have to consider additional facts that are specific to the institution when determining whether it is an IMD.^{15,16}



Qualified residential treatment programs

The FFPSA enhances federal support for services that prevent out-of-home foster care placements while limiting the use of federal funds to certain types of congregate care settings. As noted earlier, when a child's needs cannot be met in a family setting, the FFPSA generally limits Title IV-E foster care maintenance payments to 14 days unless the child is placed in a QRTP. To continue claiming Title IV-E funds, congregate care providers were required to meet QRTP requirements by October 1, 2019, or October 1, 2021, in states that chose to delay implementation.¹⁷

QRTPs provide short-term, high-quality treatment and supervision for children in foster care who cannot function in a family-like setting. In accordance with FFPSA, this new category of child care institution must be state-licensed, nationally accredited, and adhere to certain federal requirements. These include:

- providing a trauma-informed model of care to address the clinical and other needs of children with serious emotional or behavioral disorders;
- having registered or licensed nursing staff and other licensed clinical staff who are on-site consistent with the treatment model, and available 24 hours a day, 7 days a week;
- facilitating family participation in a child's treatment program (to the extent appropriate, and in accordance with the child's best interest);
- facilitating and documenting family outreach, and maintaining contact information for any known biological family and fictive kin of the child;¹⁸
- documenting how the family is integrated into the child's treatment and how sibling connections are maintained; and
- providing discharge planning and family-based aftercare supports for at least six months post discharge.

Children eligible for Title IV-E must receive an independent assessment within 30 days of placement in a QRTP to determine that their needs cannot be met in the community and the QRTP is an appropriate treatment setting. A court must review and approve of the child's placement within 60 days. While there is no deadline for moving a child out of a QRTP, longer stays (more than 6 months for a child under age 13 and more than 12 consecutive months or 18 nonconsecutive months for youth age 13 and older) must be approved by the head of the state child welfare agency.

CMS guidance on the Medicaid IMD exclusion and QRTPs

In September 2019, CMS issued guidance indicating that existing policy regarding the Medicaid IMD exclusion applies to QRTPs. This guidance also describes the circumstances under which states can provide Medicaid services to eligible children residing in QRTPs that are determined to be IMDs (CMS 2019).

States must assess each QRTP to determine whether it is considered an IMD. QRTPs that have 16 beds or fewer, for instance, would not meet the statutory definition of an IMD. However, QRTPs with more than 16 beds may be IMDs if they are primarily engaged in providing diagnosis, treatment, or care of individuals with mental illness or SUD. In these instances, FFP generally would not be available for any Medicaid services provided inside or outside of the QRTP to Medicaid-eligible children residing in those settings, with two exceptions:

- Psychiatric residential treatment facilities—QRTPs may receive Medicaid payment if they seek certification as a PRTF in accordance with the psych under 21 benefit.¹⁹ However, CMS notes that



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QRTPs will not generally qualify as PRTFs. For those that do, Medicaid pays the entire cost of care for beneficiaries, including room and board (CMS 2007).

- Section 1115 research and demonstration waivers—States may request FFP for QRTPs that are IMDs under Section 1115 demonstrations to improve care for beneficiaries with serious mental illness (SMI) and serious emotional disturbance (SED). QRTPs covered under the demonstration must meet PRTF regulations pertaining to seclusion and restraint (CMS 2018).^{20,21} States must also achieve a statewide average length of stay of 30 days or less in participating IMDs (which may include QRTPs) and take other steps to enhance the continuum of care for beneficiaries with SMI or SED (CMS 2019). However, it may be challenging for states to meet the average length of stay requirement as QRTP placements often exceed 30 days (NAMD 2021).

States that violate the IMD exclusion are at risk for an audit finding, and CMS may recoup federal funds for claims that were inappropriately paid to IMDs (CMS 2019).

