How can Medicaid support the treatment costs for youth in residential programs?

BY THE CENTER FOR HEALTH CARE STRATEGIES

Children's residential treatment programs provide services to children, youth, and young adults under 21 years of age with serious behavioral health needs. These out-of-home treatment settings are intended to be time-limited — only for as long as needed to address the behavioral and emotional challenges individuals and their families are facing. The Family First Prevention Services Act (FFPSA), signed into law in 2018, changes how Title IV-E dollars can be used to support children's residential treatment programs and creates an opportunity for child welfare agencies to collaborate more effectively with state Medicaid partners to increase access to and the quality of services, and improve outcomes for youth involved in the child welfare system.

Residential treatment programs are funded in a variety of ways, varying greatly by state and population served. In many states, Medicaid is used to support the treatment costs for youth in residential programs, with room and board covered by Title IV-E or another funding source if the child is not Title IV-E eligible. Some states use Medicaid to fund the full cost of treatment for youth in a Psychiatric Residential Treatment Facility (PRTF), which is a non-hospital facility providing inpatient psychiatric level of care services. Some states combine these funding sources. There are a few states that do not support residential services with federal dollars and use only state funds for these services.

Medicaid financing

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in Medicaid requires states to provide a comprehensive array of preventive and treatment services, and covers all appropriate and medically necessary services to Medicaid-eligible children, including residential treatment. States primarily use Medicaid to pay for residential treatment for Inpatient Psychiatric Services for individuals under age 21 (referred to as the "psych under 21 benefit") and Rehabilitation Services (referred to as the "Rehab Option").

Medicaid benefits that support children's residential treatment services

Psych Under 21 Benefit

Inpatient services under the psych under 21 benefit may be provided in a psychiatric inpatient hospital, a psychiatric unit within a general hospital, or a PRTF. The Centers for Medicare & Medicaid Services (CMS) defines a PRTF as any non-hospital facility that has a provider agreement with a state Medicaid agency to provide inpatient psychiatric services to Medicaid-eligible individuals under the age of 21. PRTFs provide comprehensive mental health treatment to children and youth who — due to mental illness, substance use disorder, or severe emotional disturbance — need treatment that can be provided most effectively in a residential treatment facility. The Medicaid rate paid to PRTFs is typically an all-inclusive daily rate.

Rehab Option

The Rehab Option allows states the flexibility to provide treatment services in the community, such as the child's home or other living arrangement. States have used this benefit category to support services provided in children's residential treatment programs. For example, Vermont established Private Non-Medical Institutions (PNMIs) under this benefit category. PNMIs are "residential child care facilities" that provide: psychiatric/psychological care; counseling services; nursing services; physical, occupational, and speech therapy; and care coordination.

States can use the Rehab Option to pay for the therapeutic components of residential treatment programs, but must finance room and board, and non-treatment supports with Title IV-E funds for eligible children or with state or local general revenue for those who are not Title IV-E eligible.

Potential limitations to Medicaid financing

Under federal law, an Institution for Mental Disease (IMDs) is a facility with 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." Federal financial participation (Medicaid funding) is not available for services provided to an individual under age 21 in an IMD, unless that individual is receiving services from a qualified provider of the Psych under 21 Benefit, such as a PRTF or psychiatric hospital.[1]

Residential treatment facilities with more than 16 beds that are not qualified providers under the psych under 21 benefit could be classified as an IMD. Services provided in such settings then would be ineligible for federal matching funds under the Medicaid program. Determining whether an institution is an IMD is based on "its overall character as that of a facility established and

21ST CENTURY CURES ACT

In December 2016, the 21st Century Cures Act was signed into law. The act requires states to provide the full range of EPSDT services to children in Medicaid who are receiving inpatient psychiatric care at Institutions for Mental Disease (IMDs) (i.e., psychiatric hospitals, psychiatric units in general hospitals, and PRTFs). CMS historically had prohibited states from seeking Medicaid reimbursement for services delivered to children, youth, and young adults in IMDs unless the services were included in the rate paid to the IMD for care, essentially denying necessary non-hospital inpatient behavioral health services to children being treated in IMDs.

According to new guidance, states must make any services under the EPSDT benefit available to children in IMDs if such services "are determined to be needed in order to correct or ameliorate health conditions [and] regardless of whether such services are identified in the child's plan of care." The EPSDT services can be provided by the hospital itself, by a qualified non-IMD provider (e.g., a licensed physical therapist to provide service to address motor delays), and/or a qualified provider in the community not affiliated with or under arrangement with the IMD (e.g., a certified peer support specialist could work with the child and his/her family to prepare for the transition back to home and school, as could a wraparound care coordinator). This provision provides the opportunity to better integrate community-based services and supports, and wraparound care coordination for children in or transitioning from an inpatient psychiatric hospital or PRTF.

maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such."

