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Leveraging Medicaid to Support Children and Youth Living With Complex Behavioral Health Needs

Framework and Strategies

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About The Commonwealth Fund

The mission of The Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

About John O'Brien and Sheamekah Williams

John O'Brien has more than 30 years of experience in behavioral health systems design, financing, and implementation. He has worked with Medicaid, mental health, and substance abuse authorities in numerous states to develop federal Medicaid waivers, Medicaid state plan amendments, and federal grant applications. His work assists states to increase access to services for children, youth and their caregivers, integrate treatment and primary care, and reduce unnecessary costs by using Medicaid and other sources to support effective systems. He is the subject matter expert for several states in their efforts to implement systems of care for children and families with serious mental health conditions and on community integration strategies for adults with serious mental illness.

Sheamekah Williams is the President and CEO of the Evolution Foundation, which provides resources, support, and technical assistance to families, community coalitions, and children behavioral health service providers in the state of Oklahoma, including community coalition building and technical assistance; coalition training; trauma training; training curriculum development; strategic planning; and liaison services for the Oklahoma Department of Mental Health and Substance Abuse Services and other child serving agencies. She is the immediate past Director of Children, Youth, and Family Services at the Oklahoma Department of Mental Health and Substance Abuse Services, where she was responsible for the administrative oversight and coordination of behavioral health services for children, youth, young adults, and families across the state.

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Leveraging Medicaid to Support Children and Youth Living With Complex Behavioral Health Needs

Framework and Strategies

Table of Contents

Leveraging Medicaid to Support Children and Youth Living With Complex Behavioral Health Needs

Framework and Strategies

Leveraging Medicaid to Support Children and Youth Living With Complex Behavioral Health Needs

Framework and Strategies

Executive Summary

The COVID-19 pandemic exacerbated the already-growing mental health and substance use disorder (SUD) (behavioral health) crisis gripping children and youth in the United States. It has spurred federal, state, and other actions to expand funding and treatment opportunities to improve the behavioral health and well-being of these young people. The crisis is impacting children, adolescents, young adults, and their families and caretakers across all social and demographic levels. Addressing it requires a concerted effort across multiple sectors, including health, education, justice, and child welfare. Medicaid, the largest health insurer for children and adolescents and primary payer of behavioral health care in the United States, can serve as a linchpin for states seeking to improve behavioral health care for children and youth.

This report provides an actionable framework and strategies for how state-level policymakers can use Medicaid and the Children's Health Insurance Program (CHIP) to respond to the behavioral health crisis among children and youth living with complex needs—those who are stuck in emergency departments for days on end, cycling in and out of psychiatric hospitals, contemplating and sometimes attempting or completing suicide, or struggling to remain in school or to find and keep a job. The framework and strategies are rooted in a family- and community-based approach that recognizes children and youth fare best when treated in the context of their families (broadly defined) and communities, as well as when interventions build on their strengths and maximize their choices and autonomy.

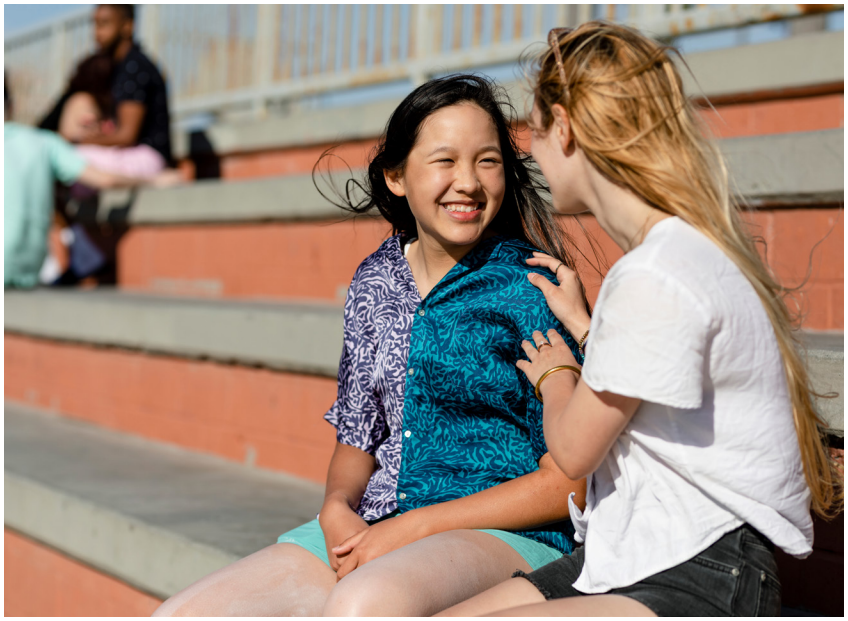
Exhibit 1. Medicaid Strategies for Supporting Children and Youth Living With Complex Behavioral Health Needs

Strategy 1: Establish a Clear Vision and Plan	• **1.1.** Engage leadership across child-serving agencies. • **1.2.** Engage youth and supportive families in the policymaking process. • **1.3.** Leverage data on service utilization, payment rates, workforce, and other key issues. • **1.4.** Include a robust implementation, monitoring, and oversight strategy.
Strategy 2: Expand and Stabilize Medicaid Eligibility and Benefits for Children and Youth Living With Complex Behavioral Health Needs	• **2.1.** Expand continuous eligibility for young people with complex behavioral health needs beyond minimum federal requirements. • **2.2.** Strengthen coverage for former foster youth. • **2.3.** Leverage Medicaid to reduce pressure on families to relinquish custody. • **2.4.** Expand eligibility and coverage for youth involved in the juvenile justice system. • **2.5.** Provide behavioral health services consistent with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to children in separate CHIP programs.
Strategy 3: Strengthen Prevention and Early Intervention in Treatment	• **3.1.** Increase take-up of behavioral health screenings. • **3.2.** Allow children and youth to receive behavioral health services under EPSDT without a diagnosis. • **3.3.** Cover coordinated specialty care for young adults experiencing first-episode psychosis. • **3.4.** Promote integrated primary care. • **3.5.** Strengthen the use of school-based services.
Strategy 4: Establish a Comprehensive, Youth-Specific Continuum of Care for Behavioral Health Conditions	• **4.1.** Ensure crisis services address the unique needs of young people. • **4.2.** Provide intensive home-based services. • **4.3.** Provide intensive care coordination to children and youth with multisystem involvement and/or co-occurring conditions. • **4.4.** Offer respite services to families seeking to help their children remain in the community. • **4.5.** Provide peer support services for youth and their families. • **4.6.** Address young people's health-related social needs. • **4.7.** Strengthen the quality of care in residential treatment settings.
Strategy 5: Ensure Use of Evidence-Based, Community-Defined, and Culturally Responsive Assessments and Practices	• **5.1.** Utilize standardized tools to help determine the appropriate services for young people. • **5.2.** Invest in a culturally diverse behavioral health workforce. • **5.3.** Provide training and support to providers. • **5.4.** Use Medicaid reimbursement strategies to increase access to linguistically and culturally appropriate care.
Strategy 6: Address the Emergency Department Boarding Crisis	• **6.1.** Gather and analyze data on youth boarding in emergency departments. • **6.2.** Prioritize diversion through crisis services and family education. • **6.3.** Permit community-based admission to inpatient facilities. • **6.4.** Encourage active treatment during stays in the emergency department. • **6.5.** Establish bed tracking tools and systems to identify open treatment spots.

Introduction

More than two years after the American Academy of Pediatrics, the Children's Hospital Association, and the American Academy of Child and Adolescent Psychiatry declared a national emergency in child and adolescent mental health, the situation remains alarming.[1] While the COVID-19 pandemic intensified the issue, researchers have been tracking rising rates of mental health issues and substance use disorders (SUDs) among children and youth for years. Today, a steady stream of news articles presents compelling personal stories of children and youth struggling with anxiety, depression, and post-traumatic stress disorder (PTSD), along with data indicating historically high levels of distress among children and youth.

The mental health and SUD (behavioral health) challenges facing children and youth require an urgent, comprehensive response that spans health care, justice, education, housing, poverty, and other social and economic factors. It is no longer enough to take one-off steps such as opening new beds in psychiatric hospitals or launching a hotline; the present situation warrants a comprehensive review of each state's challenges and resources; a structured process for responding that includes the voices of young people and families; and a sustained effort to implement, monitor, and modify changes.



> "Ensuring healthy children and families will take an all-of-society effort, including policy, institutional, and individual changes in how we view and prioritize mental health."
>
> —Dr. Vivek Murthy, United States Surgeon General

For many young people struggling with complex behavioral health challenges, the current response is missing the mark. It offers little of what they need—support addressing social and economic issues (e.g., housing instability, food insecurity, racism, discrimination, and stigma), connections to peers who share their experiences, and providers who truly listen to them and respond to their individual circumstances. Similarly, families often cannot secure the services that their children require and find themselves forced

to repeatedly turn to calls to 911 and visits to the emergency department when in crisis. Even if a child is admitted to an inpatient psychiatric unit, it may only be the beginning of the journey if, as often occurs, the child is discharged without a viable plan for keeping them safe in their community. The parents or caretakers may face stigma and condemnation for being "bad parents," and if the cycle keeps repeating itself, they may be told that the only way to get their child the help they need is to relinquish custody.

Fortunately, the youth behavioral health crisis **can** be addressed, as demonstrated by success stories in some states and the strong and powerful voices of young people themselves. As outlined in this report, the key elements of an effective response include:

- A **comprehensive, cross-agency strategy** for addressing the crisis that integrates the perspectives of youth and families;
- **Stable coverage** for children and youth with complex behavioral health conditions to ensure that they are not churning on and off coverage even as they are working to heal and gain stability in the midst of complex behavioral health challenges;
- A focus on **prevention and early intervention** that helps prevent more serious conditions from emerging;
- A robust continuum of care for children and youth with complex behavioral health conditions, including, but not limited to, intensive home and community-based services, child and youth-specific crisis response services, and flexible funds provided in a respectful and culturally and linguistically appropriate way that is rooted in what an individual child requires; and
- A specific set of **strategies to address the emergency department boarding crisis** to help ensure that children and youth receive services in their homes, schools, and communities whenever possible and that higher levels of care are reserved for clinically appropriate situations in which safety is an issue.

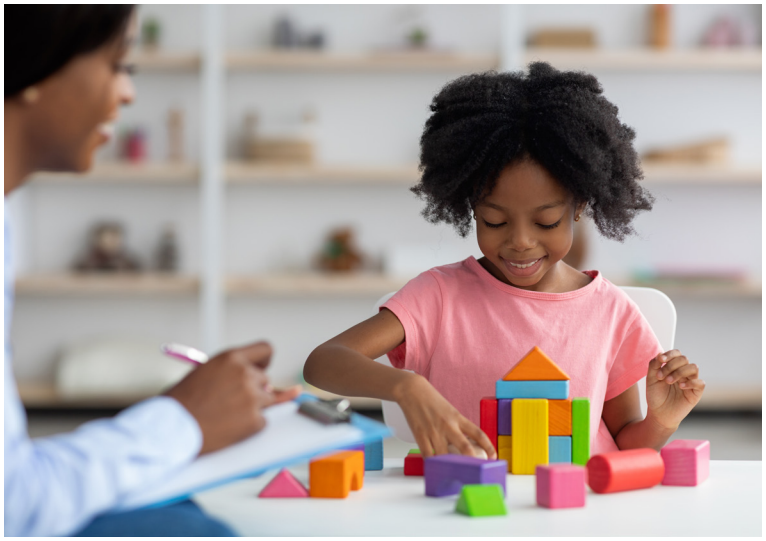
This report focuses on the role that Medicaid and its companion program, the Children's Health Insurance Program (CHIP), can play in such a response. It offers both a framework for how state-level policymakers can work with youth and families to deploy Medicaid and CHIP as part of a broader response to the youth behavioral health crisis, as well as a set of practical strategies for doing so and concrete examples from states. Building on the "systems of care" approach, this report posits that children and youth fare best when public-health-oriented systems offer early intervention and prevention; Medicaid and CHIP are used to provide treatment in—and to strengthen—supportive communities and families (broadly defined);[2] and children and youth are truly listened to and provided with the supports that they say they need. Although this report was prepared primarily for state Medicaid and CHIP policymakers, it may also be of interest to youth activists, families, providers, and advocacy organizations.

"I cannot stress this enough because it's such a basic skill, but [providers] need to listen! Give us real options and let us choose how we want to be helped."

—Ajah (18), Youth Advisory Committee member

Who Are the Children and Youth Living With Complex Behavioral Health Needs?

This report focuses primarily on children and youth living with complex behavioral health needs. These are the young people who end up boarding in emergency departments[3] for days on end, cycling in and out of psychiatric hospitals, contemplating and sometimes attempting or completing suicide, struggling to remain in school or to find or keep a job, or dealing with housing or food insecurity. Many have formal diagnoses such as bipolar disorder, borderline personality disorder, SUD, PTSD, depression, and anxiety, while others do not but face the same issues functioning in daily life.



Box 1. A Note on State Examples

When this report cites examples of states using promising strategies, it is not intended to suggest that any given state is a model across all elements of an ideal system. Even states that are well along in implementing many of the most effective strategies have other laws and policies in place that exacerbate the behavioral health challenges faced by young people. For example, some leading-edge states on behavioral health have adopted bans on access to medical care for transgender youth, limited their ability to participate in sports and other activities, and/or restricted their use of public restrooms, exacerbating the challenges faced by lesbian, gay, bisexual, trans, queer or questioning, intersex, asexual, and more identities (LGBTQIA+) youth who already often are contending with stigma and lack of family acceptance.

Box 2. Systems of Care

Many of the principles and Medicaid strategies described in this report build on the systems-of-care (SOC) approach to addressing behavioral health issues among children and youth. SOC calls for establishing a coordinated network of community-based services and supports for children with multiple, complex needs. It involves collaboration across stakeholders and systems, including physical health, mental health, child welfare, juvenile justice, and other social services systems. Along with cross-system collaboration, SOC emphasizes individualized, strengths-based practices; cultural competence; and full participation of youth and families in the decision-making process.[4]

In many instances, these children and youth are "multisystem" children, caught up in the behavioral health system, child welfare system, juvenile justice system, or special education, and/or are living with intellectual and developmental disabilities (I/DD). The reasons they are in the "deep end" of the behavioral health system can vary: they may be grappling with socioeconomic disparities; have faced exposure to abuse, neglect, or trauma; have been born with a genetic predisposition to mental illness or addiction; experienced bullying and harassment; and/or face stigma and discrimination due to their race, ethnicity, immigration status, body weight, disability status, gender identity and/or expression, or sexuality, among other factors. By definition, they are survivors, often experiencing more hardship by the time they reach their teens than many people face over the course of a lifetime. Additional data about the youth behavioral health crisis is available in Appendix 4.

"When I first started going to my primary care physician more consistently, they were assuming things about me because I am plus size, and were neglecting things that I feel like were very important. ... It made it very hard for me to actually get the help that I needed, because I had to spend so much time advocating for them to listen to me in the first place."

—Kris (29), Youth Advisory Committee member

Box 3. Behavioral Health Challenges Among Children and Youth Who Are LGBTQIA+

While many LGBTQIA+ youth thrive, especially if they have family, peer, and community support, they also have higher rates of behavioral health challenges due to the discrimination and stigma that they face. The rapid spread of state laws that ban gender-affirming care for transgender youth, restrict their participation in activities, and compromise their ability to safely use public restrooms is exacerbating behavioral health challenges among LGBTQIA+ youth and the difficulties they face in securing safe treatment options.[5] The rate of suicidal thoughts among LGBTQIA+ young people is trending upward; in 2023, more than 4 in 10 (41%) LGBTQIA+ youth surveyed seriously considered attempting suicide in the past year, and nearly 1 in 5 transgender and nonbinary youth made a suicide attempt.[6] Even so, the majority (56%) of LGBTQIA+ youth who wanted mental health care were not able to get it.[7]

Why Focus on Medicaid?

While the COVID-19 pandemic shed light on the ongoing crisis and resulted in new policies directed at strengthening youth behavioral health care, there is a critical need for a comprehensive approach to supporting children and youth living with complex behavioral health needs. No single program or initiative at the federal, state, or community level will provide "the solution," especially because many of the issues that contribute to behavioral health challenges among young people come back to foundational social and economic issues. State Medicaid and CHIP programs, however, have a critical role to play.

- **Medicaid and CHIP are significant sources of coverage for children and youth.** Medicaid and CHIP cover nearly 4 in 10 children and youth from birth through age 18 in the United States.[8] While the country currently is in the midst of a decline in Medicaid enrollment following the end of a national policy that kept Medicaid members enrolled without interruption through March 31, 2023, during the COVID-19 public health emergency, together, Medicaid and CHIP continue to serve as the single largest source of coverage for children and youth in the United States.
- **Medicaid plays a particularly expansive role for children, youth, and young adults with involvement in the foster care system.** Medicaid requires states to cover any children and youth who are currently in foster care, as well as after they age out of the system through age 26 if they were enrolled in Medicaid on their 18th birthday. In addition, children and youth who are adopted out of foster care with an adoption assistance agreement can continue to receive Medicaid. It is estimated that nearly 80% of children and youth in foster care are living with a significant behavioral health issue.[9]
- **Medicaid's EPSDT benefit establishes a right to comprehensive behavioral health services for children and youth under age 21.** Children and youth enrolled in Medicaid up to age 21 are entitled to the EPSDT benefit, which provides comprehensive and preventive health care services. Under EPSDT, states must furnish all "Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines."[10] This includes appropriate preventive, mental health, SUD, developmental, and specialty services, regardless of whether these services are covered for adults. Notably, services need only "ameliorate," or make better, a child or young person's condition, not necessarily restore them to a prior level of functioning or fully remediate their condition, as often is required by commercial plans.[11]
- **Despite the strong foundation it provides, major gaps remain in Medicaid coverage of behavioral health services.** Even with EPSDT, children and youth in Medicaid continue to face major issues securing appropriate services for complex behavioral health conditions. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), more than half of children and youth in Medicaid with a serious emotional disturbance that interferes with their ability to participate in school, get along with their peers, and get along with family members do not receive any mental health services.[12] Even in states that cover a comprehensive set of behavioral health services, youth and families often cannot secure the services they need due to a dearth of available providers, long delays in securing appointments, and other access barriers.[13]

- **States are facing growing pressure to use Medicaid more effectively in response to the behavioral health crisis.** Several states have been sued and lost in court for failing to provide required behavioral health services to children with complex needs, in violation of the EPSDT requirement and other federal laws such as the Americans with Disabilities Act.[14] In addition, the Department of Health and Human Services (HHS) is expected to release final regulations governing requirements for ensuring access to Medicaid benefits in late 2023 or 2024, creating more expansive and specific federal requirements to address access issues across the board, including with respect to behavioral health services.