State Approaches

Several stakeholders are advocating for federal action to ensure the IMD exclusion does not prevent Medicaid-eligible children in QRTPs from receiving Medicaid-covered services. Among other concerns, they contend that the loss of Medicaid financing for eligible children in QRTPs will shift costs to states, and children who would otherwise be placed in QRTPs will be shifted to more restrictive placements. The National Association of Medicaid Directors recommends that CMS provide a five-year transition period for states to conduct IMD assessments of their QRTPs, and greater deference to state IMD determinations (NAMD 2021). Others are calling for a statutory change to exempt QRTPs from the IMD exclusion (Together the Voice 2021).

Information about how states are implementing changes required by FFPSA, and how those changes affect the Medicaid program, are limited. The FFPSA does not require states to report on their use of QRTPs and other residential settings for children in foster care. Furthermore, many states are still in the process of implementing the new restrictions on Title IV-E funding for residential settings and considering how those changes may affect their compliance with the Medicaid IMD exclusion.

However, information gathered from national organizations, providers, and state officials offers some insight into their approaches. State decisions are influenced by multiple factors, such as the size of the foster care population served in residential settings, the characteristics of existing residential providers for children in foster care, and the state's assessment of whether QRTPs are subject to the Medicaid IMD exclusion. For example, some states that were subject to CMS compliance actions for previous violations of the IMD exclusion are acting more conservatively to minimize their risk. State approaches include:

- **Limiting QRTPs to 16 beds.** Colorado is requiring QRTPs to have 16 or fewer beds, so they do not meet the statutory definition of an IMD. Other states are considering this approach. In some instances, existing congregate care providers may have to reduce their capacity to become licensed QRTPs (Burton 2021). However, the cost of operating facilities that are less than 16 beds relative to the revenue that is generated may affect the financial viability of these providers.
- **Determining that QRTPs are not IMDs.** Two states, Arkansas and Kentucky, have determined that their QRTPs do not meet the definition of an IMD. In Kentucky, the state's determination rested, in part, on the



fact that QRTPs are not licensed as psychiatric facilities and are not under the jurisdiction of the state mental health authority.

- **Using Section 1115 demonstration authority.** Oklahoma received CMS approval for a Section 1115 SMI/SED demonstration that authorizes FFP for services delivered to beneficiaries residing in IMDs, including QRTPs that have been deemed IMDs. As of July 2021, however, there were no QRTPs operating in the state.
- **Shifting placements to PRTFs.** Some states are considering shifting non-family foster care placements to PRTFs, where the cost of care as well as room and board are covered by Medicaid. In some instances, existing congregate care facilities may seek certification as PRTFs. However, this would require that providers meet more stringent federal standards. Moreover, PRTFs may not be appropriate for many children in foster care as these facilities provide an inpatient level of care.
- **Not offering QRTPs.** At least six states, including Alaska, are not implementing QRTPs to avoid conflicts with the IMD exclusion (Burton 2021, Kelly 2019).

Endnotes

¹ A group home is a licensed or approved home providing 24-hour care for children in a small group setting of 7–12 children. Within the child welfare context, an institution is a child care facility operated by a public or private agency that provides 24-hour care and treatment for children who require separation from their own homes and group living experience. These facilities may include: child care institutions, residential treatment facilities, or maternity homes. These congregate care settings may also house children placed by the juvenile justice system, the mental health system, or privately by individual families (GAO 2015).

² From 2015–2019, nearly 64 percent of non-institutionalized youth age 12–17 who stayed in foster care were covered by Medicaid or CHIP. For more information about the role of Medicaid and CHIP in serving children and youth with behavioral health conditions, see MACPAC’s *Medicaid Access in Brief: Behavioral Health Services for Youth in Foster Care* (MACPAC 2021).

