Leveraging Medicaid to Reduce Youth Homelessness

Strategic Presentation

May 2022

About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access and create new ways of organizing, paying for and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

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About the Raikes Foundation

The Raikes Foundation was launched by Jeff and Tricia Raikes in 2002 with a mission to invest in youth-serving institutions and systems to make them more effective in supporting and empowering all young people, especially those who have been most marginalized. Through the Raikes Foundation, Jeff and Tricia hope to help build a more just and inclusive world for our young people. For more information, visit https://raikesfoundation.org/

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Contents

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Executive Summary

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Youth Receiving Residential and Inpatient Behavioral Health Care Are at Increased Risk of Homelessness

The Issue

Youth with behavioral health needs, particularly those receiving residential and inpatient treatment, are at greater risk of homelessness.

- Washington State found that nearly 60% of youth/young people exiting public systems of care who became homeless within 12 months left behavioral health residential/inpatient care.
- LGBTQ youth and youth involved in the foster care system face disproportionate risk of receiving behavioral health treatment and experiencing homelessness.
- COVID-19 has led to an increase in unmet need for behavioral health services among youth, and homeless youth in particular.

Why Is This Happening?

A confluence of factors helps explain why youth with behavioral health needs, particularly those receiving residential and inpatient treatment, become homeless:

- **Lack of continuum of care**
- **Reliance on residential care for placement**
- **Inadequate family engagement**
- **Cross-system fragmentation**
- **Lack of affordable housing**
- **Inconsistent oversight**

Why Now?

With calls for change from President Biden, the Surgeon General, and the declaration of a youth mental health national emergency, states and lawmakers have an opportunity to capitalize on national momentum to improve behavioral health care for youth with significant needs.

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Key Principles

These principles can guide state strategies to help prevent behavioral health crises that result in youth entering inpatient and residential care, increasing their risk of homelessness.

Family- and Youth-Driven

Comprehensive Array of Services

Equity-Focused

Coordination Across Youth-Facing Systems

Least Restrictive Setting

Stable Housing as Foundational Support

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Medicaid-Focused Strategies to Address Homelessness for Youth With Behavioral Health Needs

States and lawmakers can leverage Medicaid as a primary tool for addressing homelessness among youth with behavioral health needs and implement a range of strategies including:

Expanding coverage and access to the full continuum of services	Reframing approach to residential/inpatient treatment	Requiring that facilities cannot discharge to homelessness	Supporting families of youth at risk of treatment	Driving alignment and cross-agency coordination	Increasing oversight and accountability
❑ Housing supports ❑ Other community services and supports ❑ In-home services ❑ Crisis services	❑ Identify and connect youth to treatment early ❑ Allow youth who require institutional or residential stays to bypass unnecessary ED stays ❑ Improve discharge planning	❑ Require that treatment facilities do not discharge youth to homelessness	❑ Educate and support families of youth with behavioral health needs ❑ Provide family-centered treatment	❑ Incentivize cross-agency coordination and communication ❑ Implement a Systems of Care model ❑ Improve data collection and analysis across agencies	❑ Organize state and family accountability approach ❑ Review provider and managed care organization (MCO) performance ❑ Use “carrots” to encourage performance ❑ Use “sticks” to penalize poor performance

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Background and Level Setting

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Project Overview

Project Scope

The Raikes Foundation engaged Manatt to develop a toolkit of strategies for states and other stakeholders on ways to use Medicaid to address youth and young adult homelessness following an institutional or residential stay for psychiatric and/or substance use care.

- While Medicaid is the primary focus of this presentation, several of the strategies involve other sources of public funding, including Child Health Insurance Program (CHIP) funding and select federal grant funding.

Process

Deep Dive on Federal Policies

Deep dive on best practices across states and providers

Best Practices

Research best practices across states and providers

Stakeholder Interviews

Interviews with state officials, advocates, providers, researchers

(see appendix for list of interviewees)

Recommendation Development

Develop recommendations based on research and interviews

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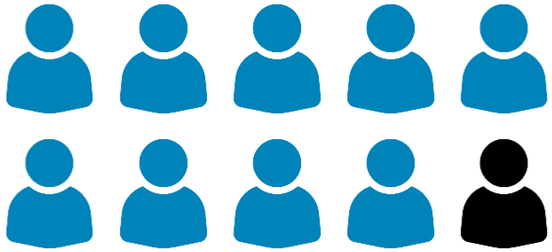
Youth With Behavioral Health Needs, Particularly Those Receiving Residential Care, Are at Risk of Homelessness

Key Stats

- **One in 10** of all young adults ages 18 to 25 and at least **one in 30** adolescents ages 13 to 17 experience homelessness over the course of a year.
- **LGBTQ youth** are at **more than double** the risk of homelessness compared to non-LGBTQ peers and tend to receive residential treatment at disproportionately high rates.
- A **significant** number of homeless youth report foster care involvement via out-of-home placements, either in foster care or institutional settings.
- Youth experiencing **behavioral health** issues, particularly those receiving inpatient and residential behavioral health treatment, face increased likelihood of becoming homeless.
- **COVID-19** has led to an increase in unmet need for behavioral health services among youth and homeless youth.

Homeless youth includes youth living on the streets, in shelter beds, and those who are living in motels or couch surfing (i.e., unstably housed).

Spotlight: Youth Homelessness in Washington State



Nine out of ten youth/young people who became homeless within 12 months of leaving a public system of care had Medicaid coverage

Key Findings

- Among youth/young people leaving a public system of care (e.g., foster care, residential behavioral health, criminal justice):
  - More than **one in ten youth** under the age of 17 experience homelessness within 12 months.
  - More than **one in four transition-aged youth** (18 to 24) experience homelessness within 12 months.
  - **More than half** are Black, Hispanic/Latin(x), Asian or Pacific Islander, or American Indian.
- While youth exiting the foster care system are at high risk for homelessness, there were about **nine times as many youth/young people** leaving residential treatment who experienced homelessness compared to those leaving foster care.*
- Of the youth/young people who became homeless after leaving residential/inpatient treatment, about **85% were young adults**.

*Note: It is unclear how researchers classified youth who both left residential/inpatient treatment and foster care.