In sum, Medicaid and CHIP have broad reach and play a critical role for children and youth living with complex behavioral health challenges, but there is more that these programs can do. As highlighted by the Centers for Medicare & Medicaid Services (CMS) in a series of guidance documents, states have significant flexibility to use Medicaid and CHIP to provide a comprehensive set of behavioral health services to children, youth, and their families. In August 2022, for example, the Center for Medicaid and CHIP Services (CMCS) issued guidance that details existing flexibilities and examples of how states can use Medicaid and CHIP funding, alone or in combination with other federal funding sources, to support children and youth living with behavioral health conditions.[15] Additional examples of recent federal action to address the youth behavioral health crisis are available in Appendix 4.

Methodology

This report is based on a literature review, a review of Medicaid and CHIP regulations and guidance, and an analysis of state strategies to improve care for children and youth living with complex behavioral health needs. In-depth case studies of three leading states are included in Appendix 2. A detailed review of Medicaid and CHIP authorities used for behavioral health and health-related social needs (HRSNs) is included in Appendix 5.

Two advisory committees, a National Advisory Committee and a Youth Advisory Committee, provided insight and expertise throughout the process. The National Advisory Committee was comprised of national and state experts, policymakers, behavioral health care providers, and representatives of family and youth. The Youth Advisory Committee, established and led by Youth MOVE (Motivating Others through Voices of Experience) National, included ten young people ages 18 to 29 with lived experience in the behavioral health, juvenile justice, and/or foster care systems who shared what has worked, what has not, and where change is needed. A list of National Advisory Committee and Youth Advisory Committee members is included in Appendix 3.

Guiding Principles

The strategies presented in this report are grounded in a set of guiding principles. These principles reflect a commitment to developing a comprehensive and coordinated response to addressing the youth behavioral health crisis, listening to youth and family voices throughout the policymaking and care planning processes, and ensuring comprehensive care that spans medical and social supports is delivered in the least restrictive setting.

- **Urgent, coordinated response.** The magnitude of the behavioral health crisis among children, youth, and young adults requires an urgent, coordinated response from Medicaid leaders and their partners. It is the responsibility of the Medicaid agency and its sister agencies—not children, youth, and their families—to align resources and planning across the multiple systems that serve young people.
- **Youth- and family-centered.** Both the policymaking and care planning processes should center on the child's or youth's voice and include their families. All services and supports identified for each child or youth and family should be individualized and responsive to reflect their unique identities and cultures and set of strengths, values, and challenges.
- **Least restrictive family and community-based care settings.** Services and supports should take place in the most inclusive, most responsive, most accessible, most affirming, and least restrictive settings possible that safely promote child and family integration into home and community life. Institutional settings are only used short term, where clinically appropriate, if there are no safe community alternatives due to a child's behavioral health condition and/or identity.
- **Access to health-related social supports like transportation, housing, food, education, and other social supports.** Children, youth, and their families require access to a broad and flexible array of community-based services and supports to address their emotional, social, educational, and physical needs. They may need assistance with transportation, housing, food, education, and other basic needs—not just "traditional" behavioral health services.

Strategy 1: Establish a Clear Vision and Plan

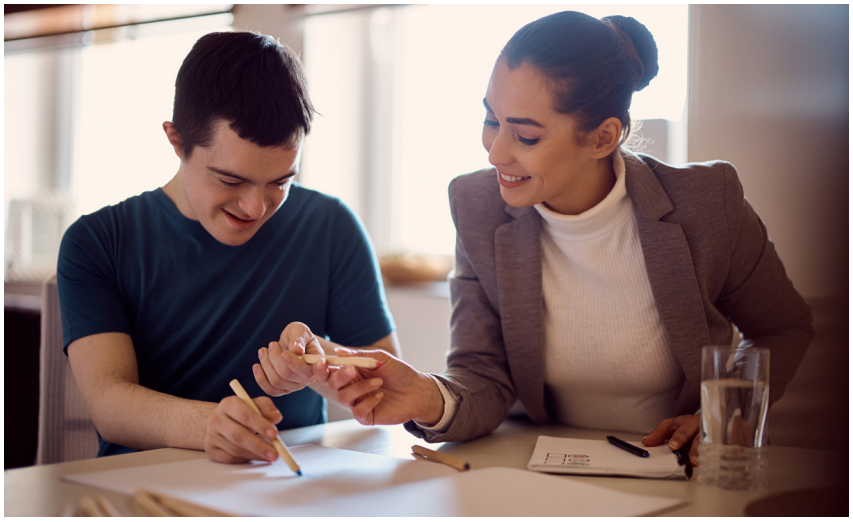
The mental health and SUD challenges facing children and youth require an all-hands approach rooted in a clear vision and plan. States can bring together the many stakeholders needed to address the youth behavioral health crisis, tap the wisdom and insights of young people and families with lived experience, and ensure their efforts are informed by data and analysis. Practically, a clear vision and plan to address the crisis allows states to maximize Medicaid funding and direct limited state and federal funding to top priorities.

> "This crisis is too deep and complex for any state or organization to solve on its own. It requires partnership from everyone, especially the folks on the ground in our communities—young people, parents, caregivers, educators as well as business, community, and faith-based leaders to work together."
>
> —Phil Murphy, New Jersey Governor and Chair, National Governors Association[16]

New Jersey offers a powerful example of the importance of creating a clear vision and plan. In 2000, the New Jersey Department of Human Services published a "Children's Initiative Concept Paper." The paper established a blueprint for how the state should serve children and youth living with complex behavioral health needs and multisystem involvement. Developed by a coalition of child-serving agencies in collaboration with families, the paper operated as a guide for New Jersey's policymakers, contributing to far-reaching changes that now serve as a model for other states around the country.[17]

1.1. Engage leadership across child-serving agencies.

To establish a clear vision and plan, it is important to convene the many state agencies charged with serving children and youth living with complex behavioral health needs (along with youth and families themselves, as discussed below). Otherwise, it is easy for each agency to operate in a silo, meeting its discrete obligations without considering whether it is duplicating efforts or missing critical supports.



Governors often are particularly effective at prompting cross-agency collaboration. For example, in 2019, **Ohio** Governor Mike DeWine established a statewide planning process to improve care for children and youth living with complex behavioral health needs. It led to development of the Resilience through Integrated Systems and Excellence (OhioRISE) initiative. OhioRISE created a specialized Medicaid managed care plan for children and youth with complex behavioral health and multisystem needs that coordinates their needs across multiple domains and includes flexible funding and family supports.[18,19]

While the creation of a cross-agency initiative can require significant time and resources, states can use Medicaid administrative funding and Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funding to help support such an initiative. States may also be able to leverage existing planning forums; for example, as part of the Mental Health Block Grant process, states are already required to operate a stakeholder group to inform their decisions.

> "So many of us don't know about the resources we are eligible for and what programs exist out there. We need to make sure programs and resources are being allocated to those who need them. I'm just now finding out about things I will soon no longer be eligible for."
>
> —Youth Advisory Committee member

Additional Resources and Examples:

- **Illinois.** In March 2022, Governor J.B. Pritzker of Illinois launched the Children's Behavioral Health Transformation Initiative, which pulled together the Illinois Departments of Human Services, Healthcare and Family Services, Children and Family Services, Juvenile Justice, and Public Health, and the State Board of Education to prepare a comprehensive blueprint for reform with assistance from Chapin Hall Center for Children at the University of Chicago.[20]
- **National Governors Association Blueprint for Reform.** Between October 2022 and May 2023, the National Governors Association convened close to 500 stakeholders to discuss the current state of youth mental health systems. As a result of the discussions, *Strengthening Youth Mental Health: A Governor's Playbook* was published in 2023 to provide state leaders with actionable cross-sector, collaborative solutions to address the youth behavioral health crisis.[21]

1.2. Engage youth and supportive families in the policymaking process.

Without engaging youth and families in the policy design and implementation process, states risk missing what is happening on the ground and what will make a difference in the lives of young people. As the youth who served on the Youth Advisory Committee for this report highlighted, there is a profound mismatch in the current system between what young people need and what is available. Rather than traditional talk therapy or higher levels of care, Youth Advisory Committee members reported that the most effective interventions connect them with peers who have similar experiences, allow them to be part of community-building

activities, and offer culturally appropriate and creative therapeutic modalities (e.g., integrating art, music, and writing into therapy). Children and youth who are part of groups that have experienced collective trauma, such as indigenous youth, may benefit from participating in community events or participating in traditional healing practices.

States can use a variety of processes to meaningfully engage young people and family members. Developing a systematic approach to engaging young people, such as a standing advisory committee comprised entirely or mostly of people with lived experience, will work better than one-off efforts to engage youth and families. States should also avoid expecting a single young person to represent all youth with significant behavioral health conditions.[22] Under any scenario, young people and their families will need compensation and support for their participation, such as monetary compensation, access to childcare, and training on their expected roles. **Oregon**, for example, has established an Advisory Council for its systems-of-care work that includes youth members. Advisory council members, including young people, are provided with the same per diem reimbursement rate as members of Oregon's Legislative Assembly (approximately $76 as of August 2023) as long as their income is below $50,000 a year (or $100,000 if filing taxes jointly), as well as reimbursed for any travel costs.[23]

Given that it can be difficult to relive challenging experiences with the behavioral health system, states also may want to consider securing expert facilitation and support for youth and families.

> "[Policymakers] should place more young people in the rooms to be an active part of the decision-making process, and respect them as experts and knowledgeable individuals."
>
> —Kris (29), Youth Advisory Committee member

States have several ways to use Medicaid funds to support youth and family engagement. All states can use Medicaid administrative dollars for this purpose, which are available at a 50% matching rate. Additionally, if a state operates a managed care delivery system, it can use its contracts with managed care organizations to require them to support member advisory councils that include families and young

people with lived experience, including through offering compensation, training, and other forms of support. States automatically receive their regular Medicaid matching rate for these payments to managed care organizations, which varies from a low of 50% to a high of 77%, depending on the state.[24]

Additional Resources and Examples:

- **Youth MOVE National and Local Chapters.** Originally founded in 2007 as a program within the National Federation of Families for Children's Mental Health, Youth MOVE National is a nationally respected trans- and youth-led, chapter-based organization dedicated to improving services and systems for young people and supporting growth and development by amplifying the voices of youth with lived experience within child- and youth-facing systems. They currently operate as a SAMHSA-funded technical assistance center and have more than 50 chapters nationwide, each focusing on the individual needs of their community or state as decided by youth in that chapter.[25] Youth MOVE can serve as a powerful partner to policymakers who are committed to integrating the perspective and lived experiences of young people into their policy design process by providing facilitation, helping to identify youth with lived experience, and more.

  As noted in the Methodology section, Youth MOVE National served as a partner in preparing this report.

- **Ohio.** As part of the development of OhioRISE, Ohio established an advisory council and work groups to offer advice on program design, provide clinical and programmatic input, and review rule development and changes. Advisory Council members include youth and families with lived experience, service providers, and other system partners.

1.3. Leverage data on service utilization, payment rates, workforce, and other key issues.

Ideally, a state's vision and plan will be rooted in data that helps identify: Who are the children and youth living with complex behavioral health needs? To what extent are they receiving the services that they should be? How much is the state relying on residential treatment versus home- and community-based services (HCBS)? If feasible, a state would compile data from all child-serving agencies. **Oregon**, for example, gathers data from a range of child-serving agencies to populate a data dashboard that allows it to monitor progress on key metrics. Stakeholders can use the dashboard to understand how many children and youth are visiting emergency departments for behavioral health reasons, where they live within the state, and how many of them are engaged with multiple child-serving agencies.

Even if a cross-agency analysis is not possible, states can still gather data on the demographic characteristics of children and youth in Medicaid living with complex behavioral health needs, as well as service utilization rates for HCBS compared to in-state and out-of-state residential and inpatient care. They can use data to:

- Examine the scope and scale of their provider networks for behavioral health services, a critical question given persistent concerns about access to services and workforce shortages;
- Evaluate how their Medicaid reimbursement rates for behavioral health services compare to those of other payers;

- Examine whether they limit the ability of providers to bill for physical and behavioral health services provided to the same patient on the same day; and/or
- Limit the behavioral health codes that primary care physicians can use.[26]

States may also want to explore if they should make acuity adjustments to reimbursement rates for providers who see children and youth with particularly complex needs, including those with co-occurring I/DD or physical challenges, reflecting the need for longer visits and/or more specialized care.

"Feedback from providers reflects that payment for mental and behavioral health services does not reflect the difficulty of the work performed by these providers. For example, I am paid better for treating a wart that takes 5 minutes than I am for spending an hour talking to a family with a suicidal child."

—Dr. Sandy Chung, President, American Academy of Pediatrics, before the U.S. House of Representatives Committee on Energy and Commerce, April 2022[27]

Additional Resources and Examples:

- **Toolkit on Conducting Data Analysis.** With support from SAMHSA, the Commonwealth Fund, and others, the Center for Health Care Strategies produced a toolkit in 2018 that states can use to evaluate utilization of services among children and youth living with complex behavioral health needs, as well as offer insight into the characteristics of children receiving such services.[28] While it may require some updating, the resource provides a strong foundation that states can use to summarize utilization and costs associated with behavioral health services, illuminate variation in service use by state payment and financing arrangements, and profile the burden of behavioral health conditions.[29]
- **Ohio.** Ohio worked closely with the Advisory Council to conduct a transparent review of rate assumptions for evidence-based services offered through OhioRISE and adjust reimbursement rates accordingly. Key services that were reviewed by the Advisory Council included intensive care coordination, intensive home-based services, and Mobile Response and Stabilization Services (MRSS).[30]

1.4. Include a robust implementation, monitoring, and oversight strategy.

A state's vision and plan could include an implementation strategy and approach to monitoring outcomes over time. This strategy might include technical assistance and support for providers (see Strategy 5.3.), as well as performance metrics to measure the quality and effectiveness of their strategy and hold the state, providers, and managed care organizations (where applicable) accountable.

Ohio, for example, has adopted quality metrics to evaluate the effectiveness of its OhioRISE plan to provide care to children and youth with complex behavioral health conditions through a specialized managed care plan).

Box 4. Measuring Quality of Services for Children and Youth With Complex Needs—Sample Measures From OhioRISE[31]

In its contract with Aetna, the plan that operates OhioRISE, Ohio requires reporting on over two dozen measures. These metrics allow the state to monitor the experiences of young people with the care they receive, the effectiveness of the plan in reducing out-of-home placements, and many other key topics. The state has reserved full discretion to establish minimum performance standards, incentives, and withholds for any or all of the measures, which include measures such as:

- Self-reported satisfaction of young people with services;
- Rates of out-of-home placements (in-state and out-of-state);
- Length of stay in psychiatric hospitals and psychiatric rehabilitation treatment facilities;
- Foster care placement disruptions due to behavioral health;
- Emergency department utilization rates;
- Initiation of and engagement with SUD treatment; and
- Access to a range of physical health, mental health, and dental services.

Box 5. Using Managed Care Payment Strategies to Meet Specified Contract Goals

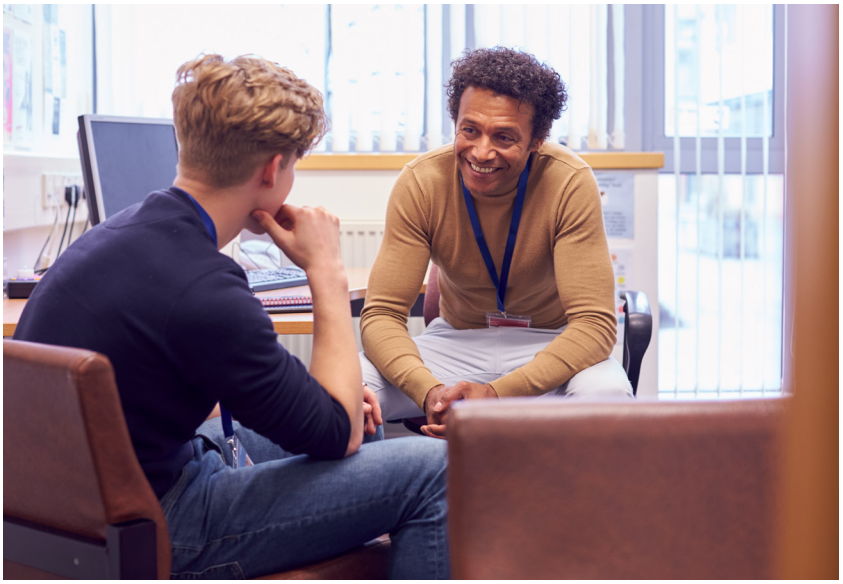
Under federal Medicaid rules, states can use incentive payments to provide managed care organizations with additional funds—above their capitation payments—to reward them for meeting goals established in their contract.[32] These additional funds can equal up to 5% of a plan's capitation revenue, an amount that, depending on the state, can total tens of millions of dollars.