³ Among those eligible for Medicaid based on child welfare assistance, 49 percent had diagnoses of mental health disorders and 3 percent had diagnoses of SUD. For other children in Medicaid, the figures were 11 percent and less than 1 percent, respectively. Child maltreatment has also been associated with increased risk of other long-term health and social problems. Specifically, childhood trauma can increase alcoholism, illicit drug use, risky sexual behavior, mental health issues (including depression and attempted suicide), as well as cancer and heart, lung, and liver disease (MACPAC 2015).

⁴ Foster care maintenance payments are made on behalf of a child eligible for Title IV-E foster care to cover the cost of providing food, clothing, shelter, daily supervision, school supplies, a child’s personal incidentals, liability insurance with respect to a child, and reasonable travel for a child’s visitation with family or other caretakers. Local travel associated with providing these items is also an allowable expense. In the case of child care institutions, such payments must include the reasonable costs of administration and operation of such institutions required to provide the items (45 CFR § 1355.20).

⁵ In addition to QRTPs, other settings may receive Title IV-E foster care maintenance payments beyond 14 days and serve a smaller subset of children in foster care. As specified in the FFPSA, these include: settings specializing in providing prenatal, postpartum, or parenting supports for youth; in the case of a child who is 18 years or older, supervised independent living; settings providing residential care and supportive services to children who are, or are at risk of becoming, sex trafficking



victims; and family-focused residential treatment programs when a child is placed with a parent who is receiving SUD treatment.

⁶ FFPSA defines child care institution as “a private child-care institution, or a public child care institution which accommodates no more than 25 children, which is licensed by the state in which it is situated or has been approved by the agency of the state responsible for licensing or approval of institutions of this type as meeting the standards established for licensing.”

⁷ The term mental diseases includes those listed as mental disorders in the International Classification of Diseases (ICD), with the exception of mental retardation, senility, and organic brain syndrome. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a subsection of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease. Because the ICD classifies SUD as a mental disorder, facilities providing SUD treatment may also be considered IMDs.

⁸ From June to July 2021, MACPAC conducted interviews and corresponded with representatives from the Commonwealth of Kentucky, State of Oklahoma, Casey Family Programs, the Congressional Research Service, the Human Resource Collaborative, and the National Association for Children’s Behavioral Health.

⁹ Residential treatment programs provide services to children with serious behavioral health needs, including those in foster care. Some of these programs offer an array of services, including therapeutic services for children and families, as well as educational support and medical care. These live-in, out-of-home placements offer a higher level of structure and supervision than what can be provided in other foster care settings. Placements are intended to be short-term and should only be considered when community-based services have proven ineffective (ACF 2021a).

¹⁰ Title IV-E provides partial federal reimbursement to states, territories, and tribes for the cost of providing foster care, adoption assistance, and guardianship assistance for eligible low-income children who have been removed from their homes. FFPSA expanded the allowable uses of Title IV-E funds to include certain foster care prevention services and kinship navigator programs (i.e., information, referral, and follow-up services to grandparents and other relatives serving as guardians) (CRS 2021).

¹¹ There are also limited exemptions to the IMD exclusion under Medicaid managed care regulations, Section 1115 demonstrations, and a time-limited state plan option for individuals with substance use disorder (SUD) under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271) (MACPAC 2019).

¹² PRTFs must meet certain federal requirements that are not applicable to QRTPs, such as regulations related to seclusion and the use of physical and chemical restraints (BBI 2019).

¹³ As of 2018, there were roughly 360 PRTFs in 31 states.

¹⁴ Facilities with more than 16 beds that follow a psychiatric model (e.g., care is performed by medically trained and licensed personnel) and provide services that are psychological in nature are considered IMDs (CMS 2015).

¹⁵ MACPAC’s *Report to Congress on Oversight of Institutions for Mental Diseases* details the process for determining whether an institution is an IMD (MACPAC 2019).

¹⁶ When a facility has multiple components (e.g., a nursing facility, or psychiatric wing of a hospital) additional facts related to the institution must be examined, including whether: all components of the facility are controlled by one owner or governing body; one chief medical officer is responsible for the medical staff activities of the facility’s components; one chief executive officer controls all administrative activities in all of the facility’s components; any components are separately licensed; separation of components means that it is not feasible for the institution; and each component can meet conditions of participation independently (CMS 2015).