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Key Issues Driving Increased Homelessness Among Youth With Significant Behavioral Health Needs

- **Lack of a continuum of care.** Gaps in coverage and access to a continuum of care for youth with behavioral health needs can result in them receiving residential/inpatient care instead of community-based care even when not clinically appropriate.
- **Reliance on residential care for placement.** Residential/inpatient treatment is too often used as a placement for youth, especially for certain populations (e.g., LGBTQ), rather than a clinically indicated treatment of last resort.
- **Lack of available and affordable housing.** Significant shortages in housing, housing supports and independent living programs are a foundational barrier.
- **Cross-system fragmentation.** Multiple child-facing systems are involved in caring for youth with significant behavioral health needs, leading to a diffusion of responsibility and confusion about which agency is in charge.
- **Youth discharged to the streets from inpatient or residential treatment.** A shortage of home- and community-based services that can meet the needs of youth with behavioral health needs sometimes leads to providers discharging youth to homelessness without regard to whether they have a viable housing option.
- **Inconsistent oversight of behavioral health policies system-wide.** Without accountability, requirements exist “on paper” rather than in practice.
- **Inadequate engagement of family and loved ones.** Lack of education and engagement of families makes it more difficult to support youth during the transition following residential care.

Increased Attention on Youth's Behavioral Health Needs

States can leverage increasingly urgent national calls to expand behavioral health care to address the crisis facing youth that has been exacerbated by COVID-19.

- **President Biden's State of the Union Address.** The March 2022 speech urged Congress to "take on mental health, especially among our children."
- **Congressional Hearings.** The Senate Finance Committee held hearings on youth mental health in February 2022.
- **Surgeon General's Call to Action on Youth Mental Health.** Dr. Vivek Murthy issued an advisory in December 2021 on the mental health crisis facing American youth.
- **Declaration of National Emergency.** The American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national emergency in child and adolescent mental health and called on policymakers at all levels of government to act in October 2021.

In early 2021, ED visits in the United States for suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same time period in early 2019.

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Federal Policies Impacting Behavioral Health Services and Incentivizing Coordination Across Child-Serving Agencies

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

- Obligates state Medicaid programs to cover medically necessary services including behavioral health services for beneficiaries under age 21 regardless of whether the services are covered in the state's Medicaid state plan.
- Courts have applied EPSDT coverage requirements to evidence-based, community-based services for youth with significant behavioral health needs such as wraparound.

Family First Prevention Services Act (FFPSA)

- Expands evidence-based practices for children, youth and families and prevents unnecessary foster care placements by expanding eligibility for Title IV-E services to children who are at imminent risk of out-of-home placement.
- Restricts the use of Title IV-E federal funds for room and board for children in foster care unless they are placed in settings that are qualified residential treatment programs (QRTPs). States have the option of delaying FFPSA until FY 2022.
- Encourages collaboration with Medicaid, as many FFPSA services are Medicaid coverable, and advises that Medicaid funding be exhausted before Title IV funding.

Section 1115 Medicaid Demonstrations

- The Centers for Medicaid and Medicare Services (CMS) has allowed states to seek *expenditure authority for services provided to children and youth in QRTPs* that are also institutions for mental disease with an exception on length-of-stay limits.
- In addition, select states, like Massachusetts and California, are seeking *expenditure authority for services provided to youth in juvenile justice settings*.

Key Principles

These principles can guide states to strengthen their behavioral health systems in order to divert youth with behavioral health needs from inpatient/residential care, which increases their risk of homelessness.

- **Family- and Youth-Driven.** It is important that youth with behavioral health needs and their families are at the center of a state's behavioral health system. Such an approach can reflect that youth with behavioral health needs may rely on friends and other loved ones for support rather than their traditional family.
- **Equity-Focused.** Services can be designed to address disparities in race, gender, ability, ethnicity and sexual orientation. It is essential that providers are equipped and services are designed to treat LGBTQ youth who are at high risk for residential/inpatient care.
- **Least Restrictive Setting.** Services should be provided in the least restrictive setting appropriate to the youth's needs, which may not be residential/inpatient care. Often, youth receive residential/inpatient care because appropriate community-based services are not available.
- **Comprehensive Array of Services.** A continuum of care tailored for youth helps divert youth from residential/inpatient care and reserves such care for those needing that support.
- **Stable Housing as a Foundational Support.** Housing and stable living arrangements are an integral part of the continuum of care for youth with significant behavioral health needs.
- **Coordination Across Youth-Facing Systems.** A coordinated system of care that brings together the different state agencies involved in serving youth with behavioral health needs and their families is easier for families to navigate and promotes more efficient care.

Strategies

Medicaid, the primary payer of behavioral health treatment, can act as a linchpin for states seeking to address youth homelessness following inpatient/residential stays.

1. Expand coverage and access to the full continuum of behavioral health and housing services.
2. Reframe approach to residential/inpatient behavioral health treatment.
3. Require that residential/inpatient facilities cannot discharge youth to homelessness.
4. Support families of youth at risk of inpatient/residential treatment.
5. Drive alignment and cross-agency coordination to organize the continuum of children's behavioral health services.
6. Increase oversight and accountability to ensure that providers and managed care organizations are meeting Medicaid requirements.

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Deep Dive on Medicaid Strategies