Similarly, states can use withhold arrangements under which a share of a managed care organization's capitation payment is withheld unless and until it meets specified requirements.[33] As with incentive payments, a state could establish a withhold aimed at ensuring performance in delivering care to children and youth living with complex behavioral health needs. Unlike incentive payments, however, states must ensure that the amount they are paying plans in capitation payments—net of any portion of the withhold that is not reasonably achievable—is actuarially sound. Both withhold and incentive payments must be linked back to a state's quality strategy for managed care.

Strategy 2: Expand and Stabilize Medicaid Eligibility and Benefits for Children and Youth Living With Complex Behavioral Health Needs

For children and youth with complex behavioral health conditions, it is particularly important that they have long-term, steady coverage that covers a comprehensive set of services. By expanding Medicaid and eliminating unnecessary churn, states can promote continuity in care, reduce medication interruptions, support strong therapeutic relationships, and connect young people with complex behavioral health needs to resources that address social and economic issues that affect their health and well-being.

> "I used to have Medicaid but now I don't apparently, and I'm not sure why, because I should still qualify."
>
> —Youth Advisory Committee member



In general, most Medicaid members, including children and youth under age 19, are eligible based on their family's income level, but federal lawmakers have also taken steps to establish Medicaid eligibility categories that are specifically designed for children and youth living with complex needs. In particular, there are specific eligibility categories for children and young people affected by foster care and, as a result of the Consolidated Appropriations Act of 2023, new coverage requirements and options for children and youth in the juvenile justice system (see Strategy 2.4.). A review of the Medicaid and CHIP eligibility pathways available to children and youth living with complex behavioral health issues is available in Appendix 4.

Even with these federal requirements and options, children and youth with complex behavioral health needs still fall through the cracks. They may be eligible for Medicaid but not consistently enrolled due to paperwork barriers or changes in their living situations. Children in foster care often move across states as they are sent to different homes or sometimes return to their families, which can result in coverage disruptions. Finally, eligibility and service access issues may leave families in the untenable position of having to relinquish custody of their children to enable them to secure access to services.

2.1. Expand continuous eligibility for young people with complex behavioral health needs beyond minimum federal requirements.

Under the Consolidated Appropriations Act of 2023, states must provide 12 months of continuous eligibility to all children who are eligible for Medicaid or CHIP beginning January 1, 2024. Some states, however, are taking this requirement further and providing multiple years of steady coverage using Section 1115 demonstration authority.

Oregon, for example, is expanding Medicaid for young adults up to age 26 with income levels up to 300% of the federal poverty level (FPL) if they have significant behavioral health or other special needs. These young adults will be provided with the full EPSDT benefit and a range of health-related social need services (e.g., short-term post-hospitalization housing, nutritional services).[34] Similarly, **Massachusetts'** Section 1115 demonstration allows it, among other things, to provide two years of continuous coverage for children, youth, and adults who are leaving incarceration or who have unstable housing.[35] Finally, **Oregon** and **Washington** have secured Section 1115 demonstrations to provide continuous coverage up to age 6 for all Medicaid and CHIP children, not just those with complex conditions.[36]

2.2. Strengthen coverage for former foster youth.

At a minimum, states must extend Medicaid eligibility up to age 26 to former foster youth who were enrolled in Medicaid on their 18th birthday, but some states are taking additional steps to strengthen coverage for children and youth involved in the foster care system. CMS guidance released in December 2022 clarifies that states can seek Section 1115 demonstration authority to cover former foster youth who aged out of foster care in another state and to enroll former foster youth in Medicaid without first screening for eligibility under other groups.[37,38]

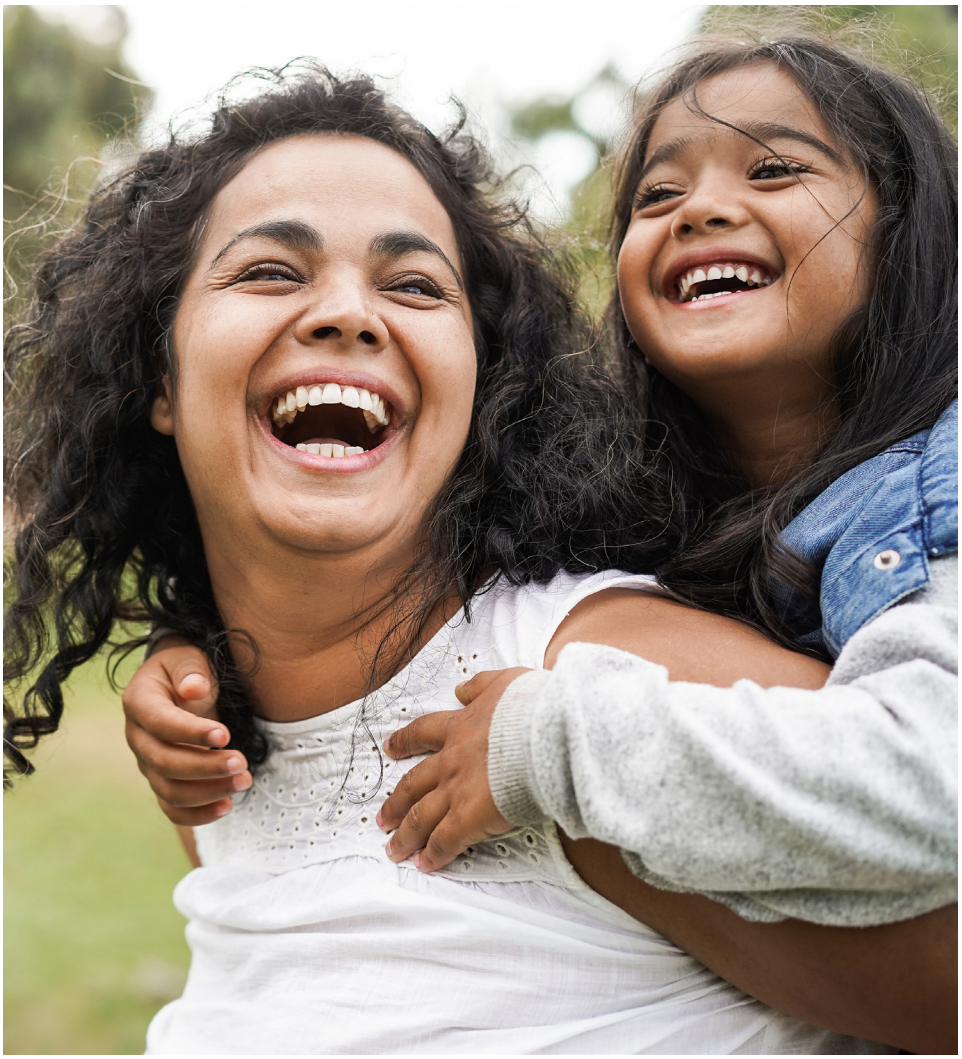
Arizona, for example, is seeking a Section 1115 demonstration to eliminate a standard requirement that former foster youth must annually document that they have applied for benefits from other programs to retain coverage until age 26. If approved, it would effectively make coverage continuous for former foster youth from age 18 up to age 26.[39]

In addition, 11 states, including **California, Georgia, and Pennsylvania**, have approved Section 1115 demonstrations to cover former foster youth from all states, not just those who were in that state's custody when they turned 18.[40,41]

2.3. Leverage Medicaid to reduce pressure on families to relinquish custody.

In the late 1990s and early 2000s, several national- and state-level reports documented the issue of families relinquishing custody of their children to the state to secure services for them. Surveys of families affected by this situation indicate that parents face shame and stigma, lose access to medical information and input in decision-making about their child's care, and, depending on the state, may be charged with abuse or neglect and placed on a child abuse registry. Relinquishment is almost always the last resort for a family. Often, a family only reaches this point after multiple treatment efforts have proven ineffective, they cannot secure the help they need to keep their child at home (e.g., intensive HCBS), and the adults in the family find themselves unable to work, sleep, or attend to their other children. A serious threat to another child in the family often seems to tip a parent into considering relinquishment, even if they previously thought it would never be an option.

In the early 2000s, several states took action, and the "custody for care" problem receded from the mainstream policy agenda. However, families are now increasingly reporting that they face pressure to relinquish custody to secure services. The extent to which relinquishment happens remains unknown, but the National Federation of Families, a national advocacy group that supports families with children living with complex behavioral health needs, reports a significant increase beginning in 2020 with the COVID-19 pandemic and continuing through the summer of 2023, driven in part by sharp workforce shortages that have made it difficult or impossible for families to secure services.



States can help address this issue by establishing or expanding HCBS waivers for young people living with serious emotional disturbance. HCBS waivers allow states to cover intensive home-based services not typically covered by private insurance or even in a state's Medicaid state plan.[42] To help families who otherwise earn too much to qualify for Medicaid, states can decide that they will evaluate HCBS eligibility based only on the child's income and assets—typically negligible—rather than that of all family members. Nine states[43] around the country, including **Texas**[44] and **Wyoming**,[45] have taken advantage of HCBS waivers to expand eligibility for children and youth with serious emotional disturbance. Appendix 5 includes a more technical description of the waiver authorities available to extend HCBS services to children and youth with complex behavioral health conditions.

While an important step, even families enrolled in HCBS waivers continue to report being pressured to relinquish custody as a means of accessing services, highlighting that Medicaid eligibility alone is not sufficient to address the problem. As discussed in Strategy 4, states also need to address the breadth and accessibility of Medicaid services.

Additional Resources and Examples:

- **Findings and Strategies to Address Custody Relinquishment.** In 2018, the National Technical Assistance Network for Children's Behavioral Health prepared a presentation for SAMHSA outlining current findings and strategies to address custody relinquishment to obtain children's behavioral health services.[46] The presentation describes frequently cited reasons families relinquish custody and strategies states can use to directly address custody relinquishment, including through expanding the availability of HCBS.

2.4. Expand eligibility and coverage for youth involved in the juvenile justice system.

Federal lawmakers are increasingly looking for ways to provide services to youth who are incarcerated despite the "inmate exclusion," a long-standing provision of the Social Security Act that precludes Medicaid from paying for services provided to an individual while they are incarcerated. Federal law now requires states to keep young people enrolled in Medicaid while they are incarcerated, even though they cannot receive Medicaid-funded services, with limited exceptions.[47] Beginning in January 2025, federal law will require states to provide some services to incarcerated youth in the 30-day period prior to their release, namely screening and diagnostic services, including for behavioral health, and targeted case management services. Congress also gave states the option to claim Medicaid and CHIP reimbursement for all services—not just screening, diagnostic services, and targeted case management—provided to youth in carceral settings pending disposition of charges (i.e., before they are brought to trial or enter a plea bargain). Since the vast majority of youth in detention centers are pending disposition of charges—in 2017, 63% of youth were detained pending disposition—this could present a significant opportunity for interested states.[48]

2.5. Provide behavioral health services consistent with EPSDT to children in separate CHIP programs.

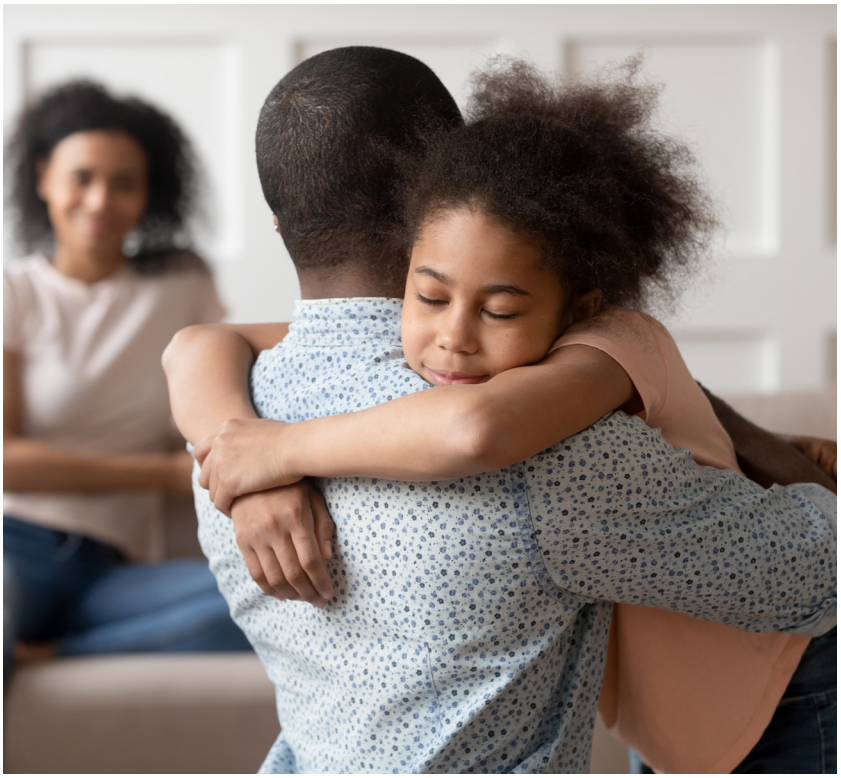
CHIP allows states to further expand Medicaid for low-income children, establish a separate CHIP program, or adopt a combination of the two strategies. As of March 2023, approximately 7 million children are enrolled in CHIP. About 4 million of those receive coverage through their state Medicaid programs, while the remaining 3 million are covered through a separate CHIP program.[49]

Historically, states were not obligated to cover any behavioral health benefits as part of separate CHIP programs; however, with passage of the SUPPORT Act of 2018, states are now required to cover mental health and SUD services "necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders in a culturally and linguistically appropriate way."[50] Even with these changes, separate CHIP programs still do not necessarily cover the full array of behavioral health services required by EPSDT. By converting separate CHIP programs to a CHIP-financed Medicaid expansion, states can provide children with coverage that includes EPSDT.

Even if a state is not able to convert its separate CHIP program to Medicaid, it can still establish EPSDT as the benefit standard that applies in separate CHIP programs, including for behavioral health services. For example, **Washington's** separate CHIP program, Apple Health for Kids, extends all Medicaid services, including EPSDT services, to children covered through its separate CHIP.[51]

Strategy 3: Strengthen Prevention and Early Intervention in Treatment

Prevention and early intervention strategies promote health and well-being by averting the onset of or lessening the progression of a child or youth's behavioral health needs. Intervening early in a child's life can protect them from experiencing problems later in adolescence or adulthood, such as criminal justice involvement, employment instability, and chronic health conditions. States, the federal government, pediatric providers, and other stakeholders are increasingly recognizing that Medicaid and EPSDT serve as key levers to promote the behavioral health of children and youth, as well as that schools and primary care providers are particularly well-positioned to serve as strong prevention and early intervention settings.



As emphasized by CMS in guidance issued in August 2022, EPSDT establishes robust requirements for the prevention, screening, and assessment of mental health and SUD issues along with treatment.[52] Consistent with CMS guidance, strategies that states can adopt to improve prevention and early intervention for children and youth include improving take-up of behavioral health screenings, allowing children and youth to receive behavioral health services without a diagnosis, promoting integrated primary care, and strengthening the use of school-based services.

> "About 75% of mental illness has an onset before age 25. About 50% of mental illness has an onset before age 14. So, we need to respond to this with the urgency it deserves."
>
> —Dr. Thomas Insel, Former Director, National Institute of Mental Health

3.1. Increase take-up of behavioral health screenings.

Consistent with the American Academy of Pediatrics recommendation that evidence-based screening tools be used to identify behavioral health needs of children and youth, state Medicaid programs can require the use of specific evidence-based behavioral health tools during well-child visits. As part of its federal settlement of a class-action EPSDT lawsuit, **Massachusetts**, since 2007, has required primary care providers to screen children and youth under 21 for behavioral health and developmental issues at well-child visits or upon parent request, using a validated screening tool from a list provided by the state. To ready providers, the state distributed information notices to primary care providers and Medicaid members, established regional educational forums for providers, and offered free telephone consultations with physician-screening experts. Critically, the state also established reimbursement rates for each screening conducted, as well as for additional evaluation and management time used for a positive screen.[53]

3.2. Allow children and youth to receive behavioral health services under EPSDT without a diagnosis.

Historically, state Medicaid programs have required children and youth to have a behavioral health diagnosis before they can receive behavioral health treatment. In recent years, CMS has encouraged states to remove diagnosis requirements for the provision of key behavioral health services that might prevent the development of a significant condition and avoid labeling a child unnecessarily, a strategy that is particularly important for young children and even infants and toddlers. For example, **California** covers evaluation and individual, group, and family therapy for individuals, including children and youth who do not have behavioral health diagnoses. Children and youth who are at "high risk" for behavioral health conditions based on exposure to significant trauma, have involvement in the child welfare or the juvenile justice system, or have experienced housing insecurity can access more specialized behavioral health services without diagnoses.[54] Since 2018, **Colorado** also has not required a behavioral diagnosis for the provision of behavioral health therapy in the primary care setting. Behavioral health providers can bill Medicaid for short-term therapeutic services delivered in the primary care setting (up to six visits per year using a set of specific codes).[55]

A variation of this strategy is to adopt the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5), a developmentally based system for diagnosing mental health and developmental disorders in infants and young children. As of 2023, only **15 states** require or recommend use of the DC:0-5.[56]

3.3. Cover coordinated specialty care for young adults experiencing first-episode psychosis.

For older children and youth, state Medicaid agencies can cover coordinated specialty care (CSC), a team-based, evidence-based service for children, youth, and young adults experiencing first-episode psychosis (FEP). CSC for FEP is more effective at helping an individual reach their health, education, and work goals than other courses of treatment following FEP.[57] The core set of services includes psychotherapy, medication

management, family supports and education, case management, supported education, and supported employment. A growing number of CSC for FEP programs are also providing primary care coordination, peer support services, and supportive housing.[58]

States often use SAMHSA Mental Health Block Grant funding to cover CSC, but some rely on Medicaid funds to cover a significant portion of the costs.[59] **Ohio** and **New York**, for example, use Medicaid to fund 41% (Ohio) and 24% (New York) of the cost of their CSC for FEP programs.[60] **Washington** recently adopted a bundled case rate for providing CSC for FEP and anticipates that it will be able to cover more than 70% of costs out of Medicaid and other public insurance programs. To obtain Medicaid financing for a fuller set of CSC for FEP services, state Medicaid agencies may need to use multiple coverage authorities, including the Medicaid state plan and waivers.

