PUBLIC SECTOR SERVICES

Fortifying Family First:

Effectively Balancing Congregate Care in the Child Welfare Continuum

Child Welfare Continuum

Where we are today

Although the Family First Prevention Services Act (FFPSA) has contributed to a reduction in congregate care placements since its enactment in 2018, challenges persist. For children in foster care, congregate care can be a useful tool to stabilize behavioral or mental health challenges, but some state systems remain overly reliant on congregate care placements due to a lack of sufficient support for family-based alternatives, like next of kin or foster family placements.[1] While more can be done to further the goals of the FFPSA, most states find that they still need some congregate care capacity to support high acuity children and prevent out-of-state placement. Additionally, some states are finding that the qualified residential treatment programs (QRTPs) supported by the FFPSA are not a viable option for a variety of reasons, including the need to modify existing 1115 demonstrations to receive federal financial participation for QRTPs over 16 beds.[2]

Why should state child welfare systems invest in transforming how they use congregate care?

Best practices and national guidance, including FFPSA, encourage the use of family-based placements — rather than institutional placements like congregate care — for children in the foster care system. And though congregate care can benefit certain high-acuity youth, research shows these placements have several negative outcomes. For example, youth who have lived in congregate care settings:

- Experience longer stays in the foster care system by around seven months;[3]
- Are at a heightened risk of experiencing ongoing physical abuse;[4]
- Are more likely to struggle with mental and behavioral health issues;[5] and
- Have poorer educational outcomes, including being less likely to graduate from high school.[6]

Seven years after FFPSA's enactment, achieving a resilient, family-first child welfare system remains complex. A&M can support state child welfare systems in navigating this complexity, by finding ways to support strategic placements that meet the needs of each child in the system, while also shaping congregate care placements to remain a targeted (but not disproportionate) part of the child welfare continuum.

1 Rachel J. Keefe et al., "State Implementation of Congregate Care Reforms for Children in Foster Care," American Academy of Pediatrics, July 1, 2024, https://pubmed.ncbi.nlm.nih.gov/38932708/

2 "Medicaid Coverage of Qualified Residential Treatment Programs for Children in Foster Care," MACPAC, August 23, 2021, https://www.macpac.gov/wp-content/uploads/2021/08/Medicaid-Coverage-of-Qualified-Residential-Treatment-Programs-for-Children-in-Foster-Care.pdf

3 "What is Congregate Care in Virginia?" FosterVA, Accessed March 19, 2025, https://www.fosterva.org/blog/what-is-congregate-care-in-virginia

4 Ibid.

5 Ibid.

6 "What are the outcomes for youth placed in group and institutional settings?" Annie E. Casey Foundation, June 29, 2022, https://www.casey.org/group-placement-impacts/

Considerations Regarding Congregate Care

Despite efforts to prioritize family-based placements, states may still be overreliant on congregate care. An American Academy of Pediatrics study found that there are four main unmet needs that act as barriers to implementing FFPSA reforms: workforce and staff, funding, therapeutic foster care models, and foster families.[7] To help fortify Families First, it is critical that congregate care serve an appropriate role across the continuum of care.

Gaps in the Continuum of Services

Considerations:

A. What **treatment models** are currently used by the state and congregate care providers; do they reflect promising practices from other states?

B. What gaps exist for care? Is the current **mix of care options**, including congregate care, meeting the state's needs?

C. What is the use of **out of state placements** and/or hoteling? Is there **parity** between in-state and out-of-state payment rates?

D. What **additional funding sources** can be leveraged to support new initiatives across the continuum of care?

Implications:

- **Redefine program offerings** based on promising practices and accounting for resource limitations. This could include plans to incorporate comprehensive family engagement for youth in congregate care.
- **More specialized programs** including having the state adjust its **ratio of psychiatric residential treatment facilities, which use a medical model, to qualified residential treatment programs**, which use an adaptive behavioral skills model

Alignment of Goals and Current Operations

Considerations:

A. What are **current perspectives on the system** from youth in foster care/congregate care and their families, foster families, state staff, contracted and community provider staff, and payers?

B. **How are families involved** in the system before, during and after a child experiences a congregate care stay?

C. What are the existing **rules and policies for the child welfare system**? Are these rules and policies aligned to incentivize providers to **limit the length of congregate care stays to only what is necessary for the child**?

D. Is the payment structure for providers aligned to **incentivize serving a child in the right setting for the right length of time**?

Implications:

- Efforts to **empower youth** in the system. This could include creating opportunities to involve youth in the development of training for providers and foster families.
- Revised funding structure that **aligns with programmatic goals and optimizes federal Title IV-E and Medicaid funds**.

7 Rachel J. Keefe et al., "State Implementation of Congregate Care Reforms for Children in Foster Care," American Academy of Pediatrics, July 1, 2024, https://pubmed.ncbi.nlm.nih.gov/38932708/

How A&M Can Help

Assessment: A&M can work with your state to assess the impact of and create mitigation plans for any barriers to prioritizing family-based placements and promoting effective congregate care stays.

Decision-making facilitation: We work with state leadership and stakeholders to prioritize which assessment outcomes to implement first, given available resources and any directives from the state and/or federal government.

Project management: We partner across teams, agencies and organizations to support implementation, track progress, and identify and mitigate risks.

Change management and communications: We know the importance of effectively supporting stakeholders through change. We can create accessible communications that explain and reinforce any change to internal and external audiences.

Reporting and monitoring: We track data to measure success and support states with federal and/or public reporting. This could include monitoring how demographics of youth and experiences in congregate care change over time, as new processes and programs are implemented.

Ongoing stakeholder engagement: We believe that regularly connecting with stakeholders is critical to project success. When it comes to foster care and congregate care, we find that engagement with stakeholders in other agencies is particularly important.

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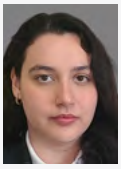

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