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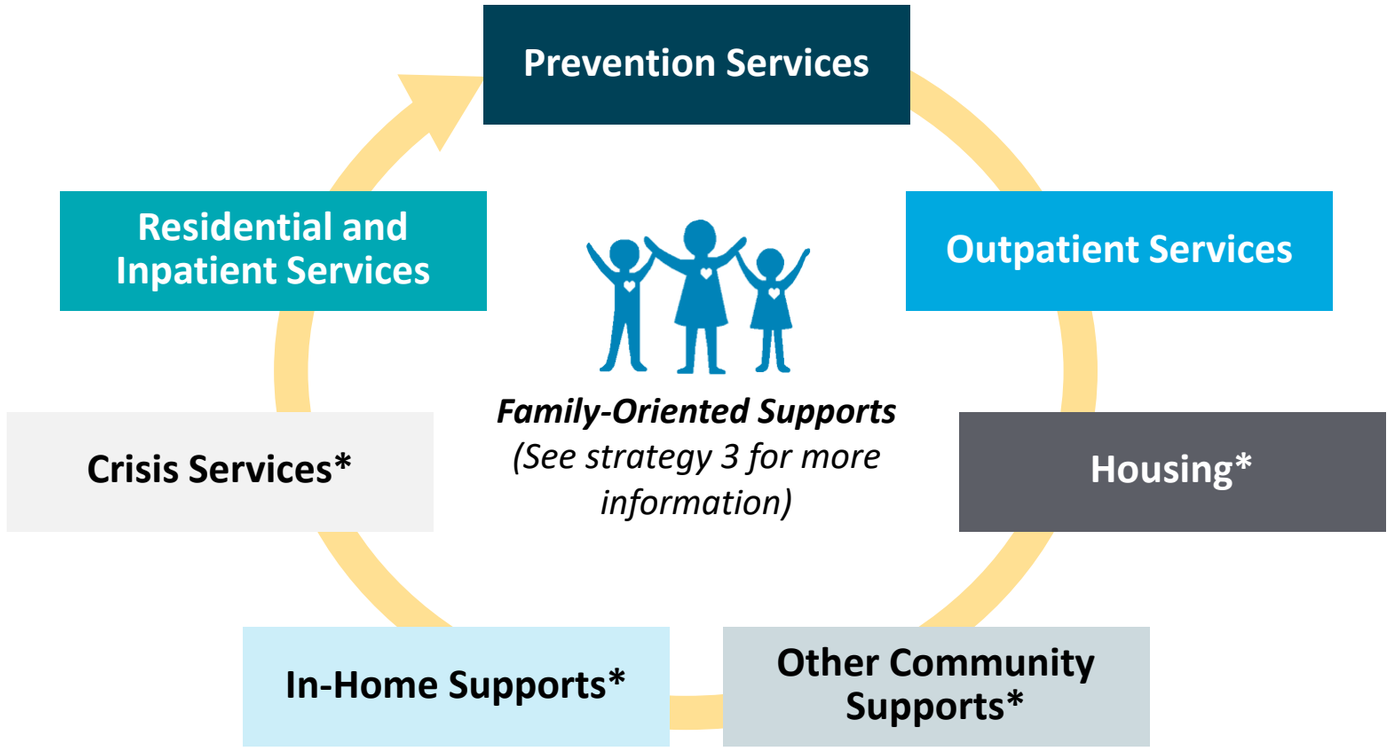
Expand Coverage and Access to the Full Continuum of Care

States can build out a Medicaid-centered continuum of care for youth that promotes the use of community-based care, diverts youth from residential/inpatient services, and supports youth transitioning from residential/inpatient services in order to mitigate youth homelessness.



In addition to Medicaid services, **in-home and other services provided by child welfare agencies** can help support youth transitioning to their families following out-of-home placements.

*Expanded upon in greater detail in this section. See appendix for more detailed continuum.

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Continuum of Care: Housing

States can leverage Medicaid to pay for services that help youth with behavioral health needs find and stay in housing.

Housing Supports

- **Definition.** Includes supportive services, like case management and tenancy supports, to help youth with behavioral health needs find, move into and sustain housing, and affordable housing options.
- **Short-Term Housing/Residential Options.** Youth transitioning out of inpatient services who do not have a residence and have ongoing medical or behavioral health needs can benefit from select services while they wait to be connected to longer-term housing supports.
  - Short-term post-hospitalization services
  - Medical respite services

*A range of **longer-term** housing and housing support options can be made available to support youth, depending on their needs, including:*

Independent living (e.g., apartments or homes) for youth who do not require onsite supports (not Medicaid reimbursable)

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Permanent supportive housing that includes wraparound behavioral health services (Medicaid coverable) for individuals requiring more supports to live independently

↓

Enhanced residential supports for youth who cannot live in independent settings, where Medicaid pays for personal care-like services

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Continuum of Care: Housing

States can braid together Medicaid, state and local funding with other federally funded programs to expand affordable and direct housing options for youth with behavioral health needs. Select federal programs include:

Foster Care Specific

- **Chafee Foster Care Independence Program** funds independent living for youth in the foster care system and enables states to use up to 30% of funds on housing subsidies, transitional housing or other housing-related costs.
- **Transitional Living Program** funds local and state governments, community-based organizations and tribal entities to provide longer-term housing and supportive services to homeless youth 16-21.

Additional Housing Programs

- **Housing Choice Voucher Program (HCV)** subsidizes rent to allow tenants to pay rent that is equivalent to 30% of their adjusted gross income. **Non-elderly persons with disabilities (NED) HCV** vouchers can enable youth with significant behavioral health needs to access affordable housing.
- **Housing Continuums of Care** coordinate local providers and agencies to address homelessness through a community-based process that identifies and addresses needs.

Spotlight

North Carolina

The Transitions to Community Living Initiative (TCL) braids together state and federal funding to provide housing and housing supports for people with serious mental illness. TCL services include Medicaid-covered mental health services, employment services and tenancy supports, as well as other federal- and state-funded housing vouchers.

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Continuum of Care: Other Community Supports

States can build on efforts to expand community supports to enable individuals with behavioral health needs to reside successfully in their communities, which largely focus on adults, and to support youth at increased risk of homelessness and institutionalization. They include:

Peer Supports

- **Definition.** Includes developing and linking with formal and informal supports; instilling confidence; assisting in the development of goals; and teaching skills to improve coping abilities.
- **Providers.** Includes those with "lived experience" who have personally faced the challenges of coping with serious behavioral health conditions.
- **Residential Treatment Settings.** Peers can play a vital role in residential settings, including liaising with families to assist with communication with the facility, co-facilitation of support groups, and collaborating with staff to support admission and transition home.

Respite Services

- **Definition.** Helps children and youth remain in their homes by providing temporary relief to their primary caregivers and preventing crises; respite services provide safe and supportive environments on a short-term basis for children with mental health conditions.
- **Settings.** Can be provided in an individual's home or other community settings.

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Continuum of Care: Other Community Supports

States can invest in Medicaid education and employment supports to help youth develop the skills necessary to support themselves financially, maintain housing and live meaningful lives.

Education

- **Definition.** Individualized services that promote engagement, sustain participation and restore an individual's ability to function in the learning environment. For youth, the services are intended to help them develop skills to improve educational competencies, promote self-advocacy and empowerment, and build community connections and natural supports.
- **Settings.** Services can be provided in and outside the classroom, and by schools or other supported employment agencies.

Employment

- **Definition.** Supported employment services help youth with behavioral health needs obtain and maintain competitive jobs, and can include vocational assessment, help finding jobs, skills training, and on-site job coaches who help the youth learn tasks and work with the employment to troubleshoot issues.
- **Individual Placement and Support (IPS).** IPS is an evidence-based model of supported employment for people living with mental illness. IPS can also be provided to adolescents and young adults and integrated into community mental health or housing services.