Child welfare financing

Children, youth, and young adults who are placed outside their home by a state's child welfare agency are disproportionately represented in residential treatment programs compared to other children in Medicaid. Title IV-E of the Social Security Act is an entitlement grant program that supports, among other functions, monthly maintenance payments for the daily care and supervision of eligible children and youth, including those in residential treatment programs. States may use Title IV-E funding for the costs of children in residential treatment programs, including the room and board costs for residential treatment programs that are not affiliated with PRTFs. Under FFPSA, only Qualified Residential Treatment Programs that are accredited and meet a specific set of criteria outlined in FFPSA are eligible to receive Title IV-E maintenance payments.

Reimbursement structures and other considerations

Several reimbursement structures can be used to fund residential treatment and maximize funding available for this service. Some of these options bring together funding from multiple sources and can be paid out in a variety of ways, including traditional fee-for-service or bundled payments.

CONSIDERATIONS FOR JURISDICTIONS TO GUIDE FAMILY FIRST PREVENTION SERVICES ACT IMPLEMENTATION

- How does your state fund residential programs? Are Title IV-E dollars used to support service delivery for child welfare-involved children and youth?
- Is there a way to work with your state's Medicaid agency and with the available funding sources to adjust the residential services continuum that will enhance service quality overall?
- What outcome measures are being evaluated across Medicaid and child welfare related to residential services? Is there a way to align them?
- Does Family First implementation provide an opportunity to use alternative payment models or value-based purchasing arrangements?
- How can Medicaid support specific provisions of Family First implementation, such as the provision of aftercare services and required assessments

- **Braided funding**: Providers in some states use multiple funding streams and "braid" them at the program level. For residential treatment programs that are not PRTFs, many states use a fee-for-service payment model for residential treatment programs where there is a payment for the length of the child or youth's stay, either per diem or per unit of service. Usually, the payment structure is broken down as follows: treatment is billed to the Medicaid agency; room and board is billed to the child welfare agency or another non-federal funding source if the child is not involved with child welfare; and, if there is an education component, it may be billed to the educational department. In Maine, for example, the Office of Child and Family Services pays a room and board rate per occupied bed day, and medical treatment is billed to MaineCare (the state's Medicaid program). Additionally, the Office of Child and Family Services may pay for some treatment that is not otherwise reimbursable under MaineCare. However, this requires prior authorization.
- **Blended funding**: Some states have blended payment models whereby funds go into one "pot" and payments are drawn down from this single source. In New Jersey, for example, existing funds are pooled from mental health, child welfare, Medicaid, and general purpose funds (approved by the Legislature) to finance its children's system of care. From the providers' perspective, the payments appear seamless or blended. However, the state Medicaid agency, supported by a statewide administrative services organization (ASO), tracks fund sources (e.g., Medicaid, Title IV-E) for claiming and audit purposes. The New Jersey Department of Children and Families is responsible for setting the rates for **residential facilities and handling reimbursement, and also is supported by the ASO.**
- **Fee-for-service vs. case rate**: Regardless of whether funds are braided or blended, payments to residential providers may be billed as fee-for-service — a reimbursement for a specific set of activities performed — or as a daily or "case" rate.

- **Rate-setting processes for Medicaid payments**: In many states, the rates for reimbursement and payment are set within the Medicaid agency. But in some states, the Medicaid rates for reimbursement are set outside of the Medicaid agency, such as by a Medicaid managed care organization (MCO) or the child welfare system for eligible children.
- **Impact of managed care**: While state Medicaid agencies make billing codes and associated rates available to MCOs, MCOs are relatively free to establish their own rate structures with their provider networks. In certain circumstances, states may set a rate floor for a particular service. The rates set by MCOs are often considered proprietary and not available to the public.

1. See 42 C.F.R. § 435.1009(a)(2) (noting that FFP is not available for services provided to "individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under §440.160 of this subchapter."); see also CMS, "Requirements of Section 12005 of the 21st Century Cures Act," CMCS Informational Bulletin, June 20, 2018, which notes that one of two exceptions to the IMD exclusion is "inpatient psychiatric hospital services for individuals under age 21, referred to as the 'psych under 21' benefit, furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable conditions of participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a 'Psychiatric Residential Treatment Facility' (PRTF) can be reimbursed (42 C.F.R. § 440.160)."; CMS, "RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance," SMD # 18-011, November 13, 2018, ("FFP also will not be available through these SMI/SED demonstrations for services provided in treatment settings for individuals 21 years of age or younger if those settings do not meet CMS requirements to qualify for the Inpatient Psychiatric Services for Individuals under Age 21 benefit.").

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This technical brief was developed by the Center for Health Care Strategies and Sheila A. Pires as part of a **series designed to help state child welfare agency staff understand the Medicaid landscape, and to coordinate with their Medicaid partners in providing timely and quality health-related services to children and youth in foster care**. *This builds on earlier work by Ms. Pires, Human Service Collaborative, and Beth Stroul, Management and Training Innovations, and complements three other briefs that cover options for ensuring consistent Medicaid eligibility and Medicaid financing for children's residential treatment.*

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