3.4. Promote integrated primary care.

Behavioral health concerns are often raised first in primary care settings and account for more than half of pediatric primary care visits.[61] Integrating pediatric primary care practices helps states and communities increase prevention and early identification of emerging behavioral issues in a manner that reduces the stigma associated with behavioral health treatment. "Behavioral health integration" refers to a team of primary care and behavioral health providers working together to provide person and family-centered care, which can occur across a spectrum, starting with coordination and communication and progressing to truly integrated care. To increase the delivery of integrated care among child and youth primary care providers, state Medicaid programs can employ the following strategies:

- **Interprofessional Consultations.** States can cover interprofessional primary care consultations with behavioral health specialists consistent with CMS guidance released in January 2023 that allows states to reimburse for interprofessional consultations to support the care of a Medicaid enrollee even when they are not present.[62] As the guidance highlights, interprofessional consultations are critical for improving access to behavioral health providers specializing in children and youth. The presence of state psychiatric telephone consultation programs makes it more likely that pediatric and other primary care providers will feel confident to start integrating behavioral health services into practices.

- **Team-Based Models.** States can pay for team-based, evidence-based primary care integrated models like the Collaborative Care Model (CoCM) and the Massachusetts-based Transforming and Expanding Access to Mental Health in Urban Pediatrics (TEAM UP) model. The CoCM provides person-centered care using a primary care provider and a behavioral health care manager who interface with the child or youth, as well as a psychiatric consultant who develops a treatment plan and provides advice to the care manager. A child or youth receives brief therapeutic intervention from the care manager and is referred to specialty mental health services if they require more support. CMS activated three billing codes for CoCM in 2017 as well as a separate code for federally qualified health centers and rural health centers. Twenty-two states have activated those codes.

  The TEAM UP model uses a fully integrated care model for children through age 21, comprised of primary care clinicians, mental health clinicians, and community health workers who receive ongoing training and technical assistance. In federally qualified health centers, the TEAM UP clinicians provide prevention, early intervention, access to mental health services, and psychiatric consultations for children and adolescents with higher needs.[63]

Massachusetts recently adopted a new approach to paying for primary and preventive care that supports use of TEAM UP and other integrated primary care practices. Specifically, Massachusetts will pay providers a sub-capitation payment to cover the cost of primary care services. Massachusetts will offer three tiers of sub-capitation payments, with the highest tier reserved for providers with especially robust, team-based primary care practices that integrate behavioral health.[64]

Additional Resources and Examples:

- **Texas.** Texas pays a higher Medicaid rate for CoCM for children aged 0 to 21 and is using grant and American Rescue Plan funding to provide free technical assistance to 18 health systems to support implementation of the model for children and adolescents. The state is also using American Rescue Plan funds to support practice transformation costs at primary care practices.[65]
- **New York.** New York pays for CoCM for individuals aged 12 and over and provides ongoing training and technical assistance to practices employing CoCM. It also requires practices to demonstrate, as part of an application process, that they can meet fidelity standards.[66]

3.5. Strengthen the use of school-based services.

Schools are uniquely positioned to provide preventive behavioral health services to children and youth; preventive services are largely educational in nature and schools are likely places to identify a need for targeted services. One in five students is estimated to experience a significant mental health concern during their school years.[67] Recognizing the outsized role that schools can play in addressing children's health, CMS released a school-based services guidance in May 2023.[68] The guidance explains how states and education agencies can better leverage Medicaid and CHIP to support the health and well-being of children in school-based settings. For example, states can adopt the following strategies:

- **Free Care Option.** Schools are well-equipped to provide preventive behavioral health services to Medicaid-enrolled students on an individualized basis. The free care option allows schools to provide and receive reimbursement for any health service, including behavioral health services, covered by the state's Medicaid state plan, including EPSDT, for a Medicaid-enrolled student. During the 2021-2022, only 34% of surveyed public schools reported providing behavioral health screenings. **Missouri** has allowed schools to provide behavioral health services to Medicaid enrolled students since 2018, as well as community behavioral health providers to provide services at schools when appropriate.[69]
- **Higher Reimbursement Rates for School-Based Providers.** To help schools build behavioral health workforce capacity, states can work to increase reimbursement for behavioral health professionals that schools employ directly and encourage community behavioral health providers to partner with schools. A number of states have increased reimbursement rates for school providers. **Arizona**, for example, incentivizes behavioral health clinics that partner with schools to provide services in school settings and accept referrals from schools to provide behavioral health services.[70]
- **CHIP Health Services Initiatives (HSIs).** The federal government allows states to use up to 10% of their expenditures on benefits for children on administrative costs, outreach and initiatives through HSIs.[71] HSIs allow states to draw down enhanced federal Medicaid matching funds for initiatives that improve the health and well-being of low-income children, regardless of their insurance status. States have broad discretion to define the allowable uses of HSI funds. CHIP funding to implement HSIs focus on improving the health of low-income children (less than 19 years of age) who are eligible for Medicaid/CHIP, but may serve any child regardless of income.[72] Schools may provide a variety of services to their entire student body using a CHIP HSI, and may also use a HSI to train staff on how to deliver those services. For example, schools could provide overdose prevention such as the distribution of opioid overdose reversal drugs and training public school employees to administer the drugs supported through CHIP HSIs.

"The more we can weave mental health knowledge, capacity, and checkpoints into places where parents feel comfortable—like the doctor's office and at school—the better. All professionals who work with young people really need the knowledge that's being generated by psychologists."

—Dr. Ann Masten, University of Minnesota

Strategy 4: Establish a Comprehensive, Youth-Specific Continuum of Care for Behavioral Health Conditions

Based on the experience of young people with lived experience, the research literature, and expert opinion, Exhibit 2 proposes an ideal continuum of services for children and youth with significant behavioral health needs. It includes "traditional" therapeutic services such as individual and family therapy and some facility-based services but also focuses on services that young people have identified as important to their recovery. These include services to address HRSNs, as well as services that offer family and community-level interventions, not just individual-level services. States may need to braid funding across Medicaid and other federal and state sources to offer the ideal continuum of care identified as important by clinicians, young people, and families.

> "I needed something more holistic, more child-friendly and engaging—and that was never really an option. Having access to some of those things would have really reshaped what I was going through."
>
> —Mariah (23), Youth Advisory Committee member

Box 6. Services to Treat Substance Use Disorders

In light of the rapid increase in overdose deaths among youth, it is critical that children and youth have access to integrated mental health and substance use disorder care. Notably, youth and their families face particularly daunting barriers to securing treatment for SUDs. Many mental health providers are not equipped to help with addiction and will not accept clients who are living with an SUD. Even providers that treat SUDs may not offer some of the most effective evidence-based services, such as medications for addiction treatment (MAT). Some providers and states, however, are breaking new ground in this area, fueled most recently by headlines of children accidentally dying after ingesting fentanyl-laced drugs.

Exhibit 2. Continuum of Behavioral Health Care for Children, Youth, and Young Adults With Complex Behavioral Health Needs

Prevention and Early Intervention Supports Prevention and early intervention supports include a wide array of strategies and services that promote health and well-being by averting the onset of or lessening the progression of a child's or youth's behavioral health condition.	**Outpatient Services** Outpatient services include a wide range of therapeutic behavioral health services that can be provided in an early child setting, school, home, clinic, office, or other outpatient setting, including individual, group, and family-based therapies; psychiatric services; and medication management (including medication for SUDs).	**Other Community Services and Supports** These are services that support a child's health and well-being in their community, including peer services provided by individuals with lived experience, supported education, and supported employment.	**Health-Related Social Services and Supports** Health-related social services and supports include rent for youth who are experiencing housing insecurity or at risk of housing insecurity, food, and assistance with addressing interpersonal violence.[73]	**Flexible Services and Supports** Flexible services and supports include resources that can be used to provide tailored, individualized care to children with complex behavioral health conditions, such as funding to support participation in sports or social activities.
Intensive Home-Based Services Intensive, home-based services include individualized, strengths-based services and intensive care coordination that help a child or youth build the skills to function successfully in their home or community.	**Intensive Care Coordination** Intensive care coordination is more intensive than care coordination and includes assessment and service planning, accessing and arranging for services, and coordinating services.	**Crisis Services** Crisis services include mobile crisis response and stabilization, crisis call centers, and other services that assess, stabilize, and treat children and youth experiencing acute distress.	**Inpatient and Residential Treatment** Inpatient and residential treatment provides intensive clinical services in structured, facility-based settings to children and youth who require constant monitoring for safety reasons.	**Family Services and Supports** These services and supports address the needs of family members, such as family-to-family peer support, respite services, and medical and behavioral health services (including SUD treatment) for parents when needed to improve a child or youth's mental health.

> "I was reunified [with my mom] completely randomly. They told me, 'You're going to go visit with your mom until we can find your next placement,' and then I never came back to foster care. She was not ready for me; she still had drug use and other things going on, and they did not give us services to make sure that she was okay and to make sure that I was okay."
>
> —Mariah (23), Youth Advisory Committee member

A handful of services outlined in Exhibit 2 are particularly important and often missing for children and youth living with complex behavioral health needs. These services have demonstrated robust outcomes in the published literature, feature strongly in the continuum of services used by leading states, or have been identified as helpful by youth themselves. A subset of these services—intensive care coordination, intensive home-based services, and mobile crisis services for children and youth—routinely end up being mandated by courts in response to litigation brought by families who are unable to secure appropriate care for their children. As described in Appendix 5, states have different Medicaid authorities that they can rely on to cover these services. An informational bulletin issued by CMCS and SAMHSA in 2013 reviews the evidence of the effectiveness of these priority services and outlines resources that are available to states to ensure these services are covered and accessible.[74]

4.1. Ensure crisis services address the unique needs of young people.

For children and youth living with complex behavioral health needs, an effective crisis system can prevent unnecessary emergency department visits and psychiatric hospitalizations and minimize encounters with law enforcement. MRSS is a well-known and effective crisis intervention model for children and youth.[75] Among other things, it allows families and youth to define when they are experiencing a crisis (instead of requiring a professional's determination); offers on-site support within one hour; integrates peers into the response team; relies on staff with specialized expertise in working with children, youth, and their families; and offers support for at least 72 hours after the immediate crisis.[76,77] MRSS are available 24/7, 365 days per year, and delivered at the young person's home, school, or another community-based setting. **New Jersey** and **Connecticut** operate MRSS, relying on state plan authority. In addition to using MRSS for crisis services, New Jersey uses MRSS for early intervention to address trauma among children and youth who have recently been removed from their families.

A full continuum of crisis services includes interventions such as urgent care centers where families can take a child who needs timely help with a behavioral health issue, just as they would for a physical health issue. It also includes interventions for children and youth with co-occurring disorders like autism and I/DD, such as teams with specialized training and expertise. Some states are deploying I/DD-specific crisis models such as the evidence-based Systemic, Therapeutic, Assessment, Resources, and Treatment (START) model; it uses a specially trained clinical team to respond to crises among children and youth with I/DD, develop a plan to prevent future crises, and maintain engagement with the young person after resolution of the crisis. The START model also includes specialized resource centers that can provide short-term planned or emergency respite.[78] **New York's** model—New York Systemic, Therapeutic, Assessment, Resources, and Treatment (NYSTART)/Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD)—provides 24/7 crisis prevention and response services to individuals aged 6 and older with co-occurring I/DD and complex behavioral health needs, as well as their caregivers.[79]

Additional Resources and Examples:

- **Oklahoma.** As part of a comprehensive approach to crisis services, Oklahoma has expanded urgent care and crisis centers across the state, which are intended to divert individuals needing inpatient psychiatric hospital care. The state plans to add 18 urgent recovery and crisis centers in 2023, which are funded by multiple sources, including Medicaid.[80]
- **MRSS Quality Learning Collaborative.** Beginning in the summer of 2023, several states are participating in the MRSS Quality Learning Collaborative (QLC), an opportunity that focuses on the structural changes necessary to fully implement MRSS. The QLC is funded by SAMHSA and led by The Institute for Innovation and Implementation in partnership with the National Association of Mental Health Program Directors.[81]

4.2. Provide intensive home-based services.

As indicated by the name, intensive home-based or intensive in-home services provide intensive therapeutic support to a young person in their home, averting or reducing the need for residential treatment.[82,83] Although there are different evidence-based models, intensive home-based services share key features, including:

- **A team-based approach** to care that includes the young person, families/caregivers, and adults the young person trusts;
- **Crisis response**, stabilization, and safety planning;
- **Skill-building** with the young person and parents/caretakers;
- **Peer support** for the child and family members;
- **Extensive in-person help** from a skilled professional;
- **Use of a plan of care**; and
- **A transition strategy** for when intensive services are no longer needed.[84]

Intensive home-based service models also emphasize the importance of addressing social and economic issues as a key part of the intervention.

Particularly because intensive home-based services are delivered in the intimate setting of a home by multiple practitioners, it is critical that the team build trust with the young person, listen to their individual needs, and show them respect. If a young person feels unsafe in their home or if their family is unsupportive, it likely is not appropriate to use intensive in-home services, and it can even be dangerous or damaging to do so.

Intensive home-based services may also include models such as therapeutic foster care or treatment foster care, a family-based placement option for children with complex needs who can be served in the community with intensive support. Care is delivered by foster parents with specialized training to best support children and youth with behavioral health needs and avoid the need for residential care. However, while many states use some form of therapeutic foster care, programs vary widely, and there is no widely used evidence-based approach.[85]

Box 7. A Note on Intensive Home-Based Services

Intensive home-based services can be an essential support for children and youth who may otherwise require residential treatment, but it is critical that they are delivered as intended and centered on the needs of the child or youth. If not, there is a risk that they will be ineffective. As Kris (29) of the Youth Advisory Committee explained, "As a peer support specialist, many youth I worked with had tough experiences with intensive home-based services. They found them to be invasive, would routinely suffer from service fatigue, and would report many times that they were being forced to participate."

Additional Resources and Examples:

- **Massachusetts.** Massachusetts' Intensive Home-Based Therapeutic Care (IHBTC) is a coordinated treatment service for youth and their families in the home.[86] The state contracts with independent agencies to provide affirming, culturally appropriate, clinically intensive treatment and outreach support to help build, strengthen, and maintain the youth's connection to family, home, and community. Each family and youth are members of an IHBTC "Family Team," which works together to develop treatment goals and appropriate supports. If there is a need for a higher level of care, the IHBTC team remains involved, leading treatment and care coordination for the duration of the stay and playing a key role in transitioning the youth back to the home.[87]
- **Ohio.** Ohio offers intensive home-based treatment (IHBT), a mental health service for youth living with serious emotional disturbance who are at risk of an out-of-home placement or who are returning home from a placement.[88] IHBT integrates core mental health services, such as individual and family therapy, community-based psychiatric supportive treatment, mental health assessment, and crisis response, into a coordinated service available 24/7. Many IHBT programs also include specific family therapies such as multisystemic therapy and functional family therapy.[89]

4.3. Provide intensive care coordination to children and youth with multisystem involvement and/or co-occurring conditions.

Intensive care coordination shares many elements with intensive home-based services but is specifically designed to support children and youth whose needs outstrip the expertise and reach of any one provider organization or child- and family-serving system.[90] High-fidelity wraparound is one practice model for intensive care coordination that has a robust track record for children and youth who are part of multiple child-serving systems.[91,92,93] It is a team-based approach in which the wraparound care coordinator works in partnership with youth and their families to identify their goals and priorities, establish a cross-sector team to support them, create an individualized plan, and, ultimately, transition out of high-fidelity wraparound services. The approach helps families navigate the multiple systems serving their child and acquire the skills to navigate such systems in the future on their own.

In **Georgia**, for example, a statewide high-fidelity wraparound program is offered as part of its Intensive Customized Care Coordination (IC3) for youth and young adults who are at risk of admission to residential treatment settings.[94,95] The program offers intensive care coordination, education, and skill-building services. The practice is supported by the Center of Excellence for Children's Behavioral Health at the Georgia Health Policy Center, which produces fidelity assessments, annual evaluation reports, and issue briefs to inform state leaders about program outcomes.[96]

As with intensive home-based services, it is critical that such services are delivered only when appropriate and that the care team builds trust with the child or youth and takes their preferences into account.

Additional Resources and Examples:

- **Illinois.** The recently launched Pathways to Success program in Illinois will provide two tiers of care coordination for Medicaid-enrolled children and youth under age 21 with complex behavioral health needs—a high-fidelity wraparound model for children and youth with the most complex needs as well as a more moderate level of intensive care coordination services.[97] The model emphasizes expanded use of evidence-based practices, particularly access to services delivered in home- and community-based settings, as well as increased youth and family involvement in treatment.

