



Medicaid, Child Welfare & Institutional Care: Qualified Residential Treatment Programs

[Jennifer Lav](#)

Introduction

Children do best with families. A properly functioning child welfare system should be built on this premise. It should support children and families to avoid unnecessary out-of-home care, and help children who cannot be with their own family remain in family like-settings.

A landmark child welfare law, the Family First Prevention Services Act ("Family First Act"), brought the country closer to this goal. First, it provides funding for services and supports to families **before** a child is removed from their family; and second, it places limits on the settings where children can be placed **after** removal. In doing the latter, the Family First Act created a newly-defined category of group homes called "qualified residential treatment programs" (QRTPs).¹ QRTPs are a type of child care institution for children with "serious emotional and behavioral disorders and services."²

¹ Bipartisan Budget Act of 2018, Pub. L. No. 115-123 (codified as amended in scattered sections of 42 U.S.C.), <https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf>.

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

The Family First Act and the creation of QRTPs put a spotlight on a longstanding Medicaid law and policy that prohibits states from obtaining federal funds for services provided to residents of mental health facilities with more than 16 beds.³ These institutions are called “institutions for mental disease” (IMD) and the payment exclusion is colloquially referred to as the “IMD Exclusion.” This exclusion has existed since Medicaid was enacted in 1965, and plays a major role in incentivizing states to invest in community-based alternatives to institutional care, as states can receive federal reimbursement for Medicaid covered community-based services. Although the IMD exclusion is not new, when QRTPs were established and states had to define the types of placements where children in the child welfare system were placed, it became clear that many states were violating the IMD exclusion—they were placing children with mental health needs in congregate facilities of more than 16 beds and still inappropriately collecting federal Medicaid funding for their services.

This issue brief discusses the intersection of the IMD exclusion with foster care placements, and advocates for a path forward where federal funding continues to be used to further the goal of keeping children with families.

The “Institutions for Mental Diseases” Exclusion

States are generally prohibited from claiming federal Medicaid funding for services to residents of mental health facilities with more than 16 beds. This is commonly referred to as the “Institutions for Mental Diseases exclusion” or “IMD exclusion.” Specifically, states may not obtain Medicaid “federal financial participation” (FFP) for services provided to any individual under age 65 in “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”⁴ The limit on FFP extends to

³ 42 U.S.C. §§ 1396d(a)(31)(B), 1396d(h).

⁴ 42 U.S.C. § 1396(i).

any services provided to a resident of an IMD, whether the service is provided inside or outside of the facility.⁵

The exclusion plays an oft misunderstood and underappreciated role in incentivizing states to provide services in smaller, more community-based settings. One of the original reasons Congress incorporated the IMD exclusion into Medicaid was to encourage states to rebalance spending towards community-based care.⁶ Because federal Medicaid reimbursement is available for mental health and substance use disorder (SUD) services in the community, but is generally not available if such services are provided in an institution, the IMD exclusion provides a powerful financial incentive for states to rely on community-based alternatives to the institutional settings of IMDs.

The IMD Exclusion Applies to Children

The IMD exclusion applies to anyone under age 65, but there are exceptions. One of these exceptions is for "inpatient psychiatric services for individuals under age 21"—often called the "psych under 21" or "psych 21" benefit. This statutory exception provides that FFP is available for services for children under age 21 in three enumerated settings that would normally be considered IMDs:

⁵ There are limited exceptions to this general rule. See 42 U.S.C. § 1396d(a) (allowing individuals who are eligible for Medicaid on the basis of pregnancy and in an IMD for substance use disorder treatment to get FFP "for items or services that are provided to the woman outside of the institution." See also 42 U.S.C. § 1396d(a)(16)(B) (allowing for FFP for all services for children in psychiatric residential treatment facilities (PRTF), whether those services are provided by the PRTF or not).