Continuum of Care: In-Home Supports

States can strengthen the provision of in-home supports to provide families and children/youth with behavioral health needs with treatment and tools to avoid out-of-home placement and institutionalization. In-home supports include:

Wraparound Approach/High-Fidelity Wraparound

- **Definition.** An evidence-based *intensive care coordination model* covering all life-domains for children with significant mental health conditions who interact with multiple child-serving agencies.
- **Child and Family Team.** Four to eight individuals including the child, family members, providers and key members of the child's formal and informal support network, including members from child-serving agencies. The child and family team develop, implement and monitor the service plan.
- **Role of the Care Coordinator.** Serves as the "facilitator" who organizes, convenes and coordinates the process.

Intensive In-Home Services

- **Definition.** *Therapeutic, team-based interventions* delivered to and in partnership with children and families in their homes and other community settings to avoid out-of-home placement in inpatient settings.
- **Components.** Includes individual and family therapy; substance use disorder treatment interventions, psychosocial education, intensive case management, crisis management, skills training and behavioral health training.
- **Team.** Usually includes clinicians for therapy and paraprofessionals for skills-training.

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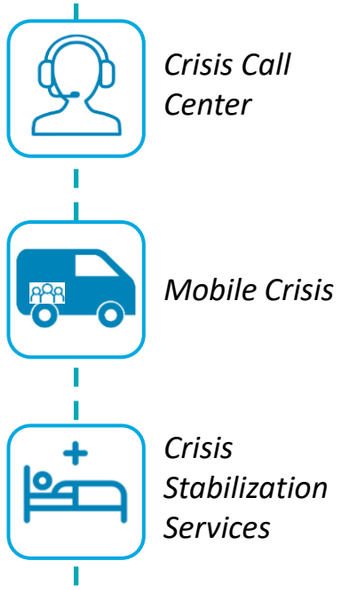
Continuum of Care: Crisis Services

States can build a strong crisis system that is payer-blind, tailored to meet the needs of children and youth experiencing behavioral health distress in order to reduce avoidable ED visits, hospitalizations, incarceration, other out-of-home placements and homelessness

Mobile Response Stabilization Service (MRSS)

- **Definition.** MRSS is a structured community-based, in-person, intervention and support service that is evidence-based for youth and families.
- **Team Composition.** In most cases, a two-person crisis team, composed of professionals and paraprofessionals (including peers) trained in crisis intervention skills with child-facing expertise, responds.
- **Response Time.** ~1 hour
- **Components.** Five key phases of crisis intervention:
  - **Crisis prevention. I**ncludes collaboration and coordination with child-welfare, school, other entities that have relationships with children at risk of behavioral health crises.
  - **Early intervention.** Includes training service providers in identifying risk factors for crises before more intensive intervention is needed.
  - **Acute intervention.** Includes triage to determine whether in-person response is needed, evaluation, assessment, crisis plan development.
  - **Crisis treatment.** Includes in-home supports, short-term care coordination, and residential crisis stabilization.
  - **Recovery and reintegration.** Facilitating the child's or youth's transition from acute intervention or crisis treatment to the community.

Core Elements of Crisis System



Beginning in April 2022, states can draw down 85% enhanced federal Medicaid match for child- and youth-specific mobile crises like MRSS for the first three years of state coverage.

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Continuum of Care: Implementation Vehicles and State Examples

Service	Implementation Vehicle	State Examples
Housing Supports		
Short-term post-hospitalization housing	1115 Demonstration	**California** covers these housing supports through its Cal-AIM demonstration for Medicaid enrollees who no longer require hospitalization, but have ongoing medical or behavioral health needs.
Medical respite		
Tenancy supports/ Supportive housing	1115 Demonstration 1915(i) SPA 1915(c) Waiver 1915(b)(3) Waiver Medicaid managed care in lieu of authority	**Hawaii** covers supportive housing services through its 1115 demonstration for Medicaid enrollees, including those with qualifying behavioral health needs who are at risk of homelessness.
Community transition services		**Virginia** covers one-time costs such as security deposits and recurring costs such as utility costs through its 1115 demonstrations for Medicaid enrollees with behavioral health needs, including those who are homeless or at risk of homelessness.
Enhanced personal care supports	1115 Demonstration 1915(i) SPA 1915(c) Waiver 1915(b)(3) Waiver	**Colorado** pays for personal care services via its 1915(c) Waiver for individuals experiencing a severe and persistent mental health need who require LTSS at a level typically provided in a nursing facility.

Continuum of Care: Implementation Vehicles and State Examples

Service	Implementation Vehicle	State Examples
Community Services and Supports		
Youth Peer Support Services	▪ Medicaid State Plan (Rehabilitative Services Option) ▪ Medicaid 1915(i) SPA ▪ Section 1115 Demonstrations ▪ Medicaid 1915(c) Waiver ▪ Medicaid 1915(b)(3)	**Georgia** covers youth peer supports via its Medicaid State Plan that is delivered by certified youth peer specialists.
Respite Services	▪ Medicaid 1915(i) SPA ▪ Section 1115 Demonstrations ▪ Medicaid 1915(c) Waiver ▪ Medicaid 1915(b)(3)	**Louisiana** covers short-term respite care to children eligible for the coordinated system of care under the 1915(b)(3) or 1915(c) waiver.
Supported Education		**North Dakota** covers supported education that does not duplicate services provided via 1915(i) special education and related services that are included in a child's Individualized Educational Plan (IEP).
Supported Employment		**Washington's** foundation community supports program authorized by its 1115 demonstration provides supported employment to individuals 18 and older.