4.4. Offer respite services to families seeking to help their children remain in the community.

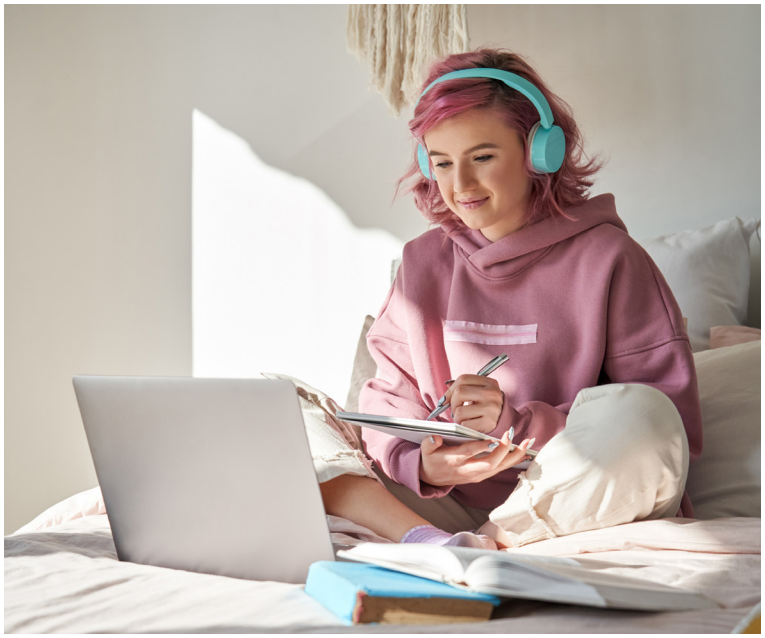
Respite services provide parents and caregivers the opportunity to take a break from the 24/7 care that many children and youth with significant mental health concerns and/or SUDs require. In states where respite is an option, families may be able to have a trained volunteer or professional come to their home, or they may have the option of out-of-home respite care. In the absence of such a benefit, parents and caregivers who are on alert around the clock to prevent self-harm, violence, or other dangerous situations may decide that they cannot indefinitely sustain home-based care for their child. Unlike the other "must have" services described here, states cannot yet cover respite services under state plan authority and, instead, must rely on the other authorities (i.e., 1915(b)(3), 1915(c), or 1915(i)), as outlined in Appendix 5. **Ohio**, for example, uses 1915(b)(3) waiver authority to fund respite services, which are available on a planned or emergency basis. Respite services are available for the primary caregivers of children and youth up to age 21 who are enrolled in OhioRISE, the state's single Medicaid managed care plan dedicated to serving children with complex behavioral health needs.[98]

Additional Resources and Examples:

- **North Carolina.** North Carolina covers respite services for the primary caregivers of children and adolescents aged 3 to 20 with a serious emotional disturbance or SUD as well as for the family members of a beneficiary with an I/DD or traumatic brain injury diagnosis.[99] Using a 1915(i) waiver, North Carolina provides both in-home and out-of-home respite services that families can use on an overnight basis, for a weekend, or on an emergency basis (excluding out-of-home crisis).[100,101,102]

4.5. Provide peer support services for youth and their families.

States increasingly are looking to individuals with lived experience and shared identities (e.g., race, sexual orientation, gender identity), or "peers," to offer support and services to Medicaid members who share similar experiences and identities. **Georgia** was the first state to bill Medicaid for peer support services in 1999; as of 2022, 40 states cover peer support services under Medicaid.[103,104] This trend responds to both the national behavioral health workforce crisis and to the long-standing focus among people living with mental health conditions and SUDs on the importance of finding community and connecting with others who share their experiences.



Working with a young person who has been through a similar experience can be powerful for a youth with significant behavioral health issues who may feel isolated from their peers. Similarly, parents and caretakers who are navigating the uncharted waters of dealing with a child who is suicidal, violent, or otherwise out of control can feel alone, scared, and unsure of where to turn.[105] In this context, the expertise of a family that has "been there" and can offer strategies and ideas for working with their child or adolescent can be priceless. Young adult and family peer partners can also play key roles as part of teams delivering intensive home-based services and intensive care coordination services.[106]

Medicaid offers a number of ways that states can cover youth and family peer support. Under guidance issued in 2007, CMS is clear that states can use Medicaid funds to pay peer or family support specialists under the preventive services benefit, which allows states to reimburse services offered under the direction of a licensed provider.[107]

"A peer support worker once showed up at a meeting with my social worker. And before we started, they pulled me out of the room and made sure we went over every single aspect of what was going to happen that day. … I was like, finally, someone is actually listening."

—Mariah (23), Youth Advisory Committee member

Additional Resources and Examples:

- **Alabama.** Alabama offers peer counseling services as a state plan service using both certified youth and parent peer specialists.[108] Young people with personal experience in the mental health and/or SUD treatment system who complete a state-approved training program can serve as youth peer specialists. Similarly, parents who have experience raising a youth with significant behavioral health needs can serve as parent peer specialists if they complete a training program.[109]
- **New York.** New York's Family Peer Advocates (FPAs) deliver family peer support services, which consist of both formal and informal supports for families raising children with significant behavioral health challenges. FPAs support parents and caretakers in enhancing their skills to promote the child's well-being, including through outreach, engagement and transition support, community connections, and skill development.[110] FPAs are trained and credentialed by the state; as of 2021, over 700 parents and family members had earned their FPA credentials.[111]

4.6. Address young people's health-related social needs.

In response to the growing recognition that physical and behavioral health care alone is not enough to support individuals with serious behavioral health needs, states and CMS are exploring new ways to deploy Medicaid funds for HRSNs.[112] To date, much of the focus has been on adults, but a handful of states have worked with CMS to use Section 1115 demonstrations, 1915(c) waivers, or 1915(b)(3) waivers to develop HRSN

resources for older youth. These demonstrations address the elemental needs of youth, such as food and housing, as well as offer them opportunities to participate in school and community activities that help them share positive experiences with peers.

For example, in 2022, **Oregon** received approval from CMS for a renewal of its Section 1115 Oregon Health Plan Demonstration.[113] The renewal includes new coverage of supports for HRSNs, including housing supports (rental assistance, home modifications, pre-tenancy and tenancy supports, and housing-focused navigation), food assistance (links to community-based food resources, nutrition education, and fruit and vegetable prescriptions), and protection from climate events. HRSNs are slated to begin in 2024–2025 for eligible populations, including children and youth involved in the child welfare system and young adults up to age 26 with significant behavioral health and/or other special health care needs.

Notably, members of the Youth Advisory Committee repeatedly highlighted that before they could meaningfully engage in treatment, they first required physical safety (including from abusive family members), as well as assistance with housing, education, food, and legal matters, especially if they were caught up in the child welfare or juvenile justice system. Many shared that they had been kicked out of their homes or bullied or otherwise had faced significant trauma that contributed to mental health challenges because they are LGBTQIA+ or based on their race, ethnicity, weight, neurodiversity, or immigration status.

Along with using Medicaid financing creatively, states are also using CHIP HSIs to address HRSNs of children and youth up to age 19.[114] States have broad discretion to define the allowable uses of HSI funds and may deploy funds, for example, to provide housing assistance or legal services to children and youth with complex behavioral health needs.

"People can't focus on [their mental health] if they don't have a roof [over their head] or a place to live, or if their identity isn't respected."

—Kris (29), Youth Advisory Committee member

Additional Resources and Examples:

- **Ohio.** Using a 1915(b)(3) waiver, Ohio has established "primary flex funds" for children and youth enrolled in the state's OhioRISE program, a special Medicaid managed care plan for children and youth with significant behavioral health needs. These dollars—up to $1,500 per year—can be used for services, equipment, or supplies not otherwise covered by Medicaid that help the child or youth participate fully in their community. For example, they could be used to buy athletic shoes or a uniform to allow a child to be on a sports team or for art or music lessons. For many children and youth, the chance to be part of regular school and community activities can help them regain confidence and reduce any stigma and isolation they feel due to their behavioral health challenges. Through a 1915(c) waiver, Ohio also established "secondary flex funds," which may be used for similar activities after primary flex funds are exhausted.

- **Arkansas.** Arkansas uses the HSI option to provide intensive home- and community-based child and family services to children and youth with significant mental health needs who are involved in the child welfare system. The CHIP HSI provides access to a range of child/youth and family support services, caregiver services, and other health- and well-being-related services.[115]
- **Wisconsin.** In 2022, the Wisconsin Department of Health Services received approval from CMS for a CHIP HSI to provide housing support for low-income families with children under age 19 and individuals who are pregnant and experiencing housing insecurity.[116] Eligible families will have access to an array of supported housing options, including housing consultations, transition supports, relocation supports, and housing sustaining supports.

4.7. Strengthen the quality of care in residential treatment settings.

While recognizing that some children and youth will require time-limited, therapeutic residential care, Exhibit 2 does not include long-term non-therapeutic custodial settings in the ideal continuum of care. Leading national children's organizations, including the American Academy of Pediatrics, have repeatedly raised concerns about the appropriateness of such settings for children and youth in the child welfare system, as have young people themselves who have lived in such settings.

Ideally, states can minimize the use of custodial-type facilities through Medicaid investments in time-limited, high-quality residential programs and in expanding the continuum of community-based behavioral health treatment, coupled with concerted oversight.

Box 8. Treatment for Children and Youth in Institutions for Mental Disease (IMDs)

With limited exceptions, Medicaid funding cannot cover the cost of long-term stays in IMDs, residential treatment facilities, or psychiatric hospitals with more than 16 beds for individuals younger than 65 years old.[117] Key exemptions from the IMD exclusion include:

- **Psychiatric Residential Treatment Facilities.** States can use Medicaid to cover the cost of care provided in psychiatric inpatient residential treatment facilities for children and youth under 21 years old, including psychiatric residential treatment facilities.[118]
- **Section 1115 Demonstrations.** States can seek Medicaid Section 1115 demonstrations to pay for care provided in IMDs, including for children and youth, if they meet a range of CMS-defined standards, maintain an average length of stay of 30 days or less, and do not receive Medicaid matching funds for any individual stay in excess of 60 days.[119,120] States can also build on CMS standards for these Section 1115 demonstrations to balance the need for short-term residential treatment for youth and young people in limited circumstances and recommit to an expanded community-based treatment continuum. They can leverage Medicaid as a tool to increase the quality of care and family- and youth-centered and evidence-based practices employed by residential facilities.

To strengthen the quality of short-term therapeutic residential services, state Medicaid agencies can enhance admission, treatment, and discharge policies by requiring:

- **Clinical assessments** by independent experts in discussion with the youth (and their family, as appropriate) prior to entry and at regular intervals to prevent unnecessary use of residential care;
- **Engagement of families** or other trusted adults in the young person's life in care throughout a stay in a facility;
- **Procedures to prevent abrupt terminations and transfers** driven by the needs of the residential treatment center rather than the best interests of the child or youth;
- **Robust discharge planning** that begins at admission and addresses clinical needs and HRSNs, such as where the young person will live and how they will continue their education or employment efforts; and
- **Data on outcomes after discharge** to provide the state and facilities with the opportunity to monitor the effectiveness of their treatment and discharge efforts.[121]

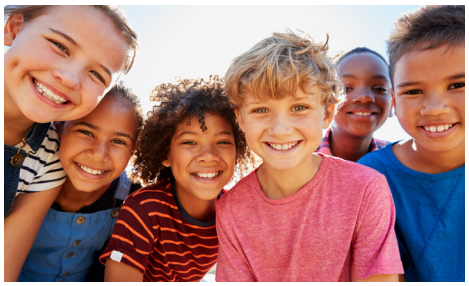
New Jersey, for example, has adopted expansive reforms to ensure that short-term residential treatment is used only when clinically necessary and that it is integrated into a young person's broader journey of recovery and treatment. Along with intensive home-based services and supports that reduce the need for short-term residential treatment, New Jersey has authorized a single nonprofit agency to assess if and when a child requires residential care or requires community-based care management organizations to see a child or youth through their residential stay; developed robust discharge plans and requirements; and restricted residential facilities from abruptly terminating children from treatment. Once residential treatment is authorized and the youth and family select a provider with an open bed, the residential provider is required to admit the youth. Following admission, the residential treatment provider cannot easily discharge a youth. A residential provider is allowed to discharge a child or youth before they are clinically ready only in rare circumstances involving safety.

Medicaid agencies can also provide more direct technical assistance and support to residential treatment facilities on their discharge policies and procedures and help them facilitate partnerships between treatment centers and community-based organizations.

Additional Resources and Examples:

- **Washington.** Washington evaluated youth experiencing housing insecurity within 12 months of their discharge from various public SOCs, including psychiatric inpatient and residential facilities, and found that a significant share (90%) of them were enrolled in Medicaid.[122] Based in part on these data analyses, Washington State adopted legislation that requires the Office of Homeless Youth Prevention and Protection to develop a plan to ensure that no youth is discharged from a public system of care into homelessness.[123] The state enacted follow-up legislation in 2022 that establishes a rapid response team that can participate in transition and housing planning for youth and young adults exiting a publicly funded SOC and provides additional funding for housing for such youth.[124]

Strategy 5: Ensure Use of Evidence-Based, Community-Defined, and Culturally Responsive Assessments and Practices.



To address the youth behavioral health crisis, states will need to consider not only whether they cover a full continuum of services, but also whether the services are available in practice (not just on paper), delivered in a culturally and linguistically appropriate way, and of high quality. In many states, Medicaid covers broad service categories such as "outpatient therapy" or "crisis services" that were set up years ago. Some states are now taking a fresh look at how their Medicaid dollars are being spent on behavioral health services, adding clarifications and details to ensure that they are used for effective, evidence-based, community-defined, and culturally responsive services. Especially for children and youth with complex behavioral health needs, receiving an **appropriate** therapeutic intervention can make a significant difference. For example, a child with complex PTSD may require EMDR (Eye Movement Desensitization and Reprocessing) or trauma-focused behavioral health therapy, not simply a series of outpatient visits with a clinician who is a generalist.

Box 9. Evidence-Based and Community-Defined Evidence Practices

There is a growing movement to identify and promote practices with robust evidence for effectiveness, impact on racial equity and other health care disparities, and sustainability. Both evidence-based practices (EBPs) and community-defined evidence practices (CDEPs) can play an important role in providing culturally sensitive, identify-affirming mental health services to children, youth, and young adults.

- **Evidence-based practices.** EBPs are interventions with documented, empirical evidence (e.g., randomized controlled trials, peer-reviewed studies) that consistently show they improve health outcomes.[125] These programs have been clinically reviewed and documented to ensure the fidelity of implementation in a variety of settings. A wide array of EBPs for behavioral health are documented in SAMHSA's Evidence-Based Practices Resource Center.[126]
- **Community-defined evidence practices.** CDEPs are practices that have been found to yield positive results as determined by community consensus over time. These practices may or may not have been measured empirically but have reached a level of acceptance by the community. CDEPs take a number of factors into consideration, including a population's worldview and historical and social contexts that are culturally rooted. It is not limited to clinical treatments or interventions.[127]

5.1. Utilize standardized tools to help determine the appropriate services for young people.

Some states are using standardized screening and assessment tools to guide a single point of access into the system of care for children with complex behavioral health needs. This can help avoid situations in which the level and type of care a child receives is driven by financial decisions or other random factors (e.g., no home-based services are available and so a child instead is sent to residential care) and, instead, help to ensure they are based on clinical need and the child's individual circumstances. **New Jersey**, for example, requires use of the Child and Adolescent Needs and Strengths (CANS) assessment in its system of care.[128] **California** likewise requires use of the CANS tool to assess strengths and needs of children and youth receiving behavioral health services. The state also conducted a robust process with multiple stakeholders to develop statewide screening and transition-of-care tools for managed care organizations and county mental health plans. The tools help determine which delivery system is most appropriate for each child or youth to ensure access to the most appropriate care.[129]

While states most commonly rely on standardized assessments to help determine whether a child requires facility-based treatment, states may also use them for outpatient services and performance measurement, making it easier to coordinate a child's care across the child-serving agencies working with a family or caretaker.[130]

5.2. Invest in a culturally diverse behavioral health workforce.

The reach, stability, and effectiveness of a state's continuum of behavioral health services for children and youth with complex needs depends on the robustness, diversity, and resilience of its behavioral health workforce. Nationally, even as the need for mental health and SUD services continues to rise, nearly half of the U.S. population lives in a mental health workforce shortage area.[131] Workforce challenges are particularly acute among child and youth providers as well as state Medicaid programs, which often reimburse behavioral health care at lower rates than other payers.

While comprehensively addressing the behavioral health workforce shortage is beyond the scope of this report, Medicaid can help address the situation through rate increases (see Strategy 5.4.) and other targeted strategies:

- **Expand the workforce through peers, community health workers, and other types of behavioral health providers.** State Medicaid agencies can decide to cover community health workers, peer support specialists, and family support specialists to expand the range of people available to support children and youth with complex behavioral health needs. Along with expanding the workforce, they bring unique skills and experiences that can be invaluable to children, young people, and their families (see Strategy 4.5.). In addition, a number of states have broadened the types of behavioral health practitioners who can bill independently to include those who are supervised and license-eligible. In **New Jersey**, for example, licensed clinical social workers are now included as a type of provider that can bill separately.[132]

- **Use Section 1115 demonstrations to make direct investments in the behavioral health workforce.** CMS recently approved Section 1115 demonstrations that offer federal Medicaid matching funds for behavioral health workforce investments. In **Massachusetts**, the 2022 renewal of the MassHealth Section 1115 demonstration included $43 million for targeted loan repayment and residency grant programs to reduce behavioral health workforce shortages and improve care access.[133] Similarly, **New Hampshire**'s Building Capacity for Transformation waiver includes a number of workforce development initiatives to bolster the capacity to treat behavioral health conditions across the state.[134]

"We need providers with lived experience who can relate to us."