⁶ In adopting the IMD exclusion, Congress explained that community mental health centers were "being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963," that "[o]ften the care in [psychiatric hospitals] is purely custodial," and that Medicaid would provide for "the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals." Comm. on Finance, S. Rep. 404 to accompany H.R. 6675, at 46, 144, 146 (June 30, 1965), <https://www.ssa.gov/history/pdf/Downey%20PDFs/Social%20Security%20Amendments%20of%201965%20Vol%202.pdf>.

- 1) a psychiatric hospital;
- 2) a psychiatric unit of a general hospital; or
- 3) “another inpatient setting that the Secretary has specified in regulations.”⁷

The Secretary created “psychiatric residential treatment facilities” (PRTFs) through regulations, pursuant to her authority under the third option. A PRTF is a specific kind of longer-term facility for youth that was created via regulations, with prescribed staffing and reporting requirements and other specific conditions of participation.⁸

Because the “psych 21” benefit carves out some exceptions to the IMD exclusion, it is sometimes said that the IMD exclusion does not apply to children. This is incorrect. **The IMD exclusion applies to anyone under age 65.** Exceptions apply for youth under 21, but **only** if the children are in one of three explicitly carved-out settings. Children that are in other settings may still be subject to the IMD exclusion. Examples of facilities that could trigger the exclusion, despite the availability of the psych 21 benefit, include non-PRTF residential treatment centers, residential child care institutions or specialty group homes.

It is important to note that **the IMD exclusion is not an eligibility exclusion.** That is, individuals in IMDs do not lose their Medicaid eligibility due to their status in the IMD. Individuals should not be terminated simply for becoming a resident of an IMD.⁹ The

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

⁸ 42 C.F.R. §§ 441.151-182, 483.350-376.

⁹ Additionally, for most youth in foster care, Medicaid coverage is mandatory, either because the child receives federal foster care payments (“Title IV-E” eligibility), has a disability, or was removed from a family with a very low income. 42 U.S.C. § 1396a(a)(10)(A)(i)(I); 42 C.F.R. § 435.145 (Title IV-E eligibility); 42 C.F.R. § 435.120 (SSI eligibility); 42 C.F.R. § 435.118 (eligible due to low income of family from which child is removed). The IMD exclusion does not limit this requirement. For other children in foster care, Medicaid coverage is optional, but most states have exercised these options to cover them.

restriction is instead on the state's ability to obtain federal Medicaid funding for services provided during the time period they are in the institution.

What is a Qualified Residential Treatment Program (QRTP)?

As noted above, the Family First Act created a new category of group homes or facilities, called QRTPs.¹⁰ A QRTP is an accredited facility designed to address the clinical needs of children with serious emotional or behavioral disorders or disturbances.¹¹ To prevent children from languishing in group homes, states may not obtain **federal foster care maintenance payments** for children who are in a child care institution for more than 14 days, unless such children are in a QRTP or another type of exempted group home.¹² In order for a state to collect federal foster care maintenance payments for children in QRTPs, they must comply with a number of additional requirements, including an assessment that meets certain criteria to establish the child's needs and ensure the least restrictive placement, and periodic review of the placement.¹³

Are QRTPs IMDs?

Even if a facility is a permissible QRTP for purposes of obtaining federal foster care maintenance payments, it may still be subject to the IMD exclusion for purposes of **federal Medicaid funds**.

¹⁰ Bipartisan Budget Act of 2018, Pub. L. No. 115-123 (codified as amended in scattered sections of 42 U.S.C.), <https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf>.

¹¹ 42 U.S.C. § 672(k).

¹² Federal foster care maintenance payments are payments made to states to help pay for the cost of food, clothing, shelter and other necessities for children in foster care. Like Medicaid, states split the cost of foster care maintenance payments with the federal government. Other exempted settings include group placements for youth that are parenting; supervised independent living for youth over 18; specialty settings for children and youth who have been found to be, or are at risk of becoming, sex trafficking victims; or family-based treatment facilities for substance use. 42 U.S.C. § 675(c)(4).

¹³ 42 U.S.C. § 675(c)(1)-(4).