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Continuum of Care: Implementation Vehicles and State Examples

Service	Implementation Vehicle	State Examples
In-Home Services		
Wraparound Approach/High-Fidelity Wraparound	▪ Medicaid Targeted Case Management (TCM) SPA ▪ Medicaid Health Home SPA ▪ 1115 Demonstration ▪ 1915(i) SPA ▪ 1915(c) Waiver ▪ 1915(b)(3) Waiver ▪ Medicaid Managed Care ▪ Other funding	States commonly pay for wraparound services using multiple federal and state funding sources depending on whether the youth eligible to receive service is eligible for Medicaid. **Texas** covers high-fidelity wraparound using a TCM SPA that has two tiers for children (routine and intensive). High-fidelity wraparound is the modality for the intensive tier. The state also provides the service to youth not enrolled in Medicaid.
Intensive In-Home Services	▪ Medicaid State Plan Rehab Option ▪ 1115 Demonstration ▪ 1915(i) SPA ▪ 1915(c) Waiver ▪ 1915(b)(3) Waiver	**North Carolina** covers intensive in-home services via its Medicaid State Plan Rehab Option for qualifying children and adolescents.
Crisis Services		
MRSS	▪ Medicaid State Plan Rehab Option ▪ 1115 Demonstration ▪ 1915(i) SPA ▪ 1915(c) Waiver ▪ 1915(b)(3) Waiver ▪ Other funding	**New Jersey** covers MRSS using a braided funding approach via: ▪ Its Medicaid State Plan Rehab Option for Medicaid-eligible children. ▪ State funding for uninsured children who are Medicaid-ineligible. ▪ Third-party liability coordination, for those families that may have other forms of insurance coverage. ▪ Wrap/Flex funds, to support services not covered by Medicaid.

Reframe Approach to Residential/Inpatient Treatment

Residential/inpatient stays are a strong signal that youth require more intensive support. These strategies encourage states to identify youth at high risk of institutionalization early to avoid stays to the extent possible and reframe required stays as part of a continuum of care with clear discharge plans centered on supporting the youth in the community.

Context

- Residential/inpatient treatment may be used in lieu of a placement or as first resort rather than a last resort when clinically indicated.
- Youth enrolled in Medicaid were more likely than their privately insured peers to receive mental health treatment in a hospital or a residential facility.
- In some states, the only way to be admitted into residential/inpatient treatment is through the ED or hospital, which can delay admission and lead to lengthy stays in the ED.
- Most youth who enter residential/inpatient care have already interacted with other child welfare, justice-involved or behavioral health institutions.
- Discharge planning from residential/inpatient treatment does not always involve community-based providers who will care for youth after transition.

Spotlight

Building Bridges Initiative (BBI)

- BBI is a national initiative working to identify and promote best practices and policies to improve coordination and collaboration between all stakeholders involved in youth residential treatment.
- BBI's five core principles for residential facilities are:
  1) Family-driven and youth-guided care
  2) Cultural and linguistic competence
  3) Clinical excellence and quality standards
  4) Accessibility and community involvement
  5) Transition planning and services (between settings and from youth to adulthood)

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Reframe Residential: Implementation Pathways

1 Identify and connect youth at risk of residential/inpatient care to ongoing treatment early

- Coordinate across state agencies to identify these youth early to link them to proper treatment and community supports and avoid inpatient/residential care by:
  - Conducting or requiring cross-agency data analysis to identify children with involvement in multiple systems.
  - Allowing for referrals from providers and families.
  - Connecting identified youth to a care team, care manager, resource line and services.
  - Comprehensively assessing youth seeking admission into residential/inpatient care using an evidence-based tool to determine patient placement and level of care required.

2 Allow youth who require institutional or residential stays to bypass unnecessary ED stays

- Allow for other points of admission into residential/inpatient treatment to circumvent the ED.

3 Improve discharge planning

- Use Medicaid to reinforce and enhance requirement that discharge planning begin upon admission.
- Incorporate housing.
- Involve community treatment providers, peers, family and informal supports.
- Require staff to maintain relationships with providers with specialized expertise (LGBTQ).

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Reframe Residential: Implementation Vehicles and State Examples

Pathway	Implementation Vehicle	State Examples
Identify and connect youth at risk of residential/inpatient care to ongoing treatment early.	Medicaid TCM SPA Medicaid Health Home SPA Data sharing agreements State law	**New Jersey** provides a single point of access for youth requiring more intensive behavioral health services, including inpatient/residential care. Once youth are identified, care management organizations (CMOs) assess youth to determine the level of care they require and refer youth and their families to community-based services and supports. **Illinois** requires any youth admitted into an inpatient hospital for behavioral health services to be screened to determine whether they should receive outpatient care.
Allow youth who require institutional or residential stays to bypass unnecessary ED stays.	Licensing regulations Medicaid provider manuals Medicaid managed care contracts	**Oklahoma's** community-based treatment providers, including mobile crisis teams, can authorize access to residential/inpatient treatment to bypass the ED. The mobile team can also recommend extending or terminating the stay once youth is receiving treatment in the facility.
Improve discharge policies.	Licensing regulations Medicaid provider manuals Medicaid managed care contracts	**Massachusetts** requires that for any patient determined by an inpatient hospital facility (PIH) to be experiencing or at risk of homelessness, the PIH facility must start discharge planning activities within three days of admission and invite providers, family members and case managers into the planning process. The PIH must ensure that the discharge team is aware of and using available community resources. The PIH must track all discharges to local shelters or the streets.

Require That Facilities Do Not Discharge Youth to Homelessness

Residential/inpatient facilities sometimes discharge youth receiving behavioral health treatment to unstable housing placements or directly to homelessness. This Medicaid strategy is focused on establishing legal requirements to ensure that youth are not discharged to homelessness.

Context

- Discharging to homelessness may occur for a variety of reasons—lack of step-down services, capacity issues, behavioral challenges, lack of coordination between relevant agencies, absence of familial supports.
- While prohibiting residential/inpatient facilities from discharging youth to homelessness is a good start, it is most effective when coupled with other strategies aimed at strengthening the continuum of care and discharge policies.

Implementation Vehicle

- State law
- State executive order
- Agency guidance

State Example: Washington

In 2018, Washington passed HB 6560, which requires the development of a statewide plan to ensure that all young people discharged from publicly funded systems exit into safe and secure housing rather than homelessness. In 2022, the state passed HB 1905, which works to set up the processes to support and operationalize the 2018 effort, including the development of a Rapid Response Team and additional funding for rent stabilization and housing stability.

Support Families of Youth With Behavioral Health Needs

It can be difficult for families of youth with significant behavioral health needs to access services that can help them care for their loved ones at home. These strategies focus on how states can use Medicaid to support families of youth with significant behavioral health needs.

Context

- Families, often overwhelmed by the needs of their child or loved one, may be ill-equipped to navigate a confusing behavioral health treatment system and may also need supports to care for their child at home.
- States can engage families in their child's or loved one's treatment and provide them with tools to navigate the behavioral health treatment landscape.
- State policies can reflect that youth define their own families. In some cases, the youth's biological family may not be supportive, so providers can cultivate friends and other individuals who play important roles in the youth's life as sources of support.