—Youth Advisory Committee member

5.3. Provide training and support to providers.

To improve the way care is delivered to children and youth with complex behavioral health needs, states are offering training to providers and establishing Centers of Excellence.[135,136] **Ohio**, for example, contracted with Case Western University to establish the Child and Adolescent Behavioral Health Center of Excellence. The center provides technical assistance, training, professional development, coaching, consultation, evaluation, fidelity monitoring, and continuous quality improvement to Ohio's providers working with children and youth with complex behavioral health needs.[137]

Oklahoma has opted to develop its own trainings on mental health and SUD treatment, rather than contract with an outside trainer or entity, to establish a unified approach to working with children and youth with complex behavioral health needs. The Oklahoma Training Institute provides mental health and SUD training to state partners, providers, and community members.[138] It provides both instructor-led and on-demand courses and conferences on topics such as cognitive behavioral therapy for children and adolescents, person-centered planning, and child and adolescent trauma screening.[139]

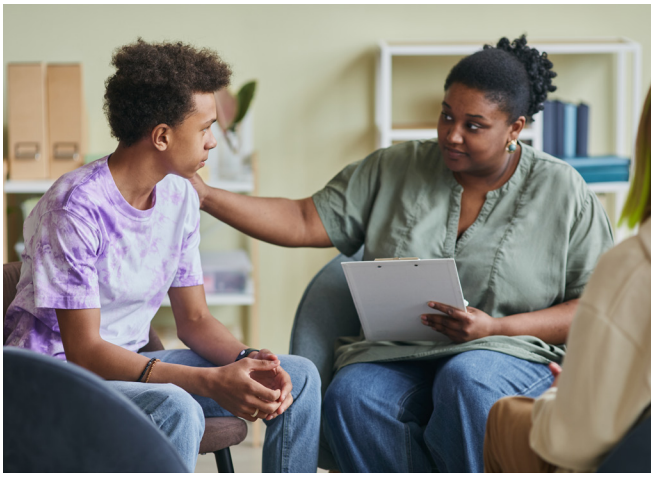
Along with increasing practical skills among providers, the investment in training also helps states to create a common approach to working with children with complex behavioral health needs across child-serving systems. As New Jersey leads have described it, by providing widespread training and technical assistance, the state encourages providers to "speak the same language" across the health care, child welfare, and other child-serving systems that work with children and youth with complex behavioral health needs.

> "We trained using [the] Nurtured Heart Approach in every part of our system. The Nurtured Heart Approach is not an off-the-shelf practice—sometimes those don't translate across the populations—but is easily transferable to families. Parents become the owners of the work, and we see the skills from the training within support groups or before people even touched on the system. People loved it; it is easily transferable and brings the language across the system."
>
> —Elizabeth Manley, University of Connecticut School of Social Work

Additional Resources and Examples:

- **New Jersey.** The New Jersey Children's System of Care Training and Technical Assistance program at the Rutgers University Behavioral Health Care Institute provides comprehensive resources for providers, as well as parents and caregivers. The training and technical assistance help ensure services are delivered in accordance with the core principles at the root of New Jersey's SOC for children and youth with complex behavioral health conditions—strengths-based, culturally competent, community-based, individualized, and youth- and family-centered.[140]

5.4. Use Medicaid reimbursement strategies to increase access to linguistically and culturally appropriate care.



In a few instances, states are using their reimbursement rates to incentivize the use of providers that offer culturally and linguistically relevant services, or increasing reimbursement rates for specific evidence-based practices when delivered with fidelity. **Oregon**, for example, uses directed payment authority to require its Medicaid managed care organizations (known as coordinated care organizations) to pay higher rates on a uniform basis to behavioral health providers—those who earn 50% or more of their revenue from Medicaid receive a 30% increase, while all others receive a 15% increase. Oregon also has established higher rates for treatment of co-occurring disorders (including peer support services) for providers who deliver culturally or linguistically specific services, and for selected services where access has been an issue—for example, residential treatment of SUDs, applied behavior analysis, and wraparound services for children and youth.

Montana assessed provider rates and, in August 2023, submitted amendments to its HCBS waiver to increase rates for providers by an average of nearly 18%.[141] **Missouri** and **Oklahoma** are also increasing provider rates to be more in line with Medicare rates.[142]

Box 10. Leveraging Digital Technology for Youth Mental Health

Mental health technology presents a unique opportunity to address access challenges for children and youth living with mental health needs and to reach young people, who are often active users of digital technologies. If thoughtfully deployed, states may leverage technology to extend the behavioral health workforce, improve access to care, and better integrate digital tools into the continuum of care for providers.[143] For example, digital technology could facilitate universal screening for children and youth, strengthen outcomes monitoring, and increase engagement with or supplement delivery of evidence-based practices.[144] Regulation and coverage of digital mental health tools under Medicaid is limited; however, initial action by the federal government and states points to the development of new policies and standards for digital mental health technologies.[145]

Strategy 6: Address the Emergency Department Boarding Crisis

The emergency department boarding crisis dominates headlines about the youth behavioral health crisis, offering the most obvious example of the failure to provide children and youth in serious distress with help. Children and teens can spend days, weeks, or even months in an emergency department or medical unit as they await an opening in a psychiatric hospital or connections to intensive in-home and community-based services that would allow them to return home safely.[146] Those who have I/DD, serious addiction issues, or physical health problems are most likely to remain in the emergency department for extended periods, reflecting that it is especially difficult to find appropriate treatment.[147,148]

The situation underscores the urgent need to invest in a comprehensive community-based behavioral health treatment system that is appropriately staffed and financed, reducing the need for emergency department visits and inpatient hospitalizations for children and youth and offering reasonable alternatives in crisis situations. No state has solved the emergency department boarding issue for children and youth, but some states are taking short-term steps to mitigate the problem even as they build out a comprehensive community-based continuum of care to avoid children being sent to the emergency department unnecessarily out of convenience or due to lack of more appropriate alternatives.

"Our children are spending weeks in emergency rooms, tied to beds because there are not enough community inpatient beds available."

—Advocates for Mental Health of Michigan Youth

6.1. Gather and analyze data on youth boarding in emergency departments.

As a first step, states can conduct a data-driven assessment of which children and youth are using emergency departments for behavioral health services, why they are landing in emergency departments, and which children are getting "stuck" due to a lack of treatment options. For example, a state might find most young people who go to the emergency department are able to secure appropriate treatment relatively quickly and to "move on," but those with complex physical needs (e.g., if they have an eating disorder that imperils their physical health), autism, an I/DD, or a history of violence and aggression are languishing. Or, a state might find that it has sufficient beds available to move children out of the emergency department who require inpatient care, but many of these beds are off-line due to staffing shortages. Until a state understands why young people are boarding in the emergency department, it will be difficult to develop a comprehensive, sustainable response.

In **Massachusetts**, for example, the Department of Mental Health, in partnership with the Office of MassHealth (which oversees the state's Medicaid program), the Department of Public Health, and the Division of Insurance, convened a task force to review and develop interventions for individuals boarding in emergency departments for extended periods.[149] The task force set clear steps and responsibilities for escalating cases where psychiatric placement has not been achieved in a reasonable time, established expectations around facilitating hard-to-place patients, and delineated the Department of Mental Health's role in ensuring that the facilities it licenses are fulfilling their responsibilities to meet the needs of individuals who require inpatient or residential care.[150] The Massachusetts Health and Hospital Association also routinely gathers and publishes data on the scope and magnitude of the emergency department boarding issue with respect to children and adults.[151]

6.2. Prioritize diversion through crisis services and family education.

In some cases, young people in crisis require emergency care, and it is vital that they be transported quickly and safely to a hospital (e.g., if they have made a suicide attempt). However, in many more cases, children and youth could successfully be stabilized in a community-based setting. As outlined above, Medicaid can help finance a child- and youth-specific crisis and stabilization service to triage and de-escalate crises and connect families to intensive in-home services and supports when inpatient care is not needed. There is strong evidence that such efforts are cost-effective compared to emergency departments and help improve the level of functioning of children and youth.[152]

States are also increasingly establishing urgent care centers for mental health issues and SUDs, which allow families and young people to get help in a timely way without having to go to the emergency department—similar to how they would visit an urgent care center for a sprained ankle or strep throat. Short-term crisis stabilization units that have a five-to-ten-day length of stay also help divert children and youth from the emergency department and hospitalization.

Along with providing alternatives to the emergency department, it is essential that families and young people be educated about whom to call when experiencing a crisis and that resources such as 988 connect them to de-escalation and treatment options when needed. As part of its comprehensive crisis response strategy, **Oklahoma** educates families about how to handle crises, including when to contact a mobile crisis unit, when to go to an urgent care center, or when to visit an emergency department.[153] Much of the family education is often done by family peer specialists who can provide reassurance and insight about how to handle a crisis based on their lived experience. The state also has developed a comprehensive "Family Field Guide" to connect families to mental health and other resources, potentially averting the need for higher levels of care.[154]

Without known and viable alternatives to emergency departments that families trust will be effective, they will continue to call 911 or bring their child to the emergency department if they think they are a danger to themselves or others.

> "[Oklahoma] does prevention and intervention work at the community level. We also have more urgent recovery clinics, mobile crisis and calm centers, and children crisis centers than we have inpatient and residential settings. We are trying to have more stops before kids get to higher levels of care."
>
> —Sheamekah Williams, Former Director of Children's Services, Oklahoma Department of Mental Health and Substance Abuse Services

6.3. Permit community-based admission to inpatient facilities.

Depending on the state, families may need to bring their child who requires inpatient care to the emergency department as a means of finding them a treatment spot in a psychiatric hospital. Even if they have been advised by a clinical professional that their child requires inpatient care and the family would like to admit them directly, they may be required to go through the emergency department—where they add to the boarding issue—as a means of securing higher-priority status in the effort to find an inpatient treatment slot. To address such situations, **Oklahoma** has authorized its mobile crisis teams to initiate admission to a psychiatric hospital when medically necessary based on their assessment of the young person, as well as to confer prior authorization for the service. This avoids the need for an unnecessary emergency department visit.[155]

> In October 2022, the Washington Post recounted the story of Zach Chafos, a teenager with autism and mental health issues who spent 76 days in a Maryland emergency department awaiting an inpatient bed.[156] His parents wanted to bring him home, but the hospital warned that as soon as Zach left, he would move to the bottom of the waitlist for a psychiatric bed. In response, some states are strengthening community-based pathways to psychiatric admissions, allowing mobile crisis teams and other community-based providers to initiate admission to an inpatient facility.

6.4. Encourage active treatment during stays in the emergency department.

Recognizing that it will take time to fully address emergency department boarding issues across the country, some states are using Medicaid to encourage treatment of patients while they are still in the emergency department. As the American Psychiatric Association has outlined in its emergency department boarding resource guide, emergency departments can play a role in initiating psychiatric care (including via telehealth if necessary) and providing counseling and therapy for individuals and families.[157] In its Medicaid managed care contract, for example, **New Hampshire** requires plans to cover without prior authorization any mental health services deemed medically necessary and delivered by qualified mental health workers in situations where a member is boarding. These "Emergency Room Waiting Measures" include providing additional clinical staff to support the provision of services and reduce the need for members to wait for inpatient services.[158]

For those living with an SUD, it may be appropriate to initiate MAT. Though not Medicaid-specific, states can also encourage their emergency departments to use their state's HRSA Pediatric Mental Health Care Access (PMHCA) program. States can provide to emergency departments the pediatric mental health consultation support that has traditionally been provided to pediatric primary care practices, which provides specialty consultation to children and youth more quickly. In addition, the PMHCA referral process is helping children with higher acuity get into community-based care faster.

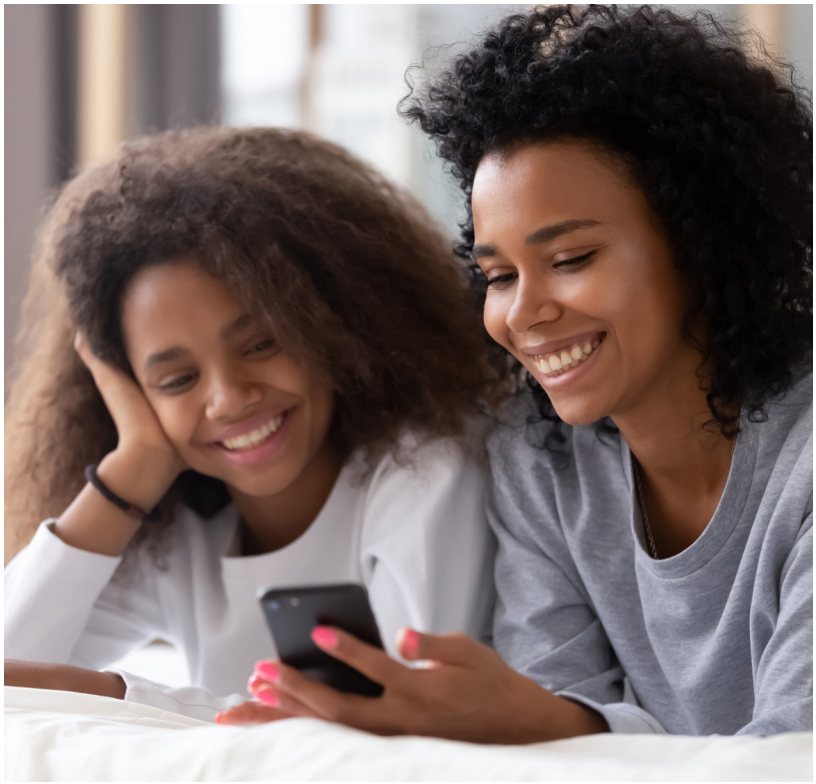
6.5. Establish bed-tracking tools and systems to identify open treatment spots.

When children and youth are stuck in the emergency department because they require an open psychiatric bed, the process of finding one can be time-consuming and surprisingly antiquated. In many hospitals, emergency department staff must repeatedly call psychiatric hospitals throughout the day, searching for an opening that matches the needs of the young person. Even if it has an opening, a psychiatric hospital may be unwilling to take a child if they have a history of violence and sexual aggression toward others, especially if the hospital is low on staff and already contending with a unit full of young people who are aggressive or at risk of running away. Along with a clinical match, emergency department staff and psychiatric hospitals need to determine whether Medicaid or the child's insurance carrier will cover the stay, spanning issues such as whether the facility is in-network and whether prior authorization requirements have been met.

To help address these practical "matching issues," some states have established bed-tracking tools and other systems for helping to make a match and get children and youth out of the emergency department and into appropriate treatment. For example, **Massachusetts** runs a bed registry, the Massachusetts Behavioral Health Access website, that tracks availability of a variety of youth and family services, mental health services, and SUD services.[159] Most information is publicly available to consumers, with the exception of some 24-hour emergency services.[160] The state requires timely updates to the bed registry and tracks timely updates as a performance metric in its Medicaid managed care contracts.

Conclusion

Addressing the growing behavioral health crisis among children, youth, and young adults requires an urgent, concentrated effort across the health, education, justice, and child welfare sectors. Medicaid and CHIP play a particularly critical role for states seeking to strengthen their continuum of behavioral health services and supports for young people living with complex needs—including those involved in multiple systems or facing discrimination due to their race, gender, sexual identity, body weight, or culture. The six key strategies presented above are intended to directly support state-level policymakers in better leveraging Medicaid and CHIP to respond to this crisis and to ensure that the children and youth served by these public systems are set up to thrive.



Appendix 1

Summary of Medicaid Strategies, State Examples, and Other Resources

Strategy	State Examples and Resources	Mechanisms
Strategy 1: Establish a Clear Vision and Plan		
1.1 Engage leadership across child-serving agencies.	• Illinois Governor Pritzker brought together cross-agency partners for the Children's Behavioral Health Transformation Initiative. • New Jersey's seminal Children's Initiative Concept Paper established a blueprint for serving children with behavioral health needs and multi-system involvement. • Ohio Governor DeWine established a statewide planning process which led to the development of OhioRISE. • The National Governors Association convened 500 stakeholders to discuss the state of youth mental health, resulting in Strengthening Youth Mental Health: A Governor's Playbook.	• Use Medicaid administrative funding and Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funding for planning processes. • Leverage existing planning forums and stakeholder groups.
1.2. Engage youth and supportive families in the policymaking process.	• Ohio established an advisory council that includes youth and families as part of OhioRISE. • Oregon established an advisory council that includes youth, and provides all members with the same per diem reimbursement rate as members of the state's Legislative Assembly. • Youth MOVE is a national chapter-based organization that partners with policymakers to provide facilitation support and identify youth with lived experience.	• Use Medicaid administrative dollars to support youth and family engagement. • Require managed care organizations to support advisory councils that include families and young people.
1.3. Leverage data on service utilization, payment rates, workforce and other key issues.	• Ohio reviewed rate assumptions for evidence-based services and adjusted reimbursement rates. • Oregon compiles data from child-serving agencies in a data dashboard to monitor progress on key metrics. • The Center for Health Care Strategies produced Examining Children's Behavioral Health Service Utilization and Expenditures: A Toolkit for States to help states evaluate utilization of key services.	• Gather data on demographic characteristics and service utilization. • Increase reimbursement for evidence-based practices or for providers treating populations with complex needs.
1.4. Include a robust implementation, monitoring and oversight strategy.	• Ohio adopted quality metrics to evaluate the effectiveness of OhioRISE.	• Require reporting on key quality measures. • Use incentive payments or withhold arrangements for managed care plans to meet specific contract goals.

Strategy	State Examples and Resources	Mechanisms
Strategy 2: Expand and Stabilize Medicaid Eligibility and Benefits for Children and Youth Living With Complex Behavioral Health Needs		
2.1. Expand continuous eligibility for young people with complex behavioral health needs beyond minimum federal requirements.	• Massachusetts has a Section 1115 demonstration to provide two years of continuous coverage for children and youth who are leaving incarceration or who have unstable housing. • Oregon is expanding Medicaid for young adults up to age 26 if they have significant behavioral health needs. • Washington has a Section 1115 demonstration to provide continuous coverage up to age 6 for **all** Medicaid and CHIP children.	• Use Section 1115 demonstrations to extend continuous eligibility.
2.2. Strengthen coverage for former foster youth.	• Arizona is seeking a Section 1115 demonstration amendment to eliminate the requirement that former foster youth document that they have applied for benefits from other programs to retain coverage. • 11 states have Section 1115 demonstrations to cover former foster youth from all states.	• Use Section 1115 demonstrations to strengthen coverage for former foster youth.
2.3. Leverage Medicaid to reduce pressure on families to relinquish custody.	• 9 states have HCBS waivers to expand Medicaid eligibility for children and youth with serious emotional disturbance. • The National Technical Assistance Network for Children's Behavioral Health prepared a presentation for SAMHSA with current findings and strategies to address relinquishment.	• Use HCBS waivers to expand eligibility for young people with complex needs.
2.4. Expand eligibility and coverage for youth involved in the juvenile justice system.	• The SUPPORT ACT prohibits states from terminating Medicaid eligibility during incarceration for an individual under age 21.	• Take up the state option to claim Medicaid/CHIP reimbursement for services provided to youth in carceral settings pending disposition of charges.
2.5. Provide behavioral health services consistent with EPSDT to children in separate CHIP programs.	• Washington extends all Medicaid services, including EPSDT, to children enrolled in its separate CHIP program. • The SUPPORT ACT requires states to cover necessary mental health and SUD services in separate CHIP programs.	• Convert separate CHIP programs to CHIP-financed Medicaid expansion. • Establish EPSDT as the benefit standard in separate CHIP programs.