A QRTP may be an IMD if it:

1. Has more than 16 beds; and
2. Is “primarily engaged in providing diagnoses, treatment or care of persons with mental diseases including medical attention, nursing care, and related services.”¹⁴

If the QRTP has more than 16 beds, the second question is central: is the facility “primarily engaged in providing diagnosis, treatment or care of persons with mental diseases”?¹⁵

According to CMS, one indication that a facility may be an IMD is that the facility specializes in “psychiatric/psychological care and treatment.”¹⁶ Other relevant factors include whether the facility is accredited or licensed as a psychiatric facility, whether the facility is under the jurisdiction of the state’s mental health authority, and whether “mental disease” is the reason that more than 50% of the residents are in the facility.¹⁷ No single factor is determinative, and the state must make the final determination as to whether a facility is an IMD by looking at the “overall character” of the facility.¹⁸

Virtually all QRTPs with more than 16 beds will be IMDs.¹⁹ QRTPs are primarily engaged in treatment or care of persons with “mental diseases,” as they are reserved specifically for children with mental health needs. The primary purpose of a QRTP is to provide “a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances.”²⁰ Furthermore, QRTPs are required to have staff with specialized

¹⁴ 42 U.S.C. § 1396d(i).

¹⁵ *Id.*

¹⁶ CMS, STATE MEDICAID MANUAL § 4390.

¹⁷ *Id.*

¹⁸ 42 C.F.R. § 435.1010.

¹⁹ CMS, Qualified Residential Treatment Program (QRTP) Reimbursement: Family First Prevention Services Act (FFPSA) Requirements: Q & A (Oct. 19, 2021) at 3, <https://www.medicaid.gov/federal-policy-guidance/downloads/faq101921.pdf> (“given the interconnectedness of these two definitions, a QRTP facility with more than 16 beds will most likely qualify as an IMD.”) (hereinafter “CMS 2021 QRTP Guidance”).

²⁰ 42 U.S.C. § 672.

psychiatric/psychological training, which according to CMS is another indicator of an IMD. QRTPs must have “registered or licensed nursing staff and other licensed clinical staff who . . . are on-site according to the treatment model.”²¹

If the QRTP is an IMD, FFP for Medicaid services is available only if the facility falls into one of the statutorily enumerated exceptions. These enumerated exceptions are a psychiatric hospital, a psychiatric unit of a general hospital, or a PRTF. But a QRTP does not fit any of these exceptions. A QRTP is certainly not a hospital, and because the staffing and treatment standards for PRTFs are generally more stringent than a QRTP, “QRTPs also likely would not meet the requirements to qualify as PRTFs.”²²

The state Medicaid agency must review each QRTP, and make an individual determination if the QRTP is an IMD. While the determine of whether an institution is an IMD must be made on a case by case basis, it given the requirements of QRTPs and the population they are intended to service, is extremely unlikely that QRTPs with more than 16 beds are not IMDs. If a state is currently improperly claiming federal Medicaid funds for services provided to children in foster care facilities that qualify as IMDs, the state must cease such claiming or risk a CMS audit and recoupment.²³

Section 1115 Waivers for QRTPs

For the past four years, CMS has permitted some states to obtain FFP for services within IMDs through a federally approved “section 1115” demonstration waivers. To date, ten such waivers

²¹ *Id.*

²² CMS, *Qualified Residential Treatment Programs and Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) Demonstration Opportunity Technical Assistance Questions and Answers* (Sept. 20, 2019), at 4, <https://www.medicaid.gov/federal-policy-guidance/downloads/faq092019.pdf> (hereinafter “CMS 2019 QRTP Guidance”)

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

²³ CMS 2019 QRTP Guidance at 4.

have been approved by CMS. However, this funding has generally been limited to adults in IMDs, ages 21-64.²⁴

Although CMS has allowed such waivers to move forward, these approvals exceeded the Secretary's legal authority. For the Secretary to approve a project pursuant to section 1115, the project must:

- be an "experimental, pilot or demonstration" project;
- be likely to promote the objectives of the Medicaid Act;
- waive compliance only with requirements in 42 U.S.C. § 1396a; and
- be approved only "to the extent and for the period necessary" to carry out the experiment

As a general matter, these waivers fail to propose a genuine experiment, demonstration or novel approach when requesting federal financial participation for stays in IMDs; the IMD exclusion provision is not contained in § 1396a, and thus that rule cannot be waived; and these waivers are not limited to the extent and for the period necessary.²⁵

In October 2021, CMS released a Q&A encouraging states to request federal Medicaid funding for QRTPs that are IMDs via Section 1115 demonstration applications.²⁶ On June 2, 2022, CMS approved an amendment to New Hampshire's current Section 1115 demonstration, permitting

²⁴ *But see* Oklahoma Section 1115 Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder, approved Nov. 22, 2021. CMS approved an Oklahoma section 1115 waiver for children in QRTPs in Oklahoma, but limited the stays there to 60 days maximum, with a 30 day average length of stay <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ok-imd-waiver-smi-sud-ca.pdf>

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

²⁶ CMS 2021 QRTP Guidance.

FFP for QRTPs that are IMDs for the first time under the present administration.²⁷ California has indicated an interest in doing so, and more states may follow.²⁸

Like the section 1115 Medicaid waivers for adults in IMDs, a section 1115 waiver for children in IMDs would likely exceed the Secretary's authority. First and foremost, there is nothing experimental about placing children with mental health needs in congregate facilities. The harm from placing children in foster care in institutional settings is well-documented.²⁹ Second, as noted above, one of the original goals and functions of the IMD exclusion in Medicaid was to reduce reliance on institutional settings. Thus, allowing FFP for IMDs does not further the goals of Medicaid. Last, the IMD exclusion provision is outside of Section 1396a, in Section 1396d, and thus is not included in the section of the statute the Secretary has the authority to waive. Despite this, CMS has clearly indicated its willingness to entertain such waivers.³⁰

In a troubling departure from section 1115 waiver precedent regarding IMDs for adults, CMS approved a provision in the New Hampshire waiver for children in QRTPs **without any length of stay requirements**. When CMS granted such waivers for adults, CMS generally

²⁷ New Hampshire Substance Use Disorder Treatment and Recovery Access, approved June 2, 2022, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-sud-treatment-recovery-access-ca1.pdf>. As noted above, Oklahoma was granted a waiver under the last administration. Oklahoma Section 1115 Institutions for Mental Diseases Waiver for Serious Mental Illness/Substance Use Disorder, approved Nov. 22, 2021. <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ok-imd-waiver-smi-sud-ca.pdf>.

²⁸ See Letter from Alissa DeBoy, Director, Disabled and Elderly Health Programs Group, CMS to Jacey Cooper, Chief Deputy Director, Health Care Programs, California Department of Health Care Services, July 30, 2020, <https://togetherthevoice.org/wp-content/uploads/2020/09/20200730-CA-DHCS-STRTP-IMD-Exclusion-CMS-Response.pdf> (rejecting California's request that CMS provide assurance that Short-Term Residential Therapeutic Program facilities (STRTPs) that will be used as QRTPs are not IMDs, but indicating that a Section 1115 waiver may be an option.).

²⁹ American Academy of Pediatrics, *et al*, *The Path to Well-being for Children and Youth in Foster Care Relies on Quality Family-Based Care* (Jan. 18, 2022), <https://familyfirstact.org/sites/default/files/QRTP%20and%20IMD%20One%20Pager.pdf>.