Spotlight: Massachusetts

Created a framework for family engagement for all their child- and family-serving agencies. The framework emphasizes the importance of engaging a broad definition of family and community, keeping family and youth voices at the center, building trusting and reciprocal relationships, and integrating culturally and linguistically responsive practices. MassHealth also established 29 geographically based Community Service Agencies (CSAs) with cultural and linguistic specialization that help serve families seeking services. The state additionally has a network of Family Resource Centers, which are in every county and provide community-based parenting support programming and educational resources.

Families: Implementation Pathways

1 Educate and support families with children with significant behavioral health needs

- Support and educate families before, during and after treatment through **family resource centers**.
  - Family resource centers can serve as community-based resource hubs where families can access information and referrals for child and adolescent behavioral health treatment and other available community supports.
- Offer **family, caregiver and peer support** to provide navigation support and advocacy to parents and caregivers; family peer support providers offer a range of services, including:
  - Information and referral; support training and education; system navigation; family support during times of crisis.

2 Provide family-centered treatment*

- Family therapy delivered to children and families in homes or community settings can improve youth/family dynamics and prevent out-of-home placement in residential/inpatient settings.
- Incorporate specialized supports into family therapy that meet the unique needs of LGBTQ youth and their families, such as interventions focused on shifting family attitudes, like AFFIRM, Family Acceptance Project, Youth Acceptance Project.

*See continuum of care strategies on slide 16.

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Families: Implementation Vehicles and State Examples

Pathway	Implementation Vehicle	State Examples
Educate and support families with children with significant behavioral health needs.	▪ Medicaid State Plan Rehab Option ▪ Medicaid 1915(i) SPA ▪ Medicaid 1915(c) Waiver ▪ Medicaid 1915(b) Waiver ▪ Medicaid 1115 Demonstration ▪ Medicaid Managed Care Contracts ▪ CHIP HSI	**Oklahoma** family support providers and a network of CBOs are stationed throughout the state to coach and support families. They help families understand and prepare for residential/inpatient treatment and navigate the system with their child. Youth under 18 who meet specific criteria are automatically enrolled, but the state does not deny services if the youth does not meet the criteria. Family support providers are covered by Medicaid.
Provide family centered treatment.	▪ Medicaid State Plan Rehab Option ▪ Medicaid 1915(i) SPA ▪ Medicaid 1915(c) Waiver ▪ Medicaid 1915(b) Waiver ▪ Medicaid 1115 Demonstration	**Massachusetts'** MassHealth pays for a range of family-centered home and community-based health services including family support and training, in-home behavioral services, and therapeutic mentoring. A care coordinator works together with the family to determine which services should be included in the treatment plan.

Drive Alignment and Cross-Agency Coordination

Youth with behavioral health needs often interact with multiple youth-serving agencies. These strategies are focused on using Medicaid to drive alignment and cross-agency coordination to better serve youth with behavioral health needs and their families.

Context

- Multiple state agencies with different areas of focus are tasked with addressing the needs of youth with significant behavioral health needs—Medicaid, behavioral health, child welfare, juvenile justice, education and housing.
- Coordination and collaboration across these agencies can be complex, and it is often unclear which agency is in the lead for ensuring that the youth's needs are met.
- Data sharing across these agencies can be complicated, which is why many states do not have a complete picture of youth behavioral health needs or those discharged from residential/inpatient treatment.

Spotlight: Washington

The state's Medicaid agency, Health Care Authority (HCA), has established a cross-agency workgroup to improve discharge processes for youth leaving inpatient/residential treatment. As part of the charter, HCA is prioritizing collaboration and communication across the various agencies involved with youth with behavioral health needs. Specifically, HCA has been working on creating cross-system mechanisms to intervene and connect youth to care more quickly before the situation has escalated to a crisis. HCA is also considering ways to engage primary care to serve as a bridge for more holistic care for youth.

Alignment: Implementation Pathways

1 Incentivize Cross-Agency Coordination and Communication

- Create cross-agency workgroups or advisory councils that meet regularly and include participation from the state's Medicaid managed care plans.
- Leverage FFPSA to drive coordination across Medicaid and child welfare (e.g., coverage of services).
- Establish memorandums of understanding (MOU) that formalize agency roles and responsibilities.

2 Implement a Systems of Care (SOC) Model

- SOC is a service delivery approach for children and youth with significant behavioral health needs that builds partnerships across the different child-serving agencies, Medicaid managed care plans and providers to create an integrated approach for meeting youths' and their families' multiple needs
- SOC are family-driven and youth-guided, community-based, culturally and linguistically competent, and incorporate specialized services for at-risk populations

3 Improve Data Collection and Analysis Across State Agencies

- Share data across state agencies, including through MOUs and data sharing agreements, to compile a more complete picture about youth with significant behavioral health needs and their interactions with public-facing systems to help avert youth homelessness by understanding a range of factors, e.g.:
  - Where they first engage a public-facing system
  - How often they are linked to treatment following their first system encounter
  - The services they most often use

Alignment: Implementation Vehicles and State Examples

Pathway	Implementation Vehicle	State Examples
Incentivize cross-agency coordination and communication.	▪ Medicaid administrative funding ▪ Medicaid managed care plans ▪ Legislation ▪ Executive order	**Rhode Island** requires health plans to sit on the Health Care Planning and Accountability Advisory Council. This council brings together physicians, consumers, agency and government officials, and advocates to assess, review, monitor and make recommendations on population health care needs, including behavioral health.
Implement an SOC model.	▪ Medicaid administrative funding ▪ Medicaid managed care contracts ▪ SAMHSA grants	**Oklahoma** established a Systems of Care (OKSOC) model to serve as a state-wide collaborative network for members of local communities, organizations, agencies, facilities and groups to provide services to children, youth and young adults. The network provides physical and behavioral health services, social services, school-based and vocational services, and other community supports through wraparound and coordinated services. OKSOC is built on five core values: Community Based, Trauma Informed, Culturally Responsive, Youth Guided, and Family Driven.
Improve data collection and analysis across state agencies.	▪ Medicaid administrative funding ▪ Memorandums of understanding	**Washington's** Department of Social and Health Services Research and Data Analysis Division issued a report that compiled data across child-facing agencies investigating and documenting the number of youth discharged from residential/inpatient treatment to homelessness in the state. The state Health Care Authority (HCA) further developed recommendations based on the report.