Strategy	State Examples and Resources	Mechanisms
Strategy 3: Strengthen Prevention and Early Intervention in Treatment		
3.1. Increase take-up of behavioral health screenings.	• Massachusetts requires screening children and youth for behavioral health issues at well-child visits.	• Require the use of evidence-based behavioral health screening tools during well-child visits. • Increase reimbursement for behavioral health screenings.
3.2. Allow children and youth to receive behavioral health services under EPSDT without a diagnosis.	• California covers evaluation and therapy for children and youth without a behavioral health diagnosis. • Colorado does not require a behavioral health diagnosis for the provision of therapy in a primary care setting. • 15 states require or recommend use of the DC:0-5 system.	• Remove diagnosis requirements for youth to receive key behavioral health services. • Adopt the DC:0-5 system for diagnosing infants and young children.
3.3. Cover coordinated specialty care for young adults experiencing first episode psychosis.	• Washington adopted a bundled case rate for CSC for FEP.	• Use Medicaid state plan and waiver authorities to cover the full set of CSC for FEP services.
3.4. Promote integrated primary care.	• New York pays for Collaborative Care Model services for individuals aged 12 and over. • Texas provides free technical assistance to support implementation of the Collaborative Care Model.	• Cover interprofessional primary care consultations with behavioral health specialists. • Cover team-based, integrated models
3.5. Strengthen the use of school-based services.	• Arizona incentivizes behavioral health clinics that partner with schools. • Missouri allows schools to provide behavioral health services to Medicaid-enrolled students.	• Take up the free care option. • Increase reimbursement for behavioral health professionals employed by schools. • Implement CHIP HSIs to support school-age children.
Strategy 4: Establish a Comprehensive, Youth-Specific Continuum of Care for Behavioral Health Conditions		
4.1. Ensure crisis services address the unique needs of young people.	• Connecticut and New Jersey cover MRSS. • New York's START model provides 24/7 crisis response for individuals aged 6 and older with co-occurring I/DD and behavioral health needs. • Oklahoma has established a set of urgency recovery and crisis centers. • The MRSS Learning Collaborative brings together states to focus on the structural changes necessary to implement MRSS.	• Use Medicaid state plan authority to cover MRSS. • Braid Medicaid and other funding to establish urgent care and crisis centers.

Strategy	State Examples and Resources	Mechanisms
4.2. Provide intensive home-based services.	• Massachusetts has a coordinated, intensive home-based service for youth and families in their home. • Ohio covers a coordinated, 24/7 intensive home-based service that includes evidence-based family therapies.	• Use Medicaid state plan authority to cover evidence-based, intensive home-based services that are centered on the needs of the child or youth.
4.3. Provide intensive care coordination to children and youth with multi-system involvement and/or co-occurring conditions.	• Georgia offers high-fidelity wraparound as part of its intensive customized care coordination service. • Illinois covers two tiers of care coordination—high-fidelity wraparound for children and youth with the most complex needs, and a more moderate level of intensive care coordination.	• Use Medicaid state plan authority to implement intensive care coordination using the high-fidelity wraparound model.
4.4. Offer respite services to families seeking to help their children remain in the community.	• North Carolina uses a 1915(i) waiver to provide in-home and out-of-home respite services for primary caregivers of children and youth with serious emotional disturbance or a SUD. • Ohio uses 1915(b)(3) authority to fund respite services for primary caregivers of children and youth enrolled in OhioRISE.	• Use 1915(b)(3), 1915(c) or 1915(i) authority to cover respite services for parents and caregivers.
4.5. Provide peer support services for youth and their families.	• Alabama uses Medicaid state plan authority to cover peer counseling services using both youth and parent peer specialists. • Georgia was the first of 40 states to cover peer support services under Medicaid. • New York works with family peer advocates to deliver family peer support services.	• Use Medicaid state plan authority to cover youth and family peer support services.
4.6. Address young people's health-related social needs.	• Arkansas has a CHIP HSI to provide child/youth and family support services, caregiver services, and other HRSNs. • Ohio's 1915(b)(3) waiver covers primary flex funds for children and youth in OhioRISE. • Oregon uses a Section 1115 demonstration to cover housing supports, food assistance, and protection from climate events for children and youth in child welfare and young people with significant behavioral health needs. • Wisconsin has a CHIP HSI to provide housing support for low-income families with children under age 19.	• Use Section 1115 demonstrations, 1915(c) waivers, or 1915(b)(3) waivers to cover HRSN services for young people. • Use CHIP HSIs to address HRSNs of children and youth up to age 19.
4.7. Strengthen the quality of care in residential treatment settings.	• New Jersey adopted extensive reforms to ensure short-term residential treatment is used only when necessary. • Washington passed legislation to ensure no youth is discharged into homelessness.	• Enhance admission, treatment and discharge policies in residential treatment settings. • Offer technical assistance to residential treatment facilities on their discharge policies.

Strategy	State Examples and Resources	Mechanisms
Strategy 5: Ensure Use of Evidence-Based, Community-Defined and Culturally Responsive Assessments and Practices		
5.1. Utilize standardized tools to help determine the appropriate services for young people.	• California conducted a stakeholder process to develop statewide screening and transition tools to determine which delivery system is most appropriate for each child or youth. • New Jersey requires use of the CANS assessment in its system of care.	• Require use of a standardized, evidence-based assessment tool.
5.2. Invest in a culturally diverse behavioral health workforce.	• Massachusetts's Section 1115 demonstration includes loan repayment funding and residency grants to strengthen the behavioral health workforce. • New Hampshire has a Section 1115 demonstration that includes workforce development initiatives. • New Jersey allows licensed clinical social workers to bill independently.	• Cover services delivered by peers, community health workers, and other behavioral health practitioners. • Use Section 1115 demonstrations to invest in the behavioral health workforce.
5.3. Provide training and support to providers.	• New Jersey established a System of Care Training and Technical Assistance program at Rutgers University. • Ohio contracted with Case Western University to establish the Child and Adolescent Behavioral Health Center of Excellence. • Oklahoma's Training Institute provides training to state partners, providers, and community members.	• Establish Centers of Excellence for youth behavioral health. • Fund training for providers, state agencies, and members of the community.
5.4. Use Medicaid reimbursement strategies to increase access and linguistically and culturally appropriate care.	• Missouri and Oklahoma are increasing Medicaid provider rates to be more in line with Medicare rates. • Montana is amending its HCBS waiver to increase rates for providers. • Oregon requires managed care organizations to pay higher rates to behavioral health providers.	• Incentivize use of providers that offer culturally and linguistically relevant services. • Increase reimbursement for evidence-based practices.

Strategy	State Examples and Resources	Mechanisms
Strategy 6: Address the Emergency Department Boarding Crisis		
6.1. Gather and analyze data on youth boarding in emergency departments.	• Massachusetts convened a task force to review data on emergency department boarding and develop policies to address the issue.	• Conduct a data-driven assessment of youth boarding in emergency departments.
6.2. Prioritize diversion through crisis services and family education.	• Oklahoma educates families about how to handle behavioral health crises.	• Develop training and resources for families and caretakers on how to handle crises.
6.3. Permit community-based admission to inpatient facilities.	• Oklahoma authorized its mobile crisis teams to initiate admission to a psychiatric hospital.	• Ensure families are not required to go through the emergency department before securing inpatient treatment.
6.4. Encourage active treatment during stays in the emergency department.	• New Hampshire requires plans to cover mental health services when a member is boarding.	• Require managed care organizations to cover key behavioral health services delivered in the emergency department. • Encourage emergency departments to use the HRSA Pediatric Mental Health Care Access program.
6.5. Establish bed-tracking tools and systems to identify open treatment spots.	• Massachusetts established a bed registry to track availability of youth and family services.	• Establish a bed-tracking tool to move children and youth into appropriate treatment.

Appendix 2

Below, find in-depth reviews of three states—Ohio, Oklahoma, and New Jersey—that are among those implementing comprehensive systems of care to improve youth behavioral health outcomes. These case studies are not intended to suggest that the three states are models across all policies and programs directed toward children and youth. However, they demonstrate a coordinated, cross-agency response to reach children and youth with complex needs, and they are implementing many of the promising strategies discussed in this paper.

Case Study 1: Ohio

In July 2022, Ohio launched the Resilience through Integrated Systems and Excellence Plan (OhioRISE), a specialized Medicaid managed care plan for children and youth with complex behavioral health and multisystem needs. It serves children and youth between the ages of 0 and 20 who are Medicaid-eligible and living with significant behavioral health needs, generally as determined by a Child and Adolescent Needs and Strengths assessment. The initiative represents a coordinated effort to prevent children and youth with significant behavioral health needs from having to navigate multiple different and uncoordinated systems and to help them avoid custody relinquishment.[161,162] It grew out of a statewide, systematic planning process launched by Governor Mike DeWine in 2019. The process involved creation of an advisory council and workgroups to offer advice on program design, provide clinical insight, and review rule development and changes. Advisory Council members included youth and families with lived experience, service providers, and other system partners.

While still in the initial stages of implementation, OhioRISE is charged with expanding community-based care options for children and youth with complex behavioral health needs or multisystem involvement, providing localized care coordination through 18 care management entities, and administering expanded behavioral health services.[163] These include intensive and moderate care coordination, intensive home-based treatment, behavioral health services, 1915(c)-covered out-of-home respite services, primary and secondary 1915(c)-covered flex funds to support a youth's individualized needs, 1915(c)-covered transitional services and supports, and new MRSS as a specialized child and youth crisis service.[164]

Ohio used Section 1915(b)(3) waiver authority to secure Medicaid funding for the respite services, which are available on an emergency or a planned basis to families and caretakers of children throughout the state. The state used this same authority to finance "primary flex funds"—up to $1,500 per year per eligible child or youth—that can be used for services, equipment, or supplies not otherwise covered by Medicaid that help the child or youth participate fully in their community.[165] For example, they could be used to buy athletic shoes or a uniform to allow a child to be on a sports team or for art or music lessons. Ohio's "secondary flex funds" may be used for similar activities after primary flex funds are exhausted.[166]

Along with establishing a new delivery system and enhanced benefits, Ohio funded a Child and Adolescent Behavioral Health Center of Excellence to support providers in delivering more effective care. The center provides technical assistance, training, professional development, coaching, consultation, evaluation, fidelity monitoring, and continuous quality improvement to build and sustain capacity in delivering evidence-based practices.

Case Study 2: Oklahoma

Oklahoma's behavioral health treatment system for children and youth with behavioral health needs centers on a community-based, trauma-informed, culturally responsive, youth-guided, and family-driven approach. Oklahoma established a SOC model to serve as a statewide collaborative, county-based coalition for members of local communities, organizations, agencies, facilities, and groups to identify systemic issues and provide services to children, youth, and young adults. The network provides physical and behavioral health services, school-based and vocational services, and other wraparound and coordinated services to meet health-related social needs.

The state's early improvements to its behavioral health services array involved expanding and integrating peer and family support services. Children, youth, and families receiving wraparound services are paired with a family support partner. Family support providers available across the state through local community mental health centers help families navigate the system with their child. They also help families prepare for residential and inpatient treatment when necessary. As part of their work to help families identify formal and informal supports needed to promote stabilization, the wraparound team can use flex funds for purchases such as exercise classes, tickets to cultural events, and respite care.

The state's children and youth behavioral health crisis continuum has also been steadily growing. It includes mobile crisis, an expanding number of family-style urgent care centers, residential crisis centers, and calm centers. Calm centers provide assessment and stabilization for an emotional, behavioral, or SUD issue at all times for children and youth between the ages of 10 and 17. During a brief stay, children and youth receive assessment and diagnosis and receive individual, group, and family therapy to help identify trauma and explore strengths to deal with issues, and life management skills to prevent future crises. Services also include medically supervised detox, medication management, and after-care coordination. Peers and bachelor's degree–level staff act as first responders when a crisis arises, and they can access a licensed clinician as needed.

The state develops and directly provides ongoing training to providers, community organizations, and families, consistent with the state's emphasis on person- and family-driven, high-quality, community-based services. As part of the state's comprehensive crisis response strategy, Oklahoma law enforcement, schools, faith-based entities, and other local groups are on crisis response. The state also educates families about how to handle crises, including when to contact a mobile crisis unit, when to go to an urgent care center, or when to visit an emergency department.[167] Much of the family education is often done by family peer specialists, who can provide reassurance and insight about how to handle a crisis based on their lived experience. The state also has developed a comprehensive "Family Field Guide" to connect families to mental health and other resources, potentially averting the need for higher levels of care.[168]

The Oklahoma Training Institute provides mental health and SUD training to state partners, providers, and community members.[169] It provides both instructor-led and on-demand courses and conferences on topics such as cognitive behavioral therapy for children and adolescents, person-centered planning, and child and adolescent trauma screening.[170]

Case Study 3: New Jersey

Over the past 20 years, New Jersey has transformed and improved its behavioral health treatment system for complex children and youth. A growing recognition that an overreliance on psychiatric hospital beds caused by a lack of community-based services and supports was overburdening the state's system of care spurred the state to action. First, the state developed a concept paper with input from families and community stakeholders that laid out a vision for the state's system of care for children and youth with complex behavioral health needs, regardless of coverage status.[171] It started by detailing the challenges of the current system across the siloed child welfare, juvenile justice, mental health, education, and court systems and then set forth a vision for where the state wanted to go. The concept paper outlined a plan, which the state then implemented by:

- Developing family-run community support organizations to bolster family participation and engagement in care planning and system improvements;
- Establishing community-based nonprofit care management organizations (CMOs) to support children and youth requiring the most intensive services;
- Establishing and using standardized screening and assessment tools to guide a single point of access into the behavioral health system;
- Developing and/or expanding community-based behavioral health services, including through mobile crisis services and intensive home-based services;
- Creating a responsive accountability approach closely overseen by the state at each level throughout the system of care;
- Providing free training and technical support to provider organizations, direct care staff, and parents and caretakers using a Center of Excellence operated by Rutgers University; and
- Increasing the level of funding available to support the reformed system (e.g., by adding new services and updating the reimbursement rates for providers).

Consistent with the concept paper, the state created one statewide system of care and 15 local systems throughout the state. It contracts with a single agency, PerformCare, that acts as the "front door" to the system of care for children and youth with complex needs, regardless of insurance status. PerformCare operates a call line, provides utilization management for all levels of care, and manages the electronic health records and data collection. Depending on the child's or youth's need, PerformCare deploys an MRSS team to respond to a crisis or a CMO that provides high-fidelity wraparound services, after which the team will follow the child or youth for up to eight weeks. For children and youth requiring more intensive care coordination

and supports, mobile crisis teams connect them to a CMO and the system of care. MRSS teams do not respond to help a child or youth who is already engaged with a CMO. Rather, the CMO operates its own crisis response with a person on call to respond.

If a child or youth requires intensive care coordination, the local CMO helps develop the child and family team to facilitate the sharing of resources and to maintain conversations around intensity of care in partnership with the local family resource center. The CMO stays with the child/family throughout the placement process and all levels of care, including residential. If a child or youth needs a residential level of care, the CMO makes a referral that PerformCare reviews and authorizes.

If residential treatment is clinically necessary, the child or youth and their family choose from among residential providers included in the system of care. As part of its system redesign, New Jersey created smaller residential facilities throughout the state to ensure that every community has access to integrated residential facilities and that discharge proceeds as smoothly as possible. Once the child and family team applies to a residential treatment provider, the provider cannot deny care. If a child or youth requires a higher level of care, the residential facility can ask to discharge the individual and transfer their care to the state. To support the transition process, residential providers are also Medicaid-licensed, home-based providers that can provide intensive home-based services when needed to children, youth, and their families upon discharge.

Medicaid finances most of New Jersey's SOC. To maximize coverage for children and youth with complex behavioral health needs, the state obtained an eligibility expansion for children with severe emotional disturbance through a Section 1115 demonstration. In addition to Medicaid funding, the state distributes flex funding using state funds to provide additional support to children and youth.

Appendix 3

The framework and strategies described in this report were informed by a series of meetings with a National Advisory Committee and a Youth Advisory Committee, along with interviews with other experts and state policymakers.