¹⁷ At least 11 states implemented these new restrictions for congregate care settings by October 1, 2019 (Thompson 2021). States that opted to delay implementation were not permitted to use Title IV-E funds for prevention services under FFPSA (ACF 2018). As of July 22, 2021, the federal Administration for Children & Families had approved Title IV-E prevention plans for



11 states (Arkansas, Iowa, Kansas, Kentucky, Maryland, Nebraska, North Dakota, Oregon, Utah, Washington, West Virginia), the District of Columbia, and one tribe (ACF 2021c).

¹⁸ Fictive kin include other unrelated adults that have a significant relationship with a child, including close family friends or godparents (CDF 2020).

¹⁹ To participate in Medicare, facilities must obtain certification, generally through a state survey agency or a CMS-approved accrediting organization. These entities determine compliance with federal quality and safety requirements known as conditions of participation. Although PRTFs are not recognized by Medicare, CMS adopted Medicaid-only conditions of participation for such providers (MACPAC 2019).

²⁰ Among other requirements, QRTPs exempt from the IMD exclusion under a Section 1115 SMI/SED waiver must comply with CMS regulations regarding seclusion and restraint found in 42 CFR Part 483 Subpart G (CMS 2019). However, in its 2018 guidance on Section 1115 SMI/SED demonstrations, CMS writes, “FFP also will not be available through these SMI/SED demonstrations for services provided in treatment settings for individuals 21 years of age or younger if those settings do not meet CMS requirements to qualify for the Inpatient Psychiatric Services for Individuals under Age 21 benefit” (CMS 2018). This may suggest that QRTPs that are covered IMDs under a Section 1115 SMI/SED demonstration must meet all federal requirements for PRTFs, not just those specific to seclusion and restraint.

²¹ SED refers to a diagnosable mental, behavioral, or emotional disorder that results in functional impairment that substantially interferes with or limits the child’s role or functioning in family, school, or community activities. SMI refers to adults aged 18 or older who currently have a diagnosable mental, behavioral, or emotional disorder that results in substantial impairment in carrying out major life activities (e.g., eating, bathing, taking daily medications). All of these disorders have episodic, recurrent, or persistent features that vary in terms of severity or disabling effects (SAMHSA 2020).

References

Administration for Children & Families (ACF), U.S. Department of Health and Human Services. 2021a. Group and residential care. Washington, DC: ACF. <https://www.childwelfare.gov/topics/outofhome/group-residential-care/>.

Administration for Children & Families (ACF), U.S. Department of Health and Human Services. 2021b. Child Welfare Policy Manual 8.1B, question 4: “Can administrative costs for processing and management of foster child health care services be claimed against Title IV-E?” Washington, DC: ACF. https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=36.

Administration for Children & Families (ACF), U.S. Department of Health and Human Services. 2018. Program instruction regarding implementation of Title IV-E plan requirements in Public Law 115-123, the Family First Prevention Services Act Washington, DC: ACF. <https://www.acf.hhs.gov/sites/default/files/documents/cb/pi1807.pdf>.

Administration for Children & Families (ACF), U.S. Department of Health and Human Services. 2021c. Status of submitted Title IV-E prevention program five-year plans. Washington, DC: ACF. <https://www.acf.hhs.gov/cb/data/status-submitted-title-iv-e-prevention-program-five-year-plans>.

Building Bridges Initiative (BBI). 2019. *Comparison of federal requirements for qualified residential treatment programs (QRTPs) and psychiatric residential treatment facilities (PRTFs)*. Milwaukee, WI: BBI. <https://www.buildingbridges4youth.org/sites/default/files/BBI%20QRTP-PRTF%20Comparison%20Document%20-%20Final.pdf>.