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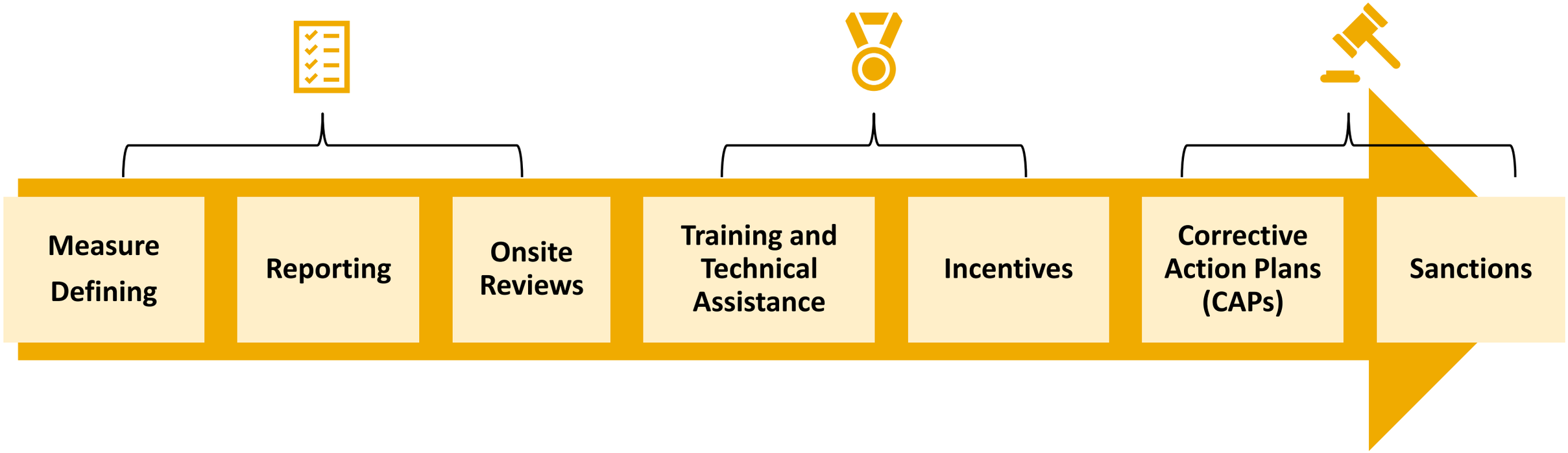
Increase Oversight and Accountability

Robust state oversight and accountability policies are critical to ensure that behavioral health providers, including residential/inpatient treatment facilities and managed care organizations, comply with requirements. States can leverage performance review tools, "carrots" and "sticks" to hold providers and managed care organizations accountable.



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Accountability: Implementation Pathways

1 Organize State and Family Administrative Accountability Approach

- **Train and allocate dedicated staff** to handle administrative oversight and accountability to help ensure agency alignment with Medicaid requirements and state behavioral health goals.
- Meaningfully **engage families and youth** in accountability and oversight via advisory groups and committees.

2 Review Provider and MCO Performance

- Define **measures** that providers and MCOs will be accountable for meeting and obtain cross-system buy-in on measures. Measures could include:
  - Rate of approvals/denials for behavioral health treatment by service
  - Length of service treatment authorization, including length of stay for residential/inpatient service
  - Youth awaiting discharge and average length of time awaiting discharge
  - Out-of-home placements
  - Service referrals following discharge, including step-down services from inpatient/residential care
  - Youth homeless/insecurely housed following Medicaid-funded inpatient/residential stay
  - Quality measures, including HEDIS/NCQA measure
  - Youth and family satisfaction surveys
- Establish ongoing **reporting** requirements for providers and MCOs (as applicable).
- Conduct **on-site and chart reviews** of providers and MCOs (as applicable) to review compliance with requirements, including admission and discharge policies.

Accountability: Implementation Pathways

3 Use "Carrots" to Encourage Provider and MCO Performance

- Establish Centers of Excellence (COEs) to deliver **training and technical assistance** to providers and MCOs (as applicable) as they implement new requirements, services and practice transformation.
  - **Providers:** Support the delivery of evidence-based practices and conduct fidelity reviews.
  - **MCOs:** Support oversight of providers and new services, and provide tools to improve and enhance provider performance.
  - **Services:** COEs can focus on supported employment, intensive in-home services, wraparound approach, MRSS, among others.
- Create **incentive programs** to reward MCOs and providers for meeting or exceeding performance metrics.
  - States can leverage their quality strategy and reporting requirements (see previous slide) to identify aligned metrics, and can identify other process- or outcome-related benchmarks.

4 Use "Sticks" to Penalize Poorly Performing Providers and MCOs

- Subject providers and MCOs (as applicable) to **corrective action plans** to address deficient compliance with requirements identified through performance review
- Impose sanctions on **providers and MCOs** for failing to meet requirements
  - Sanctions can include **financial penalties and exclusion from Medicaid program** for repeated or egregious violations

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Accountability: Implementation Vehicles and State Examples

Pathway	Implementation Vehicle	State Examples
Organize state administrative oversight and accountability approach.	▪ Medicaid administrative funding	**Massachusetts'** MassHealth interagency Children's Behavioral Health Initiative (CBHI) is charged with monitoring, evaluation and reporting of progress and data to the public, state leadership and the courts.
Meaningfully **engage families and youth** in accountability and oversight via advisory groups and committees.		**Virginia** established a Behavioral Health Advisory Council to advocate for family-driven services and supports for youth and adults with behavioral health needs. The council works directly with the governor, state agencies and the Legislature to monitor, evaluate and review the state's behavioral health policies.
Review Provider and MCO Performance		
Define measures that providers and MCOs will be accountable for meeting and obtain cross-system buy-in on measures.	▪ Medicaid MCO contracts ▪ Medicaid provider manuals	**Ohio's** statewide MCO for children and youth involved in multiple state systems or children and youth with other complex behavioral health needs will be required to report on measures including rate of out-of-home placement; out-of-state residential placements; LOS for inpatient and PRTF services; awaiting discharge; ED utilization; satisfaction surveys; rate of expulsions and suspensions.
Establish ongoing reporting requirements for providers and MCOs.		**Illinois** subjects all providers who conduct screening, assessment and support services, including behavioral health providers, to onsite review, which can include desk audits and review of policies and procedures, training materials, clinical care records, treatment plans, and parent/guardian consent and involvement in the care plan.
Conduct on-site and chart reviews of providers and MCOs.		