National Advisory Committee

- Eric Bruns, National Wraparound Initiative
- Lynda Gargan, National Federation of Families
- Brooks Keeshin, University of Utah
- Kim Lewis, National Health Law Program
- Dr. Ron-Li Liaw, Children's Hospital Colorado
- Elizabeth Manley, University of Connecticut School of Social Work
- Joan Mikula, Massachusetts Department of Mental Health
- Deborah Ogles, Medicaid Expert
- Maegan Rides at the Door, National Native Children's Trauma Center
- Arc Telos Saint Amour (Tay), Youth MOVE National
- Bryan Samuels, University of Chicago Chapin Hall Center for Children
- Dr. Sala Webb, Aetna
- Marisa Weisel, Ohio Department of Medicaid

Youth Advisory Committee

- Mialissa F. (22)
- Daniel B. (27)
- Monica E. (25)
- Lania W. (22)
- Mariah C. (23)
- Ayshah (22)
- Kris L. (29)
- Fern A. (18)
- Ajah Y. (18)
- Heaven B. (21)

Other Interviewees

- Sheila Pires, Human Service Collaborative
- Zach Laris, American Academy of Pediatrics
- Traci Donnelly, The Child Center of New York
- Jesse Noonan and Sarah Fathallah, Think of Us
- Sheamekah Williams, Oklahoma Department of Mental Health and Substance Abuse Services
- Michael Milham, Child Mind Institute

Appendix 4

Key Data on Children and Youth Living With Complex Behavioral Health Needs

Across the board, young people are living with high rates of mental health issues and SUDs, and the rates are higher for children of color and those who are LGBTQIA+, low-income, and/or involved in the child welfare or juvenile justice system. It is estimated that 1 of every 10 children between the ages of 3 and 17 has a diagnosis of anxiety (9.4%) or behavior problems (8.9%).[172] In addition, an estimated 30% of young adults aged 18 to 25 are living with a mental illness.[173]

- **Income.** More than 1 in 5 (22%) children in poverty is living with a mental, behavioral, or developmental disorder.[174]
- **Race and ethnicity.** Children who have been discriminated against based on race or ethnicity are significantly more likely to have one or more mental health conditions.[175] In addition, compared to white children, children of color are less likely to receive mental health care or to access school-based mental health services.[176]
- **LGBTQIA+.** Nearly three-quarters (73%) of LGBTQIA+ youth aged 13 to 24 experienced symptoms of anxiety, and more than two-thirds (67%) reported a depressive disorder in a 2020 survey. In 2021, almost half (45%) of lesbian, gay, or bisexual youth reported they had seriously considered suicide, three times the rate of other students (15%).[177]
- **I/DD.** Between 30% and 50% of children and adolescents with I/DDs have co-occurring mental disorders compared to 8%–18% of youth in other groups.
- **Child welfare system.** As many as 8 of every 10 children in the foster care system are living with a mental health condition.[178] Children in foster care and youth aging out of foster care are significantly more likely to have experienced multiple adverse childhood events and to have a history of complex trauma.[179]
- **Juvenile justice system.** Nationally, 7 of every 10 youth between the ages of 13 and 18 involved in the juvenile justice system have a mental illness, compared to 2 in 10 youth in the general population.[180] These youth have high rates of comorbidity, including high rates of polysubstance use disorder.[181] The prevalence of psychiatric disorders increases with further justice system involvement (e.g., detention or placement).[182]

Recent Federal Action to Address the Behavioral Health Crisis Among Children and Youth

In response to the behavioral health crisis among children and youth, the federal government has taken a number of steps to respond:

- **National Recognition of the Youth Behavioral Health Crisis.**
  - In 2021, U.S. Surgeon General Vivek Murthy issued a public health advisory calling on the nation to respond to the growing youth mental health crisis worsened by the COVID-19 pandemic. The public health advisory echoed the October 2021 declaration of a National Emergency in Child and Adolescent Mental Health from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association, and a follow-up letter in October 2022 to the Biden Administration to issue a National Emergency Declaration on children's mental health.
  - In 2022, CMS issued an Informational Bulletin reiterating the federal requirements for the EPSDT benefit, including all screenings and medically necessary treatment for children and youth living with behavioral health conditions.
- **Increased Mental Health and Substance Abuse Block Grant Funding.**
  - In 2021, the American Rescue Plan allocated $1.5 billion each for a Mental Health Block Grant and a Substance Abuse Prevention and Treatment Block Grant to states to improve community-based mental health and SUD services for children and adults. The funds can be used for activities such as developing a comprehensive crisis continuum for children, supporting school-based services, and addressing adverse childhood experiences to help avert substance misuse. However, it is worth noting that block grants, in general, have a history of misallocation in certain states.
  - In March 2022, the U.S. Department of Health and Human Services (HHS) announced nearly $35 million in funding opportunities funded by the American Rescue Plan and other sources to strengthen and expand community mental health services and suicide prevention programs for children and young adults. Opportunities include the Statewide Family Network Program to support families and caregivers and the System of Care Expansion and Sustainability Grants to improve mental health outcomes for children and youth living with serious emotional disabilities.
- **Focus on School-Based Services.**
  - In July 2022, the Department of Education (DOE) and HHS issued a joint letter to state governors encouraging partnerships at state and local levels and outlining resources to support youth living with behavioral health conditions.
  - The Bipartisan Safer Communities Act of 2022 commits more than $1 billion over five years to support schools in addressing youth behavioral health needs, including funding for the school mental health workforce. The law also directs the HHS and DOE to create a technical assistance center to help states and schools better use Medicaid dollars for school-based services.

  - The School-Based Mental Health Services grant program provides competitive grants to state and local educational agencies to increase the number of credentialed mental health services providers working in schools.
  - In May 2023, the DOE and HHS released three strategies to improve access to mental health services for students.
- **New Opportunities to Support Individuals Experiencing a Behavioral Health Crisis.**
  - On July 16, 2020, the Federal Communications Commission adopted rules to establish 988 as the nationwide, easy-to-remember three-digit dialing code for people in crisis to connect with suicide prevention and mental health crisis counselors, which was implemented in July 2022.
  - In the American Rescue Plan, Congress created an option for states to establish qualifying community-based mobile crisis intervention services and to receive enhanced matching funds for doing so.
- **New Behavioral Health Supports for Justice-Involved Youth and Youth Involved in Child Welfare.**
  - Under the Consolidated Appropriations Act passed in December 2022, state Medicaid and CHIP programs are required to provide screenings and diagnostic services, including behavioral health screenings and diagnostic services, to eligible juvenile youth in public institutions. States also have a new option to provide full Medicaid and CHIP benefits to juvenile youth in public institutions during the initial period, pending disposition of charges.
  - In February 2018, the Family First Prevention Services Act was signed into law as part of the Bipartisan Budget Act of 2018, which provides families with greater access to evidence-based mental health services, SUD treatment, and parenting skills services such as home visits, to increase the number of children in the child welfare system who can remain safely at home with their families.

Medicaid and CHIP Eligibility Pathways for Children and Youth Living With Behavioral Health Conditions

- **Mandatory Medicaid Eligibility for Children Under Age 19.** Many states set a higher income limit than the federal minimum, the highest being 324% of the federal poverty level (FPL) in Washington, D.C. ($97,200 for a family of four in 2023). States are required to provide Medicaid coverage for children aged 0–18 whose household income is no more than 133% of the FPL ($39,900 for a family of four in 2023).
- **CHIP Eligibility.** Title XXI of the Social Security Act authorizes CHIP, which provides health coverage to eligible children whose families earn too much to qualify for Medicaid. Eligibility levels for CHIP programs are as high as 405% of the FPL in New York State ($59,049 for an individual in 2023).
- **Current Foster Care Children Title IV-E Eligibility.** Children who are in the publicly funded foster care system (i.e., children and youth for whom Title IV-E foster care or guardianship assistance payments are made or who are subject to a Title IV-E adoption assistance agreement) are automatically eligible for Medicaid.

- **Former Foster Care Children Group Eligibility.** States are required to cover youth who were enrolled in Medicaid when they aged out of foster care—regardless of their income or assets—until age 26, via the Former Foster Care Children (FFCC) Group eligibility pathway. In addition, effective January 2023, states are required to cover youth under the FFCC Group who were enrolled in Medicaid **in any state**. Additionally, children who are adopted out of the foster care system are made eligible for Medicaid (as part of the adoption subsidy or agreement). States also have the option to make youth eligible for the FFCC Group if they were enrolled in Medicaid **at any point** during their period in foster care from which they aged out.[183]
- **Eligibility for Incarcerated Youth.** States are prohibited from terminating Medicaid eligibility for an individual under 21 or a former foster youth up to age 26 during their incarceration and instead are required to redetermine and, if applicable, restore Medicaid enrollment prior to their release from incarceration.[184] By January 2025, Medicaid and CHIP programs will also be required to provide certain screenings and diagnostic services, including those for behavioral health, in the 30 days or one week prior to a young person's release from incarceration.[185] State Medicaid and CHIP programs must also provide targeted case management to juvenile youth in the 30 days preceding or following their release. In addition, states were given the option to claim Medicaid and CHIP reimbursement for all services—not just screening, diagnostic services, and targeted case management—provided to youth in carceral settings pending disposition of charges, starting in January 2025.

Extended Eligibility Through Home and Community-Based Services Waivers.[186] At their option, states can use home- and community-based services waivers to expand Medicaid eligibility requirements and cover children living with severe emotional disturbance. Expanded eligibility may be based on the child's own income and assets, which are typically negligible, and may include children and youth who have private coverage through a parent's employer.

Appendix 5

Medicaid and CHIP Authorities Used for Behavioral Health and Health-Related Social Needs

Description	Potential Uses	Considerations and Limitations	Examples
1905(a) State Plan: Rehabilitation Services			
1905(a)(13) allows states to cover "any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level" (i.e., "rehabilitative services").	• Rehabilitative services can be used for a wide array of behavioral health services, including outpatient therapy, intensive outpatient therapy, peer and family support, and psychosocial rehabilitation.	• Services provided under Section 1905(a) must be provided on a statewide basis to all eligible individuals unless a state secures a waiver of statewideness and comparability. • EPSDT requires that any service that can be provided under Section 1905(1)(13) must be provided to an individual under age 21 when medically necessary. • States need only file and secure approval of a state plan amendment to provide rehabilitative services. • Many of the services that are most important to children and youth with complex behavioral health conditions have not yet been approved as coverable under 1905(a)(13) (e.g., flexible funds, respite services for parents and/or caretakers).	• **New Jersey** and **Connecticut** use state plan authority to operate tailored crisis services using the MRSS model for children and youth. • Forty states cover peer support services as a state plan service; **Alabama** and **New York**, among others, use family and parent peer partners under this benefit.

Description	Potential Uses	Considerations and Limitations	Examples
1915(g)(2) State Plan: Targeted Case Management			
1915(g)(1-2) allows states to cover "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services." Targeted case management services for a designated group of Medicaid enrollees, including those with mental illness, must include assessment, care plan development and monitoring activities.	• Targeted case management services can be used to authorize intensive care coordination, including high fidelity wraparound, for children and youth with behavioral health needs.	• Targeted case management services does not need to be provided on a statewide basis. • States need only file and secure approval of a state plan amendment to provide targeted case management. • Federal Targeted case management requirements are more flexible than health home requirements. • The state plan amendment for targeted case management follows a pre-set template ("pre-print") that includes a highly prescriptive service description, including the following elements: – Comprehensive assessment and periodic reassessment of individual needs – Development (and periodic revision) of a specific care plan – Referral and related activities – Monitoring and follow-up activities • The state plan amendment must specify the: – Target group – Areas of the state in which services will be provided – Case management provider agency and case manager qualifications (amongst whom members would have to have freedom of choice) – Other certifications (freedom of choice; access to services; payments; other limitations)	• **Massachusetts** covers intensive care coordination using the wraparound model for youth with serious emotional disturbance who are under the age of 21 under a targeted case management state plan amendment.

Description	Potential Uses	Considerations and Limitations	Examples
Section 1115 Demonstration			
Under Section 1115 of the Social Security Act, the Secretary of HHS can permit states to use federal Medicaid funds in ways that are not otherwise allowed under the federal rules as long as the Secretary determines that the initiative is an "experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives of the program." Section 1115 demonstrations can be used to make broad changes in Medicaid eligibility, benefits, and cost-sharing, and/or provider payments. In some instances, they also can be used to fund infrastructure investments in the systems and providers that serve Medicaid beneficiaries.	• Provide continuous coverage over a multiyear period for children and youth with complex behavioral health needs. • Offer housing services and services for other HRSNs for young people at risk of housing insecurity or who are leaving the child welfare system or an institutional setting (e.g., residential treatment). • Fund investments in the behavioral health workforce.	• Demonstrations are designed to experiment with new ideas and are time-limited (though they can be renewed). • Must be "budget neutral" to the federal government, i.e., they cannot cost more than a state otherwise would have spent on its Medicaid program in the absence of the demonstration. • Complex rules govern budget neutrality calculations in any scenario, particularly if a state wants to experiment with paying for housing and other HRSNs. • CMS has established specific requirements for states that use demonstrations to finance housing and other HRSNs. These include, but are not limited to, obligations to ensure adequate reimbursement rates for primary care, behavioral health, and obstetrics services; caps on the funds available for HRSNs; and requirements that Medicaid not displace states' expenditures on social services. • It can be a time-consuming process to negotiate a Medicaid demonstration.	• **Arizona** and **Oregon** are providing housing and other social services to children and youth leaving institutional care or juvenile detention centers (among other populations). • **Oregon** provides an enhanced set of benefits to populations with complex needs, including youth leaving foster care and young adults with significant mental health and SUDs up to age 26 with income levels up to 300% of the federal poverty level. • **Massachusetts** secured Medicaid matching funds for investments in its primary care and behavioral health workforce. • **Oregon** and **Washington** provide continuous coverage for children up to the age of 6.

Description	Potential Uses	Considerations and Limitations	Examples
Managed Care: 1915(b)(3) Flexibility[187]			
Section 1915(b) of the Social Security Act allows states to establish mandatory Medicaid managed care programs. Under 1915(b)(3), states can use savings generated from managed care to provide additional services to Medicaid enrollees.	States can use 1915(b)(3) to provide a wide array of flexible services that are important to children, youth, and young adults with complex behavioral health needs, including: • Flexible funding dollars to support participation in community and school-based activities • Housing, food, and other HRSNs • Supported employment and supported education • Respite care for caregivers	• Only available to states that operate mandatory managed care programs and that do so via 1915(b) authority. • The dollar amount available is limited to savings derived from mandatory managed care. • Many other populations also can benefit from additional services financed through 1915(b)(3), creating significant demand for limited funds.	**Ohio** uses 1915(b)(3) authority to cover both respite care for parents and caretakers of children and youth living with complex behavioral health needs, as well as for "flex funds" that can be used for school and community-based activities.
Home- and Community-Based Services: 1915(c) Waiver			
Section 1915(c) of the Social Security Act allows states to provide home- and community-based services to individuals who would require an institutional level of care in the absence of the services. The services can be targeted to groups of individuals based on age, condition, and geography. For purposes of 1915(c) waivers, Medicaid's statewideness and comparability requirements do not apply. When evaluating eligibility for an HCBS waiver, states can disregard parental income.	• Extend coverage for intensive behavioral health services to children and youth who are above other Medicaid income eligibility limits, providing coverage to children and youth who are underinsured or whose families might otherwise need to relinquish custody to secure Medicaid coverage for them as long as they meet the institutional level of care. • Respite care for caregivers. • Supported employment and supported education. • Housing support services, such as help finding housing and remaining in housing. • Nonmedical transportation. • Family supports and training. • Environmental modifications.	• HCBS waivers are approved initially for a three-year period, and then must be renewed every five years. • States must demonstrate that they spend no more on HCBS services for the target population than they would have spent on institutional care. • States must meet beneficiary protection requirements and ensure an adequate set of providers. • States can limit the number of "slots" available for any given home- and community-based waiver. • Must have conflict-free case management, which can limit team-based care and be a challenge in rural states. • States also must meet specified standards for eligibility, assessments, case management, and quality requirements.	**Maryland** uses a 1915(c) home- and community-based waiver to provide the following: • Family peer support. • Intensive home-based services. • Respite care. • Adjunctive therapies such as art and music therapy.

Description	Potential Uses	Considerations and Limitations	Examples
1915(i) State Plan Amendment			
States can use 1915(i) to provide services to specific groups of individuals with incomes up to 150% of the federal poverty line who require intensive home-based care, including children and youth with major behavioral health needs. States can use a state plan to provide services through 1915(i)—no waiver is required—and to provide services to children and youth with significant impairments even if they would not otherwise require institutional care. However, they cannot limit enrollment or disregard Medicaid's statewideness requirement.	Same as available under 1915(c).	• States can use a State Plan Amendment to implement 1915(i), though they must reapply every five years. • There are no numerical limits on the number of people served through this authority. • The target population can be broader for a 1915(i) than 1915(c), because the population served need not meet the institutional level of care. • States must use independent, unbiased assessment processes to establish eligibility for services, set provider standards, use person-centered service plans, and implement a quality strategy. • States must extend 1915(i) services on a statewide basis, though they can be targeted based on age, condition, and level of care requirements. • Must have conflict-free case management, which can limit team-based care and be a challenge in rural states.	**Illinois** uses 1915(i) authority to provide community-based supports to children and youth under age 21 with a severe emotional disturbance, including: • Care coordination and support. • Family peer support. • Intensive home-based services. • Respite. • Therapeutic mentoring. • Therapeutic support services. • Individual support. • Supported employment.* • Housing supports.* *Additional eligibility criteria apply.
Other			
States also can use a range of additional Medicaid tools not covered in depth in this report, including establishing fee schedules for behavioral health services; requiring plans to make directed payments to providers meeting specified conditions (e.g., delivering culturally and linguistically appropriate care); using certified community behavioral health centers to provide integrated outpatient, care coordination, crisis, psychiatric rehabilitation and peers services for children and youth complex behavioral health needs; using case rates to promote quality of care and coordination across state agencies; directing managed care plans to invest a share of their profits in HRSN; and, deploying value-added services and/or in-lieu-of services to promote greater coverage of services required by children and youth with complex behavioral health needs.			

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[2] In this report "family" signifies the trusted adults in a young person's life as defined by the young person themself. In most instances, this will be the young person's biological or adoptive parents, but it also might be other relatives or trusted adults in the young person's life. For example, a young person subject to abuse or rejected by their biological parents may define their family as the grandparent who took them in.

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[6] "2023 U.S. National Survey on the Mental Health of LGBTQ Young People." The Trevor Project. Accessed July 31, 2023. https://www.thetrevorproject.org/survey-2023/.

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[13] Ibid.

[14] Perkins, Jane. "Medicaid EPSDT Litigation Trends." National Health Law Program, October 14, 2018. https://healthlaw.org/resource/medicaid-epsdt-litigation-trends/.

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