³⁰ CMS 2021 QRTP Guidance.

restricted such payments for stays in IMDs to a maximum of 60 days, and has required states to maintain an IMD average length of stay of 30 days. In a departure from precedent, the New Hampshire Section 1115 waiver does not require the state to adhere to any length of stay requirement for children in QRTPs. Initially in 2019, CMS said that any potential section 1115 waiver for youth in QRTPs would require states to adhere to a 30 day average length of stay and a 60 day maximum. However, in the 2021 guidance, CMS backtracked and said that “For a limited time (not to exceed two years from the effective dates of the new demonstration or demonstration amendments), states may propose a SMI/SED 1115 demonstration that also includes an exemption from the foregoing limitations on length of stay for foster care children residing in QRTPs that are IMD.”³¹ The guidance, and the special terms and conditions for New Hampshire, state that the typical length of stay parameters will only apply two years after the date of approval.³²

CMS has stated that if it grants a waiver, it intends to ensure compliance with CMS regulations regarding seclusion and restraint that are application in PRTFs, and that states cannot not seek reimbursement for room and board.³³ CMS included these requirements in New Hampshire’s Special Terms and Conditions.³⁴

CMS has also stated that as a condition of receipt of a waiver for children:

[S]tates will be required to provide CMS with a plan, including key milestones and timeframes, for transitioning children out of QRTPs that are IMDs. This transition plan will take into account the up-to-two-year period during which children residing in QRTPs

³¹ Compare CMS 2019 QRTP Guidance with CMS 2021 QRTP Guidance.

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

³³ CMS 2019 QRTP Guidance at 5-6.

³⁴ New Hampshire Substance Use Disorder Treatment and Recovery Access, approved June 2, 2022, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-sud-treatment-recovery-access-ca1.pdf>.

are exempt from the typical length of stay parameters; those parameters will apply to children residing in QRTPs at the expiration of this up-to-two-year period.”³⁵

It is unclear when and how CMS intends to require such a transition plan, and whether they intend to wait until the two-year period expires before requiring a transition plan. Notably, New Hampshire’s recently approved waiver contains no clear plan to address transition of children out of QRTPs that are IMDs. Instead, the state notes that it is signing **new contracts** with residential treatment programs.³⁶

State Advocacy Opportunities

If a state intends to request a section 1115 waiver to pay for institutional stays for children, advocates will have an opportunity to submit comments, first at the state level, and then at the federal level.³⁷ For state advocates to maximize their impact, through advocacy, it is essential that they are involved from the earliest stages, and raise any concerns and objections.

Even if a state decides pursues such a waiver, it remains important for advocates to weigh in on the details. For example, CMS has previously stated that if it grants a

³⁵ CMS 2021 QRTP Guidance at 2.

³⁶ New Hampshire Substance Use Disorder Treatment and Recovery Access, approved June 2, 2022, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nh-sud-treatment-recovery-access-ca1.pdf>.

³⁷ See Catherine McKee et al., Nat’l Health Law. Prog., *Quick Review Section 1115 Waiver Requests: Transparency and Opportunity for Public Comment* (Apr. 28, 2017), <https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2017/04/Sec1115TransparencyCommentQR2-4.28.17.pdf>. See also, Nat’l Health Law Prog., *Comments, Indiana SMI/SED Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver* (Oct. 11, 2019), <https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/NHeLP-IN-SMI-Final-3.pdf>; Nat’l Health Law Prog., *Comments, District of Columbia Section 1115 Medicaid Behavioral Health Transformation Demonstration Program* (July 10, 2019), <https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/07/NHeLP-Comments-on-DC-1115-Application-FINAL.pdf>.

waiver, it intends to ensure compliance with CMS regulations regarding seclusion and restraint that apply in PRTFs.³⁸ Such a protection is essential for children’s well-being, and it will be important for advocates to ensure that states do not attempt to circumvent these protections via a waiver demonstration.

Although CMS has indicated a willingness to extend the average length of stay in QRTPs, CMS has failed to clarify any guardrails that would ensure that such waivers do not encourage long-term placements. Advocates who know the harms to children of institutionalization can push for limited lengths of stay, clear transition plans with intensive transition support, and expansion of community-based services.