Accountability: Implementation Vehicles and State Examples

Pathway	Implementation Vehicle	State Examples
Use "Carrots" to Encourage Providers and MCO Performance		
Establish COEs to deliver training and technical assistance.	▪ Medicaid administrative funding ▪ Medicaid Section 1115 Demonstrations ▪ SAMHSA funding	**New Jersey's** Rutgers University partners with the state's Department of Children and Families to offer training and technical assistance for the New Jersey Children's Systems of Care.
Create incentive programs to reward MCOs and providers	▪ Medicaid managed care ▪ Medicaid Section 1115 Demonstrations	**California** implemented an incentive payment program for Medi-Cal managed care plans intended to increase access to school-based and school-linked care for students' mental health and wellness.
Subject providers and MCOs to **corrective action plans**	▪ Medicaid MCO contracts ▪ Medicaid provider manuals	**Arkansas'** behavioral health providers must submit a Corrective Action Plan (CAP) designed to correct any deficiencies noted in on-site inspections of care. After approval of the plan, a utilization review agency will monitor the implementation and effectiveness of the CAP through on-site review.
Impose sanctions on **providers and MCOs** for failing to meet requirements		**Montana's** Medicaid-reimbursed children's mental health providers are subject to sanctions if issues are identified by a Utilization Review Contractor. If the provider fails to correct the deficiencies identified, the Department of Public Health & Human Services may impose additional sanctions.

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Key Takeaways and Next Steps

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Medicaid-Focused Strategies to Address Homelessness for Youth With Behavioral Health Needs

States and lawmakers can leverage Medicaid as a primary tool for addressing homelessness among youth with behavioral health needs and implement a range of strategies including:

Expanding coverage and access to the full continuum of services	Reframing approach to residential/inpatient treatment	Requiring that facilities cannot discharge to homelessness	Supporting families of youth at risk of treatment	Driving alignment and cross-agency coordination	Increasing oversight and accountability
❑ Housing supports ❑ Other community services and supports ❑ In-home services ❑ Crisis services	❑ Identify and connect youth to treatment early ❑ Allow youth who require institutional or residential stays to bypass unnecessary ED stays ❑ Improve discharge planning	❑ Require that treatment facilities do not discharge youth to homelessness	❑ Educate and support families of youth with behavioral health needs ❑ Provide family-centered treatment	❑ Incentivize cross-agency coordination and communication ❑ Implement a Systems of Care model ❑ Improve data collection and analysis across agencies	❑ Organize state and family accountability approach ❑ Review provider and MCO performance ❑ Use “carrots” to encourage performance ❑ Use “sticks” to penalize poor performance

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Next Steps

States and lawmakers can take a series of actions to begin to address youth homelessness among youth with behavioral health needs.

- ❑ Establish cross-agency working group with early and active participation of youth and families with lived experience.
- ❑ Conduct a comprehensive review of current policies, including on the continuum of care available for children and youth, residential/inpatient admission, care provided during residential/inpatient stays, and discharge policies.
- ❑ Engage a broad range of stakeholders to identify key measures of success.
- ❑ Design and implement policies to improve care combined with new support and accountability.
- ❑ Review data available to the state to understand the scope of youth homelessness and intersection with youth with behavioral health needs, and measure progress.

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Appendix

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Multiple State Agencies Are Involved in Supporting Youth With Significant Behavioral Health Needs

- **State Medicaid agencies.** Medicaid and CHIP cover more children than any other insurer, and are a major source of coverage for adolescents with significant mental health conditions, covering one in three adolescents with a past year major depressive episode with severe role impairment.
- **State child welfare agencies.** Low-income youth currently or formerly involved with the child welfare system are generally eligible for Medicaid and often have substantial behavioral health needs and receive residential treatment (MACPAC 2015).
- **State behavioral health authorities.** State mental health and substance use disorder authorities oversee the public behavioral health system and administer federal grants for behavioral health services, including Substance Abuse and Mental Health Services Administration (SAMHSA) grants. They often fund behavioral health services that are covered by Medicaid.
- **Juvenile justice agencies.** Many youth served in the juvenile justice system are eligible for Medicaid or CHIP, though federal law prohibits the use of Medicaid funds to pay for nearly all health care services delivered to incarcerated individuals. Mental health conditions are prevalent among youth in the juvenile justice system, with as many as 70 percent of individuals having a diagnosable mental health problem (DSG 2017).

Core Continuum of Care for Youth With Significant Behavioral Health Needs

Prevention Services

- Services and assessments that educate and support youth and their families to maintain healthy lifestyles and prevent acute or chronic conditions, including primary care screenings and health promotion activities

Outpatient Services

- Services delivered on an outpatient basis including assessments, specialized evaluations, service planning, individual therapy, group therapy, family therapy, school-based mental health services, medication management and SUD pharmacotherapy

Housing

- Includes affordable housing and housing supports such as tenancy supports and transition costs

Other Community Supports

- Services designed to promote independent living among youth and avoid homelessness, including peer support services, respite, supported education, supported employment

In-Home Supports

- Services such as intensive in-home services, multi-systemic therapy, and high-fidelity wraparound services delivered to youth and their families using a multi-disciplinary, team approach in home and community settings

Crisis Services

- A range of a services, including mobile response and stabilization services, crisis residential services and crisis respite services that assess, stabilize and treat youth in acute distress

Residential and Inpatient Services

- Structured, facility-based services provided to youth requiring 24/7 care for mental health or substance use disorders on a short-term basis; may be provided in acute care hospitals, psychiatric hospitals, psychiatric residential treatment facilities, qualified residential treatment facilities

Stakeholder Interviews

Washington State Health Care Authority
Washington State Office of Homeless Youth
Washington State Department of Children, Youth, and Families
Campaign Advocacy Fund
Legal Counsel for Youth and Children
Schultz Family Foundation
A New Way Home Washington
Daybreak Youth Services Washington
Suzanne Fields, Former Director of the MassHealth Office of Behavioral Health
Elizabeth Manley, Former Commissioner for New Jersey’s Children's System of Care
Sheamekah Williams, Director of Oklahoma Children, Youth and Family Services
SOGI Health Research Group, University of Maryland
Los Angeles LGBTQ Center
Youth Move International
Catholic Charities, Maryland
MonmouthCares, New Jersey
Bonnie Brae, New Jersey