Burton, L. 2021. Presentation for the National Association of Children’s Behavioral Health Public Policy Conference, July 21, 2021, virtual.



Casey Family Programs. 2020. *How can Medicaid support the treatment costs for youth in residential programs?* Seattle, WA: Casey Family Programs. <https://caseyfamilypro-wpengine.netdna-ssl.com/media/20.07-KM-LFOF-Residential-reimbursement.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. Center for Medicaid and CHIP Services guidance regarding “Qualified residential treatment programs (QRTTP) and serious mental illness (SMI) and serious emotional disturbance (SED) demonstration opportunity: Technical assistance questions and answers.” Baltimore, MD: CMS. <https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. Letter from Mary Mayhew to state Medicaid directors regarding “Opportunities to design innovative service delivery systems for adults with serious mental illness or children with a severe emotional disturbance.” November 13, 2018. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. Medicaid and Children’s Health Insurance Program (CHIP) programs: Medicaid managed care, CHIP delivered in managed care, Medicaid and CHIP comprehensive quality strategies, and revisions related to third party liability. Final rule. *Federal Register* 81, no. 88 (May 6): 27497–27901. <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrenshealth-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. *State Medicaid manual: Part 4, services*. Baltimore, MD: CMS. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/P45_04.ZIP.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2007. Memorandum on psychiatric residential treatment facilities (PRTF) clarification. February 16, 2007. Baltimore, MD: CMS. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-15.pdf>.

Children’s Defense Fund (CDF). 2020. *Implementing the Family First Prevention Services Act. A technical guide for agencies, policymakers, and other stakeholders*. Washington, DC: CDF. <https://www.childrensdefense.org/wp-content/uploads/2020/07/FFPSA-Guide.pdf>.

Kelly, J. 2019. Alaska dropping federal group home claims to comply with Family First Act in 2019. *Imprint News*, July 1.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. *Medicaid access in brief: Behavioral health services for youth in foster care*. August 2021. Washington, DC: MACPAC. <https://www.macpac.gov/publication/access-in-brief-behavioral-health-services-for-youth-in-foster-care/>

Medicaid and CHIP Payment and Access Commission (MACPAC). 2019. *Report to Congress on oversight of institutions for mental diseases*. December 2019. Washington, DC: MACPAC. <https://www.macpac.gov/wpcontent/uploads/2020/01/Report-to-Congress-on-Oversightof-Institutions-for-Mental-Diseases-December-2019.pdf>.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Chapter 3: The intersection of Medicaid and child welfare. In *Report to Congress on Medicaid and CHIP*. June 2015. Washington, DC: MACPAC.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2020. *2019 National Survey on Drug Use and Health (NSDUH): Methodological summary and definitions*. Rockville, MD: SAMHSA. <https://www.samhsa.gov/data/report/2019-methodological-summary-and-definitions>.

Thompson, V. 2021. Implementing the Family First Prevention Services Act: What to watch in 2021. Washington, DC: National Academy for State Health Policy. <https://www.nashp.org/implementing-the-family-first-prevention-services-act-what-to-watch-in-2021/>.



Medicaid and CHIP Payment
and Access Commission
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Together the Voice. 2021. Letter from state and national organizations to congressional leadership regarding “Request to exempt qualified residential treatment programs from the institutions for mental diseases exclusion.” July 23, 2021.

Pires, S.A. 2019. *Technical assistance brief: Institutions for mental disease and residential treatment facilities for children and youth*. Washington, DC: Human Service Collaborative.

U.S. Department of Health and Human Services (HHS). 2020. FY 2021 Budget in Brief. Washington, DC. <https://www.hhs.gov/about/budget/fy2021/index.html>.

U.S. Government Accountability Office (GAO). 2015. *HHS could do more to support states’ efforts to keep children in family-based care*. Report no. GAO-16-85. Washington, DC: GAO. <https://www.gao.gov/assets/gao-16-85.pdf>.