Furthermore, state Medicaid programs must still comply with the Americans with Disabilities Act (ADA), which requires states to “administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”³⁹ As the Supreme Court explained in *Olmstead v. L.C. ex rel. Zimring*, in passing the ADA “Congress explicitly identified unjustified segregation of persons with disabilities as a form of discrimination.”⁴⁰ Advocates should be aware of the potential for state over-reliance on QRTPs, and be vigilant against proposals that would lead to unnecessary segregation of children with disabilities.

Last, even if CMS grants a state a waiver over objections, it is imperative that the waiver has an endpoint.⁴¹ When it ends, the state should have a functioning community-based system of

³⁸ CMS 2019 QRTP Guidance at 5-6.

³⁹ 28 C.F.R. § 35.130(d).

⁴⁰ *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 600 (1999)(internal citations omitted). States must provide community-based treatment for individuals with disabilities when: a) “the State’s treatment professionals determine that such a placement is appropriate”; b) “the affected persons do not oppose such treatment,” and c) “the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.” *Id.* at 607

⁴¹ Social Security Act § 1115(a); *see also id.* §§ 1115(e)(2), (f)(6) (limiting the extension of “state-wide, comprehensive demonstration projects” to one initial extension of up to 3 years (5 years, for a waiver involving Medicare-Medicaid eligible individuals) and one subsequent

care that can obviate the need for institutional placement. At a minimum, under Medicaid, states have an obligation to provide enrolled children with medically necessary services, including community-based services for children intensive support needs. Such services include but are not limited to: intensive care coordination, mobile response and crisis stabilization services specifically designed for children, and in home services and supports.⁴² States also can and should provide therapeutic foster care services.⁴³ Particular attention should be paid to ensuring that such services are provided in adequate quality and quantity to meet the population's needs, and to reduce reliance on institutional placements. CMS can require states to ensure an adequate continuum of care under EPSDT as a condition of any waiver.

Conclusion

Placement in a QRTP may affect children's access to Medicaid-funded services. States must determine if QRTPs are IMDs. If the QRTP is an IMD, federal Medicaid funding is not available for services to children while they are placed there. State advocates should closely monitor this situation and ensure that states do not attempt to use section 1115 to circumvent the

extension not to exceed to 3 years (5 years, for Medicare-Medicaid waivers). In 2017, a CMS Informational Bulletin announced the intent "[w]here possible, . . . [to] approve the extension of *routine, successful, non-complex*" section 1115(a) waivers for a period up to 10 years. Ctr. for Medicaid & CHIP Servs., CMS, CMCS Informational Bulletin 3 (Nov. 6, 2017) (emphasis added). The Bulletin should be disregarded because it conflicts with, among other things, section 1115's limitation of approvals to experimental, pilot, or demonstration projects (not for "routine" projects) and only for the period necessary to carry out the experiment (not to maintain a successful experiment as an ongoing policy).

⁴² MACPAC, Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and Chip (June 2021) at 105. <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-3-Access-to-Behavioral-Health-Services-for-Children-and-Adolescents-Covered-by-Medicaid-and-CHIP.pdf> (describing home and community-based behavioral health services for children and adolescents, and including: wrap-around approach, peer support services, intensive in-home services, respite services, and mobile crisis response and stabilization services).

⁴³ Like most children's mental health specialty services, the term "therapeutic foster care" is not found in federal statute, but CMS has approved FFP for such services. See, e.g., Cal. State Plan Amendment 4.19-B, approving payment for specialty mental health services provided in treatment foster homes, http://www.dhcs.ca.gov/formsandpubs/laws/Documents/09-004_ApvPkg.pdf; Okla. State Plan Amendment 4.19-B, approving payment for mental health services in Therapeutic Foster Family Homes, <https://www.medicaid.gov/State-resource-center/Medicaid-State-PlanAmendments/Downloads/OK/OK-13-12.pdf>.

important reforms contained in the Family First Act, and the intent of Medicaid to encourage community-based mental health services. If they do, advocates should get involved in opposing such efforts through state and federal level public comment opportunities.