REDUCING RELIANCE ON CONGREGATE CARE DRIVEN BY PLACEMENT SHORTAGES

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EXECUTIVE SUMMARY

The use of institutional care for youth in the child welfare system, particularly psychiatric residential treatment services (PRTS), often occurs when family-based placements are unavailable. Although the Family First Prevention Services Act (FFPSA or "Family First") was intended to reduce congregate care and expand family-based alternatives, significant gaps remain (Bipartisan Budget Act of 2018, 2018). Medicaid and privately funded placements fall outside Family First oversight, allowing institutional care to function as a default rather than a medically necessary intervention (Government Accountability Office, 2026). This report recommends expanding oversight to all placements regardless of funding source, strengthening clinical assessment requirements, establishing independent review mechanisms for residential care, and increasing investment in family and community-based alternatives. These reforms would limit residential treatment to medically necessary use and the shortest appropriate duration while prioritizing less restrictive settings for youth in foster care.

PERSONAL REFLECTION

My interest in this issue stems from both personal experience and policy analysis. I have seen how easily institutional care becomes a default rather than a last resort, especially when appropriate placements are unavailable or caregivers decline placement. In these situations, youth are often placed in psychiatric residential treatment facilities even when they no longer meet the clinical criteria for that level of care (Engler et al., 2022). These experiences shape my perspective on how policy decisions directly affect youth in the foster system. While legislation such as Family First was intended to reduce unnecessary institutionalization, its restriction to Title IV-E funding allows youth to remain in institutional settings longer than necessary or outside of federal oversight. This gap highlights the need for more comprehensive oversight across all placement types.

THE PROBLEM & CURRENT LAW

Inappropriate institutionalization and extended use of residential treatment remain persistent issues in the child welfare system (Engler et al., 2022). When family-based placements are unavailable or declined, youth often have no safe discharge option, leading agencies to default to congregate care (Fathallah & Sullivan, 2021). This

THE PROBLEM & CURRENT LAW *(CONTINUED)*

is reinforced by structural incentives: emergency hotel placements are costly and resource-intensive, while institutional care is more readily reimbursed through Medicaid or state funding and externally staffed, reducing administrative burden on child welfare agencies (Government Accountability Office, 2026).

Federal and state policies have not sufficiently limited the use of Psychiatric Residential Treatment Services (PRTS). The Family First legislation established important safeguards, but its protections apply only to placements funded through Title IV-E (Family First Prevention Services Act, 2018). Because many placements are funded through Medicaid or private insurance, these cases fall outside Family First oversight (Government Accountability Office, 2026).

Under Family First, a qualified individual must complete an assessment within 30 days of placement in a Qualified Residential Treatment Program (QRTP) to determine whether residential care is necessary or a less restrictive placement would better meet the child's needs. Within 60 days, the placement must be approved by a court or authorized body for Title IV-E reimbursement to continue. Agencies must also demonstrate ongoing medical necessity and active efforts to transition the child to a family-based setting. However, these protections apply only to Title IV-E-funded placements, leaving Medicaid and privately funded placements outside this oversight framework (Family First Prevention Services Act, 2018).

At the state level, most legislation provides guidance rather than enforceable limits. States such as California, Colorado, Minnesota, New Hampshire, and Vermont outline placement criteria and duration standards, but these remain flexible (2022 Colorado Code; 2025 New Hampshire Revised Statutes; Vermont Laws, n.d.; Legalfina, n.d.). This creates a risk that historical diagnoses or past behaviors may be weighted more heavily than a youth's current clinical presentation. Best practice would prioritize current symptoms, current risk, and demonstrated failure of less restrictive interventions, with historical information used only as context (Trubey et al., 2024).

Michigan offers a stronger model. Its policies limit residential placement and require ongoing justification, including formal attestations that continued care is necessary. These measures have contributed to reductions in institutional placements. In 2024, 423 youth (4.4% of the foster care population) were in residential care, down from 444 in 2023, despite overall system growth (National Council for Adoption, 2025). This suggests stronger oversight can reduce reliance on congregate care.

Oregon similarly prioritizes family-based placements. In 2024, 6,799 children were served, with most in foster care (3,261) or kinship care (1,764), and only 173 in institutional settings. Additionally, 52.8% of youth exiting care were reunified (National Council for Adoption, 2025). While this reflects strong use of family-based placements, nearly half of youth still are not reunified, underscoring persistent system gaps.

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THE PROBLEM & CURRENT LAW *(CONTINUED)*

While residential treatment settings are intended to provide short-term stabilization during periods of acute need, extended stays can inadvertently disrupt normal adolescent development and limit opportunities for community integration. Youth placed in congregate care often experience reduced access to consistent family relationships, school continuity, and community-based supports that are essential for developing independence. In many facilities, programming prioritizes behavioral stabilization over skill-building in areas such as financial literacy, housing readiness, employment preparation, and self-directed care. As a result, young people may exit care without the independent living skills or stable support networks necessary for successful transition into adulthood.

POLICY RECOMMENDATIONS

In order to reduce reliance on congregate care driven by placement shortages, Congress should:

- **Amend Title IV-E of the Social Security Act to create a dedicated funding stream for family-based placement capacity,** including recruitment and retention of therapeutic foster care providers, minimum foster care maintenance payments sufficient to sustain kinship and therapeutic care, and mandatory respite and wraparound services.

- **Direct the U.S. Department of Health and Human Services to issue guidance requiring states to apply Family First residential placement oversight standards to all children under state supervision, regardless of funding source.** These standards should include clinical assessments within 30 days of placement, judicial or administrative review within 60 days, documented medical necessity, and ongoing reassessment to ensure placements remain clinically appropriate and focused current needs rather than historical diagnoses or system constraints. Currently, these protections apply primarily to Title IV-E placements, leaving Medicaid- and state-funded placements without consistent oversight or timely review. HHS should further clarify that compliance will be evaluated through the Child and Family Services Reviews (CFSRs), to strengthen accountability and incentivize reduced use of residential care.

POLICY RECOMMENDATIONS *(CONTINUED)*

- **Mandate the U.S. Department of Health and Human Services issue guidance encouraging states to establish independent oversight mechanisms**, such as review boards or ombuds offices, to monitor residential placements, evaluate length of stay, and assess continued medical necessity, while also supporting expansion of kinship, foster, and therapeutic foster care through increased provider support, targeted incentives, and broader use of federal funding mechanisms.